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The topic of family presence with patients undergoing emergency lifesaving measures such as cardiopulmonary resuscitation and invasive procedures has been a controversial one since the mid-1990s. Supporters of the practice, simply known as family presence (FP), claim that family members should be allowed to stay with the patient when possible to minimize the trauma they feel if the patient does not survive. They also contend that families who are present say they are able to have some control over how their loved one is treated. Opponents of FP claim that such visitation could compromise patient care if the family members were physically in the way or if they distract the health care team from its task. cover

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An elderly woman, hospitalized with a chronic medical condition, refuses to consent to a surgical procedure her physician believes is necessary to treat her illness and doesn't offer a reason. After speaking with the patient, the physician calls the hospital chaplain, also the co-chair of the ethics committee, and asks her to speak to the woman. Hospital chaplains have specialized education and training that uniquely prepare them to help providers and patients address the complex emotional, spiritual, and psychological aspects that go hand in hand with the provision of clinical care in the hospital setting. 28

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Study: Patients supportive of family presence during lifesaving procedures

Hospital policies help providers in critical time

The topic of family presence with patients undergoing emergency lifesaving measures such as cardiopulmonary resuscitation (CPR) and invasive procedures has been a controversial one since the mid-1990s. At that time, a small group of emergency medicine and critical-care providers across the country began allowing family members to stay with patients during these events.

Supporters of the practice, simply known as family presence (FP), claim that family members should be allowed to stay with the patient when possible, to minimize the trauma they feel if the patient does not survive. Supporters also contend that families who are present say they are able to have some control over how their loved one is treated.

Opponents of FP claim that such visitation could compromise patient care if family members were physically in the way or if they distract the health care team from its task.

However, follow-up studies of patients, families, and providers experienced with allowing FP found those fears to be largely false. The majority of family members and providers who experience FP find it a positive experience.^{1,2}

For example, a study published in the May 2001 issue of the *American Journal of Nursing*,³ finds that patients who undergo lifesaving or invasive procedures also largely approve of FP, and say it is not only beneficial for families but for patients as well.

In the study, nine patients who had undergone emergency lifesaving procedures in the emergency department of Parkland Health and Hospital

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Telling patients about death is a hard lesson to learn

✓ *Make hospice a part of medical education*

Despite recent efforts to increase physician training in palliative care measures and improve access to hospice for terminally and chronically ill patients, many people still suffer needlessly at the end of life, experts contend. A key problem, they say, is that physicians still are uncomfortable making the determination that a patient's condition is not likely to improve and initiating a discussion about treatment alternatives. According to statistics compiled by the National Hospice and Palliative Care Organization, 33% of those served by hospice in the year 2000 died after receiving care for seven days or less. The average length of service was 48 days and the median length of service was 25 days 31

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System, a large, level-1 trauma center in Dallas, were interviewed approximately two months after the event. Eight patients had invasive procedures performed, and one had CPR. The subjects answered a series of questions designed to elicit how they felt about the presence of their family members.

Overall, several themes emerged: patients felt that their family members' presence comforted them; that it provided help; that it served to remind providers of the patient's "personhood"; it helped maintain patient-family connectedness; that family members were comforted and helped; and that patients felt that family presence was a right.

"This data are from the same study that we published in February of 2000, when we looked at provider and family responses,"¹ says **Diana Mason, RN**, editor-in-chief of the *American Journal of Nursing*. "At that time, no one had looked at the patient side and analyzed those responses. This is the first time that anyone has looked at anybody's responses to allowing family presence. And, I think it provides the important perspective that is very in favor of, in the patient's view, of having the family present."

Hospital policies needed?

An important piece of the two papers published out of the Dallas study is the inclusion of the hospital's policy on FP, which specifically delineates:

- situations in which FP is to be considered;
- who will be designated to remain with family members during the episode;
- how families will be "screened" to determine whether they will be allowed to remain in the room with the patient while the procedure is going on.

"The criteria that were set up for this study follow the protocol established by the Emergency Nurses Association; those criteria have to do with whether the family members seem like they are going to be able to emotionally handle it, or they are going to become hysterical, whether they are under the influence of any substance that might impair judgment, etc.," explains Mason.

Some providers have questioned whether it is ethical to screen family members without their knowledge in order to make a determination about whether they should be allowed to go back to the room with the patient, says **Dezra Eichhorn, RN**, lead author of the article.

Eichhorn is a former emergency department (ED) nurse now working as a nurse practitioner in Arkansas.

“Some people feel that it is an opportunity that should be offered across the board to everybody,” Eichhorn says. “I thought we were doing the right thing by assessing them and making sure they were OK. But, some have said that we are making the decision for them and assuming that they cannot handle a given situation. At that point in time, we felt it more important to err on the side of caution rather than have any problems occur.”

The criteria in place rule families out if they are extremely unstable or combative (not just upset) or under the influence of some type of substance, such as alcohol or drugs, she adds.

However, some ethicists have questioned the practice of making judgments about family members without informing them, says Mason. “It raises the issue of cultural bias in that determination, if the criteria are not explicit, and if you are not telling the family, ‘I need to make a decision about whether you can go in the room.’”

Changing hospital culture

At many hospitals, excluding family members from the rooms or bedsides of patients during emergency procedures is a common practice in the ED or intensive-care unit (ICU) — so common that attempts to bring family members in often meets with significant resistance, says **Theresa Meyers**, RN, a former nurse at Parkland, who currently works at Memorial Hospital in Colorado Springs, CO.

It took Meyers and fellow nurses at Parkland five years of research and advocacy to get a policy in place to allow family presence there, she says.

In 1994, Meyers brought the mother of a critically injured teen-age boy to his bedside in the ICU while CPR and other resuscitative measures were performed. Although the resuscitation was unsuccessful, the child’s parents were able to touch him and talk to him during the last moments of his life, an experience that the child’s mother later said helped her deal with her son’s death.

However, Meyers’ actions caused a stir among members of the medical staff and almost cost her job, she says.

At an institution that never before had FP, it might be beneficial to develop a concrete policy and get the buy-in of administration and physicians, she

SOURCES

- **Diana Mason** and **Thomas Schwarz**, *American Journal of Nursing*, 345 Hudson St., 16th Floor, New York, NY 10014.
- **Theresa Meyers**, 1400 E. Broad St., Colorado Springs, CO 80909.

says. “I am not saying I think you should only do this if you have a definite policy in place, because I think it needs to be done more often. But it is something to consider.”

The policy that was developed at Parkland was not necessarily to “defend” the practice, but to have it in black and white and provide it to anyone who questioned the practice, says Eichhorn.

“It shows that we had support, it was reviewed by a multidisciplinary team, and we got input from every department, from infection control to running it by the legal department,” she says. “A lot of times, the docs just think, ‘Well, you’re just going to rush in here with every family member,’ and it makes them nervous.”

Will a ‘right’ become an obligation?

One issue for ethics committees and providers to consider is how to ensure that family members who still don’t want to witness invasive procedures still feel comfortable saying no if they are offered the option.

“Is family presence a right, an obligation or a privilege?” asks Mason. “I think that’s an important issue to look at. In the original study, 13% of families still did not want to go into the room.”

Some advocates for FP compare the practice to that of allowing fathers into the delivery room to witness the birth of their children — a practice once considered taboo.

“But, we’ve seen the whole issue of fathers in the delivery room become an expectation,” continues Mason. “I know of a person at work who had a friend who did not want to go into the delivery room, but his family and friends were so appalled he felt that he had to.”

Meyers agrees that part of any approach to establishing FP as a hospital policy needs to include measures to support family members who do not wish to be present.

“The thing I always go back to is to look at it as an option,” she says. “I don’t think it is appropriate in every situation. But, we need to be able to raise the questions: ‘Is the family here? Do they

want to come in?' If they don't want to come in, the key is to not make them feel badly or guilty if they do not. You want to support them in that decision."

Remember the patient

It's also important not to forget the patients undergoing the procedure, adds **Thomas Schwarz**, RN, former ED nurse at Northern Dutchess Hospital in Rhinebeck, NY, and editorial director of the *American Journal of Nursing*.

In an editorial accompanying the May article, Schwarz expressed support for the research and policy developed at Parkland but reminded providers to consider consulting the patient (if the patient is conscious and able to respond) before approaching family members.

"I am an emergency room nurse with more than 25 years experience. But, more recently, I have also been the patient in several instances," Schwarz says. "And I have children. I know my children, and there are times when I can see that it would not be in anyone's best interest to have them in the room if I were that patient *in extremis*."

The Parkland policy is a wonderful resource for other providers, he adds. "And they emphasize asking the family and bringing together all of their resources to help the family cope with that situation. But don't forget the patient."

As much as he might want to say goodbye to his son or daughter or wife, he would not want their last vision of him to be traumatic, Schwarz says.

"If someone were to come to me as I lay on a stretcher and said, 'Your family is outside; do you want us to bring them in?' Depending on the situation, I might say no. I just hope someone asks me, as well." ■

Chaplains must understand self before helping patients

Individual analysis first step in offering support

An elderly woman, hospitalized with a chronic medical condition, refuses to consent to a surgical procedure her physician believes is necessary to treat her illness and doesn't offer a reason. After speaking with the patient, the physician

calls the hospital chaplain, also the co-chair of the ethics committee, and asks her to speak to the woman.

"I will go up and spend some time talking to her, eventually getting around to saying, 'I understand you don't want this surgery, could we talk about that a little bit?'" explains the Rev. **Martha Jacobs**, director of pastoral care at New York (NY) United Hospital, about her role as a member of the health care team. "It turns out she may be afraid of many things, fears about dying, about her children, lots of things they may not talk to their doctor about because they do not think the doctor will understand."

Addressing patient concerns

Jacobs is usually able to initiate a dialogue with such patients, eliciting their concerns and working with the patient to address them.

"I ask them, 'What do you think happens when you die? What are your concerns about your children? Let's talk about them. Let's get your children in here and talk about the fears that you have,'" she says. "I have the time to do that, which a lot of health care professionals don't have."

Jacobs and other hospital chaplains also have specialized education and training that uniquely prepares them to help providers and patients address the complex emotional, spiritual, and psychological aspects that go hand in hand with the provision of clinical care in the hospital setting.

"When someone trains to be a chaplain, they go through a program called clinical pastoral education (CPE). Part of what you do during that time is, not only do you see patients, but you sit with your peers and talk about different issues in your life and how they are affecting your ability to minister or not to minister," Jacobs says. "You have to look at what your own issues are: whether it is an issue about abortion, about a respirator being turned off, about euthanasia, you look at all of those things about yourself."

Extensive examination of situations that challenge their beliefs and standards ensures that chaplains are aware of their own biases and perspectives when such situations arise with individual patients and even caregivers, says the Rev. **Curtis Hart**, director of pastoral care and education at New York-Presbyterian Hospital and Weill Cornell Center in New York City.

"We had an experience at this institution with some staff who found it very hard to accept the reality of late-term abortions," Hart says, providing

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an example. "I was not involved in the counseling of the individuals. I was involved in the counseling of the staff involved — all of whom were, interestingly, 'lapsed' Catholics. They had been instilled with the values that all life is sacred and you do not do this. Yet, they are bound by their roles as professionals to uphold a person's autonomy."

His task was to help the clinicians resolve their own feelings and beliefs about the care that should be provided and to help them decide how they could balance those beliefs and respect the autonomy and differing beliefs of the patients, he adds. "Part of balancing the competing interests and goods and conflicting alternatives really has to do with our understanding of what our values are and what we are honestly uncomfortable advocating."

Maintaining trust

Chaplains, by virtue of their recognized religious status, are invested with a high level of trust by the public and by health care providers at their hospitals.

Maintaining this level of trust is a vital but difficult line to walk for most pastoral care providers, says Hart.

"In the pastoral relationship, if people don't have trust and people do not feel safe, they are never going to tell you what is really on their mind," he explains.

For many of the people she encounters —

patients, families, and providers — she represents "God's presence," whether she wants that role or not, Jacobs notes.

"One of the things I think chaplains face all the time is people saying to them, 'You have a closer connection to God,'" she continues. "I have to say back to them, 'No, I don't. I am no more perfect than you are.'"

At the same time, she senses that providers and patients feel that pastoral care providers' main function on ethics committees and in patient encounters is to "make sure things are done the right way," she says.

They are then much more willing to share their thoughts, beliefs, and fears about a particular situation.

"And, people know that as an ordained minister, what they tell me stays with me," she says. "And, many chaplains are willing to talk about difficult issues with patients — like death and dying — that many doctors are not willing to talk to patients about."

Talking about issues of faith

Many patients and providers have beliefs about a higher power, or about right and wrong that they want to see addressed by someone they feel knows what they are talking about, adds Hart, an Episcopal priest and certified professional chaplain.

This person does not necessarily have to share

their specific faith, he says. “Many times, providers want to know whether we will try to convert the person. No, but we can help each patient get their religious needs met, whether we are of that faith or not.”

Pastoral caregivers provide a link between patients and members of the clergy of that person’s faith, and can help the patient talk about their beliefs and feelings in order to help them determine what course of care would be consistent with their values, he says.

“These kinds of things happen when people are needing a great deal of emotional support, particularly in end-of-life issues,” he continues. “We often provide what I would call some helpful re-education about religious ethics and values.”

For example, a member of the pastoral staff at his hospital was recently asked to counsel a family of an elderly patient in the intensive care unit. The family was aware there was no apparent hope for significant improvement in the patient’s condition, let alone a cure, but they were conflicted about ceasing medical intervention, he says.

There had been no precise advance directive written, but the family members felt they knew the patient well, Hart says.

The pastoral care provider, in this case, a Roman Catholic nun, was able to help the family in a number of ways:

- first, by helping the family express their grief at the loss of a loved one;
- second, the family obtained clear communication from the hospital staff about the prognosis and any additional options for treatment;
- lastly, the family members discussed their views that the church had taught them to do everything possible to sustain life.

“While listening carefully and responding with respect to the family members expressing this belief, the pastoral care staff person shared that life is sacred in the eyes of God and the church, and that it is possible to provide support and comfort without extending life, and that this approach would seem appropriate and, in fact, a benefit,” Hart explains.

The relieved family eventually was able to accept comfort care measures as not only a medically reasonable choice, but a morally acceptable one as well, he says.

Resource for patients and clinicians

The role of the hospital chaplain is not just to counsel patients and families and work with

providers on individual patient issues, say both Hart and Jacobs. They also serve as a resource for providers and administrative staff as well.

“If I have a definite role here, it is to be a kind of sounding board for the staff. To have an atmosphere where people feel free to ask questions about different issues, and then to incorporate those values,” says Hart.

Jacobs is frequently called by physicians and administrators to help them “talk through” difficult situations, she says.

“I have had several doctors say, ‘Can you come talk to me about this patient?’” she explains. “Sometimes, it is just having someone else who knows what questions to ask. ‘What do you think? Do you think she will be safe if discharged home? Can we ensure her safety? If there’s a way, let’s try that. If there isn’t a way, maybe the family needs to talk about admitting the person to a nursing home.’”

Many times it is simply a matter of helping the caregiver understand that they have done all that they can do for a patient, she adds.

“Particularly in cases at the end of life, physicians often feel as though there should be something more to do, that there might be something they are just not thinking of,” she says. “Sometimes, my function is just sitting with that doctor and saying, ‘It really sounds like you’ve tried everything. I think you’ve done everything you can do.’”

Role in organizational ethics

Pastoral staff not only play a role in clinical ethical decision making, but also are starting to play a part in shaping a hospital’s organizational ethos as well, says Hart.

However, chaplains serving on organizational ethics committees and advising administrators on organizational issues is a role that requires careful examination, he believes.

“It can become a very sensitive issue because, as a religious figure, you run the risk of ‘blessing’ certain courses of action by your presence,” he says. “You don’t want to end up being the mouthpiece of the organization. I don’t personally believe that ministers are more sacrosanct than anyone else, but people tend to project certain values and beliefs on to them.”

There is a perception among nonpastoral providers and administrative staff that clergy often have an “anti-business” bias, and that feeling is not always unfounded, he adds.

SOURCES

- The Rev. **Curtis Hart**, New York-Presbyterian Hospital, 167525 E. 68th St., New York, NY 10021.
- The Rev. **Martha Jacobs**, Department of Pastoral Care, New York United Hospital Medical Center, 406 Boston Post Road, Port Chester, NY 10573.

The atmosphere at most seminaries, academic institutions, and religious institutions tends to discount concerns about financial viability and may lead people to, indeed, have an anti-business bias, he says. "It can be a problem for people who have not been exposed to nor associated with people who have a different set of cultural norms and values."

Pastoral staff must determine whether or not they can overcome these obstacles to provide a valuable perspective to those shaping the hospital's future, he says.

"They must decide whether they have a well-developed, articulate outlook and philosophy suited for involvement in major institutional decision making and can avoid simply vacillating between passivity and outrage in the face of perceived organizational and system dysfunction," he says.

If they can, pastoral providers can provide a vital perspective and resource for shaping organizational ethical decision making as well as clinical situations, he says.

Further reading

- Association of Professional Chaplains. *Guidelines for the Chaplain's Role in Health Care Ethics*. Available on the association's web site: www.professionalchaplains.org. ■

Telling patients about death is a hard lesson to learn

Make hospice a part of medical education

Despite recent efforts to increase physician training in palliative care measures and improve access to hospice for terminally and chronically ill patients, many people still suffer needlessly at the end of life, experts contend.

A key problem, they say, is that physicians still are uncomfortable making the determination that a patient's condition is not likely to improve and initiating a discussion about treatment alternatives.

"There are a lot of statistics showing that people get into hospice and die a week later," says **Matt Stolick**, PhD, assistant professor of philosophy at Findlay University in Findlay, OH. "Hospice never really gets a chance to help the dying patient achieve closure with the people around them."

According to statistics compiled by the National Hospice and Palliative Care Organization, 33% of those served by hospice in the year 2000 died after receiving care for seven days or less. The average length of service was 48 days and the median length of service was 25 days.¹

Most people are eligible for hospice care under Medicare guidelines when they have a diagnosis of six months or less to live, Stolick notes. "If they have that six months to prepare, you are able to address a lot of those issues. If you pursue a cure until the end of life, these patients end up suffering the loss of that opportunity."

In an article in the recent issue of the *American Journal of Hospice and Palliative Care*, Stolick argues that medical student education must be expanded to include more student experiences with dying patients.²

In particular, hospice volunteer training might help students learn more about how to help terminally ill patients have a "good death," and the value that this has at the end of life, he says.

"My suggestion for this problem is working hospice volunteer training into medical education," Stolick adds. "This is something that I have done. I have worked as a volunteer with two different hospice organizations."

The volunteer training program, an eight-week course, forced Stolick to face his own feelings about death and dying, so that he was better able to consider the perspective of patients facing this reality.

"We did a lot of exercises that challenged us to consider our own mortality, and our own personal experiences with death," he explains. "Being open and honest, you really learn a lot about yourself. You cannot do the volunteer work effectively if you have not considered that you yourself are going to die and are no different from the person with whom you are visiting. I think it is obvious that that should carry over into medical education, especially for people who expect to face patients in the dying process."

As part of the volunteer training, Stolick and his colleagues were asked to pretend that they had just been given a diagnosis of six months or less to live and then answer a list of questions.

“The questions to ask are ‘What are the most important things in your life?’ sort of getting you to write a personal narrative,” he says. “What have you achieved? What is the meaning of certain events?”

As the volunteers answer the questions, they start to tell “their” story and realize that all people have a life narrative or story to tell, he says. “People are stories in a strong sense and understanding and being able to respectfully treat people as human beings can benefit from understanding them and what matters to them.”

In another exercise, volunteers were asked to list eight of the most important people in their lives, and eight of the most important things, he adds. “Then, as you go through ‘treatment’ you cut those in half, over and over, until you are just left with two items.

“It just shows you what is important in life and helps you understand the meaning of your life,” he says.

‘Lying’ to patients

Many physicians have not had to address their own feelings about death and dying and are, therefore, unable to address the subject with their patients. The result, Stolick says, is that patients end up being misled about the reality of their situation, only to find out when it’s too late to do things they might feel necessary to do.

“I used the term ‘lying’ in the article, and it was a very tough term for me to use because it seems intentional,” he says. “To me, the lie that I am talking about is just ignoring the obvious. To just come in and do rounds, for example, and say, ‘Keep up the good work,’ and ‘Hope you’re feeling better’ to use general clichés from the patient’s point of view is just ignoring mortality and the reality of the situation.”

Such interactions can not only be irritating to the patient, but may also keep that patient on a curative path instead of a palliative path, which may not be in his or her best interests.

Admittedly, physicians are not always able to tell from a patient’s condition whether they are within six months of the end of life, he notes.

“Sometimes, you simply don’t know — in addition to all of the medical technology — you also have to consider the will of the person.”

But, even in cases where it would seem obvious to a reasonable person that a discussion about palliative care measures should at least be initiated, these conversations often do not happen, he says.

“That is where my lie argument gets stronger. If they know, or have a pretty good idea, and are not initiating that discussion, that’s what we need to do something about here.”

Professional mentoring vs. volunteer training

While many physicians do have problems communicating bad news to patients — particularly deciding when to initiate discussions about palliative treatment — hospice volunteer training is not the best solution, says **David M. McGrew**, MD, president of Hospice and Palliative Physician Services, LLC, in Spring Hill, FL. McGrew also is president-elect of the Glenview, IL-based American Academy of Hospice and Palliative Medicine.

“There’s no question that there is a problem, absolutely no question,” he says. “I don’t necessarily think volunteer training in hospice would fix anything, though. I think what is really needed is more specific palliative care exposure, and hospice exposure from a physician’s standpoint, not as a volunteer.”

McGrew practiced in general medicine before specializing in palliative medicine 15 years ago and says he sympathizes with the struggle physicians have in deciding when patients should begin considering comfort measures as opposed to curative treatment.

“I have some colleagues who do recognize the importance of hospice and palliative medicine, but they really struggle with that transition,” he says.

Identifying ‘triggering’ events is difficult

Part of the confusion stems from the difficulty physicians have in identifying “triggering” events in the patient’s course of care. The triggers should serve as a signal that a discussion about palliative care should be initiated, he says.

“Medical schools now accept doctors for training based solely on intelligence, not communication skills. They look at your MedCat scores and your GPA.”

SOURCES

- **Matt Stolick**, Assistant Professor of Philosophy, Main 313 A, 1000 N. Main St., Findlay, OH 45840-3695.
- **David M. McGrew**, MD, 4644 Keyville Ave., Spring Hill, FL 34608-3515.

For example, a patient with congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD) who is hospitalized more than twice within a 12-month period should at least be asked to consider the goals of his or her care and what role palliation may play.

For patients with CHF and COPD who have two hospitalizations in that scope of time, the mortality rate in the following year is fairly high, he says. “The discussion we should be having is about hospice for many of these people.”

Just initiating the discussion does not mean that you are asking the patient to “give up”, he says. In fact, some patients may say that they want all possible measures to be taken, no matter what. But, they need to be presented with all of the options as well as realistic information about the expected outcomes of different treatments.

“The perception of most doctors is that most patients want anything and everything to be done,” he says. “But, these decisions are most often made without informed consent. It is not as if anyone has explained to the patient what the issues are, they just say, ‘Do you want everything done?’ Well, who in their right mind is going to say no?”

But just identifying the point at which discussions about treatment options should begin is difficult for many physicians, he continues.

“It’s different for different patients; that’s what makes it difficult. You can’t say that, ‘Here are the times you should do it and here are the things to talk about.’”

‘Learning’ palliative care methods

It’s important for medical students to spend time with physicians who specialize in palliative care and in hospice care to get a sense of how these discussions should be initiated and when, and how these physicians make the decision, he says.

“A lot of it needs to be modeled by physicians who do the work. The communication issues really can’t be taught in a class,” McGrew says.

“Even if we ignored all the how-to’s, we’d be fine if we could get hearts won over and a belief on the part of physicians going into practice that it is not their job to necessarily save the patient at all costs.”

Medical schools are beginning to include the “presence” of palliative medicine in their curricula, McGrew adds.

“When I started doing hospice work 15 years ago in Florida, none of the medical schools had exposure to hospice care and palliative medicine,” he says. “Now we have mandatory presence, at some level, at all of the medical schools in the state. It is not what it should be, but it is a step in the right direction.”

Communication issues are key

McGrew and Stolick agree that improved emphasis on communication skills will go the longest way toward improving end-of-life care.

“In volunteering, I talked with patients about their own life narrative, who they were, what they’ve done; and as we went through and came to their current situation, we just moved into talking about where they were doing, what their death meant to them,” he says. “I tried to listen and not talk, but sort of be a mirror and be there for them. There is a rapport that needs to be built first.”

Medical schools need to — as much as possible — re-emphasize the “softer” subjects in medicine, asserts McGrew. “It used to be in medical training that we got a lot of training in psychology, sociology, communication. These sorts of things are very important to what makes a good physician — being able to communicate with people,” he says. “Medical schools now accept doctors for training based solely on intelligence, not communication skills. They look at your MedCat scores and your GPA.”

But if you cannot communicate, you cannot do a good job of taking care of patients, he adds. “As the amount of clinical things that we need to learn increases, a lot of these other issues just get crowded out.”

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1. National Hospice and Palliative Care Organization. Research Department. *NHPCO Facts and Figures*. Available on-line: www.hnppo.org.
2. Stolick M. Overcoming the tendency to lie to dying patients. *Am J Hosp Palliative Care* 2002; 19(1). ■

DA in hockey dad case blocked heart donation

The family of Michael Costin, the Massachusetts man who died after being knocked unconscious in a fight at a hockey rink in July 2000, had wanted to donate his heart, but was prevented from doing so by the district attorney prosecuting the man accused of causing Costin's death.

According to a report in the Jan. 25, 2002 *Boston Globe*, Middlesex District Attorney Martha Cloakley blocked the donation of Costin's heart after he was declared brain dead because she wanted to prevent any possibility that the defendant's lawyer might contend that Costin died of a pre-existing heart condition rather than the beating.

Surgeons express dismay

Transplant surgeons have expressed dismay that the organ was withheld, saying that doctors would not have accepted an organ that was not healthy and that there was ample evidence to indicate that Costin's death was caused by brain swelling brought on by internal bleeding.

"With heart transplants, it's literally a life-or-death situation," **Lachlan Furrow**, a general internist and director of the ethics program at Boston-based Beth Israel Deaconess Medical Center, told the newspaper. "It's very, very likely that, because of this decision, someone with heart disease died. I think it's tragic."

But some ethicists said the interests of justice should hold equal value with that of saving lives.

"There's an obvious value in saving lives using donated organs," argues **Ronald Munson**, professor of philosophy and science and medicine at the University of Missouri-St. Louis. "But there is also the interest in making sure we have all the evidence necessary so that justice is served. As useful as it is to have these organs for donation, indeed to save lives, we may have to make an exception here to let justice be done, realizing the price we are paying." ■

Prisoner heart transplant renews scarcity debate

A California prison inmate serving 14 years for robbery received a heart transplant in January, turning up the heat in the debate over who should get desperately needed, but scarce, human organs. And, whether patients who have committed crimes against society "deserve" to receive transplants paid for with taxpayer funds.

Taxpayer financed

The transplant, paid for by the California Department of Corrections, is expected to cost \$1 million with follow-up care, and occurred as 500 Californians waited for hearts, according

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to the *Associated Press*.

The operation saved the 31-year-old inmate from dying of a viral heart condition, says **Russ Heimerich**, spokesman for the California Department of Corrections.

Citing two court rulings in favor of inmate care, Heimerich said, "Our hands are pretty much tied. It's not a question for this department to decide."

A 1976 U.S. Supreme Court ruling held that it is "cruel and unusual punishment" to withhold necessary medical care from inmates. And, in 1995, a federal court ordered prison officials to give a kidney transplant to an inmate whose request had been denied.

In addition, the ethics policy of the United Network for Organ Sharing, the organization that oversees the national transplant organ network, outs prison inmates on equal footing with all other patients.

The patient is currently in satisfactory condition at a prison medical facility near San Francisco. ▼

Group advocates HIV-positive fertility assistance

A person's HIV status should not necessarily preclude them from receiving assisted reproductive technologies to have children, according to new ethical guidelines developed by the Birmingham, AL-based American Society for Reproductive Medicine (ASRM).

The standards issued in February by ASRM say therapies now exist that can greatly reduce the risk of passing HIV, the virus that causes AIDS, to the baby.

However, they do not encourage HIV-infected couples to have children and caution that physicians should ensure that parents understand their baby could be infected, regardless of what precautions are taken.

Since 1994, the group's ethics guidelines have discouraged fertility treatment if a potential parent has HIV. The risks of infecting the unborn child were too great.

Special care can reduce risks

Today's therapies allow many HIV patients to live longer, healthier lives, and most patients are

in their prime childbearing years. Special prenatal care can greatly reduce — although not eliminate — the risk of infecting a baby, the society's ethics committee concluded.

According to the Centers for Disease Control and Prevention, an estimated 200-300 infants are born with HIV each year, most thought to have been born to mothers improperly tested or treated for HIV.

The fertility society's new guidelines, available on-line (www.asrm.org) state:

- Appropriate drug therapy, a cesarean section,

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CE/CME Questions

CE/CME subscribers: Please save your monthly issues with the CE/CME questions in order to take the two semester tests in June and December. A Scantron form will be inserted in those issues, but the questions will not be repeated.

9. A survey of patients who underwent emergency lifesaving procedures found that most patients felt that having family members present during the procedure:
 - A. Helped the caregivers to see the patient as a person.
 - B. Helped comfort the patient in a time of crisis.
 - C. Helped comfort family members.
 - D. All of the above
10. According to the article, what part of their training best equips pastoral care staff to serve on ethics committees and in ethics consults?
 - A. The fact that they must closely examine their own beliefs and feelings about major health care issues like death, withdrawal of life support, and abortion, etc.
 - B. They are trained by religious institutions.
 - C. Ethics education is a key portion of their curriculum.
 - D. All of the above
11. According to the article, how might medical students and physicians be better prepared to know when they should initiate discussions about palliative care?
 - A. Participate in hospice volunteer training.
 - B. Train with a mentor who specializes in palliative medicine.
 - C. Improve communication skills.
 - D. All of the above
12. The new ASRM policy supports use of ART for HIV-positive people:
 - A. In all circumstances.
 - B. When the providers can be reasonably sure the patient will take precautions to prevent maternal-to-infant transmission.
 - C. Under no circumstances.
 - D. None of the above

and no breast-feeding drops an HIV-positive pregnant woman's chances of infecting her baby from 20% down to about 2% — but the risk isn't zero.

- If only the potential father has HIV, both mother and fetus could be infected. Unprotected intercourse is not safe. Special sperm washing and testing before artificial insemination appears to greatly reduce risk, but more proof is needed. Couples should be counseled about considering donor sperm, adoption, or not having children.

- If both potential parents have HIV, they must be counseled about the risk of infecting and orphaning a baby.

Treatment ethically acceptable

Many couples at risk for genetic diseases such as cystic fibrosis attempt conception despite a 25% chance of having an ill child, the guidelines note. Fertility specialists who treat those couples also "should find it ethically acceptable to treat HIV-positive individuals or couples who are willing to take reasonable steps to minimize the risks of transmission." ■

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