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## IN THIS ISSUE



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# The VA leads change toward IntegratedEthics approach

*"Throughout our health care system, VA patients and staff face difficult and potentially life-altering decisions every day — whether it be in clinics, in cubicles, or in council meetings. In the day-to-day business of health care, uncertainty or conflicts about values — that is, ethical concerns — inevitably arise."* — IntegratedEthics: Improving Ethics Quality in Health Care (U.S. Department of Veterans Affairs monograph)

Ethical questions, concerns and issues probably are part of most health care providers' daily lives — from physicians to nurses to risk managers and institutional executives.

Recognizing this, the Department of Veterans Affairs, which manages the largest health care system in the United States, took on an initiative designed to raise the bar of ethics quality, and therefore the quality of health care delivered, throughout the VA health care system.

The result: IntegratedEthics — a program rolled out to the VA's 153 facilities since May 2007, and the VA's **Ellen Fox**, MD, chief ethics in health care officer at the VA's National Center for Ethics in Health Care, believes that the organization is, indeed, setting a new standard.

"When we first began to develop this, we developed the conceptual approach and communicated the ideas related to integrated ethics to our ethics community," Fox recalls. "And people were very excited about the ideas, particularly the idea that a piecemeal approach to ethics really doesn't adequately meet the challenges that employees face, and that to be truly effective, an ethics program must do more than just respond to ethics questions on a case-by-case basis."

The effort to establish standards for both ethics consultation and ethics consultants is a point of much discussion in the health care community currently. For example, the American Society of Bioethics and Humanities has an initiative underway to establish

core competencies for ethics consultants **(See article, "Core competencies for ethics consultation," on pg. 27 of the Nov. 1, 2008, issue of *Medical Ethics Advisor*, as well as the article "Who can be a 'medical ethicist'? Absent formal definition, anybody," the cover story in the April 1, 2008, issue.)**

To have an effective program, Fox says you really have to address "the issues more comprehensively and systematically," which includes the idea that an "ethics program needs to foster an organizational environment and culture that makes it easy for employees to do the right thing."

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Editor: **Karen Young**, (404) 262-5423, (karen.young@ahcmedia.com)
Editorial Group Head: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).




**Editorial Questions**

Questions or comments?
Call **Karen Young**
at (404) 262-5521.

## *The program in concept*

"First, let me say that I don't think that there's anything about IntegratedEthics that doesn't apply to every health care system . . . Every health care organization has its own mission, its own unique characteristics, and the VA is no exception . . ." Fox says.

However, while the VA is different in that it is a government institutional system designed specifically to serve veterans of U.S. military service, "I think in terms of what we're trying to achieve with IntegratedEthics — it's really the same thing that every other health care organization is trying to achieve," she says.

The greatest challenge with this initiative, Fox says, is that "really what we're trying to achieve here is a fundamental culture change."

The image that the VA uses to describe the underlying concept of IntegratedEthics is that of an iceberg.

"That is really the symbol that we use now to represent the whole program — the idea that what you see — the things that are most visible in terms of ethical practices . . . represent only the tip of the iceberg."

As Fox says, most people "don't get up in the morning and say, 'I'm going to do something ethically problematic.'"

"Everybody wants to do the right thing, but you're powerfully influenced by the systems and processes and the environment and culture in which you work every day, so in order to influence ethical practice, which is what we believe ethics programs should be about in a health care organization, you really need to target directly not only the individual decisions and actions, but perhaps more importantly, the systems and processes and the organizational culture," Fox says.

This approach — using preventive ethics to target systems and processes "through a quality improvement approach," as well as the ethical leadership component — are what make the program unique, Fox says.

Asked if she considered IntegratedEthics a possible model for other health care institutions, Fox declares, "Oh, absolutely."

In developing the program, the VA leaders relied on experts from around the country and those outside the VA. The development process also included an extensive review guided by an advisory board for "certain aspects of development."

"So, yes, all along we were aware of the fact that we would be going well beyond what had already been done in the field, and therefore felt a responsibility to make sure that it was equally applicable to other health care systems."

## Five years of tool development

When initially set forth, the ideas that are the backbone of the IntegratedEthics approach resonated with employees, Fox says, but the employees really didn't know how to create the change required.

"We went back and realized that we had to put a lot more resources and time and expertise in developing practical tools that would allow people to translate the vision, and the excitement they had about these ideas, into reality on the ground," Fox says, noting the year as 2001.

The VA spent five years developing tools that are built around the three building blocks of the Integrated Ethics model:

- ethics consultation;
- preventive ethics;
- ethical leadership.

Those tools are available on the VA's web site. **(See Source at end of story.)**

Because, the VA has "resources that an individual health care system wouldn't have," the department was able to "develop a very comprehensive package to support this whole initiative," Fox says.

## Ethics consultation facet

According to Fox, "Another really important aspect of IntegratedEthics is that we are standardizing processes and developing concrete standards for how we do business in our ethics program, so we've put a lot of energy into insuring the quality of ethics consultation, developing standards for ethics consultants . . . "

So, she says, although other health care institutions and facilities often conduct ethics consultations, the VA program, "establishes a standard and really raises the bar on ethics consultation, as well."

The VA model also adopts the same standards for ethics consultants as those set forth by the ASBH.

While there is a great deal of anecdotal evidence that the IntegratedEthics model is also achieving the stated objectives and goals of its own "Business Case for Ethics" (see the VA web site), it's still too early to have gained actual performance measures.

### SOURCE

For more information, contact:

- **Ellen Fox**, MD, Chief Ethics in Health Care Officer, the National Center for Ethics in Health Care, Department of Veterans Affairs, Washington, DC.

## Results to date

Its own "Business Case for Ethics" suggests that a strong ethics program "can reap many concrete benefits for a health care organization," including:

—increasing patient satisfaction;
—improving employee morale;
—enhancing productivity;
—conserving resources/avoiding costs;
—improving accreditation reviews;
—reducing ethics violations;
—reducing risk of lawsuits;
—sustaining corporate integrity;
—safeguarding the organization's future.

All 153 facilities in the VA system were charged with implementing certain standards related to the IntegratedEthics model by the end of FY 2008, which ended Sept. 30. With this charge, the facilities had 13 possible points that they could score for the implementation. A passing score was 9 points. Of the 153 facilities, all but one facility received a passing score, Fox says.

Fox also notes the result from a year-long demonstration project completed in 2006 in which 25 facilities participated.

"We did exit interviews with those 25 facilities, and 100% said they thought the Integrated Ethics program was worthwhile and would significantly improve ethics quality in their health care organization," Fox says.

Also, an IntegratedEthics staff survey was completed in August and September of this year for the first time, involving a database of 99,000 responses from the all-employee survey, Fox says.

"As you can imagine, there's tremendous opportunity there for us to be able to correlate the ethics-related data to other quality data in our organization and really get to what's going

on in an individual facility," she says.

And her overall perspective is this: "The fact that [this program is] resonating suggests that we're filling a need." ■

## Widespread interest in VA ethics program

*VA wants to partner on material distribution*

The IntegratedEthics program developed by the Department of Veterans Affairs (VA) for its facilities, which comprise the largest health care system in the United States, has drawn interest and attention both domestically and internationally.

**Ellen Fox**, MD, chief ethics in health care officer for the VA, tells *Medical Ethics Advisor* that there is interest from a variety of countries in developing not only ethics standards for providers within their countries, but also perhaps developing global standards for ethical care.

Fox says that she has given many presentations on the IntegratedEthics approach.

"We've presented the Integrated Ethics model at professional conferences throughout the U.S., and also in Canada and Europe, and we've gotten very positive feedback," Fox says.

The VA has had discussions with a variety of organizations about the adoption of the VA's ethics material and program, including the province of Alberta, the public health system in Canada and Japan, where the material has been translated into Japanese for use in health care institutions in that country, she says.

"I would point out that this program has just been released within the VA within the last year, so this is the year for us to start sharing beyond VA what we're doing," Fox says. "I mean, we haven't really emphasized that, because we've been focusing on our internal launch. But that's well established, and we've had success in implementation internally, and we are poised to share the results externally."

Towards that end, the VA ethics center is seeking partners to distribute its materials

"We think it will require more than just putting [the materials] on our web site," Fox says.

As further example of the interest in the program, the VA says that "In the past year alone, the Internet site for the National Center for Ethics In Health Care (www.ethics.va.gov) has had over 96,000 files related to IntegratedEthics downloaded by visitors.

Internet referral visits resulting in these downloads have come from the web sites of over 22 major U.S. educational institutions, including Harvard University, Yale University, UCLA, Vanderbilt, Johns Hopkins and Columbia."

"International referrals have come from 54 nations representing a cross section of countries from Australia to Zimbabwe." ■

## 73% of physicians discuss mistakes with colleagues

*Doctors also need emotional support*

Even with the driven culture of modern medicine, one study published recently in the *Journal of Medical Ethics* found that 73% of 338 respondents said that they usually discuss their mistakes with their colleagues.

The study's lead author is **Lauris Kaldjian**, MD, PhD, associate professor, division of internal medicine at the University of Iowa Carver School of Medicine, and director of that school's program in biomedical ethics and medical humanities, both in Iowa City, IA.

"Three-quarters of doctors said that they usually discuss their mistakes — that's evidence that . . . as physicians, our self-perception is that we are the kind of people who talk to our colleagues about our mistakes," Kaldjian tells *Medical Ethics Advisor*.

The study presented a hypothetical scenario of clinical error with the incorrect antibiotic being administered with three outcomes, with Outcome #1 being no harm; Outcome #2 having caused minor harm; and Outcome #3 having caused major harm.

With the outcomes going from no harm to major harm, the survey responses were 77%, 87%, and 94%.

"If that is a true representation of how physicians generally respond in these three different categories of errors based on their outcomes, I would find that encouraging, statistically speaking," Kaldjian says.

One of the authors' points made in the discussion is: "Discussions of medical errors by physicians will always be a challenging yet vital responsibility, one that cannot be avoided if we want to learn from our mistakes and receive support as we work through their implications.

"This responsibility derives from a commitment to respect our patients and our colleagues, and it is directed towards quality patient care and the integrity of the profession," the authors write.

Kaldjian described medical errors in teaching environments as a "vicarious resource." Not only that, he describes medical errors as a "precious resource," noting that if physicians choose not to share this resource, then they are "depriving" colleagues of something from which not only they, but their patients, could benefit.

"I think the good news here is that there is a very long history of discussing cases in health care to teach and discussing cases where things have not gone well or unexpectedly badly . . . ." Kaldjian says. "The question, I think, in my mind is: Is it sufficiently a part of our current traditions, or not?"

## Individual vs. group sharing

One of the survey questions asked whether the respondent knew at least one colleague who would support him or her if he or she needed to discuss a medical mistake. Of those surveyed, 89% said yes.

Also, 70% of respondents said they believed that discussing mistakes strengthened professional relationships.

The "self-administered, paper-based" survey did not ask respondents whether they would be more likely to share their experience with a medical mistake individually or in a group setting.

There are some circumstances where group sharing is the goal, such as morbidity and mortality conferences, which are more frequent in surgical settings, Kaldjian says. Those "conferences" are designed so that physicians, meeting on perhaps a weekly or monthly basis, discuss the deaths and complications that have occurred with patients in their care.

When medical errors occur, especially in teaching hospitals, there is a "dual agenda that has to be considered," Kaldjian says.

"That is to say that the individual involved in the error needs two things: They need support from their colleagues, especially emotional support, and they also need education — they need learning," he says. "Especially, trainees need to learn from their errors."

One-on-one communication is more likely to fulfill the emotional needs of a physician, while a group setting is more likely to fulfill the teaching opportunities available when medical mistakes occur.

"It's less likely in my mind that you're going to get a group that's so exceptional that in the same setting . . . you can create an environment where there's learning, but also emotional support for the individual or the individuals involved," Kaldjian says.

## Why physicians share their mistakes

Regarding attitudes toward errors, 91% of the survey respondents said they are motivated to discuss errors in order to learn whether a colleague "would have made the same clinical judgments and decisions I did."

Eighty percent of respondents said they were motivated to discuss errors with colleagues "to allow them to learn from my mistakes"; 79% said they were motivated in order "to receive their support and understanding"; while 60% responded positively "to unburden myself."

On the opposite side of this perspective, 27% indicated it would be hard for them to talk about their mistakes with colleagues because they thought it would "damage their reputation."

But Kaldjian suggests that role-modeling is important, especially in teaching environments, so that students are given the opportunity to see more experienced clinicians reveal and discuss their medical mistakes as learning opportunities. Interestingly, the study found that "having observed a more experienced clinician discuss a mistake makes you at least four times more likely to have tried to serve at least once as a

### SOURCE

For more information, contact:


- **Lauris C. Kaldjian**, MD, PhD, Director, Program in Biomedical Ethics and Medical Humanities; Associate Professor, Department of Internal Medicine, University of Iowa Carver College of Medicine, Iowa City, IA. E-mail: Lauris-kaldjian@uiowa.edu.

role model by discussing an error."

Sixty-four percent of respondents agreed that "in my experience, physicians tend to expect perfect performance from each other." Likewise, 69% agreed with the statement that "competition in medical education and training encourages students and trainees to keep silent about their mistakes."

And finally, the study indicated that physicians believe they are their own worst critics when they make a mistake.

According to Kaldjian, there are "three directions of disclosure, and I think whenever an error occurs, the clinician involved should ask themselves at least three questions":

- Should I disclose the error to the patient?
- Should I report it to the hospital to increase patient safety?
- Should I discuss it with a colleague?

Kaldjian says, "I think one way to help make sense [of these results] is that if we actually deal honestly with our fallability, we actually improve our excellence and make it less likely that we're going to make another mistake."

### Reference

1. Kaldjian, LC, et al. Do faculty and resident physicians discuss their medical errors? *J. Med. Ethics* 2008;34;717-722. ■

# AMA's Ethical Force program aims for measures

*"Increasingly, physicians and managed care organizations are being held accountable for quality of care based on the processes and outcomes of medical care and patient satisfaction. Yet high-quality care delivery involves more than good technical quality and acceptable customer service — it also means upholding high ethical standards."*

— AMA web site literature on the Ethical Force Program

The mission of the American Medical Association's Ethical Force Program is to develop performance measures for ethics.

By taking domains of quality care and breaking them down into manageable components or activities that can be measured, yet still support the overall goal, the Ethical Force Program seeks to make it easier for health care institutions to heed the contemporary call to bring measureable goals — and most importantly, measurable outcomes — to health care.

"The issue that we're having to address now is that there's a lot of people who really buy this notion that 'if you can't count something, it doesn't count,'" says **Matthew Wynia**, MD, MPH, FACP, director, The Institute for Ethics, at the AMA in Chicago. "And as a result, the things that people are going to pay for are going to be things that you can count."

The bottom line, Wynia says, is, "If we can't figure out a way to monitor the ethical environment of a health care organization, then that's what will suffer."

Unlike whether a patient gets a flu shot or has a scheduled mammogram, it's not as simple a matter to determine if a physician really listened to a patient or communicated in a way the patient could understand so that he or she, for example, understood how to take medication as prescribed.

Recognizing that, the Ethical Force Program was first considered when the AMA began expanding its ethics group in the late 1990s in order to study different areas of health care and to develop practical tools that both hospitals and large group practices are using today, Wynia says.

"When the AMA decided to really re-commit to building the ethics group here, they brought in several of us who felt like the AMA did a terrific job of speaking to the patient-doctor relationship, and that our Code of Ethics really focused on the doctor-patient relationship, but that ethics in the health care system was so much broader than that," Wynia tells *Medical Ethics Advisor*.

A lead into the formation of the Ethical Force Program was the quality improvement movement, he says.

"The thing that we saw happening was a lot of interest in measuring how physicians were performing, which makes perfect sense," Wynia says. "But you have to realize, of course, that doctors work in organizations, and organizations can make it harder or easier for physicians to perform up to their ethical responsibilities."

So, enter the discussion of how organizations might do a better job of supporting quality health care, as well as physicians focused on quality. Part of that conversation and thinking was to focus on how to better understand how to measure performance of physicians and

organizations, he says, but also to determine "Who has responsibility for what?"

## The program's components

The Ethical Force Program has about 22 members on what it calls an oversight body, which according to the AMA is "responsible for selecting topics for performance measurement development as well as reviewing and approving all research programs and products."

Among those on the oversight body are representatives from The Joint Commission, the American Nurses Association, the National Institutes of Health and the National Committee for Quality Assurance.

"Our sense at the beginning was that we wanted patients at the table, we wanted providers, meaning provider organizations, so — health plans, hospitals," Wynia says. "We wanted doctors, nurses, and we wanted purchasers, so employer groups and so on."

Those categories, he said, have "remained the big four."

The agency is charged with selecting specific, broad topic areas for performance measurement development. For example, the Ethical Force Program's most recent topic of study was patient communication.

That broad topic can be broken down into "content areas," which Wynia says some in the ethics field might also refer to as "domains."

The program tends, however, to think of domains as larger, he says. So, "effective communication is the domain." Within any given domain, there are then a number of content areas for specific attention.

For example, patient communication can be dissected from this very broad topic down to steps to raise the health literacy level of patients. Program members can do this by asking a series of questions that become more and more pointed toward a specific action to take, with an expected outcome that could be measured.

## Tools for hospitals

The Ethical Force Program offers "toolkits" for such providers as hospitals and large physician group practices that may be looking for ways to improve the ethics environment of their institution, facility or practice.

"We've been field-testing these for the last three years, and so we actually have a set of hospitals and larger group practices that are using these toolkits in an iterative fashion….They're doing quality interventions to see if they can improve their performance," Wynia says.

He says one of the advantages of breaking down domains into content areas is that a hospital might find that it, for example, may get an A-plus on language services, but the facility's signage isn't very good.

Many of the needed improvements institutions learn by using the toolkits are quick fixes, while others are more costly and more systemic in nature. In one example, one of the sites has a large number of Spanish-speaking patients. And while it was determined that the site, or facility, offers very good interpreter services, there was one small problem. It was determined through a survey that 30% of the people who used that facility thought interpreter services were an additional cost.

So, the next step that the facility took was to distribute flyers and put up posters letting patients know that interpreter services were offered at no charge to the patient.

The entire approach includes a self-assessment tool, or patient survey, a staff survey of both the clinical staff and the non-clinical staff, a leadership survey, and a policy checklist that "looks at the whole organizational environment and what policies are in place," Wynia says.

All of those components are analyzed by members of the Ethical Force Program, and a Feedback Report is provided to a site, or facility.

While the toolkit can be used completely by a institution or practice on its own, some of the components can be analyzed by members of the program for a fee.

"We have a lot of data now from sites around the country, and so if you want to see how you're doing in relation to others, then we have a lot of ideas that we have [gathered] over time that address different deficiencies that you might find," Wynia says.

### SOURCE

For more information, contact:


- **Matthew K. Wynia**, MD, MPH, FACP, Director,The Institute for Ethics, American Medical Association, Chicago. E-mail: matthew.wynia@ama-assn.org.

What hospitals and practices tend to like about the toolkits is that the allow them to focus, and they give the users "a way to measure and find out whether what you're doing is making a difference in the patients' experience of care."

"I think almost everyone these days does some kind of a patient satisfaction survey, and this is a little different, because it involves . . . a 360-evaluation," Wynia says. "So, you really, I think, get a much better understanding of the climate of the whole organization." ■

# Maintain infrastructure in flu pandemic

*Emphasis on maintaining basic supply lines*

In a new study, for which **Nancy Kass**, ScD, of the Johns Hopkins Berman Institute of Bioethics is the lead author, she and others outline their vision of an ethical response to a severe influenza pandemic: Keep society functioning.

That goal of maintaining such basic necessities as Internet, cable, gas and electricity is critical in an already stressful situation, and scarce resources should be considered for those workers who keep basic utilities functioning.

"Where I think we differ is that most response plans that were written in the past, although I think this is changing, most of the response plans that were written in the past privileged health care providers, vaccine manufacturers, and what I will call traditional first responders – and very often, rarely mentioned anybody else," Kass tells *Medical Ethics Advisor*.

But in the study, Kass and her co-authors suggest that "the secondary consequences of severe pandemic influenza could be greater than deaths and illness from influenza itself. Response plans, then, must consider threats to societal as well as medical infrastructures."[1]

One of the primary threats to continued societal function likely would be absenteeism, they write: "Rationing strategies will need to be considered not only for ventilators and medical countermeasures but also for potentially threatened resources, such as food, water, and gasoline."

The study suggests that during a severe pandemic, absenteeism estimates are as high as 40%, which could be due to illness, other family members who are ill and require care, or self-isolation due to fear of contracting the flu from others.

That, the study says, could lead to "significant interruption of usual services across multiple sectors."

"Indeed, if individuals, at the extreme, found themselves with no functioning toilets or clean water, no electricity or heat, no radio or cell phone or Internet, and extremely limited access to gasoline or food, there could be widespread social chaos, significant outbreaks of other infectious diseases, and severe anxiety, with the possibility of social degeneration, looting, or even violence as people try to secure needed supplies," the authors write.

Public mental health in such a scenario also could be severely impacted.

## What is the ethical approach?

The authors suggest that an ethical response plan should focus on these essential functions. But how should that be implemented?

In addition to vaccine makers, first responders, and health care providers designated to receive scarce medical resources, an ethical response plan should also consider "privileging, for example, some utility workers, key communications personnel, and truck drivers who can deliver food or fuel to communities in need," the study says.

While Kass emphasizes that she is "not trying to suggest that a truck drivers is more important than an ICU doctor by any means," a response plan designed to keep society functioning must be "sensible about all the different players it takes to keep those functioning."

Essential personnel might also include people "willing to remove infectious waste and run lab-

**SOURCE**

For more information, contact:

- **Nancy E. Kass**, ScD, Deputy Director, Berman Institute of Bioethcis and Department of Health Policy and Management, Bloomberg School of Public Health, Johns Hopkins University, Balitmore, MD. E-mail: nkass@jhsph.ed.

oratory facilities at every functioning hospital."

### Three-pronged response strategy

The suggested response from the authors includes three components:

- state-organized public-private coordination;
- industry/organizational preparedness;
- individual/household preparedness.

In the preparedness stage, local governments will be called upon to carry out the lion's share of the response plan.

"As part of the dialogue, state and local health departments should ask each critical sector and business whether it plans to stockpile antiviral drugs, protective equipment and perhaps emergency supplies of food and water, and how the state can facilitate intersector cooperation and assistance," the authors write.

Individual and family preparedness is also key, the authors write.

"Federal, state and local governments must identify additional ways to convince individuals that they should prepare emotionally and practically for a pandemic and to give them the confidence and practical tools to be increasingly self-sufficient," they write.

### Reference

1. Kass, Nancy et al. "Ethics and Severe Pandemic Influenza: Maintaining Essential Functions Through a Fair and Considered Response." *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science*. 6; 3:227-236. ■

# End-of-life discussions with physicians have benefits

*Hospice enrollment is sooner*

According to a recent study,[1] terminally ill patients who had end-of-life discussions with physicians had earlier hospice enrollment (65.6% vs. 44.5%), compared to patients who did not have these discussions. Also, longer hospice stays were associated with better patient quality of life, while more aggressive medical care was associated with worse patient quality of life.

Also, patients who had the end-of-life discussions were not more likely to experience emotional distress, compared to patients who did not have those discussions.

End-of-life discussions give patients the opportunity to define their goals and expectations for the medical care that they want to receive near death. "But these discussions also mean confronting the limitations of medical treatments and the reality that life is finite, both of which may cause psychological distress," the authors wrote.

Physicians and patients are ambivalent about talking about death and often avoid these conversations, they write. "To date, however, research has not examined whether these discussions are associated with patients' psychological distress or medical care near death," the authors state. "Without this information, physicians cannot weigh the risks and benefits of end-of-life discussions."

**Alexi A. Wright**, MD, hematology-oncology fellow at the Dana-Farber Cancer Institute, Boston, and colleagues examined the associations between end-of-life discussions with physicians and the medical care that terminally ill patients receive near death. The study included patients with advanced cancer and their informal caregivers (n = 332 pairs). Patients were followed up from enrollment to death, a median (midpoint) of 4.4 months later. Bereaved caregivers' psychiatric illness and quality of life was assessed a median of 6.5 months later. Of 332 patients, 123 (37%) reported having end-of-life discussions with their physicians.

The researchers found that such discussions were not associated with higher rates of major depressive disorder or more worry, but those patients received significantly fewer aggressive medical interventions near death: lower rates of ventilation (1.6% vs. 11%), resuscitation (0.8% vs. 6.7%), and ICU admission (4.1% vs. 12.4%).

Patients who reported engaging in those conversations were significantly more likely to accept that their illness was terminal, prefer medical treatment focused on relieving pain and discomfort over life-extending therapies, and have completed a do-not-resuscitate order.

Caregivers of patients who received any aggressive care were at higher risk for developing a major depressive disorder, experiencing regret, and feeling unprepared for the patients' deaths, compared with caregivers of patients who did not receive aggressive care. They also had worse quality-of-life outcomes, including

overall quality of life, self-reported health, and increased role limitations. Better patient quality of life was associated with better caregiver quality of life at follow-up.

"Our results suggest that end-of-life discussions may have cascading benefits for patients and their caregivers," the authors wrote. Despite physicians' concerns that patients might experience psychological harm due to end-of-life discussions, the authors found no evidence that they were significantly associated with increased emotional distress or psychiatric disorders. "Instead, the worst outcomes were seen in patients who did not report having these conversations." the authors wrote.

The adverse outcomes associated with not having end-of-life discussions points to what appears to be a need to increase the frequency of these conversations, they wrote. "By acknowledging that death is near, patients, caregivers, and physicians can focus on clarifying patients' priorities and improving pain and symptom management," they wrote.

### Reference

1. Wright AA, Zhang B, Ray A, et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA* 2008; 300:1,665-1,673. ■

## AMA lauds action on mental health coverage

In early October, the American Medical Association in Chicago issued a statement by board member **Jeremy Lazarus**, MD, regarding Congressional action on mental health care coverage:

"Today, the U.S. Congress took action to bring vitally important mental health care coverage to the 57 million Americans who struggle daily with a mental illness. Passage of the bill ends more than ten years of gridlock on the issue of mental health parity, and requires that insurance coverage for mental health and substance use disorders is on par with physical health care coverage for all Americans.

"Health insurers routinely impose more benefit restrictions on mental health services than on physical health services, despite the similarities in cost. Nearly half of all patients with a mental health disorder do not receive needed treatment. Thanks to congressional action, we can bring an end to insurance discrimination against patients with mental health needs." ■

## Criminal charges unlikely for prescribing opioids

Criminal or administrative charges and sanctions for prescribing opioid analgesics are rare, according to a recent study.[1] In addition, there appears to be little objective basis for concern that pain specialists have been "singled out" for prosecution or administrative sanctioning for such offenses, the study found.

The study was conducted by the Center for Practical Bioethics in Kansas City, MO, the Federation of State Medical Boards, and the National Association of State Attorneys General.

The authors identified criminal and administrative cases of these types between 1998 and 2006. They analyzed the numbers and types of cases and physicians involved, criminal and administrative charges brought, case outcomes and sanctions, specialties, and other characteristics of the physicians involved.

The authors found that 725 doctors, representing about 0.1% of practicing patient care physicians, were charged between 1998 and 2006 with criminal and/or administrative offenses related to prescribing opioid analgesics. About 39.3% were general practice/family medicine physicians, compared with 3.5% who were self-identified or board-certified pain specialists. Physicians in this sample were more likely to be male, older, and not board-certified. Drug Enforcement Administration (DEA) criminal and complaint investigations averaged 658 per year (2003-2006) and "for-cause" surrenders of DEA registrations averaged 369.7 (2000-2006).

### Reference

1. Goldenbaum DM, Christopher M, Gallagher RM, et al. Physicians charged with opioid analgesic-prescribing offenses. *Pain Med* 2008; 9:737-747. ■

### CME answers

45. A; 46. A; 47. A; 48. A.

# NHPCO awards grants to hospice providers

The National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA, has received funding from the Department of Veterans Affairs (VA) to launch a program improving access to quality hospice and palliative care to veterans, with a specific focus on reaching homeless veterans and those living in rural areas.

The project will identify innovative programs providing care and services to veterans at the end of life and provide recommendations to the VA on ways to improve outreach to homeless veterans and veterans living in rural areas.

NHPCO will award a minimum of 10 grants to existing providers that are working collaboratively with the Department of Veterans Affairs. Grant recipients may be hospice and palliative care organizations, state hospice-veterans partnerships, state hospice organizations, state veterans homes, or other organizations providing care and services to veterans.

Grants to cover a nine-month period will range from $5,000 to $25,000 and will be awarded by the end of January 2009. The specific grant process and more detailed requirements will be available in mid-November with applications due in early January. Interested applicants should contact Donna Bales at dbales@nhpco.org to receive this information when it is available. ■

# Palliative care saves money, study says

A palliative care program can save hospitals an average of at least $279 per day, up to $374 per day, according to a study of eight hospitals by the Center to Advance Palliative Care and the National Palliative Care Research Center.

The two-year study analyzed administrative data to evaluate the cost of providing care to patients who received palliative care compared to patients who did not receive palliative care.

Palliative care patients who were discharged alive had an adjusted net savings of $279 per day compared to patients who received usual care and palliative care patients who died had an adjusted net saving of $374 in direct costs per day. Significant cost reductions in pharmacy, laboratory, and intensive care unit costs were seen with palliative care patients, according to the authors. ■

## CME instructions

Physicians participate in this continuing medical education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge.

To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity, you must complete the evaluation form provided at the end of each semester and return it in the reply envelope provided to receive a credit letter. When your evaluation is received, a credit letter will be mailed to you. ■

## CME objectives

After reading each issue of *Medical Ethics Advisor*, you will be able to do the following:

- discuss new information about hospital-based approaches to bioethical issues and developments in the regulatory arena that apply to the hospital ethics committee;
- stay abreast of developments in bioethics and their implications on patient care, risk management, and liability;
- learn how bioethical issues specifically affect physicians, patients, and patients' families. ■

## *COMING IN FUTURE MONTHS*

- Profile: The CDC and ethics
- What leads people into clincial ethics?
- Ethics training: From PhDs to weekend seminars
- Health care provider bill collection tactics and ethics

# CME Questions

45. Integrated Ethics is a model developed by the VA to improve the ethical quality of health care delivered in all of its facilities.
A. True
B. False

46. There is widespread interest both nationally and internationally in the Integrated Ethics model developed and adopted by the VA.
A. True
B. False

47. In a study on medical errors by Lauris Kaldjian et al, MD, PhD, the authors found the physicians "usually discuss medical errors with their colleagues."
A. True
B. False

48. In a study by Nancy E. Kass, ScD, and others, they consider privileging workers such as first responders, as well as individuals who maintain utilities, to be of critical importance in an ethical response to a severe influenca pandemic.
A. True
B. False

# Medical Ethics Advisor

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