

MEDICAL ETHICS ADVISOR®

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guide to ethics decision making



Fundamental questions remain; science, tech creating new challenges

"Old wine in a new bottle"

[Editor's note: With this month's issue of Medical Ethics Advisor, we mark 25 years of efforts to bring you the most up-to-date research and news in the ethics arena of health care. Going forward, we hope to continue this tradition, and we invite you, the readers, to share your own ideas and experiences with our editorial advisory board and editor.]

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To gain perspective on what the last 25 years have brought forth in medical ethics, *Medical Ethics Advisor* spoke with three experts in a position to know. Their consensus was that while there have been some genuine changes, primarily in the level of transparency with which hospital activities occur for patients and their families, many of the fundamental questions are still being debated.

"I think there's a lot of medical ethics that we're still talking about — that we've been talking about as long as I've been in the field, and I've been in the field about 30 years," says **John D. Banja**, PhD, clinical ethicist, Center for Ethics, and associate professor of rehabilitative medicine, Emory University in Atlanta. "I still think we have problems with informed consent issues; we have ongoing issues with privacy and confidentiality."

Marc D. Hiller, DrPH, of the Department of Health Management and Policy in the College of Health and Human Services at the University of New Hampshire in Durham, NH, voices a similar sentiment, saying, "I'd say the disappointing reality is that, given the nature of the ethical dilemmas, I would argue that we have not successfully resolved many of the ethical dilemmas that plagued us 25 years ago.

"We're still debating issues regarding the creation of life and when does life begin. We're still debating issues with regard to what constitutes death, and who has the right to make decisions regarding end-of-life decision making," Hiller says. "So, we're still being pushed as much, I think, as we were possibly 25 years ago in wrestling with

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questions on both ends of that continuum, in terms of before or at the beginning of life, and on the opposite end, the end-of-life questions.”

Another one of the things that is “clearly true” is that “ethicists have become more of a routine part of the health care environment, whereas 25 years ago, it was unusual to have a professional ethicist around — it was quite a luxury,” says **Mark Kuczewski**, PhD, The Fr. Michael I. English, SJ, Professor of Medical Ethics, and director, Neiswanger Institute for Bioethics & Health Policy, Stritch School of Medicine, Loyola University in Chicago, and current president of the American Society for Bioethics and Humanities.

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Managing Editor: **Karen Young**, (404) 262-5423, (karen.young@ahcmedia.com).

Associate Publisher: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).

Production Editor: **Ami Sutaria**.

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Editorial Questions

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“Virtually all of the major academic centers have people who devote a significant amount of their time to medical ethics,” Kuczewski says. “And increasingly, hospitals and health systems in the community have access to additional resources, as well, sometimes from full-time people if they are a large system and fortunate. But more often, from people who are part of their administration or caregiving staff who get additional training, such as a masters degree.”

End-of-life issues number one

“Probably the most glaring problem that endures and continues is end-of-life issues, where, when you stop and think that the Karen Quinlan case was in 1975-76 — that’s 35 years ago . . . and yet hospitals all over the country, as we speak, are having trouble over issues of discontinuation and withholding of life-prolonging treatment,” Banja says.

Like the Karen Quinlan case, Banja notes, the issues “oftentimes are relational issues . . . between the health care team and the family, the patient’s family, but oddly, the proponents of the positions have changed.”

For example, in the time of the Quinlan case, “it was the health care providers who aggressively wanted to treat [such] patients, when family members were saying, ‘We don’t want you to treat them anymore.’ Today, it’s just the opposite, with the health care team being quite comfortable in de-escalating treatment — and usually a very demanding family wanting you to do everything for their loved one,” Banja says.

Addressing end-of-life questions is probably the number one issue confronting hospital ethics committees, Banja says.

“I think the root issue that maintains this as a problem is the failure of health care providers to improve their empathic communications,” he notes. “I think we still have a long way to go in our medical curriculum and in our nursing curriculum to teach health care professionals how to conduct emotionally uncomfortable conversations, and to do it in a way where the patient or the family — usually it’s the family in these end-of-life cases — feel respected, feel understood, and feel supported. So, [then] they can go ahead and make a decision that they would, of course, not wanted to have made, in a situation that they would give anything to have come out differently than their loved one dying,” Banja says.

Not only does he think medical schools and

nursing schools should offer specific courses in communication skills, but also they should be “repeated and revisited” every year for these students, until they become adroit in “emotionally stressful, emotionally difficult kinds of conversations.”

Not only do empathic conversations help the patient and family feel more appreciated and respected, they also often help health care providers elicit more information from the patients and their families, “so that [the health care provider] can make sound clinical decisions,” he says.

“I think it makes them more appreciative of the doctor-patient relationship — less narcissistic, more appreciative of what is really a relationship, upon which a lot depends,” Banja says. “The outcome of the course of treatment may very, very often depend on how much that patient or family members trusts the doctor.”

What is old is also new

As a result of ethicists being more of the norm on health care provider staffs than the exception, “increasingly, health care institutions turn to such people when a new area of issues opens up,” Kuczewski says.

“I think there are some areas that we’ve seen newly evolving or recently coming into the limelight, one of which obviously, we’ve talked about in the context of public health — disaster planning and that area — but I really think that one of the driving forces behind what we’ve seen — that goes back to the beginning but has evolved into new issues — is the impact of advances in science and technology,” Hiller says.

“And as science has advanced and as new technology has evolved, we’re confronting a lot of different issues that reflect the main, core ethical questions but manifest themselves in different ways,” Hiller notes.

In clinical ethics, Hiller suggests that “the biggest domain that we’re going to be wrestling with in the future is regarding genetics.”

With the successful mapping of the human genome, he says, a host of issues have come to the fore, such as stem cell research and issues involving genetic testing. Within genetic testing, society will face questions such as “who is going to be tested for what, and who’s going to have access to results of those tests — and the risk of discrimination and employment-related questions that come up within the context of genetic

testing [and] the workplace.

“We’re probably going to be wrestling with, again, issues [that arose] within the last decade or so that are becoming more prominent in the context of: What are the issues associated with what has been referred to or termed designer babies, where people can go out and say: ‘I want this characteristic vs. that characteristic in my newborn,’” Hiller says.

Another issue related to assisted fertilization came to the forefront — not just in health care circles, but also in the mainstream consciousness — just last year, with the birth of the octuplets.

“As more and more people, because of changes in our society, are choosing to create families later in life, and the inherent need often to benefit from technologies that have advanced, there are implications of those technologies — obviously, one being that multiple births are now becoming much more of a norm than they were 25 years ago,” Hiller says.

Multiple births, in excess of twins and triplets, create ethical dilemmas. One of those is whether a decision should be made prior to birth to prevent multiple births, such as the octuplets to one parent, Hiller says.

Hiller expects even more questions related to genetic screening and testing. For example, if genetic screening and testing uncover that an individual is at a higher risk for a particular disease, should that individual be told of his or her increased risk?

“Is it fair to tell someone, ‘Yes, you are at some point going to develop Huntington’s chorea, and we have absolutely no way of preventing and/or treating that disease, so you can live your entire life — however many years that may be — under this fear that this is going to happen to you, and there’s nothing that can be done to help you,’” Hiller says.

“Is it better for that person not to know that and live their life . . . with a sense of quality?” Hiller asks.

Ethicists are now “at the table”

The real change, according to Kuczewski, is that these types of high-level problems, which require complex answers — from the new reliance on medical homes to repatriation of ventilator-dependent undocumented immigrants — is that medical ethicists are now at the decision-making table.

And ethicists, he notes, contribute to the topics

SOURCES

- **John D. Banja**, PhD, Clinical Ethicist, Center for Ethics; Associate Professor of Rehabilitative Medicine, Emory University, Atlanta, GA. E-mail: jbanja@emory.edu.
- **Marc D. Hiller**, DrPH, of the Department of Health Management and Policy in the College of Health and Human Services at the University of New Hampshire in Durham, NH. E-mail: marc.hiller@unh.edu.
- **Mark Kuczewski**, PhD, The Fr. Michael I. English, SJ, Professor of Medical Ethics, and director, Neiswanger Institute for Bioethics & Health Policy, Stritch School of Medicine, Loyola University in Chicago, and current president of the American Society for Bioethics and Humanities.

that are top-of-mind, in many cases.

“Typically, ethicists start to look at issues and to write about them and to chart them,” Kuczewski says. “Then, there’s a complex process that tends to happen that brings an area to the fore. Certainly, in research ethics, scandal has often done that, [like] the Jesse Gelsinger case in the 1990s, which brought [forth] the relationship of a study sponsor to a physician investigator, so that brings it to the fore. And then, there is kind of an orderly process where you do have reports issued from core bodies . . . that offer guidelines — and again, ethicists participating in this process the whole way,” he notes. ■

As ethics enters mainstream, “politicization” results

Media often distort information

One fortunate change in 25 years is that medical ethics has entered the mainstream of discussion and debate, but increased visibility can have unfortunate drawbacks, as well.

Medical ethics often involves an aspect of law and policy at the federal or state level, as much as it includes patient/family decision-making with the physician or other health care provider at hand.

“To me, the most upsetting thing that has

occurred over the last 10 years has been the way so many of these bioethical issues become politicized, and quite frankly, distorted by politicians and the media,” **John D. Banja**, PhD, tells *Medical Ethics Advisor*.

“With these health care reform debates, we’ve seen so many people — and let us hope they’re not representative of America — I mean, people acting in a very selfish, narcissistic kind of way [by saying] ‘I’m concerned about what this health care reform means particularly to me; I don’t want to lose my benefits.’ And number two, we’ve seen, I believe, a profoundly uninformed public nevertheless weighing in on these kinds of issues,” Banja says.

Death panels, or end-of-life conversations?

Probably the most widely publicized disagreement in meaning was then Gov. Sarah Palin’s terming as “death panels” what medical ethicists say were simply financial incentives included, at one time, in health care reform legislation, as a way to incentivize physicians to have end-of-life planning conversations with their patients.

According to Kuczewski, the legislation’s financial incentive provision “was just a meager attempt to say, ‘Well, if we give some reimbursement for this, maybe more people will have these conversations with their doctors.’”

In the proposed legislation at that time, Kuczewski says, “the doctor could claim a small reimbursement for having a conference with the patient to talk about their end-of-life wishes and advance directives.”

The “hopeful” aspect of the attention the topic received was that as a result, the thinking shared by many in health care — that patients are not participating to the extent they could in their overall plan of care — is “getting some attention nationally,” he says.

Confusion over screening mammogram debate

Another difference of opinion between a medical ethics approach and politicization occurred approaching the end of 2009, Banja says, when new research supported a change in existing guidelines by suggesting that women would not get screening mammograms until the age of 50. The previous screening guidelines suggested that women begin getting screening mammograms at age 40.

“The Obama [health care reform] plan was

being criticized because of the possibility that it might not cover screening mammograms for women, and that caused a big furor," Banja says, noting that this particular message was a "falsehood."

"Doesn't America understand that those kinds of problems are part and parcel of what it means to provide insurance coverage? That insurance companies are constantly making these benefits-burdens tradeoffs, [that is], if we pay for this particular coverage, it may cost us a tremendous amount of money and may actually not yield very, very much by way of patient satisfaction or patient treatment," Banja says.

What is likely to come

Participatory democracies "work best when the public is informed," Banja says, and that is endangered when various media either don't understand or distort the truth.

"I'm very, very worried that . . . so many of the ethical dilemmas are going to be politicized, and in the process of that, we're going to lose the kind of rational and informed debate we should have about these kinds of issues," Banja says.

Rather than becoming educated about ethical issues related to health care provision in the United States, Banja suggests that instead, individuals may make choices because a particular news pundit suggests they see the issue a certain way.

"That's one of the most upsetting things I'm anticipating for the next decade," he says. ■

MT court rules state policy allows assisted suicide

Opinion issued in Baxter v. Montana

The Montana Supreme Court issued a ruling just as 2009 ended, on Dec. 31, which determined Montanans have the right — under that state's public policy — to seek a physician's aid in assisted suicide, with no threat of sanction or legal action against the physician.

The opinion was issued in favor of the plaintiff in *Baxter v. Montana*, which also included as plaintiffs certain physicians and the nonprofit group, Compassion & Choices, whose mission is to improve care and expand choice at the end of

life.

That means Montana joins Oregon and Washington in being the third state to allow assisted suicide.

At least, Montanans who are mentally competent and terminally ill have this right unless or until the state's legislature should decide to take up the matter when it convenes again. The state's law-making body will not meet again until 2011, as Montana's legislature convenes every two years.

"This case was about the right of mentally competent, terminally ill patients to request a prescription for medication from their doctors, which they can ingest to bring about a peaceful death," said Compassion & Choices Director of Legal Affairs **Kathryn L. Tucker**, co-counsel to the plaintiffs/respondents, in a news release.

"The Montana Supreme Court has determined that this is a choice the public policy of Montana supports. Montanans trapped in an unbearable dying process deserve, and will now have, this end-of-life choice. This is the first state high court to find protection of this choice, and makes clear that in Montana, patients are able to make this choice and physicians can provide this care without risking sanction."

Roberta King, of Missoula, the daughter of plaintiff Bob Baxter, said in a statement in the release, "My father died without the peace and dignity he so dearly wanted for himself and others. He feared when he filed this lawsuit that he would not live long enough to benefit from it. I'm sure he would be deeply gratified that other terminally ill Montanans will have the choice and comfort that aid in dying affords them."

Missoula attorney **Mark Connell**, who argued the case before the Montana Supreme Court on behalf of the plaintiff physicians and patients, said in the release that the high court's decision is "a victory for individual rights over government control. "The Montana Supreme Court has now recognized that, where intensely personal and private choices regarding end-of-life care are involved, Montana law entrusts those decisions to the individuals whose lives are at stake — not the government."

Legislature could reverse decision

Tucker noted in the release that there is no further appeal from this decision in a court of law, as the Montana Supreme Court is the "highest court available to decide state issues."

However, following the ruling, Montana's State Solicitor, Anthony Johnstone, released a statement on the Montana Supreme Court's decision, saying, "Today, the Montana Supreme Court recognized that physician-assisted suicide is a policy question for the people of Montana and their legislature. As we have argued, that is where the resolution of this important issue belongs."

Also, the release noted that, with its decision, "The Court rejected a broad constitutional challenge to the state's homicide law. Instead, the Court's decision allowed a narrow defense under existing law for physicians who assist in the death of a consenting, terminally ill patient."

As for the possibilities that the ruling could be reversed legislatively, Tucker tells *MEA* that "there [are] a number of things that could happen. First, as it stands now in Montana, we have clarity that patients can ask for aid in dying, and physicians can provide it. And that will remain the law of the state until the legislature, in its wisdom, takes action, which it may choose to do — and it may choose not to do. "So, between now and 2011, this is the law of the state, and we expect that patients will start having open, candid conversations with their physicians about their end-of-life wishes, including if they want aid in dying, and that Montana physicians who would provide that intervention will feel safe and confident about doing so," Tucker says.

In the ruling, the court relied heavily on language in an existing Montana statute, the Rights of the Terminally Ill Act, passed by the state legislature in 1985, according to the opinion. That piece of legislation "squarely addresses the modern complexities of physician- and technology-dependent end-of-life care provided to terminally ill Montanans."

The Rights of the Terminally Ill Act is part of a "carefully cultivated . . . statutory scheme that gives terminally ill Montanans the right to autonomously choose what happens to them at the end of painful terminal illness," according to the Montana Supreme Court ruling.

Baxter v. Montana, according to Tucker, also challenged one of that state's criminal statutes.

"The fear in the physician community was if the physician provides a prescription for a dying patient, which the patient could ingest to bring about a peaceful death — if the physician did that, and the patient consumed the medication and died, the question was: Could that physician be prosecuted under the physician homicide

statute? What the court said was that in the Montana homicide law, if the person whose death is precipitated has consented to that death, then there isn't a basis to prosecute someone for homicide, unless there would be a public policy reason to do so."

At that point, the court relied on the Rights of the Terminally Ill Act, she said, to demonstrate that there would be "no public policy to support prosecuting a physician who provides aid in dying."

There are exceptions outlined in the ruling where a physician could be prosecuted by providing medication to allow a patient to take his or her own life.

"If there were duress or coercion," Tucker says. "I mean, obviously, there would be situations where you did want to prosecute a doctor or if anyone tried to force a patient to their death — that would still be prosecuted."

Tucker contends that anyone or any group that would hope to criminalize what Compassion & Choices terms as "aid in dying" in Montana would have an uphill battle.

"I think the reality is that there is very broad, public support for dying patients having this choice in Montana, as is true across the nation," she notes. "The burden on these so-called right-to-life activists, who might want to introduce an aid-in-dying crime, would be to convince legislators — in the face of such broad, public support to enact a fresh, new crime that would target physicians providing this compassionate option to suffering and dying patients. I think that's a very hard bill to pass in any legislature," she explains.

Tucker says that there is only one state — Arkansas — in the United States that "has ever passed such a bill."

How Oregon, Washington differ

The path to permission for assisted suicide was different for Oregon and Washington, compared to Montana.

"Oregon and Washington, because they established the right to aid in dying through statutory enactment, the statutes are what govern in those states," Tucker explains.

Accordingly, there is a defined process that an individual and his or her physician must follow in order to legally pursue and complete assisted suicide in Oregon and Washington.

"They have all of these provisions built into the statute about witnessing and waiting periods and reporting requirements," Tucker notes. "Those

SOURCE

• **Kathryn L. Tucker**, Director of Legal Affairs, Compassion & Choices. E-mail: ktucker@compassionandchoices.org.

provisions don't apply in Montana, [because] Montana doesn't have, at this time, statutory enactment."

"The common element among the three states [is] that they all limit the choice of aid in dying to mentally competent, terminally ill patients who can self-administer medication that would bring about a peaceful death," she explains. ■

Authors: Be sensitive to patient ability to pay

Doctors can assist when patients self-pay

With the advent of consumer-directed health care (CDHC), two professors argue, contrary to the common notion that physicians should ignore financial considerations when treating patients, that it is entirely appropriate for physicians to be sensitive to a patient's financial position when a patient is paying out of pocket. In fact, what most ails the patient may be his or her financial ability to pay for optimal health care services.

That is the message **Mark Hall, JD**, Fred D. & Elizabeth L. Turnage professor of law & public health and director, Center for Bioethics, Health & Society, Wake Forest University, Winston-Salem, NC, conveys in an article he co-authored titled "Professional obligations when patients pay out of pocket." The article was published in *The Journal of Family Practice* in November and co-authored by Carl E. Schneider, Chauncey Stillman professor of law and professor of internal medicine, University of Michigan in Ann Arbor.¹

"Patients' modest understanding of health insurance, providers, and medicine rarely equips them to make medically and financially prudent decisions," the authors write.¹ "For sound information and sage guidance, your patients must rely on you, their physicians. In other words,

under CDHC, patients present not just with medical symptoms and a social history, but also with a financial condition."

Self-paying patients are not new to medicine, as that is how the practice of medicine began before the advent of health insurance, Hall notes.

"It's only been in the last 50 years that money has sort of receded, as insurance became more comprehensive and more widespread, first for hospitalization and then for physician fees," Hall says. "Physicians have had the luxury of the last several decades [of] just assuming most patients had pretty good coverage."

Traditionally, family doctors may have known their patients and their family and financial situations so well that they could recommend the best course of action to those patients without directly addressing finances.

"In the past, a hundred years ago, they did that," Hall tells *Medical Ethics Advisor*. "In the classic situation, the doctor delivered the baby and knew the parents and knew everything about the family — some even made house calls . . . and so they understood what the family could afford and what they couldn't, and could adapt their recommendations accordingly. [Money] wasn't put front and center, in that it wasn't negotiated, but it was just that the doctor made informed decisions about what made sense under the circumstances and then would send periodic bills and collect them — and sometimes not," Hall explains.

Hall maintains that the CDHC movement started even before the current economic downturn, in which so many have lost health insurance.

"It's really a reaction — a backlash to the concept of managed care and the idea that people didn't want insurance companies telling them what [they would pay for and what they wouldn't pay for]," he explains.

"But physicians had adapted their practice styles based on their assumption that most patients had insurance coverage. And they practiced historically in a way that they would do what is best for the patient, "and somehow the bill would get paid, and for the percentage that didn't pay, well, that's just professional obligation," he says.

"But now, we're looking at a situation where for many patients, or perhaps for most, at least in a primary care setting, and especially in a referral setting, those understandings are beginning to return to the old days, where patients pay a good portion, or the entire portion of the bill," Hall says.

SOURCE

• **Mark Hall, JD, Fred D. & Elizabeth L. Turnage**
professor of law & public health and director, Center for
Bioethics, Health & Society, Wake Forest University,
Winston-Salem, NC. E-mail: hallma@wfu.edu.

Strategies to approach the topic

In the article, Hall and Schneider note that if physicians are to help their self-pay patients, they “need to know to what extent money is an issue for patient.” That means somehow addressing the topic of money and ability to pay with the patient.

“But both doctors and patients often dislike discussing money,” the authors write.¹

Still, they write, “patients may be grateful for help in acknowledging the elephant in the room.”

The authors suggest that physicians, therefore, “approach finances as forthrightly as you would a potentially embarrassing clinical problem.”¹

Some of the physicians interviewed for the article suggested that physicians “watch for clues patients give” about their financial situation, just as they would when patients provide clues to their health situation.¹

“One doctor we interviewed at a low-income clinic said that his patients may be ashamed or embarrassed to acknowledge their financial problems,” the authors write.

The authors also encourage physicians to “share your knowledge of treatment costs” to help the patient with decision-making.

Reference

1. Hall, Mark A. Schneider, Carl E. “Professional obligations when patients pay out of pocket.” *The Journal of Family Practice*. Vol. 58. No. 11, November 2009. ■

Organ donation and the use of psychosocial criteria

UNC philosopher has “justice concerns”

While **Rebecca Walker**, PhD, assistant professor, Department of Social Medicine Adjunct Assistant Professor, Department of Philosophy at

the University of North Carolina at Chapel Hill, says she does not “mean any one thing” by the use of the term “justice,” she does have justice concerns regarding the use of psychosocial criteria in determining individuals who are selected to receive organs from donation for transplantation.

Walker gave a presentation on this topic at the American Society of Bioethics and Humanities annual conference in Washington, DC, in October, and spoke to *Medical Ethics Advisor* later in the year regarding that presentation.

“I’m talking about theoretical perspectives on justice, and in particular, I think I look at utilitarian considerations and equity-based considerations . . . I don’t have an assumption about what constitutes justice,” Walker tells *MEA*.

“And then I also think about substantive concerns, and by that I mean how you would actually allocate things, in comparison with procedural concerns, so, how you would go about setting up the right process for allocation,” she explains.

One of her concerns about the use of psychosocial criteria is that the criteria in use don’t appear to be uniform from institution to institution, and what is meant by that term within the transplant community.

Although she says that within the transplant community anything described as psychosocial means anything non-medical, “it’s not really what you might think of as psychosocial.”

“So, you might think that term would just indicate psychological issues or social issues, like support networks,” Walker explains. “It means those things, but it also means behavioral issues. So, things like addiction would be encompassed by that term.”

As for other conditions that might be considered as part of psychosocial criteria, she explains, “Well, this is, again, an area where it’s kind of tricky, because there are different kinds of criteria that get considered in different places, so it’s not entirely clear what the full, comprehensive list would be. But the kinds of things that can be considered, as I mentioned, [one is] social support, which would be ‘Is your family going to be able to support you through this process? Are there other people who are going to be able to help you [following transplantation]?’”

The behavioral issues that come into play relate to addiction, including alcohol, cigarette, and illegal drug use. However, it might also mean “cognitive capacity,” Walker says.

Walker's specific concerns

Walker says there are “a number of areas” that create concern. For example, she notes, the assessments of potential recipients “take place as a determination of whether or not a person is eligible for receiving an organ at all. So, it’s not a question of determining how high somebody is on a priority list, but rather determining if someone is eligible or completely not eligible for the resource.”

The essential problem, as she sees it, is that “it’s not entirely clear what the relationship is between some psychosocial evaluations and outcomes after transplant. So, you would think that if a psychosocial evaluation was going to cut somebody off from the possibility of receiving an organ at all, that you’d want to have very, very strong reasons for thinking that the organ actually would not do [the recipient] any good, or would be very badly allocated if you allocated it to [a particular recipient],” she explains.

There is a Catch-22 to this situation, as she explains it, which is that because individuals with addiction issues, for example, are typically screened out of receiving organs for transplant, there’s very little “good” research to determine how they fare on health outcomes.

“So, for some kinds of psychiatric disorders, for example, there just really isn’t very good research,” Walker says. “For some kinds of criteria, there [are] some kinds of research, but it’s not really clear what the implications are. The only kind of meta-analysis that I could find on psychosocial evaluations across the board, it really seemed like there wasn’t very good overall evidence, so that was something that, I think, was a little bit concerning.”

As to how psychosocial criteria became part of the screening criteria for organ recipients, she says that she believes people “just think that there’s good reason to think that these criteria are linked to outcomes . . .”

In theory, she notes, it may “seem like that’s correct.”

Standardizing the criteria

While she hasn’t found evidence-based medical research that would indicate psychosocial criteria are necessarily linked to outcomes, she does think that psychosocial evaluations can play a valuable role in identifying “needs that potential recipients have and hooking them up with ser-

SOURCE

• **Rebecca Walker**, PhD, Assistant Professor, Department of Social Medicine Adjunct Assistant Professor, Department of Philosophy University of North Carolina at Chapel Hill. Email: rlwalker@med.unc.edu

vices that can fill those needs.”

Transparency is also very important, she notes. If institutions are going to use these criteria, she suggests that they make the evaluation process transparent to both potential recipients and their families, as well as to the general public.

Another area of concern relates to standardizing the criteria, so that the same criteria are used by all institutions.

“It is pretty clear that not everybody is using the same criteria,” Walker says. “There’s no obvious reason why people should use different criteria, other than sort of specific institutional features. If those are important, then those could be recognized in a transparent way,” she says.

On a positive note, she does think this is a topic that is just now coming to the forefront of people’s thinking when it comes to organ allocation.

“I think as it comes out more as something to think about — not just in terms of where the organs should go, but in terms of justice concerns, I think they’re more likely to take some action,” Walker says. ■



Four physicians honored for end-of-life care

A surgeon and a pediatrician are among the four American physicians have been named as recipients of the first Hastings Center Cunniff-Dixon Physician Awards.

The awards were given by the Cunniff-Dixon

Foundation, whose mission is to enrich the doctor-patient relationship at the end of life, in partnership with The Hastings Center in Garrison, NY.

Robert A. Milch, MD, FACS, of The Center for Hospice and Palliative Care, near Buffalo, NY, will receive the established physician award of \$50,000. He has been involved with hospice and palliative care for more than 30 years, most of it at Hospice Buffalo, where he initially served as a volunteer medical director.

Early-career physician awards of \$15,000 each will be given to Elisabeth Potts Dellon, MD, MPH, of the University of North Carolina; Jeffrey N. Stoneberg, DO, of San Diego Hospice and The Institute for Palliative Medicine; and Eytan Szmuiłowicz, MD, of Northwestern Medical Center in Chicago.

The Cunniff-Dixon Foundation was founded in 2005 by Matthew A. Baxter in memory of his wife, Carley Cunniff, who died of breast cancer, and her attending physician, Peter S. Dixon, MD, who has a private practice in Essex, CT.

"He was the guiding light who enabled her to die a peaceful death at home with her family and loved ones," said Baxter in a statement from The Hastings Center news release. ■

CMS, ONC issue EHR definition

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) in late 2009 issued two regulations - for which they are seeking public comment — regarding "meaningful use" of electronic health records (EHRs).

The regulations are designed to help implement the EHR incentive programs enacted under the American Recovery and Reinvestment Act of 2009 (ARRA).

A proposed rule issued by CMS outlines proposed provisions governing the EHR incentive programs, including defining the central concept of "meaningful use" of EHR technology.

An interim final regulation (IFR) issued by ONC sets initial standards, implementation specifications, and certification criteria for EHR technology.

Both regulations are open to public comment.

"These regulations are closely linked," said **Charlene Frizzera**, CMS acting administrator in a news release issued by the U.S. Department of Health & Human Services. "CMS's proposed regulation would define and specify how to demonstrate 'meaningful use' of EHR technology, which is a prerequisite for receiving the Medicare incentive payments.

"Our rule also outlines the proposed payment methodologies for the Medicare and Medicaid HER incentive programs. ONC's regulation sets forth the standards and specifications that will enhance the interoperability, functionality, utility, and security of health information technology," Frizzera said.

The IFR issued by ONC describes the standards that must be met by certified EHR technology to exchange health care information among providers and between providers and patients. This initial set of standards begins to define a common language to ensure accurate and secure health information exchange across different EHR systems.

The IFR describes standard formats for clinical summaries and prescriptions; standard terms to describe clinical problems, procedures, laboratory tests, medications, and allergies; and standards for the secure transportation of this information along the Internet, according to the HHS news release.

The IFR calls for the industry to standardize the way in which EHR information is exchanged between organizations and sets forth criteria required for an EHR technology to be certified. These standards are designed to support meaningful use and data exchange among providers who must use certified EHR technology to qualify for the Medicare and Medicaid incentives.

Under the statute, HHS was required to adopt an initial set of standards for EHR technology by Dec. 31, 2009. The IFR will go into effect 30 days after publication, with an opportunity for public comment and refinement over the next 60 days. A final rule will be issued in 2010.

The American Medical Association issued a statement by board member **Steven J. Stack**, MD, who said, "The AMA is committed to HER adoption that streamlines physician practices and helps them continue providing high-quality care to patients. We will carefully review the proposed rules on standards for HER use and incentives and provide our formal comments before the 60-day comment period ends."

"We have provided ongoing input this year on standards for the use of EHRs, and have stressed the importance of realistic time frames for adop-

tion, the removal of extraneous requirements that would delay successful adoption and reasonable reporting requirements.

“We want physicians in all practice sizes and specialties to be able to take advantage of the stimulus incentives and adopt new technologies that can improve patient care and physician workflow.” ■

NHPCO commissions book for the seriously ill

The “Legal Guide for the Seriously Ill” - a project by the American Bar Association Commission on Law and Aging commissioned by the National Hospice and Palliative Care Organization (NHPCO) — was designed for both the seriously ill individual and those caring for someone who is seriously ill.

The guide explains “Seven Key Steps” while offering additional tips and resources for readers looking for more detailed information and guidance.

The recently released guide addresses societal issues that have gained prominent media attention in recent years, such as paying for health care, managing health and personal decisions, and patient rights.

In addition, the Legal Guide for the Seriously Ill is designed to shed light on recent legislative and regulatory changes, such as the recently enacted American Recovery and Reinvestment Act of 2009, which provides a 35% subsidy of the COBRA premium for up to nine months, according to a NHPCO release.

The NHPCO said “the views expressed in the book have not been approved by the House of Delegates or the Board of Governors of the American Bar Association and, accordingly, should not be construed as representing the policy of the ABA.

Ellen M. Klem, staff attorney of the ABA Commission on Law and the Aging, indicates that the book does not give legal advice, but is designed to “arm readers with knowledge about the options they have during this difficult time.” ■

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 with the **June** issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a credit letter. When your evaluation is

CME objectives

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

- Discuss new developments in regulation and health care system approaches to bioethical issues applicable to specific health care systems.
- Explain the implications for new developments in bioethics as it relates to all aspects of patient care and health care delivery in institutional settings.
- Discuss the effect of bioethics on patients, their families, physicians, and society. ■

COMING IN FUTURE MONTHS

■ The ethics of neuroimaging

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CME Questions

1. What issue continues to be brought by providers to hospital ethics committees most often, according to John Banja, PhD, clinical ethicist at Emory University and professor of rehabilitative medicine?
A. abortion
B. end-of-life decision-making
C. physician credentialing
D. fertilization treatments
2. What is the one area within the health care arena that is likely in the future to present the most difficult ethical issues, according to Marc D. Hiller, DrPH, of the Department of Health Management and Policy in the College of Health and Human Services at the University of New Hampshire in Durham, NH?
A. abortion
B. end-of-life decision-making
C. physician conduct
D. genetics
3. According to John D. Banja, PhD, clinical ethicist at Emory University and professor of rehabilitative medicine, what is the most "upsetting" trend related to medical ethics that he anticipates in the future?
A. lack of interest in medical ethics
B. politicization of medical ethics
C. inability to determine hospital policies toward medical ethics
D. abortion
4. The Montana Supreme Court issued a ruling Dec. 31 that would allow mentally competent, terminally ill patients to seek a prescription for life-ending treatment from a physician.
A. True
B. False

Answers: 1. B; 2. D; 3. B; 4. A.