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July 2012: Vol. 28, No. 7
Pages 73-84

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AHC Media

“Rationing” vs. defensive medicine? New approach is neither of the two

Response is “collective sigh of relief”

Some commonly used diagnostic tests or treatments do *not* benefit patients, according to the ABIM Foundation’s “Choosing Wisely” initiative. “This is not about ‘rationing’ care,” says **Christine K. Cassel, MD**, president and CEO of the American Board of Internal Medicine and the ABIM Foundation.

“Physicians and the public have been waiting to have this conversation for some time,” she says. “The response we’ve heard signals to us a collective sigh of relief that we are now able to have reasonable conversations about overuse and waste.”

Nine participating societies produced a list of 45 tests and procedures physicians and patients should question, including an annual stress test in otherwise healthy adults, chest X-rays before outpatient surgery, and antibiotics for acute sinusitis. (To view the complete list of tests and procedures, go to www.choosingwisely.org.)

“We are not talking about care that would benefit patients, but that which could potentially harm,” says Cassel. “Physicians sometimes order tests for defensive reasons. This isn’t good for the patient, and it is not good for the health care system.”

EXECUTIVE SUMMARY

Some commonly used diagnostic tests and treatments often don’t benefit and can potentially harm patients, according to the “Choosing Wisely” initiative, which calls for patients and physicians to work together to make decisions about their care.

- Physicians’ behavior may be driven by protection against malpractice litigation instead of what’s best for the patient.
- “Defensive” medicine adds to costs without benefiting patients.
- Eliminated waste in the health care system frees up much-needed resources.

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While there are times when each and every one of these tests is appropriate, the majority of times they are not necessary, she explains.

“Patients and physicians need to work together to integrate the best medical evidence and patients’ values and preferences in promoting ‘wise’ choices about their care,” says **Steven Weinberger, MD, FACP**, executive vice president and CEO of the American College of Physicians.

Weinberger notes that the physician’s behavior may be driven primarily by self-interest, such as

protection against malpractice litigation, instead of what’s best for the patient.

The practice of “defensive medicine” may add to societal costs without benefiting patients or improving their care, adds Weinberger. “How far is it reasonable or appropriate to go, to make sure every possible diagnosis has been explored, even when unlikely?” he asks.

Waste reduced

Rationing refers to withholding care that benefits patients, says Weinberger, while the “Choosing Wisely” approach aims to “do the opposite — withhold care that does not benefit patients.”

Eliminated waste in the health care system frees up much-needed resources, argues Cassel. “We could deliver on the promise of accessible and affordable care for everyone in our country who needs it and reduce the burden on consumers and employers,” she says.

If providers don’t decrease the overuse and misuse of diagnostic testing and treatments, there will be fewer dollars to spend on care that truly helps patients, adds Weinberger. “Thus, when resources are limited, failure to provide rational care actually makes rationing worse,” he says.

Providers should utilize the “Choosing Wisely” approach with these practices, says Weinberger:

- Being informed about areas of potential overuse and misuse of care;
- Speaking openly with patients about the relative benefits and harm of specific tests and treatments that are overused or misused;
- Avoiding the ethical pitfalls that often contribute to overuse and misuse of care, such as practicing “defensive” medicine, failing to spend time with patients to explain why something is not recommended, or performing tests and procedures due to financial incentives.

Determine “value” of test

If there is potentially some benefit to a test or treatment, providers must balance individual patient and societal needs, says Weinberger — and these may be in conflict.

The issue of cost effectiveness may be raised, for instance, when trying to determine the “value” of a test. “This is obviously an important issue for some forms of cancer treatment that may provide some limited prolongation of life but have significant cost, as well as toxicity,” he says.

Medical Ethics Advisor® (ISSN 0886-0653) is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Medical Ethics Advisor®, P.O. Box 105109, Atlanta, GA 30348.

AHC Media is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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Subscription rates: U.S.A., one year (12 issues), \$499. Add \$17.95 for shipping & handling. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Back issues, when available, are \$83 each. (GST registration number R128870672.)

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EDITORIAL QUESTIONS

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The question, says Weinberger, is how much should individual physicians, payers, and society define what is appropriate to spend to extend life by a limited amount?

Similarly, he says, there are ethical issues involving appropriateness of care at the end of life, in particular, “assuring that patients and families understand how much or little such care may be of benefit, and that their values and preferences are known and taken into account.”

Open discussion is needed

While it may be easier, and even financially beneficial, for the care team to give the patient the tests he or she wants, it is important to have an open discussion in terms the patient can understand about the real risks and benefits, according to **William A. Zoghbi**, MD, FACC, president of the American College of Cardiology.

“Testing and treatment decisions should be based on the needs of the individual patient and the best available evidence,” says Zoghbi. “Sometimes patients believe more care is better care, or more tests are better. This isn’t true.”

An important aspect of patient-centered care is talking about the patient’s goals, preferences, and options for testing and treatment, adds Zoghbi.

“There are times when ‘watch and wait’ is better than a test or an invasive procedure,” he says. “But ‘watch and wait’ can be disconcerting to a patient who is worried about their health.”

The American College of Cardiology has created guidelines called “Appropriate Use Criteria” for many tests and treatments. These help the cardiac care team and patients tailor the right test to the right patient at the right time, Zoghbi explains.

“The ethics that should be driving our health care and decision making are those pertinent to how best to diagnose and treat patients, with the ultimate goal of improving their health outcome and quality of life,” says Zoghbi. (See related story, p. 75, on how “defensive” medicine can harm patients.) ■

SOURCES

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Patients face real risks with “defensive” medicine

It’s often left out of ethical debates

Careful stewardship of scarce resources remains an ethical obligation of physicians, but avoiding harm to patients is a higher priority, argues **Howard Brody**, MD, PhD, John P. McGovern Centennial Chair in Family Medicine and director of the Institute for the Medical Humanities at the University of Texas Medical Branch in Galveston.

Brody says it is not generally appreciated that defensive medicine “is virtually, by definition, unprofessional.” Defensive medicine is generally defined as a test or procedure that the physician does not think is indicated, but is done solely to ward off a hypothetical lawsuit possibility, he notes.

Professionalism requires that the physician do what’s best for the patient, not what’s best for the doctor, says Brody, and avoiding a lawsuit is clearly putting the physician’s self-interest ahead of the interests of the patient.

“That said, it is very sad that good physicians spend so much time and energy worried about lawsuits under the current system,” he says. “Everyone would be better off if there were meaningful changes in the current tort system.”

Brody says the fact that important consumer groups, including Consumer Reports and AARP, are on board with Choosing Wisely and that the media coverage when the initiative was rolled out in April 2012 was largely positive, are a signal of progress.

“They are not saying these tests and procedures should not be done, or not paid for by insurers,” he says. “Rather, they say that before these are done, physicians and patients should have a serious conversation about the pros and cons.”

Ethical justification

Discussions about cost containment typically revolve around “rationing,” and assume that saving money for society is the only ethical justification, as opposed to a far more important ethical justification, says Brody, referring to the adage “primum non nocere.”

“A test or procedure that cannot provide any patient benefit according to our best evidence can still cause harm,” says Brody.

There is no possible justification for exposing patients to that risk of harm if the physician sees no benefit to a test, he argues — at least not unless the patient is fully informed of the risks and chooses to accept them.

“It is very hard to find ethical objections to shared decision-making, which ought to be done routinely in medicine anyway,” says Brody. ■

Study reveals doctors’ unethical online practices

Boards taking serious disciplinary actions

Physicians misrepresented their credentials online, violated patient confidentiality, had inappropriate communications with patients online, and used the Internet to prescribe medications to patients with whom they had no therapeutic relationship, according to a study of violations reported to state medical boards.¹

“My colleagues and I were definitely surprised at how frequently boards were taking serious disciplinary actions such as restriction, suspension, or revocation,” says **Ryan Greysen, MD, MHS, MA**, the lead author of the study and assistant professor of hospital medicine at University of California, San Francisco. “I think it underscores that boards do see this issue as within their responsibilities to regulate.” The researchers published a previous study on unprofessional online content in 2009, focusing on

EXECUTIVE SUMMARY

State medical boards are frequently taking serious disciplinary action against physicians due to unethical online behaviors, including limiting doctors’ licenses to practice medicine.

- One of the most commonly reported violations involved physicians contacting patients socially.
- Physicians should not communicate with patients using publicly accessible social media sites, according to newly developed guidelines.
- Patient confidentiality may be violated, misunderstandings may occur, and patients may learn personal information about providers.

medical students because they thought they would be more frequent users of social media.²

“We began wondering about whether this was just an issue among medical trainees or if this was happening among licensed physicians as well,” Greysen says.

Next, the researchers partnered with the Federation of State Medical Boards to see how the issue was playing out on a national scale. “They immediately appreciated the importance of this issue. They were proactive in forming new policy and guidance in response to our study data, even before it was published,” he says. (To view the FSMB’s 2012 policy on social media, go to: <http://fsmb.org/pdf/nr-social.pdf>. To view the AMA’s 2011 policy on physician use of social media: <http://www.ama-assn.org/ama/pub/meeting/professionalism-social-media.shtml>.)

Education is needed

New social media policies should make it easier for state boards to adopt more consistent standards for oversight, says Greysen. “I think we will see increased awareness about this issue at the regulatory level,” he predicts. “Nonetheless, I think the larger issue going forward will be less about how to more effectively monitor or report physician online behaviors, and more about how to educate and prevent unprofessional behavior online.”

Many hospitals, medical schools, health care systems, or other large practices have their own policies about social media use by physicians and other healthcare professionals at their institutions. “It makes good sense for physicians to familiarize themselves with these more ‘local’ policies as well,” Greysen says. (See related stories on a new social media policy for physicians and some specific ethical challenges involving providers’ use of social media, p. 77.) ■

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- **Ryan Greysen, MD, MHS, MA**, Assistant Professor of Medicine,

New policy outlines ethical social media use

When physicians were first using the Internet to do e-prescribing back in the 1990s, this led to the Federation of State Medical Boards (FSMB) forming a committee to define a physician-patient relationship, recalls **Humayun J. Chaudhry**, DO, MS, FACP, FACOI, the FSMB's president and CEO.

"What we came up with is that it begins any time a patient seeks out a clinician for medical care or advice and that clinician agrees to provide that care, whether at the bedside or electronically," he says.

This year, the FSMB became focused on social media due to research showing that a significant number of medical students were inappropriately using Facebook. "We wondered if there was a similar issue with licensed physicians who had been in practice much longer," says Chaudhry.

Research revealed that almost half of the state boards that investigated unprofessional online behaviors by physicians had to limit a doctor's license to practice medicine as a result.¹

"The mission of the state medical boards in the U.S. is to protect the public, so if they see examples of ethical violations, they will take action," he says. "What was surprising was the extent to which they had been doing this on social media. That was a wake-up call."

Physicians need reminder

One of the most commonly reported ethical violations involved physicians contacting patients socially. "Obviously, that is wrong under any circumstance, but the numbers were quite high when it came to social media," he says.

As a result of the study's findings, an FSMB committee adopted a policy to educate physicians on how to behave ethically online. Often, physicians who behave inappropriately online would never do the same behaviors in person, adds Chaudhry.

"Physicians don't always realize that it's the

exact same equivalent of talking to somebody or examining somebody," says Chaudhry. "It's a little impersonal, yet people end up saying things that are quite personal. These are the kind of conversations that typically occur in the privacy of an examining room."

According to the policy, physicians should not communicate with patients using social media sites accessible by the public at all. "This is not the setting to engage in conversations about health care," says Chaudhry. "The dangers are too great, with too many possibilities for things to go wrong."

Other individuals may see a physician's advice and act on it themselves, third parties may view the communication, and individuals may misrepresent themselves as either the patient or the physician.

"That doesn't mean that physicians and patients should never engage online. There are settings under which those types of encounters can be quite beneficial, especially if there is an access-to-care issue," says Chaudhry, adding that a number of health systems have patient portals with safeguards such as password protection.

"Medical regulators and educators will do their best to educate physicians about what's right and wrong," he says. "But sometimes, technology moves so far ahead that the precautions lag behind a little bit." ■

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Ethical challenges with social media

When a patient is communicating with a provider online, it is "quite easy for a physician to cross ethical boundaries that are inherent to the physician-patient relationship," says **Toby Schonfeld**, PhD, associate professor of medicine and director of the master of arts in bioethics program at the Center for Ethics at Emory University in Atlanta.

"It can be difficult to both communicate meaning and to interpret meaning simply by reading text," says Schonfeld. "Not everyone is equally gifted in clear communication."

Patients may fail to include the severity, frequency, and specificity of their symptoms, they may fail to describe an important symptom or to prioritize symptoms in a way that is diagnostically appropriate, or may fail to emphasize the true nature of their condition.

“Physicians may be unable to recommend interventions or to tailor therapies to a particular patient if the physician is only getting partial information,” says Schonfeld. Health care providers get important non-verbal cues from patients when they see them face-to-face, she adds, and electronic communication eliminates this important tool. Here are other ethical challenges involving online patient-provider communication:

Patient confidentiality may be violated.

Email is only as secure as the service provider and the individual computer’s settings are set to be, says Schonfeld, and many individuals ignore these safeguards.

While academic medical centers often have encryption systems for their communication involving protected health information, retrieving this information requires another step that not all patients will be willing or equipped to take, adds Schonfeld.

Communicating with health care providers via text or a social media site gives the provider access to details of one’s attitudes, habits, or beliefs that the patient might otherwise like to keep secret from their providers, says Schonfeld. “I have a right to safeguard my information and only disclose what I choose,” she underscores. “If the provider goes trolling for information about me on the Internet, he may find out information I have deliberately withheld for whatever reason.”

Patients may learn personal information about providers.

“Communication via some of these sites will require patients to be ‘linked’ to their health care providers in a way that may, in fact, compromise that provider’s privacy,” she adds.

Some providers create separate sites for their professional and personal uses, but making sure cross-over is limited can be a challenge, says Schonfeld.

Misunderstandings may occur.

Providers should think in advance about whether or not they are prepared to engage in electronic communication with their patients, and if so, to what extent, she advises.

“These practices should be made clear to patients at the outset of the relationship,” says Schonfeld. “That way, expectations are clear from the beginning.” ■

Bias toward low-income patients may be unconscious

Physicians wrongly believe they’re likely to sue

Low-income patients are less likely to sue physicians than patients with higher incomes, according to an analysis of litigation rates and medical malpractice claims.¹

The fact that many physicians wrongly believe poor patients are more likely to sue “is a reflection of the ongoing reality of conscious and unconscious bias that impacts health care in a very pervasive way,” says **Augustus A. White III**, MD, PhD, chair of the Culturally Competent Care Education Program at Harvard Medical School in Boston.

In *Seeing Patients: Unconscious Bias in Health Care* (Harvard University Press, 2011), White discusses 13 groups of people that experience disparate care simply because of the group they are in. These include disabled individuals; African-Americans; Native Americans; Asian Americans; Latinos; prisoners; women; the Appalachian poor; certain religious groups; elderly people; obese people; immigrants; and gays, lesbians, bisexual and transgendered people.

“Socioeconomic biases also exist. These can be operative in this situation, as with the myth that poor people are more likely to sue you,” he says. “This can represent either unconscious bias toward poor people, or it could be partially cultural.”

Physicians may rationalize their decision not to accept Medicaid patients, for instance, with the mis-

EXECUTIVE SUMMARY

Many physicians believe low-income patients are more likely to sue, but research suggests the opposite is true.

- Physicians may rationalize their decision not to accept Medicaid patients with the misconception that they’re more likely to sue.
- Transportation, employment status, and lack of access to physicians are barriers to low-income patients seeking redress.
- Training in culturally competent care can help physicians provide equitable care.

conception that poor people are more likely to sue. “This could be an excuse for not wanting to get involved in their care,” White says.

Physicians should obtain training in culturally competent care, says White, to help them provide equitable care to all patients regardless of their gender, sexual preference, or race.

“Even if they think they are not biased toward Asian patients or obese patients, maybe, in fact, they are,” he says. “Physicians need suggestions for how to avoid giving disparate care.”

Lack of access is issue

Arthur R. Derse, MD, JD, director of the Center for Bioethics and Medical Humanities at the Medical College of Wisconsin in Milwaukee, says that if a patient is low-income enough to be eligible for Medicaid and is unemployed, there is less likelihood that a private practice attorney will agree to take his or her case.

“This is because the attorney may be able to recover very little compensation for economic damages because the patient either wasn’t earning anything or didn’t have the potential to earn much,” he says. “Also, low-income patients do not have as many ways to access an attorney as a middle-income or high-income person may.”

Derse says that in his experience, low-income patients are often more accommodating and appreciative of the medical care they receive than high-income patients, who may have higher expectations for quickly delivered services; may be more demanding of additional testing, interventions, and sub-specialty services that may be unnecessary; and have more resources to seek redress should an untoward outcome occur.

Lack of transportation, an inability to articulate what transpired during the medical encounter, and unwillingness of low wage earners who are undocumented immigrants to go to court are other barriers, says Derse.

“If people can’t get medical care anywhere else, they may be unwilling to sue the one physician who is taking care of them,” he adds. “A higher income group can always see a different doctor.” ■

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Should providers warn others of genetic results?

Only do so with patient’s consent

If a genetic test reveals a patient is at high risk for cancer, the ordering physician may think it’s important for this information to be shared with others in the family, but the patient may think otherwise.

“Often, this poses ethical dilemmas. To some extent, the law has something to say about it,” says **Reed E. Pyeritz**, MD, PhD, director of the Center for the Integration of Genetic Healthcare Technologies and professor of medicine and genetics at the University of Pennsylvania. “If the patient says, ‘Don’t share this with anybody,’ the physician is obligated not to share it. That is true not just with genetic testing, but any medical information.”

Because the results of genetic testing could well pertain directly to relatives, the physician may see genetic information as “special” and feel an obligation to warn relatives of a potential risk, says Pyeritz, while others view genetic test results as highly personal, and the most privileged type of information in terms of patient privacy requirements.

EXECUTIVE SUMMARY

If genetic test results have a direct bearing on the health of a patient’s relatives, the physician may feel an obligation to warn them about a potential risk, but the physician is obligated not to share the information without the patient’s consent. If the patient agrees to share the information:

- Physicians can prepare something for the patient to hand out to relatives.
- It is incumbent on the patient to convey the information to his or her relatives.
- Physicians can encourage patients to disclose findings with serious health implications to relatives.

“Undoubtedly, as all sorts of health care providers become more familiar with genetic testing, they will also become more comfortable with the ethical issues involved,” says Pyeritz.

An example of a test with a direct bearing on the health of relatives is any gene that conveys a high risk for cancer, such as BRCA1 and BRCA2, says Pyeritz. “Here, the risk of breast or ovarian cancer for a woman with a mutation is 50% to 80% in her lifetime, and if this risk were known, effective steps could be taken to reduce the risk greatly,” he says.

Even if the test has a direct bearing on the health of a relative, the patient has the right to maintain confidentiality, he stresses. “Physicians would be in violation of the law if they did pass on that information,” says Pyeritz. “There are very strict boundaries. The physician might feel badly about that, but nonetheless, their hands are tied.”

Patient must decide to share

If the patient agrees his or her family members should be aware of the test results, the physician can help by preparing something for the patient to hand out to relatives, Pyeritz explains.

This is more easily done if a family physician is caring for multiple relatives, but this isn't typically the case, he notes. “It really is incumbent on the patient to let the relative know there is something they may want to know about,” Pyeritz says.

The patient can say, for example, “I've been told I'm at risk, and you should talk to your physician about it,” or copy educational material he or she was given and pass these on to a relative.

“The physician doesn't have any obligation beyond that,” Pyeritz says. “The ethical principles that pertain are the standard ones that apply to all medical practice. Autonomy, privacy, and confidentiality are all relevant to this situation.”

There are cases where a compelling argument can be made for reporting genetic findings to relatives, such as a finding with life-threatening or serious health implications such as polycystic kidney disease, according to **Jeffrey Kahn**, PhD, MPH, professor of bioethics and public policy at Johns Hopkins University in Baltimore, MD.

“Usually, the physician will encourage the patient to disclose the information to relatives,” he says. “It would be very difficult to justify disclosure to a relative against the patient's wishes. We would need

to find a parallel to required contact tracing for infectious disease, and I don't think there is an example in genetics.”

Employers have no right

Kahn stresses that employers should “definitely not” have access to genetic testing results, except in situations where genetic information may protect employees in the workplace. For instance, an individual may have some increased risk from workplace exposure to toxic substances that can be predicted based on genetic information.

“But even then, the information should only be available to employers with consent of the individual,” says Kahn.

Even with single gene Mendelian disorders, let alone whole genome sequencing, it is standard practice *not* to share genetic testing results with family members unless the original patient gives his or her consent, says **Charis Eng**, MD, PhD, FACP, chair and director of the Cleveland Clinic's Genomic Medicine Institute in Cleveland, OH.

“It is certainly anathema to even think that employers can have access to whole genome sequencing data,” says Eng. ■

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Study: Most doctors have been untruthful

Lying was “routine for years”

One out of 10 physicians said they had told a patient something untrue in the previous year, according to a 2009 survey of 1,891 practicing physicians nationwide.¹

Barron H. Lerner, MD, professor of medicine and public health at the Columbia University's Mailman School of Public Health in New York City, says the fact that a fair percentage of physicians admit to lying

to patients isn't too surprising. "This was routine for years. In the 1950s and 1960s, lying was rampant in medicine," he says. "You wouldn't expect a 180 degree turn from the past."

It was once commonplace for physicians to "protect" patients by concealing a diagnosis of cancer, adds Lerner. "With the rise of informed consent and autonomy, the pendulum swung away from the paternalistic mindset of protecting people from bad news," he says.

Today's medical students are taught never to lie to patients as an ethical standard, "but I think that is unrealistic," says Lerner. "It's easy to say if you are sitting around a conference table, but with a real patient in front of you, things are more complicated."

Craig Bates, MD, MS, FACEP, clinical assistant professor of emergency medicine at Case School of Medicine and an attending emergency medicine physician at MetroHealth Medical Center, both in Cleveland, OH, says the study "definitely has worrisome results. We all like to believe that physicians are truthful most of the time."

However, Bates notes that interactions with patients are more complicated than single encounters with direct questions and answers would suggest. "There is a lot of information involved in modern health care. Physicians often have to heavily filter this information for patients," he explains.

This can result in information not being passed along to patients, either unintentionally or because it doesn't seem relevant. "If a physician's judgment is off when making those determinations, the result can be major information that is not shared with patients," Bates says. (See related story on "sugar-coating" information given to patients, p. 82.)

EXECUTIVE SUMMARY

One out of 10 physicians reported being untruthful with a patient in the previous year, according to a study, but lying to patients was once much more commonplace in medicine.

- Providers should not conceal information if this impairs the patient's ability to make informed medical decisions.
- Physicians may need to consult with hospital risk managers to become comfortable disclosing errors.
- Patients may need a period of time to process information about a new diagnosis of cancer.

Here are other key findings from the survey:

More than a third of surveyed physicians said it is sometimes OK not to disclose significant medical errors to affected patients.

"Fifty years ago, doctors almost never told patients about errors," says Lerner. "I'll admit that in practice there are often mitigating circumstances. You can't just go marching around the hospital announcing to patients every single time there is an error."

Physicians may need to get comfortable with error disclosure by asking others with expertise for help, such as hospital risk managers. "When I was in medical school, nobody told us how to break bad news," says Lerner. "People did it all the time, but nobody talked about it."

There are now dozens of articles on the Internet on the topic, he notes, with protocols including turning off beepers and giving the patient a hug. "People have been educated on how to do an uncomfortable thing better," he says, adding that the same can happen for error disclosure.

A physician's first inclination may be to hide the error, adds Lerner, "but you have to catch yourself and say, 'wait a minute, times have changed,'" he says. "I'm a strong advocate of disclosing errors. I feel patients deserve to know, and I disclose errors as best I can."

More than a third of surveyed physicians said it is sometimes OK to hide financial relationships with pharmaceutical companies and device makers from patients.

"To me, that is black and white, and I don't see any wiggle room. I think every single patient deserves to know every single potential conflict of interest," says Lerner. "Study after study has shown that doctors are influenced by money."

Lerner suggests that a physician might say to a patient, "I feel obligated to tell you something. This might surprise you, but if this bothers you in any way, here is my phone number and I'm happy to talk to you." ■

REFERENCE

1. Iezzoni LI, Rao SR, DesRoches CM, et al. Survey shows that at least some physicians are not always open or honest with patients. *Health Affairs* 2012;31(2):383-391.

SOURCES

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How much “sugar-coating” is unethical?

Over half (55%) of physicians told a patient that his or her prognosis was more positive than the medical facts warranted within the previous year, according to a survey conducted in 2009 of almost 2,000 physicians in seven specialties.¹

“Sugarcoating” or holding back information is “completely inappropriate” if it impairs the patient’s ability to make informed medical decisions, according to **Craig Bates**, MD, MS, FACEP, clinical assistant professor of emergency medicine at Case School of Medicine and an attending emergency medicine physician at MetroHealth Medical Center, both in Cleveland, OH.

“The question of what is appropriate when discussing prognosis, when there is some ‘gray zone,’ depends on the situation,” he says. “If the patient has to make choices that can alter their course of treatment, it is critical that physicians are as upfront as possible.”

This is the only way that patients can give truly informed consent, emphasizes Bates. “In situations where leaning towards one side or the other will *not* alter the patient’s choices or compromise their ability to give informed consent, I will try to choose the path that seems the best for the patient’s needs at the time,” he says.

Patients may need time

Many patients appreciate information being presented in a more optimistic manner than the facts warrant, says **Barron H. Lerner**, MD, associate professor of Medicine and Public Health at the Columbia University College of Physicians in New York City.

“The lie that gets told the most is when someone has metastatic cancer or end-stage disease. The doctor usually puts a more favorable spin on it at first than is warranted,” he says.

This is to give patients a period of time to process the information. “With a new diagnosis of cancer, there are different ways to talk about it. You can harp on the bad or the good, or be ambiguous and talk about multiple possibilities,” says Lerner.

The physician needs to be careful not to conceal information, however, cautions Lerner. “If patients get too unrealistic in their expectations, I will pull them back to earth a little bit,” he says. “That is not a pleasant thing to do, but it’s certainly in the job description.”

Wait for right time

When a patient presents to an emergency department in cardiac arrest, health care providers know that the chance of meaningful recovery overall is very low, says Bates.

“The trick is that there are a small subset of reversible causes that can have a much better prognosis,” he adds. Identifying those reversible causes will likely require the assistance of family present who can describe the events and any pertinent past medical history.

“If one of those relatives asks me what the probability of survival is during the time period that I am trying to identify reversible causes, I will generally not be forthcoming with specifics,” he says. “I need that family member to focus on providing assistance.”

At that point in time, says Bates, the physician really doesn’t know the chance of survival until reversible causes are exhausted.

“I will make it clear that they have a very serious problem, but I won’t quote statistics,” he says. “As soon as we have determined enough information to figure out the true prognosis, I start informing the family so they know what to expect.” ■

REFERENCE

1. Iezzoni LI, Rao SR, DesRoches CM, et al. Survey shows that at least some physicians are not always open or honest with patients. *Health Affairs* 2012; 31(2):383-391.

Physician payments: Public trust is issue

Payments made to physicians by pharmaceutical companies may undermine the trust of patients and the general public in medicine and science, according to **Henk ten Have**, MD, PhD, director of the Center for Healthcare Ethics at Duquesne University in Pittsburgh, PA.

“The past decade has been characterized by many conflicts and scandals, where sometimes huge payments have been made to medical doctors and researchers without any disclosure,” he says.

Although physicians ethically should reveal potential conflicts of interest, says ten Have, there is systemic underreporting since the disclosure is only voluntary.

“If my doctor is receiving extra payments for the medication he is prescribing from the company producing the medication, how can I be sure that I will receive the medication that is in my interest and not in the interest of the doctor?” he asks.

Similarly, ten Have asks, if virologists are advising governments to buy vaccines, how can the public know if they are acting for the public good or their own financial interests?

“Physicians should have only one primary goal: the best interest of the patient, as endorsed in virtually all codes of ethics,” he says. If a physician is receiving additional gifts and payments besides a salary and usual income, it’s possible that he or she continues to put the patient’s best interest first, but the possibility of a conflict of interest is raised, ten Have explains.

“As a patient, I need to know whether this risk exists or not,” he says. “If the information is publicly available — and I think it certainly should be — it can only be misleading if it is biased and not complete.”

The information should indicate the source of the gift or payment, the quantity, and the frequency, he says, so that patients and the general public can assess the relevancy of the data made public.

If a patient learns that his surgeon received payments from a prosthesis manufacturer, for instance, he may choose to discuss this with the physician to ensure that the prosthesis is actually the best available device and not being recommended simply because of the doctor’s financial interest.

After learning of a financial relationship, “patients may lose trust and confidence in a physician who they have regarded in high esteem for a long time,” says ten Have. “But they can discuss the issue with the physician, and be reassured that the payments have not impacted patient care.”

When physicians receive payments from pharmaceutical companies, they end up wearing two hats, according to **Rosalind Ekman Ladd**, PhD, a visiting scholar in philosophy at Brown University in Providence, RI.

Loyalty or bias toward the sponsoring company can conflict with the doctor-patient relationship, which requires always acting in the patient’s best interest, she emphasizes.

“Many doctors claim that their clinical judgment is not affected by payments from drug companies. But the influence can be subtle and unrecognized,” says Ladd. “Even small souvenirs such as inscribed pens or notepads can establish brand name recognition, which can affect prescription choice.”

Ladd says that her best guess is that disclosure will not protect patients. “Let’s face it: As a patient, you

don’t really know what prescription or treatment is best for you,” she explains.

Even if a physician is unduly influenced by a relationship with a drug company, it may still be the case that that company’s drug is objectively the best medication for a given patient.

“The downside of public disclosure is that it may erode trust in physicians in general, which would be an unfortunate result,” says Ladd. ■

CME INSTRUCTIONS

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1. Read and study the activity, using the provided references for further research.
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CME OBJECTIVES

Upon completion of this educational activity, participants should be able to:

- 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 they relate 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

- DTC advertising poses pitfalls
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- Practices involving involuntary admission

CME QUESTIONS

1. What is the purpose of the ABIM Foundation's "Choosing Wisely" initiative?
 - A. physicians and patients having conversations about the benefits or harm of specific tests and treatments that may not always be necessary
 - B. less involvement from patients regarding decision making regarding specific tests and treatments
 - C. providers avoiding discussions with patients regarding the potential harm of specific tests and treatments
 - D. providers recognizing that certain overused tests and procedures should never be performed
2. According to Reed E. Pyretz, MD, PhD, which does the Federation of State Medical Board's social media policy recommend?
 - A. Physicians and patients should never communicate with one another online.
 - B. Physicians should not communicate with patients using publicly accessible social media sites.
 - C. Providers should not communicate with patients online, even if patient portals with safeguards such as password protection are used.
 - D. Physicians should openly communicate with patients using publicly accessible social media sites.
3. Which is *true* regarding sharing results of genetic testing?
 - A. Physicians can more freely share results of genetic testing with a patient's family members than they can do with other kinds of test results.
 - B. Physicians have an ethical and legal obligation to share test results with relatives if there is a direct bearing on their health, even if this conflicts with the patient's wishes.
 - C. Even if the test has a direct bearing on the health of a relative, the patient has the right to maintain confidentiality.
 - D. It is generally appropriate for employers to obtain this type of information from providers, even without the patient's consent.
4. Which is *true* regarding a physician communicating with a patient about his or her prognosis, according to **Craig Bates**, MD, MS, FACEP?
 - A. Holding back information is often appropriate, even if it impairs the patient's ability to make informed medical decisions.
 - B. If the patient has to make choices that can alter the course of treatment, it is critical that physicians are as upfront as possible.
 - C. In no instances should information be presented by providers in a more optimistic manner than the facts warrant.
 - D. It is sometimes appropriate for physicians to conceal information, even if this results in unrealistic expectations.

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