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ACA ruling is ethical landmark: Health care is "moral imperative"

But many will still lack access to care

The most important ethical implication of the Supreme Court's ruling upholding the Affordable Care Act is "the recognized national responsibility to provide medical care for all citizens," according to **Neil S. Wenger,** MD, MPH, director of the University of California--Los Angeles (UCLA) Health System Ethics Center and professor at UCLA's Division of General Internal Medicine.

"There is a collective responsibility to ensure that people receive the medical care that they need — both because this is respectful for individuals and because it is necessary for the nation as a whole," he says.

The Supreme Court's decision "moves us closer to satisfying what I see as the moral imperative to provide access to health care for all," says **Jeffrey Kahn**, PhD, MPH, professor of bioethics and public policy at Johns Hopkins University in Baltimore, MD.

Ruth Berggren, MD, professor and director of the Center for Medical Humanities & Ethics in the School of Medicine of the University of Texas Health Science Center at San Antonio, says that while the decision "does not *solve* the mismatch between our health needs and our health resources, it opens the door for our society to work towards a more equitable distribution of health, and by extension, to that most American of values, freedom."

Wise use of resources

"The nation will need to grapple with prioritization of use of

EXECUTIVE SUMMARY

The Supreme Court decision upholding the Affordable Care Act is an important step to ensure access to health care for all Americans, according to medical ethics experts. These issues are central:

- The nation will need to grapple with prioritization of use of resources.
- Some people will have problems accessing care under the new system.
- Physicians will need to discuss treatment limitations with patients.

resources, both the distribution between health and other societal programs, as well as within healthcare," says Wenger. "These are value-laden decisions, which means confronting the ethical choices inherent in prioritization." (*See related story, p. 87, on ethical considerations for clinicians when discussing this with patients.*)

Because illness is expensive, patients must take greater responsibility for preventive measures and in caring for their own health, says Berggren.

"If we want to distribute health equitably in our society, we need to ask serious questions about where it is most just to invest the greater portion of our limited health care dollar," she says. "Is it early in life when preventive measures can still become habits or late in life when expensive heroics can only prolong the final weeks?"

The law has its underpinnings in the collective responsibility to ensure that all individuals have the opportunity to receive the medical care they need, which underscores the importance of using health care resources wisely, says Wenger.

"This means that health care professionals have the responsibility to use their knowledge and skills to steward resource use appropriately, and that individuals receiving medical care should similarly be prudent," he says.

Some may lack access

While more than 30 million uninsured individuals will get health coverage, according to some estimates, this still leaves more than 20 million without coverage, and those who are covered are not necessarily guaranteed access, says Berggren. "Thus, affirming the individual mandate is a positive but incomplete step toward the physician's obligation to support access to care for all," she says. (*See related story, p. 87, on ethical implications of the individual mandate.*)

Virtually all patients in Washington state will have insurance or Medicaid coverage and "the promise of access to care" by 2014, says **Doug Myers**, MD, president of the Washington State Medical Association. Society has an obligation to make access to an adequate level of health care available to all its members regardless of ability to pay, he adds.

"Certainly, the ACA is a step towards accomplishing that endeavor," he says. Myers expects to see less inappropriate use of the emergency department due to fewer uninsured individuals — *if* solutions to the anticipated gaps between patient demand and physician supply can be bridged.[1]

"Our mission now is to make sure these patients develop a long-term, stable relationship with a physician to ensure that they get the care they need, when they need it, in an appropriate setting," he says. ■

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Individual mandate: "Right, not privilege"

The Supreme Court's decision to affirm the individual mandate moves the country toward the philosophy that health care is "a right, not a privilege," says **Vivian Ho**, PhD, Baker Institute Chair in Health Economics at Rice University and professor of medicine at Baylor College of Medicine, both in Houston, TX.

Up until now, patients who lacked the financial resources to pay for medical care have had to depend on a patchwork of publicly subsidized clinics and hospitals for health care, Ho explains.

"Even with this public safety net, these patients have experienced long wait times and denial of care. Uninsured patients suffer lower health status and consume less health care, relative to those with health insurance," she says.

The Affordable Care Act provides individuals in families earning up to 133% of the poverty level with Medicaid coverage, and partial subsidies to purchase health insurance for families up to 400% of the poverty level. "These subsidies will allow many more individuals to have health insurance coverage, regardless of their income level," says Ho.

Research suggests that approximately 9% of households in the United States that can afford to purchase health insurance choose not to.[1] When these individuals become seriously ill, federal law requires that most hospitals provide care to these people, regardless of their ability to pay, says Ho.

"The cost of this uncompensated care is born by the taxpayer," she adds. "Therefore, the individual mandate prevents those who can afford to buy health insurance from free-riding on the taxpayer." ■

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Patients likely unprepared for difficult new choices

Physicians incentives are ethical issue

"We offered this treatment previously largely because we were incentivized to do so, but that is no longer the case." This may be a truthful statement in light of the changes resulting from the Affordable Care Act (ACA), but it's unlikely a clinician would say this to a patient, according to **Paul Helft**, MD, director of the Charles Warren Fairbanks Center for Medical Ethics and associate professor in the Department of Medicine at the Indiana University School of Medicine, both in Indianapolis.

The ACA is going to put some clinicians in a difficult ethical position at the bedside — one they are largely unprepared to deal with, he predicts.

"The way the law is constructed is clearly to incentivize hospital systems — which are no more than an amalgamation of individual physicians — to make choices about what treatments we do and do not provide to a population of patients," says Helft.

Patients haven't changed

Currently, when clinicians offer a cost-ineffective treatment to patients, the physician gets paid for providing the treatment, and the cost comes out of the pocket of the government insurance agency or private insurer — not the hospital system, notes Helft.

"That's not going to be the case now. The law, shrewdly in a sense, has re-incentivized us to limit cost-ineffective treatments," he says. "The problem is that patients are not any different after the law than they were before the law."

Patients are likely to expect that they'll be the ones to decide whether to receive a $500,000 treatment that might add a marginal amount of survival, for instance, and clinicians will be put in the uncomfortable position of disavowing patients of this notion.

"It's not going to be people sitting in offices that are going to have to talk to patients and families about this. It's going to be clinicians and nursing," Helft says.

This raises the ethical question of how much physicians should reveal about the role of incentives. "Patients may say, 'How am I ever going trust somebody who is incentivized financially *not* to spend money on my mother?' This will radically alter our relationship with patients," he says.

Pathways and treatment algorithms that are meant to maximize the cost-effectiveness of a given set of diseases "only makes sense," says Helft. "We *should* be making these choices. But we are very much unprepared to do it at the level of the interaction of patients and families. And patients are very unprepared for this."

Public won't accept limits

"If there is a treatment out there, no matter how theoretically cost-ineffective that treatment is, some people are going to want it," Helft says. If the family of a critically ill intensive care unit patient with a poor prognosis is told there is a 1% chance of survival with a given treatment, some families may expect the treatment to be offered if they decide they want the 1% chance, for instance.

"For the last 30 years, that is what we have been doing. Under the ACA, physicians are going to be in a position of saying, 'We did that a year ago, but well, we've reconsidered that. We're not sure that a month of life is worth the tens of thousands of dollars that it's going to cost to provide this treatment,'" he says.

The populace of other countries "is more accepting that we don't just spend money on hopeless treatments, just for the one in a million chance that there will be another month of life," says Helft. "In the U.S, the general public, in the end, is unlikely to accept limitations. They will not accept Accountable Care Organizations saying, 'There are certain treatments we will no longer provide.'" ■

SOURCE

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Diagnostic neuroimaging for psych patients — ethical?

Costly scans may not reveal anything useful

Does a psychiatrist offer diagnostic neuroimaging to their patients and claim to diagnose and treat psychiatric disorders using the results?

"It's misleading to tell patients that we can identify what psychiatric disorder they have, or don't have, by looking at the activity in their brains," says **Seth J. Gillihan**, PhD, visiting assistant professor at Haverford (PA) College and former assistant professor of psychology at the University of Pennsylvania's Center for the Treatment and Study of Anxiety in Philadelphia. "The science simply isn't there at this point."

No useful information

Under certain conditions, it's possible to distinguish a group of individuals with a particular diagnosis from a group of individuals without that diagnosis by showing that, on average, the groups differ in brain activity or brain size, Gillihan explains.

"But generally, there's great variability in the brain measures within groups, such that an individual's diagnostic status tells us almost nothing about what his or her brain will look like," he says. "Knowing a person's brain activity or structure tells us next to nothing about the diagnostic status of that individual."

Therefore, single photon emission computed tomography (SPECT) scans, in the context of a psychiatric evaluation, are not worth what they cost because they don't provide any useful information, says Gillihan.

"It would be a much bigger problem, in terms of patient care, if doctors relied solely on SPECT scans to make psychiatric diagnoses, given the low signal that comes from these scans," he says.

The fact that doctors are instead using them as collateral information in psychiatric assessments, says Gillihan, "should tell us something about the usefulness of these scans, compared to the less expensive and more reliable method of asking patients about their experiences."

EXECUTIVE SUMMARY

Diagnostic neuroimaging scans used for psychiatric patients are costly but don't provide useful information and likely would not change treatment decisions, according to medical ethics experts.

- The scans aren't relied on solely to make psychiatric diagnoses.
- Asking patients about their experiences may be less expensive and more reliable.
- Radiation exposure and incidental findings are two ethical concerns.

"I don't know of many people who think many psych patients can benefit from neuroimaging. We just don't know enough," says **Hank Greely**, JD, director of the Stanford (CA) Law School's Center for Law and the Biosciences and chair of the Stanford Center for Biomedical Ethics steering committee. "And what we do know can probably be revealed by a structural scan, not a functional one."

For instance, a brain tumor in the prefrontal lobes can be a possible explanation for odd behavior without needing SPECT. "Doing useless things but charging money for it — sometimes big money — is an ethical problem," he adds. "This is especially true if what you are doing is very expensive, involves a serious condition like autism, and really cannot lead to any generally accepted findings."

Greely says other ethical problems are interventions without clinical value involving radiation exposure to the brain, and incidental findings such as a potentially medically significant aneurysm or tumor.

"I am optimistic that we will be able to use neuroimaging — whether structural or functional and, if functional, whether SPECT, [positron emission tomography], [functional magnetic resonance imaging], or something else — regularly in diagnosis," says Greely. "We just can't now." ■

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Patients and family may be "easily mesmerized"

It could appear that single photon emission computed tomography (SPECT) scans are offered to psychiatric patients largely for profit, given the cost associated with these scans and the lack of additional information that they provide, says **Seth J. Gillihan**, PhD, visiting assistant professor at Haverford (PA) College.

"That doesn't mean that clinicians cynically market these scans knowing that they have little value," he adds. "My guess is that many genuinely believe that they are useful."

However, even if the scans provided reliable information that duplicated information obtained through lower-tech options like talking to patients, they likely would not change treatment decisions at all, he adds.

"One potential value in these scans is that they confirm for patients that there is a physical basis for what they're experiencing emotionally," he says. "Many patients find this kind of knowledge comforting. It's just that we don't have to image *their* brains to know about the physical basis for psychiatric conditions."

Patients or their loved ones who are looking for answers about why they are suffering may be "especially vulnerable" to suggestions that the answers lie in looking at the brain, adds Gillihan.

"It does seem to be true that most of us are easily mesmerized by color images of the brain, and probably put more stock in what the images are telling us than we should," he says. ■

"Difficult trade-off" with research regs

More low-risk research may occur

The goal of proposed reforms in regulations governing human research subjects is to enhance protections for research subjects while reducing burden, delay, and ambiguity for investigators, according to the National Institutes of Health (NIH) Office of Science Policy, which received more than 1,000 public comments on the proposed changes.

The NIH is dealing with a "difficult trade-off" between giving research participants the right kind of information and control over their participation

EXECUTIVE SUMMARY

Proposed changes to regulations aim to reduce research burdens while protecting research subjects. Some ethical concerns:

- Behavioral research may involve the use of deception or discussion of psychologically disruptive topics.
- Overprotection could deny access to research that could improve medical knowledge.
- Data banks are less useful if individual permission is always required.

and not bogging down research with excessive oversight and consent procedures, according to **Megan Allyse**, PhD, a postdoctoral fellow at the Center for the Integration of Research on Genetics and Ethics/Center for Biomedical Ethics at Stanford (CA) University.

In a 2012 paper, researchers argue that relying on the Health Information Portability and Accountability Act to protect participants from participation-related risks in noninvasive research is insufficient to protect the autonomy and psychological health of potential research participants.[1]

"The current proposed changes were an attempt to see if there were any areas in which oversight requirements could be lowered without sacrificing the autonomy of participants," says Allyse, the paper's lead author.

One suggestion in the proposed regulations was that social science research methodologies — in particular, surveys and interviews — should be exempted from prospective review as long as the informational risks associated with protected health information (PHI) were contained, she notes.

"We found this proposal problematic because it suggests that PHI is the only thing at stake in behavioral research," she says. "On the contrary, there are a variety of potential psychosocial consequences to participating in behavioral research that involves the use of deception or discussion of psychologically disruptive topics."

These include the realization of adverse health risk or status, the experience of significant trauma, severe social stigmatization, persecution, or discrimination.

"We suggest, rather than forcing researchers to relearn the requirements for minimal risk research, some baseline institutional review should be conducted to ensure the actual level of risk at stake in such studies," she says.

Overprotection is concern

Edward Goldman, JD, associate professor in the OB/GYN Program in Sexual Rights and Reproductive Justice at University of Michigan Health System in Ann Arbor, says, however, that as long as privacy is protected, the proposed change would allow more low-risk research to occur without any real risk to the subject population.

"The existing and proposed regulations are designed to protect human subjects from improper research. They are not designed to advance research," says Goldman.

While it is, of course, ethical to protect subjects from harm, overprotection has the potential of causing injury because it could deny some access to research that could improve medical knowledge and treatment, he argues.

"Expanding the regulations to all research should increase safety. But we need to be sure we are not unnecessarily stopping useful research," he says. *(See related story on patient consent and data sets, p. 90.)* ■

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Access to data sets is ethical concern

There are potential ethical concerns in asking donors of blood, DNA, or tissue samples to give consent before those samples could be used in subsequent research, argues **Edward Goldman**, JD, associate professor in the ObGyn Program in Sexual Rights and Reproductive Justice at University of Michigan Health System in Ann Arbor.

"We generally believe that consent is critical to make sure a potential subject wants to participate and to show the public that we are not using their data without their knowledge or permission," he says.

The problem is that as large data sets are accumulated from newborn screening, cancer databanks, and trauma databanks, and the necessary steps are taken to protect privacy, the databanks are less useful if individual permission is always required, says Goldman.

"This is a delicate balancing act. We never want the public to believe we are using clinical data for research without permission. But as these databanks grow, permission is less and less possible," he says.

"The revised regulations seek to expand protection, but do not consider the value of community."

Every academic medical center has large repositories of clinical data that could be used for epidemiological research with proper privacy protection, he explains.

One possible solution is the government's recognizing the value of this data and allowing its use with a general consent from all patients with the opportunity for an opt-out, says Goldman.

"Individual consent may not be possible, due to the large size of the repositories," he acknowledges. "But it is exactly the large size that makes the repository useful for certain types of research."

Genetic samples

There are ethical concerns with the proposed suggestion that participants should be asked to give blanket consent to all future uses of their genetic samples once they are contributed to a biobank, unless the study intends to return results to participants, says **Megan Allyse**, PhD, a postdoctoral fellow at the Center for the Integration of Research on Genetics and Ethics/Center for Biomedical Ethics at Stanford (CA) University.

"As past litigation has demonstrated, participants are often uncomfortable with certain uses of genetic samples — especially if they were not explicitly aware of those uses when they consented," says Allyse.

Allyse argues that since consent is a major stumbling block in many genetic studies, this provision would create a positive incentive to design studies that do not return results.

"Given that most of the ethical analysis that has been done on the subject supports the return of genetic results where feasible, and almost always if the results have direct health implications, this incentive is problematic," she says. ■

Placebos: What place do they have in medicine?

Honesty is foremost ethical concern

There are several ethical questions surrounding the American Medical Association's policy prohibiting physicians from giving substances they believe are placebos to their patients unless the patient is informed of and agrees to use of the substance, according to a 2012 report from the Hastings Center.[1]

Irresponsible use of placebos could harm patients by preventing them from getting more effective treatment, acknowledges **Anne Barnhill**, the report's author and a lecturer for the Department of Medical Ethics and Health Policy at the University of Pennsylvania in Philadelphia.

"Undisclosed use of placebos might violate a patient's autonomy because the patient doesn't have the opportunity to give informed consent," she says. "However, not all ethicists agree that undisclosed placebo use is always a violation of patient autonomy."

Trust is biggest issue

Matthew Wynia, MD, MPH, director of the American Medical Association's Institute for Ethics and an assistant clinical professor at the University of Chicago Hospitals, says that being honest with patients is "absolutely critical, and that holds true when dealing with the use of a placebo."

If patients learn they were given a placebo without their knowledge, this might erode the patients' trust in their individual doctor and also in doctors more generally, says Barnhill.

The patient might feel "duped into taking a 'fake' treatment, or that his doctor is a quack, and the patient might consequently lose trust in his doctor," says Barnhill. "On the other hand, the patient might think that a doctor who uses placebos is really cutting edge, or savvy, about mind-body connections."

Given that the doctor doesn't know what patients will conclude in these cases, the most cautious

EXECUTIVE SUMMARY

Patients could be harmed by irresponsible use of placebos because it prevents them from getting more effective treatment, and they may not have the opportunity to give informed consent.

- Patients may be given the option of comparing a treatment with a placebo.
- The significance of the placebo effect is still being debated.
- Even empathy could be considered as a placebo.

approach to protecting the patient's trust in medicine is for the doctor to tell the patient whether the treatment is commonly considered a placebo, says Barnhill.

Wynia agrees. A physician telling a patient he or she was given a medication when the patient actually got a placebo, such as a saline injection instead of a narcotic for a migraine headache, would be an "egregious practice," he says.

"I suspect that this has gone down substantially," says Wynia. "The value that people place on honesty and shared partnership is so much higher now than it was 30 or 40 years ago," he says. "It's a rare patient these days that would tolerate a doctor they thought was lying to them."

How big is effect?

There is also some debate as to whether the placebo effect exists, says Wynia, noting that if a particular drug is compared with a placebo and both groups of patients get better, this isn't necessarily the result of the placebo effect.

"To really test the placebo effect, you would have to compare it against a 'no treatment' arm," he says. "If you are only comparing a placebo versus a drug, there is a chance that all you are witnessing is regression to the mean."

Of the few studies that have been done with treatment, placebo, and no treatment arms, says Wynia, "it doesn't look like the placebo effect is very large at all. It could be that people are using things as placebos in the belief that the placebo effect is very important, when in fact it may not be."[2] (***See related stories on non-deceptive practices and what constitutes a placebo, p. 92.***) ■

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Non-deceptive options do exist

"It's often argued that patients would be less trusting of their doctors if they later discovered that their physician had intentionally prescribed a placebo," says **Charlotte Blease**, PhD, faculty at the School of Politics, International Studies and Philosophy at the Queen's University Belfast in Northern Ireland, UK.

"Theoretically at least, gone are the days of paternalism in medical practice, whereupon physicians were not obliged to be fully honest about the treatment choices available to patients," she says.

Nowadays, failing to allow patients to make fully informed, autonomous decisions about the treatments available to them, including allowing patients to choose not to be treated, is considered "not only to be unethical but unlawful," says Blease.

While it's usually assumed that for a placebo to work it must involve deception on the part of the medical professional, this isn't necessarily the case, says Blease, pointing to a 2010 study that concluded that open-label placebos may be an effective treatment for irritable bowel syndrome.[1]

"This, at least, opens up the possibility of 'non-deceptive' placebos in clinical practice," Blease says.

If a physician is uncertain about whether a treatment is going to work for a particular patient, he or she may give the patient the option of comparing the results of the treatment with a placebo for a period of time and tracking his or her symptoms.

"That is personalized medicine. It shows respect for the patient and engages them in treatment," says **Matthew Wynia**, MD, MPH, director of the American Medical Association's Institute for Ethics. ■

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Ethical gray area: What *is* a placebo?

When most people hear the word "placebo," they probably think of sugar pills, but some bioethicists argue that even the physician's ability to listen and show empathy could fit the definition.

In fact, there are lots of "gray areas" with regard to what constitutes a placebo, according to **Charlotte Blease**, PhD, faculty at the School of Politics, International Studies and Philosophy at the Queen's University Belfast in Northern Ireland, UK.

In a recent paper, Blease argued that it may be better to use the term "positive care effects" rather than "placebos." "The term placebo seems to conjure up the rather simplistic notion of sugar pills," she explains.[1]

While an American Medical Association's policy requires doctors to tell patients if they believe a treatment is a placebo, it doesn't doesn't explicitly address cases in which the doctor disagrees with the consensus view about whether a treatment *is* a placebo, notes **Anne Barnhill**, a lecturer for the Department of Medical Ethics and Health Policy at the University of Pennsylvania in Philadelphia.

"Doctors might wonder, in those cases, 'Must I report the consensus view about a treatment, or may I just tell the patient what I believe?'" she says.

One kind of "gray area" case is when a physician offers a treatment that he or she believes is effective for the condition being treated, but the physician doesn't know whether it works because it has a specific effect on the condition being treated or whether it works via the placebo effect, says Barnhill.

"Another 'gray area' case is when a physician offers a treatment that she believes has a specific effect on certain conditions," she says. "But for the condition she is now trying to treat, she is unsure whether the treatment has a specific effect or is effective at all." ■

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Melanoma misdiagnosis brings ethical pitfalls

There are multiple ethical and legal considerations involved with the misdiagnosis of a melanoma, according to a recently published commentary.[1]

"It is sometimes very difficult to diagnose a melanoma," says **Jane Grant-Kels**, MD, one of the article's authors and chair and professor of the Department of Dermatology at the University of Connecticut Health Center in Farmington, CT.

Even an expert dermatologist can misdiagnose a melanoma as a benign lesion, and this is especially common in melanomas that are amelanotic or without pigment, adds Grant-Kels. "Once the lesion is biopsied and the correct diagnosis is made, the most important next step is to get the patient appropriately treated. The clinician should not cover up a misdiagnosis," she advises.

A misdiagnosis is not an error, as other experts also may have incorrectly diagnosed the lesion, says Grant-Kels, and this doesn't necessarily mean a malpractice case.

Even if the patient is litigious, that does not mean that they will find an expert to testify against a reasonable doctor who has examined the skin appropriately and missed a melanoma initially because it was a mimicker of a benign lesion, she says.

"The ethical next step is for the clinician to be truthful with the patient and arrange for them to be seen as soon as possible by a skilled surgeon for wide excision and possible sentinel lymph node biopsy," she says.

The major ethical concern with melanoma diagnosis is that some clinicians believe that they need to cover up their error, says Grant-Kels. "That is ethically wrong and will create legal issues. Do not tamper with your records," she says.

Instead, clinicians should add a detailed note to the chart as to why they initially did not recognize the lesion as a melanoma, and "immediately do whatever is needed to get the patient the best care moving forward," she advises. ■

SOURCE

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EXECUTIVE SUMMARY

Difficulties involving melanoma diagnosis pose ethical challenges. To avoid unethical practices, physicians should:
- Never cover up a misdiagnosis.
- Arrange for the patient to be seen by a skilled surgeon.
- Add a detailed note to the chart on why the lesion wasn't initially recognized as a melanoma.

Ethical responses needed for inappropriate requests

Substandard care is biggest issue

When a friend or acquaintance asks for informal medical advice, **Steven Brown,** MD, a clinical associate professor at Texas Tech University in Lubbock, gives this standard reply: "I would be doing you a great disservice by pretending that I could give you good medical advice outside the context of a thorough review of your full medical history and an appropriate physical examination."

The risk of giving substandard care is the biggest ethical issue when an individual asks for medical advice inappropriately, according to Brown.

The format of a medical visit results in good medical care, he says, beginning with the chief complaint, moving on to the history of present illness, then reviewing the past medical history and other symptoms, performing an adequate physical examination, and finally coming up with a plan based on a full consideration of potential diagnoses, testing, and treatments.

"This was developed in the 20th century as a way of ensuring that issues were not overlooked," he says. "This type of evaluation will not happen standing in line at the supermarket."

Incomplete information

"Having incomplete information is almost always a problem outside the formality of an office consultation," says Brown.

When Brown was a medical student, one of his professors told him about a medical intern whose toddler son was having lower abdominal pain. She took him to the emergency room, bringing him not through registration and the throngs of people in the waiting area, but directly to the emergency room doctor.

"The emergency room doctor, thinking he was doing his young colleague a favor, was happy to take a quick look at him, give him a diagnosis of a stomach bug, and let him go home," says Brown.

Several hours later, when the child became more ill, the intern returned with her son, and the doctor now removed his diaper and examined him properly.

As it turned out, the child had testicular torsion, a condition where the testicle becomes twisted, losing its blood supply. The child had to have the testicle removed, a surgery that would not have been necessary if he had been examined properly, as he would have been if he had been treated the same as everyone else, says Brown.

"The lesson to us as medical students was clear: Treat everyone the same way every time, and you won't miss important facts," he says. "You are not doing anyone a favor by taking shortcuts."

Family members

Brown says that appropriate thoroughness is the biggest ethical issue when advice is given outside the context of a full, proper evaluation, and another ethical issue is objectivity. "'The doctor who treats himself has a fool for a patient' refers to the problem of not being objective," he says. "This problem is so profound that the [American Medical Association] Code of Ethics forbids treatment of a family member."

The Texas Medical Board recognizes that there are mitigating factors that sometimes occur, and that emergent or urgent treatment and brief treatment of clearly benign problems does not rise to the level of being unethical, even though it is not ideal, notes Brown.

"The Board also decided that it would be legal to treat family and friends, as long as there are adequate medical records," says Brown. "This requirement ensures that the care is thorough, and follows the proper format of a medical evaluation."

Brown says that another ethical issue is that, if physicians have a family member who is ill, their primary role should be as a comforting son, daughter, father, or mother, not as the doctor. "Who wants their doctor daughter badgering her to lose weight as her physician?" he asks. "It is annoying enough when she does it as her daughter." (***See related story, p. 95, on ethical considerations when physician colleagues are the ones asking for advice.***) ■

EXECUTIVE SUMMARY

Physicians often field inappropriate requests for medical advice from friends, acquaintances, and colleagues, but incomplete information can lead to substandard care.

- Important facts may be missed if shortcuts are taken.
- Advice shouldn't be given outside the context of a full, proper evaluation.
- The format of a medical visit results in good medical care.

SOURCE
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Consider ethics of "curbside consults"

Sometimes an emergency room doctor will ask **Steven Brown**, MD, a cardiologist, "What should I do with this patient?"

"My answer is always the same: 'I can't tell you what to do with the patient,'" says Brown, a clinical associate professor at Texas Tech University in Lubbock. "I can tell them that a hypothetical patient with a problem exactly as they have described to me, with no other issues, can be treated in this way or that."

Brown says that if he were to see the actual patient, however, he might very well learn things that would change his opinion.

"The 'What should I do with the patient?'" question is very common with physician assistants and nurse practitioners, adds Brown, and if this occurs, he asks to speak with their supervising physician.

"The doctor seeing the patient is the one responsible for making that call," he explains. "I am happy to see the patient in the emergency room or, if they feel it is safe, see the patient in the office the next day. But to direct their care would be foolish."

When a physician asks a colleague about a situation with a patient, the physician asking the question assumes professional responsibility for making the final decision, and should be well aware of the limits of such a consultation, says Brown.

It is generally recognized that when advice is offered to the treating physician in this context, there is no physician-patient relationship between the patient and the advising doctor, adds Brown.

"This legal principle underlines the limits of the value of informal advice. It is worth what was paid for it, which is nothing," he says. ■

CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

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 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

■ Failing to offer treatments due to cost

■ Identifying unethical practices in ICUs

■ Including ethics in error disclosure policies

■ Ethical issues involving praying with patients

CME QUESTIONS

1. Which is true regarding single photon emission computed tomography (SPECT) scans, according to **Seth J. Gillihan**, PhD?
   A. SPECT scans clearly provide useful information in the context of a psychiatric evaluation.
   B. It is acceptable for psychiatrists to rely solely on the scans to make psychiatric diagnoses.
   C. If the scans provided reliable information that duplicated information obtained through lower-tech options such as talking with patients, they would likely change treatment decisions in many cases.
   D. It's misleading for a psychiatrist to tell patients that he or she can identify what psychiatric disorder they have, or don't have, by looking at the activity in their brains.

2. Which is true regarding requirements for donors of blood, DNA, or tissue samples to give consent before those samples could be used in subsequent research, according to **Edward Goldman**, JD?
   A. Databanks are less useful if individual permission is always required.
   B. Individual consent may not be possible due to the large size of clinical data repositories.
   C. Participants are often uncomfortable with certain uses of genetic samples, especially if they were not explicitly aware of those uses when they consented.
   D. All of the above.

3. Which is true regarding ethical issues with placebos, according to **Matthew Wynia**, MD, MPH?
   A. For a placebo to work, it must always involve deception on the part of the medical professional.
   B. Giving the patient the option of comparing a treatment with a placebo is an ethical practice.
   C. It is acceptable, in most cases, for physicians to inform patients they were given a medication when they actually got a placebo.
   D. Physicians should bear in mind that studies have overwhelmingly shown the placebo effect to be very important.

4. Which is true regarding physicians responding to requests for medical advice from friends or colleagues, according to **Steven Brown**, MD?
   A. Having incomplete information is almost always a problem outside the formality of an office consultation.
   B. No state medical board allows for mitigating circumstances for physicians to treat family members, even when emergent or urgent treatment is required.
   C. When a physician asks a colleague about a situation with a patient, the physician asking the question no longer assumes professional responsibility for making the final decision.
   D. When a treating physician is given advice by a colleague, there is a clearly recognized patient-physician relationship between the advising doctor and the patient.