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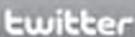
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AHC Media

Do physicians give life support recommendations? Practices vary

Surrogates often aren't asked preferences

Approximately one in five (22%) out of 608 critical care physicians surveyed reported always providing surrogates of critically ill adult patients with a recommendation about limiting life support, while one in 10 (11%) reported rarely or never doing so, according to a just-published study.¹ Surrogates' desires for recommendations and physicians' agreements with surrogates' likely decisions may influence whether recommendations are provided.

"We were surprised to find that while there was broad support for providing life support recommendations to surrogates, there was considerable variation in physicians' reports of providing such recommendations," says **David R. Brush**, MD, the study's lead author and a former fellow in the Section of Pulmonary and Critical Care Medicine and the MacLean Center for Clinical Medical Ethics at the University of Chicago.

The majority of physicians felt it was their duty to provide such recommendations, felt comfortable providing them, and felt they were appropriate, adds Brush, noting that additional factors such as physicians' personal values, fear of litigation, and prognostic uncertainty might determine whether physicians actually do so.

Forty-one percent of surveyed physicians believed recommendations

EXECUTIVE SUMMARY

Critical care physicians vary widely as to whether they provide patient surrogates with recommendations about limiting life support, according to a just-published study. Ethical issues involve the likelihood of benefit and the problem of overtreatment. Some key findings:

- Most physicians felt it was their duty to provide such recommendations.
- Forty-one percent of physicians believed recommendations were only appropriate if sought by surrogates.
- Physicians aren't routinely asking surrogates about their desire for recommendations.

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were only appropriate if sought by surrogates. “We were surprised by the size of the effect that surrogates’ desires for a recommendation had on whether a physician would be likely to provide a recommendation, especially when one-third of physicians reported rarely or never inquiring whether surrogates wanted physicians’ recommendations,” says Brush.

Nearly half of surrogates for intensive care unit (ICU) patients might prefer *not* to have a physician recommendation, according to another recent study.² “Most critical care physicians seem to be willing to modify their provision of recommendations if surro-

gates explicitly make it clear whether a recommendation is wanted. But physicians are not routinely asking surrogates to clarify their wishes about receiving recommendations,” says Brush.

Shared decision making

Previous research suggests that the majority of surrogates want physicians’ input in decision making for critically ill adults.²⁻⁴ “Providing recommendations to surrogates is a component of shared decision making, which has been endorsed by ethicists and professional societies as the preferred approach to medical decision making, especially in decisions about limiting life support,” says Brush.⁵⁻⁸

Physicians who never or rarely provide recommendations to surrogates may be interested to read about their colleagues’ broad support for, and frequent provision of, recommendations to surrogates, says Brush. The study’s findings about physicians’ sensitivities to surrogate preferences for recommendations raise important ethical issues, such as how much physicians should adjust recommendations based on their own preferences, he adds.

“If physicians feel strongly about their recommendations, and view themselves as the patient’s advocate, should they withhold their recommendations if the surrogate does not want it?” asks Brush.

As patient advocates, physicians clearly have a duty to provide unwanted recommendations when surrogates are making decisions that seem to go against patient preferences, says Brush. “But should physicians provide unwanted recommendations when there is more uncertainty about patient preferences?” he asks. “In such circumstances, physicians can be placed in a difficult position of wanting to avoid conflict with surrogates, but also to advocate for their vulnerable patients.”

“Moral distress” for providers

The primary ethical consideration for physicians who are making recommendations to limit life support is whether or not the treatment offers a reasonable likelihood and quality of life benefit for the patient, according to Nancy S. Jecker, PhD, a professor in the Department of Bioethics and Humanities at University of Washington in Seattle. “When life-saving medical interventions are withheld or withdrawn, health professionals remain obligated to pursue treatment that maximizes comfort and dignity for the patient,” she says.

Instead of saying to the patient, “There is nothing

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EDITORIAL QUESTIONS

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I can do for you,” health professionals should instead affirm that everything possible will be done to ensure the patient’s comfort and dignity, says Jecker. “Too often, patients and families insist on futile efforts because such efforts symbolize caring. There are better ways of caring for patients,” she adds. “Medicine, nursing, and the other healing professions are not practiced merely on demand, but instead aspire to moral goals, such as helping the sick.”

For instance, Jecker says physicians are committed to helping patients understand the disease and its effects on their life, lessening the pain or disability caused by disease, and helping patients die with dignity and peace. “Physicians should not undertake medical efforts that frustrate these goals,” she says.

One of the greatest ethical challenges for health care professionals is to avoid over-treating patients, says Jecker. “When providers act contrary to their own sense of what is right, over-treatment creates ‘moral distress’ — understood as the suffering that occurs when the right course of action is known but is not carried out,” she says. “Moral distress is not just a bad feeling. It has been demonstrated to be seriously detrimental to a provider’s family relationships and professional performance.”

To address the problem of over-treatment, physicians need to focus on benefitting the patient, Jecker underscores. “If a treatment produces an effect, not a benefit, then it is not a duty to use that treatment,” she says. “Where futile therapies provide psychological benefits, such benefits can be achieved in other, and better, ways.” ■

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More ethical care possible with long-term ICu patients?

History of cardiac arrest has ethical implications

The history of cardiac arrest as an indication for resuscitation is “loaded with implications for current standards of care,” says **Daniel Brauner**, MD, associate professor of medicine at the University of Chicago. At one point in time, resuscitation was used only in very limited instances, he explains.

“The resuscitation we practice now can really be traced back to open cardiac massage, which was first used at the turn of the last century and through the 1940s almost exclusively for people whose hearts had stopped in the OR, usually as a consequence of anesthesia,” he says.

Open resuscitation became increasingly popular

EXECUTIVE SUMMARY

Inadequate attention to individual patients’ circumstances is an important ethical concern for long-term intensive care unit patients. An alternative to the advance directive paradigm and guidelines with an emphasis on palliative care and reduced conflict are two possible approaches for more ethical care.

- The effectiveness of guidelines should be evaluated.
- The family needs to understand the patient’s condition and prognosis.
- Staff need to understand the goals motivating the family’s requests.

and was moved out of the operating room in the 1950s, as the indications for the procedure expanded to include those with other, mostly iatrogenic or else primarily cardiac, causes for their heart to stop, adds Brauner. “With the move to closed chest compression in the 1960s, it became increasingly widespread,” he says. “In a few years, it was the standard of care for nearly everybody who died in the hospital.”

Default status of CPR

When the do not resuscitate order was established in the 1970s, this “sealed the default status” of cardiopulmonary resuscitation (CPR), says Brauner, by opting everyone in who didn’t opt out. “The default application of CPR displaced the primacy of the question: ‘Is this the best thing for my patient at this moment?’ and replaced it with faith in a larger project that promised to, and did, save some patients through the prompt and skillful application of CPR,” he says.

Doctors were then charged with convincing patients who would not benefit from the procedure to opt out, says Brauner, which served as a model for the advance directive paradigm. “Other procedures that would no longer benefit patients became defaults whether or not they would help the patient,” he adds. “Of course, there is always some uncertainty. That needs to be acknowledged.” (*See related stories on ethical concerns with do not resuscitate orders, and identifying goals for ethical care, p. 113.*)

What’s needed, argues Brauner, is “better present care. This involves a higher level of honesty from physicians about what therapies may actually help and which ones won’t, along with a willingness to discuss prognosis.” Some patients may not want to be considered for any non-palliative care, and that wish should be respected, but the vast majority of patients want care that has a reasonable chance of helping, and not therapies like CPR at the end of life, which doesn’t, he says.

Less attention should be paid to the patient’s resuscitation status, argues Brauner. “This won’t help in the vast majority of patients who are dying, and is often used as a signifier for level of aggressiveness of care, even though it should only speak to the application of CPR. It should actually be the last question,” he explains.¹

Brauner acknowledges that CPR is “a great therapy for unexpected iatrogenic events and primarily cardiac-related arrests. But more attention should be paid to the real issues that arise in every patient’s disease trajectory. We need fewer general guidelines, and

more attention to the individual circumstances of each patient.” ■

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ID goals in ICU for more ethical care

When conducting ethics rounds in intensive care units (ICUs), **Paul B. Hofmann**, DrPH, FACHE, president of Hofmann Healthcare Group, Moraga, CA, often encounters significant ethical issues often associated with longer-stay patients. “Consequently, I strongly encourage hospitals to develop guidelines to assist staff in addressing these issues,” he says.

Hofmann is currently assisting a hospital in developing guidelines for improved ICU management of longer-stay patients, which describe similarities that characterize these patients and identify goals for ethical care. Among the goals he cites are:

- enhanced patient-centered care;
- improved patient outcomes;
- greater family understanding of each patient’s condition and prognosis;
- better staff understanding of the values and goals that are motivating the family’s requests;
- more appropriate ICU lengths of stay;
- more timely provision of palliative care; and
- reduced conflict between physicians/staff and families.

Hofmann says the guidelines should be developed by a multidisciplinary team and be reviewed and approved in the same manner as other clinical guidelines and policies. He also recommends a process be designed to monitor use of the guidelines and to evaluate their effectiveness. ■

DNR discussion: Is it an “absurd choice”?

Consider patient as a whole

A discussion about whether to choose to have a do not resuscitate (DNR) order is a typical starting point for a provider to have a “goals of care” conversation with a patient, says **Daniel Brauner, MD**, associate professor of medicine at University of Chicago, and this is often the moment when patients are finally given their prognosis.

“They are given this choice, which has become a hallmark of ethical medicine. But for many patients, it’s an absurd one — do you want CPR that probably won’t help you, or do you want us to let you die?” Brauner says. “If they make the wrong decision, doctors may call ethics or palliative care consults to help patients come to the “right” decision. The patient is supposed to have the choice, but it’s a bit of a charade.”

The “goals of care” discussion, during which the DNR question is often discussed, becomes the moment when doctors finally admit their inability to offer any meaningful non-palliative therapy, says Brauner. “It is generally thought of as a moment of patient autonomy, but this may be more illusory,” he adds. “In some ways, it’s analogous to the mob selling protection. We promise to protect patients from ourselves, if they agree to opt out of the default therapies that we will subject them to regardless if we think they will help them or not.”

In many cases, the price patients pay is to give up being considered for potentially aggressive care that may actually help them, says Brauner. “The problem is that what these actual therapies may be in the future is hard to predict,” he says. “Instead, patients and their families are forced into a binary choice — to pick either aggressive or palliative care in advance.”

Patients are being offered choices that really aren’t relevant, since many of the therapies offered, like resuscitation, won’t help the vast majority of people, says Brauner. “They may languish a little longer on a ventilator. But CPR won’t alter the ultimate outcome for most patients,” he says. “By forcing patients to opt out of these non-effective therapies, we automatically opt everybody else in. The current model is that default therapies will be applied based on isolated indications: CPR for cardiac arrest, dialysis for renal failure, feeding tube for not eating, and intubation for respiratory failure.”

Patients are subjected to these interventions by default based on isolated indications, instead of con-

sidering the patient as a whole at a particular point in their disease trajectory, says Brauner. “Part of the reason is that doctors fear they’ll be viewed as withholding therapies, and may be uncomfortable admitting they are unable to do anything therapeutic in the non-palliative sense, for the patient,” he adds.

Brauner says that in order to truly improve the current system, physicians have to be more truthful about the limitations of what medicine has to offer. “Many patients come with the expectation that any problem can be fixed, and this is reinforced by the rhetoric and advertising of medicine today,” he says. “Patients continue to receive ‘everything’ until it becomes obvious that our aggressive therapies are not working.”

It is at that point that the intensivist or hospitalist may bring in the palliative care team. “The meteoric rise of palliative care comes out of that need. It takes better care of people because the default model of care exposes patients to unnecessary harm,” says Brauner, adding that another problem with the advance directive model is that patients can’t really know how aggressive they want their care to be until they know the chances of it actually helping them, and doctors will frequently not know this until the situation arises. “The whole idea of having to decide beforehand what you would want in the future, for patients that may still benefit from medical interventions, is an impossible situation.” ■

Focus on satisfaction: Too much autonomy?

Doctor-patient relationship may be harmed

Linking payment to patient satisfaction could have a profound impact on the doctor-patient relationship, argues **James N. Kirkpatrick, MD**, an assistant professor of medicine at the Hospital of the University of Pennsylvania who is affiliated with the University of Pennsylvania Department of Medical Ethics and Health Policy. “As part of the larger context of ‘patient-centered medicine,’ paying attention to patient satisfaction scores represents several things,” he says. “One is another step away from the classical context of physician paternalism, and toward the paradigm of patient autonomy and patient empowerment.”

At one point in time, doctors held all of the power and made all of the decisions, says Kirkpatrick, but decisions today are made more jointly. “Patients and physicians should work together to decide what to do,” he says. In this context, he says, it may be helpful to rate physicians on communication skills, their

EXECUTIVE SUMMARY

Linking physicians' payment to their patient satisfaction scores has important ethical implications involving the doctor-patient relationship, with these possible outcomes:

- Physicians might be more likely to order unnecessary tests.
- Physicians might be more likely to avoid difficult discussions with patients.
- Physicians could be allowed increased time for patient encounters.

bedside manner, and their ability to elicit patients' goals and expectations. "I'm not sure I like the idea of moving past that into a world where patients tell the doctors what to do, and the doctors had better do it, for fear of losing income from declining patient satisfaction scores," he says.

A "consumerist focus" in health care is the likely result, which is something that neither patients nor physicians really want, says Kirkpatrick. "I haven't met many patients who expect that our relationship will consist of them telling me what to do," he says, adding that physician training involves not only acquisition of knowledge and skills but also training in judgment. "That is the sort of thing that doesn't come out of a book, and the sort of thing that patients need from us."

The concern, says Kirkpatrick, is that the "pay for patient satisfaction" approach might stifle this part of the patient-physician relationship, which has negative public health implications. "It is already much easier, and less time-consuming, to write a patient a script for an antibiotic than to explain why they don't need it," he says. "If one adds on a potential financial penalty for making the patient dissatisfied, the choice becomes even easier. Patients seem to resonate with the idea of a 'pan scan' to find anything that could be wrong." It is difficult to explain to them that even the best of tests have a certain false-positive rate, potentially leading to unnecessary and potentially risky procedures and follow-up testing, let alone unnecessary expense, he explains.

"We already order lots of unnecessary tests in order to avoid lawsuits. We'll see lots more of this if our pay is docked because of disgruntled patients," says Kirkpatrick.

Patients answering satisfaction questionnaires may have a less positive view toward the provider after a tough discussion, adds Kirkpatrick, which may result in providers avoiding difficult end-of-life discussions.

"That said, a very positive upside may be increased time allowed for the patient encounter," he says. "If administrators see patient satisfaction scores rising when patients get to spend more time with physicians, they may allot more time for these encounters." ■

SOURCE

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Underinsured patients will need cost-effective options

Less expensive alternatives should be considered

It's a "tremendous victory to have something approaching universal access" as a result of the Patient Protection and Affordable Care Act, but the resulting increase in underinsured patients will pose ethical challenges for providers, according to **Joseph J. Fins**, MD, MACP, chief of the Division of Medical Ethics at Weill Cornell Medical College and director of medical ethics at New York Presbyterian Hospital-Weill Cornell Center in New York City.

The fact that patients are insured should not be taken as a guarantee that they are adequately insured, he explains. "There are people who, by virtue of the mandate to buy health insurance, will buy the cheapest insurance they can afford, which comes with higher deductibles," says Fins. "The fact that they are insured doesn't mean they are protected against under-treatment. So the next policy challenge is not just access to care, it's access to sufficient care."

EXECUTIVE SUMMARY

Providers might need to consider less costly alternatives for underinsured patients, but should not put patients at risk. Physicians have these ethical obligations for underinsured patients:

- to prevent non-compliance by discussing the cost of care;
- to advocate for patients to get needed medical treatment covered;
- to spend adequate time when determining if diagnostic testing is necessary.

Practicing evidence-based care and trying to avoid waste saves the patient money and provides better care, he argues. “This is a clarion call for patients and doctors to talk about the various ways of working up medical problems,” he says. “Patients may be able to avoid dire choices promoted by underinsurance.”

On the other hand, Fins underscores the importance of not breaching professional standards to save patients money, such as ordering an X-ray instead of a magnetic resonance imaging or CT scan for the evaluation of back pain in a cancer patient. “Care of patients comes first, and finances come second,” he says. “Just as cost containment is never a malpractice defense, underinsurance is not an excuse for bad medical care.”

There may be legitimate alternatives in which evaluation can be performed in a less costly way, but it is unacceptable to deviate from the standard of care if this puts the patient at risk, warns Fins. “I think we have to appreciate now that families unfortunately have to sometimes make choices,” says Fins. “Physicians need to be aware of that, because if they don’t speak about the cost of care, they may prescribe things that are not followed-up on. There may be a problem with non-compliance.”

Fins observes that the scope of this problem is larger than it appears. He notes that health service investigators have described under-insurance as “a moral hazard.”¹ Research has shown that the metric of out-of-pocket costs, by which under-insurance is tracked, underestimates the scope of the problem because the under-insured delay, defer, or avoid care when a more fully insured patient would seek it.

“So by the time an underinsured patient gets to the point of seeking care, a diagnostic or therapeutic inadequacy has already occurred,” he explains. “The opposite is true with patients who are very well insured, say without a deductible, who will over-utilize services.”

Inability to pay

Marianne L. Burda, MD, PhD, a Pittsburgh, PA-based ethics consultant and educator, says that patients should never be denied emergency care and treatment due to their inability to pay or inadequate insurance coverage. Physicians have an ethical obligation to do the following, says Burda:

- ensure that the tests, treatments, or procedures they recommend to their patients are medically indicated and not unnecessary or a result of practicing defensive medicine;
- consider whether there is a less expensive alterna-

tive that is comparable to a higher-priced test, medication, or treatment and will obtain the same result, such as an older generic medication or a different diagnostic test;

- fully inform patients of all care and treatment options including doing nothing, risks and benefits associated with each option, and the costs of all options;

- advocate for underinsured patients to get needed medical treatment covered;

- provide some free or discounted care to patients.

“If they are unable to do so for a particular patient, they should help the patient locate financial assistance, or free or reduced sources of the needed medications, tests, and treatments,” says Burda. For example, physicians can refer patients to social workers or agencies in their community that can work to locate and secure these resources.

- work with patients to design affordable payment plans that do not delay patients receiving needed care.

“Insurance discounts to costs of care should apply. Underinsured or uninsured patients should not be charged full costs for care, as they are the least able to pay these prices,” says Burda. ■

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Limited resources will pose ethical challenge

More time with patient is key

Physicians want the best for their patients, but part of their ethical challenge is to advise patients how to use their limited resources wisely, according to **Rosalind Ekman Ladd**, PhD, a visiting scholar in phi-

losophy at Brown University in Providence, RI. “This is a problem that is not going to go away,” she says. “Even if we were to assure that 100% of Americans have health insurance, there would still be critical ethical questions to confront: How much health care? What kinds of health care?”

One answer that is commonly heard is that everyone should be assured a decent minimum of health care, notes Ladd. “But what does that include? Heart and liver transplants are usually understood to go beyond the minimum, but what about MRIs and CT scans that are useful but very expensive?” she says.

Various schemes have been proposed to achieve a fair system of allocation, notes Ladd. “Some states pay for all childhood vaccinations because it is in the public interest and is very cost-effective,” she says. “In 1972, the federal government agreed to fund kidney dialysis for anyone who needs it, but it was a decision based more on emotional impact than careful comparison and planning.”

An attempt at rational allocation of resources was made in Oregon in 1994 when a committee of citizens determined how to prioritize the services that Medicaid would fund. “It was a frank acknowledgment that resources are limited, but it continued to provoke controversy and was eventually abandoned,” Ladd says.

More time with patients

“A lot of Americans consider, ‘I need an MRI as a chief complaint,’” says Faith T. Fitzgerald, MD, professor of internal medicine at University of California, Davis School of Medicine in Sacramento. “That is part of the American psyche, and also a mark of respect from the patient. If you don’t order a test they want, they think, ‘You’re saying I’m not worth it.’”

While most practicing physicians saw indigent patients before the managed-care era, this has become much more difficult as doctors are typically overwhelmed with existing patients, says Fitzgerald. “If you see patients who don’t have any money and you have to pay to support a private practice, you will go out of business. That means there is one fewer doctor to see patients, whether or not they have insurance,” she says.

The physician’s ethical obligation to care for the patient is “the basic core of the oath,” says Fitzgerald, but most modern oaths have the addendum, “I will serve my individual patients and serve humanity.” This means that physicians are profess-

ing to two things that the current system does not allow to occur simultaneously, she says.

“You may do one or the other, but you can’t do both,” she says. “Caring for the individual patient may bankrupt the ability to care tomorrow for other individual patients.” Fitzgerald says the answer likely lies in the growing movement for cost-conscious care, and an increase in the ability of physicians to spend time with patients.

Time-pressured physicians are now seeing even patients with complex multisystem diseases in 15 minutes, she says, and might order needless diagnostic tests as “a kind of proxy for care, but at vast expense.” Each physician should be given enough time with the patient to decide whether or not expensive tests are actually necessary, argues Fitzgerald.

Medical students might observe physicians ordering diagnostic tests because this is quicker than spending time with the patient, and mirror these habits in their own practice, she warns. “There is a danger that what they may be taught is good medicine is largely test-based, that good medicine is what you get in the way of studies on the patient,” Fitzgerald says. “Doing something gets paid for; thinking does not. And I believe it is the ethical obligation of physicians to think.” ■

Focus on ethics of narcotics prescribing

Over- and under-treatment are both concerns

Prescribing potentially addictive medications “is often a very challenging situation for physicians,” says David A. Fleming, MD, MA, FACP, professor and chairman of the Department of Internal Medicine and director of the Center for Health Ethics at University of Missouri in Columbia. “We have to pause and take time to connect with the patient and think the situation through, to come up with the right response. It is very important that we are prescribing for the right reasons.”

The number of narcotic prescriptions in America has increased dramatically in recent years, and prescription drug abuse is the nation’s fastest-growing drug problem.^{1,2} This increased demand may be based on the intensified marketing efforts of the pharmaceutical industry through direct-to-consumer advertising, according to a recent study.³

If a patient asks for narcotics that the provider doesn't believe is medically indicated, Fleming says it is reasonable to instruct the patient to go back to the provider who originally prescribed the medication and ask if they will continue it. "If the patient says, 'I tried that, but my other doctor wouldn't give that to me anymore,' that often helps to validate the decision I make not to prescribe," he says.

It's clearly unethical if a provider prescribes a controlled substance for financial gain or other self-serving reasons. However, addiction can result from sound medical practice when narcotics and other controlled substances are given for legitimate reasons, says Fleming. "Patients often become addicted to narcotics when prescribed and taken for long periods," he says.

Physicians might inappropriately prescribe narcotics because patients demand these when they are drug-seeking for illegitimate reasons, or even when they feel their pain is not adequately relieved, says Fleming. "We should be careful not to respond to threats or coercive behavior," says Fleming. "When it's appropriate to treat, we should treat. It's also easy to take the path of least resistance when under pressure or when busy, but it's OK to say no sometimes." If providers believe they have the evidence needed to make a medical decision whether to prescribe or not to prescribe, they should feel comfortable making the appropriate decision in spite of those pressures, he says.

If a patient gives a reasonably plausible explanation for why a prescription needs to be refilled, it may be faster for the physician to prescribe and get to the next patient than to carefully consider the situation. "That is a slippery slope that we can go down very quickly when we are not being objective," says Fleming. "Not every patient with back pain is the same. Different

patients have different needs, different findings, and different levels of pain." Physicians need to customize responses to the specific needs and concerns of every individual patient, he emphasizes.

"Physicians are increasingly under pressure to offer prescriptions for controlled substances. The public is used to getting what they want and need to make them feel better, younger, and more productive," says Fleming. "We must be ever vigilant that what we are giving patients is medically indicated and ethically appropriate." (See related story, p. 118, on unethical prescribing practices.)

Pain undertreated

Even if a chronic pain patient has been taking narcotics long-term and is asking for more medication, providers have to avoid being judgmental, says Fleming. "Because a patient comes to us unkempt, unbathed, or covered in tattoos, we should not jump to the conclusion that they are trying to game the system. There may be very legitimate reasons for a request to refill or provide a new prescription for narcotics," he says.

Narcotics can be overused and misused, acknowledges Fleming, but under-treatment of pain remains a serious concern.⁴ "Patients with chronic illness or conditions that cannot be cured may experience severe pain, but for various personal reasons they are hesitant to take narcotics because they don't want to become addicted," he says. "Physicians have an obligation to advocate for the use of controlled substances like narcotics when they are medically indicated."

Physicians might also under-prescribe narcotics when patients legitimately need them because they fear sanctions, says Fleming. "The problem is that the pendulum may have swung the other way in our prescribing habits," he says. "The evidence is very strong that we still under-treat pain." ■

EXECUTIVE SUMMARY

Providers face ethical challenges when prescribing potentially addictive medications, including coercive behavior from patients and fear of sanctions, and may over-treat or under-treat pain as a result. Medical ethics experts say that:

- Physicians should avoid prescribing outside the standard of care.
- Physicians should take the time to obtain a detailed history.
- Physicians should advocate for narcotics when appropriate.

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SOURCES/RESOURCES

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• **David A. Fleming**, MD, MA, FACP, Professor and Chairman, Department of Internal Medicine/Director, Center for Health Ethics, School of Medicine, University of Missouri, Columbia. Phone: (573) 884-2013. Email: flemingd@health.missouri.edu.

• New guidelines from the Food and Drug Administration include requirements for prescriber continuing education and patient counseling for prescribing of potentially addictive medications. (To view the FDA guidelines, go to www.fda.gov. Click on "Drugs," "Drug Safety and Availability," "Information by Drug Class," and "Opioid Analgesics — Risk Evaluation and Mitigation Strategies (REMS) for Extended-Release and Long-Acting Opioids.")

Avoid these unethical prescribing practices

Prescribing potentially addictive medications without obtaining adequate informed consent that covers risks including addiction and withdrawal is a clearly unethical practice, according to **Harold J. Bursztajn**, MD, associate clinical professor of psychiatry at Harvard Medical School in Boston and president of the American Unit of the United Nations Educational, Scientific and Cultural Organization (UNESCO) Bioethics Chair in Cambridge, MA.¹ He says these are other unethical prescribing practices:

- Failure to present the risks of withdrawal and side effects of non-schedule II medications such as atypical antipsychotics;
- Failure to rule out drug-seeking behavior in patients who show impairments consistent with drug-seeking;
- Stigmatizing all chronic pain patients as drug-seeking;
- Failure to inform patients of potential conflicts of interest based on direct or indirect ties between the prescribing physician and the pharmaceutical company;
- Failure to perform an adequate medical and psychiatric evaluation to rule out treatable causes of chronic pain or sleeplessness;
- Failure to rule out comorbid medical and psychiatric disorders;
- Failure to inform the patient about potential cognitive and motor impairments relevant to daily function.
- "Providers should educate patients as to risks of addiction, and alternative non-addictive treat-

ment modalities vital to the standard of care," says Bursztajn.² ■

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2. Johnson B, Bursztajn HJ, Paul R, et al. Reducing the risk of addiction to prescribed medications. *Psychiatr Times* 2007;24(4).

Is compensation for organ donation ethical?

Current system in "dire straits"

The evolution of "transplant tourism" drives home the point that people are willing to go to extreme lengths to procure an organ, according to **Leslie M. Whetstine**, PhD, an assistant professor of philosophy at Walsh University in North Canton, OH. "Despite the fact that the public overwhelmingly supports organ donation in this country, our actions unfortunately do not reflect that sentiment," she says. "In the United States, there are over 100,000 people on the waiting list, and each day 18 people will die on it."

The National Organ Transplant Act of 1984 prohibits buying and selling organs, but it doesn't prohibit incentives to donate. "Bone marrow donors can now get compensated with vouchers for education or housing, and a number of states allow for tax deductions/credits for living donors," says Whetstine. "While it remains to be seen if such inducements will have an impact on the shortage, creative programs that seek to influence donors within the limits of the law will likely continue."

EXECUTIVE SUMMARY

About 60% of the public supports some form of compensation for organ donation, and although the National Organ Transplant Act of 1984 prohibits buying and selling organs, it doesn't prohibit incentives to donate. Some current developments:

- Bone marrow donors can now be compensated with vouchers for education or housing.
- A number of states allow for tax deductions or credits for living donors.
- Lower-income individuals are more likely to participate in living donation, regardless of incentives.

Considering that tax credits and education vouchers are now allowed as incentives for living donors, Whetstine says “it isn’t difficult to imagine other types of motivators. Health insurance, compensation for loss of wages, and reimbursement for travel have all been proposed at one point or another for living donors.”

Other suggestions to persuade individuals to donate after death include covering funeral expenses for the decedent, cash payment to their designee or charity of choice, and even offering priority on the waiting list should the individual find him- or herself in need of an organ in the future. “A colleague of mine suggested child care vouchers, or other goods that the majority of Americans may find helpful in an otherwise floundering economy,” says Whetstine.

The medical community’s ethical obligations require authentic screening programs, donor advocacy, and a genuine commitment to upholding the prohibition on buying and selling organs, says Whetstine. “This last requirement may prove to be the most difficult, as the debate over compensation continues to grow more heated while cultural norms shift,” she says.

Compensation supported

A May 2012 survey of 3000 adults conducted by NPR — Thomson Reuters showed about that 60% support compensation in the form of credits for health care needs for organ donation, and 41% supported cash as a form of reimbursement. (To view the survey questions and complete results, go to: <http://bit.ly/JnHUz1>.)

“The biggest obstacle facing hospitals and staff may be how to enforce rules that may be out of sync with changing views and attitudes,” says Whetstine. One of the most pervasive arguments against organ vending has been the claim that the poor would necessarily be exploited if organs were commodified, she notes. “These fears are legitimate if one is talking about some sort of black market,” she says. “However, new data suggest that if proper oversight and strict regulations were implemented, the sale of organs may yield much more benefit than harm.”

According to a 2010 study, the prospect of payment does not create an impediment to informed consent or unfairly prey upon the poor, and in fact, lower income individuals are more apt to participate in living donation, specifically kidneys, regardless of incentives.¹ “This study shed further light on whether the public still perceives organ vending as a corrupt enterprise, or if the fact that 18 people will have died by tomorrow while waiting for an organ has caused

us to reevaluate those rules,” says Whetstine. “This is to simply say that the current system is in dire straits. The public may no longer support the National Organ Transplant Act’s prohibition on cash incentives.”

Given the extreme disparity between supply and demand, it seems that altruism might be insufficient for individuals to sign a donor card, let alone motivate them to volunteer as living donors, argues Whetstine. “Curiously, instead of hosting a public discussion regarding acceptable incentives for donation, the transplantation community has responded to the pressing demand for more organs by revisiting the use of Donation After Cardiac Death donors, a practice that is mired in ethical controversy,” says Whetstine.

Organ procurement organizations are proceeding with protocols including Donation After Cardiac Death in the Emergency Department, the use of extra-corporeal membrane oxygenation in Donation After Cardiac Death, and organ recovery ambulances, she explains. “Such an approach is dishonest and ultimately harmful to the public trust,” says Whetstine. “The transplantation community would be better off engaging in an open discussion of incentives, rather than foisting ethically questionable procurement practices upon the public with the promise that all is well.” ■

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SOURCE

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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 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.

CME QUESTIONS

1. Which is true regarding physicians providing recommendations about limiting life support, according to a study published in the *American Journal of Respiratory and Critical Care Medicine*?
A. The vast majority of critical care physicians always provide surrogates of critically ill adult patients with a recommendation about limiting life support.
B. Most critical care physicians rarely or never provide surrogates with recommendations about limiting life support.
C. Most physicians did not feel it was a physician's duty to provide such recommendations.
D. Surrogates' desires for recommendations and physicians' agreement with surrogates' likely decisions might influence whether recommendations are provided.
2. Which is true regarding ethical obligations for providers caring for underinsured patients, according to **Joseph J. Fins, MD, MACP**?
A. It is acceptable for physicians to occasionally breach professional standards in order to save underinsured patients money.
B. Physicians should not routinely consider whether there is a less expensive alternative that is comparable to a higher-priced test, medication, or treatment.
C. Physicians should consider whether there are legitimate alternatives where evaluation can be performed in a less costly way, but it is unacceptable to deviate from the standard of care if this puts the patient at risk.
D. Physicians have no ethical obligation to advocate for underinsured patients to get needed medical treatment covered.
3. Which is true regarding ethical considerations involving prescribing practices of potentially addictive medications, according to **David A. Fleming, MD, MA, FACP**?
A. It is ethical for providers to prescribe medications that are not medically indicated in order to preserve the patient-physician relationship.
B. It is ethical for providers to refuse to prescribe narcotics if they fear sanctions, even if they *have determined* that narcotics are medically indicated.
C. It is unethical for providers to encourage patients to take narcotics when indicated, due to the risk of addiction.
D. If providers believe they have the evidence needed to prescribe or not prescribe narcotics, they should feel comfortable making that decision.

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.

COMING IN FUTURE MONTHS

- Responses to drug-seeking patients
- Concerns with large-scale adverse events
- Controversial organ donation practices
- Why some screening tests might be unethical

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