

MEDICAL ETHICS ADVISOR®

For 25 years, your practical
guide to ethics decision making

April 2013: Vol. 29, No. 4
Pages 37-48

IN THIS ISSUE

Education needed on tools
identifying patients' end-of-life
wishes.....cover

Why existing state laws present
barriers to POLST programs39

Ethical considerations when treating
suspected "drug-seekers" 41

Unrealistic expectations common
with high-tech interventions43

How tax incentives actually affected
organ donation rates.....45

Why payment reform is opportunity
for more ethical care46

FOLLOW US ON 

@MedEthicsAdv

Statement of Financial Disclosure:
Arthur R. Derse, MD, JD (Consulting Editor),
Shelly Morrow Mark (Executive Editor),
Leslie Hamlin (Managing Editor), and **Stacey
Kusterbeck** (Contributing Editor) report no
consultant, stockholder, speakers' bureau,
research, or other financial relationships with
companies having ties to this field of study.

AHC Media

Momentum to better respect patients' end-of-life wishes "growing every day"

POLST is option, but education needed

A growing number of states are promoting Physician Orders for Life Sustaining Treatment (POLST) Paradigm Programs, with the goal of helping physicians to better respect their patients' wishes for end-of-life care. The tool turns an advance directive into actionable medical orders, allowing seriously ill patients to specify choices about certain interventions, giving patients more control of what end-of-life care they receive.

"The big challenge now is the number of states who want to implement POLST, and need support, because the document has been found to be so much more effective than other instruments that have been developed, like out-of-hospital DNR orders," says **Susan W. Tolle, MD, FACP**, director of Oregon Health & Science University's Center for Ethics in Health Care in Portland.

A 2010 study of 90 nursing homes in three states showed a lower rate of unwanted hospitalizations in people who had marked "comfort measures only" on a POLST form.¹ "The momentum is growing every day," says Tolle. "We are struggling to meet the demand for states which want to be evaluated for endorsement. The demand for assistance is five-fold compared to three or four years ago."

EXECUTIVE SUMMARY

A growing number of states are promoting Physician Orders for Life Sustaining Treatment programs, with the goal of helping physicians to better respect their patients' wishes for end-of-life care.

- The tool turns an advance directive into actionable medical orders.
- Unwanted hospitalizations were reduced for people who marked "comfort measures only."
- Health care providers need education on which patients should be offered the form.

NOW AVAILABLE ONLINE! Go to www.medicalethicsadvisor.com
Call (800) 688-2421 for details.

This is partly due to the public's growing expectations that their wishes will be honored, and pressure from emergency medical services (EMS) providers who don't want to perform interventions that patients never wanted. There is also increasing pressure on hospitals to decrease re-admissions for the same diagnosis within 30 days to avoid being financially penalized.

"If the patient doesn't want to be readmitted, and you are going to be reviewed negatively by Medicare, your institution may be more motivated to build a program to respect those wishes," says Tolle. "If you want to stay exactly where you are,

whether that's in a long-term care facility, private home, or hospice, and you don't want to go back to the hospital, and your comfort is managed where you are, and your wishes are respected, that changes the death rate in the hospital."

States vary regarding how much education is needed, or whether there are any policy issues that create an impediment to moving forward. (*See related story, p. 39, on current laws.*)

"The details of implementation look very different depending on how long you've been working on this," Tolle explains. "For example, in a state like Oregon, where hospitals often offer POLST to every patient going to a nursing home at discharge, the needs are different than in a state that is just getting started building a POLST program. The overall goal in every state is to better respect patients' wishes to have or limit treatment, whatever those wishes may be."

While EMS would like to know the patient's wishes about resuscitation, the information that has a greater impact is whether the patient wants to go back to the hospital or not, she says. "And if you do want to return to the hospital, whether you want to go to the [intensive care unit] or not, that decision has a profound impact on care at the end of life," says Tolle.

Education is needed

Every state continues to struggle in educating physicians and patients on the difference between POLST and advance directives, reports Tolle. "Both the lay public and health care professionals need boosters on how these work together and who needs which one," she says. (*To view a POLST in Action video, go to <http://www.oregonpolst.org>.*)

If a state is just beginning a POLST program, providers might not have heard of it or have no idea how to implement it. "One area that physicians get into trouble with is in knowing what patient population they should actually be offering POLST to — who is too healthy for POLST, and who is ideal," says Tolle.

Another challenge is what to do if a patient is asking for a POLST form but is too healthy. While all adults should have advance directives, POLST forms should be used for patients with advanced illness or frailty. "The advance directive is a futuristic document, saying that 'If bad things happen to me, I would or would not want life-sustaining treatment.' POLST is when the future becomes the present — tonight, if I'm found down, I do or do not want CPR [cardiopulmonary resuscitation]," Tolle explains. "With POLST you can't say 'if' anything

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.

AHC Media designates this enduring material for a maximum of 18 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity is intended for acute care physicians, chiefs of medicine, hospital administrators, nurse managers, physician assistants, nurse practitioners, social workers, and chaplains. It is in effect for 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

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.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media LLC. Address: P.O. Box 105109, Atlanta, GA 30348. Telephone: (800) 688-2421. Web: <http://www.ahcmedia.com>.

Senior Vice President/Group Publisher: **Donald R. Johnston.**

Managing Editor: **Leslie Hamlin** (404) 262-5416 (leslie.hamlin@ahcmedia.com)

Executive Editor: **Shelly Morrow Mark** (352) 351-2587 (shelly.mark@ahcmedia.com).

Copyright © 2013 by AHC Media. Medical Ethics Advisor® is a registered trademark of AHC Media. The trademark Medical Ethics Advisor® is used herein under license. All rights reserved.



EDITORIAL QUESTIONS

Questions or comments?
Call Leslie Hamlin at
(404) 262-5416.

— you have to say ‘yes’ or ‘no’ about your current state of health, in the here and now, as a medical order.”

Health care professionals need to be educated about which patients to offer the form to and how to use the document appropriately to achieve the patient’s goals, she underscores. “Until providers have watched educational materials themselves, some of the nuances about how they work together are confusing,” says Tolle. “If they don’t understand that perfectly, they will have trouble educating their patients.”

Comfort measures are always provided to patients with POLST orders, which is something that a clear-cut “do not transfer” order would not accomplish, adds Tolle. If a patient has orders for comfort measures only, and breaks a hip and cannot be turned because it’s too painful, he or she needs to be transported to the hospital to get the hip pinned, for instance.

“When transfer to the hospital was needed for comfort, their POLST orders keep the system focused on the patient’s goals. It prevents CPR and transfer to intensive care if the hospital course is complicated by pneumonia or a myocardial infarction,” says Tolle. “The goal remains to assure their comfort and return them to the prior setting of care as quickly as possible.”

Role of bioethics

Bioethicists can be very helpful to advancing POLST because they know the value of good advance care planning and are aware of the time, resources, and emotional distress that go into medically complex situations in which the patient’s wishes are unknown, says **Judy Citko**, JD, executive director of the Coalition for Compassionate Care of California in Sacramento. Bioethicists can help with establishing policies and procedures for POLST form completion that are clear and grounded in good communication, she adds.

“Unfortunately, many tasks in health care are seen as just that — tasks to be checked off a list. Approaching POLST as a ‘task’ is likely to result in forms that don’t accurately capture the patient’s true wishes,” says Citko. “POLST needs to be grounded in a rich discussion in the context of the patient’s diagnosis and prognosis. Bioethicists can help with this.”

Bioethicists sometimes unintentionally serve as a hindrance to POLST by making the “perfect” the enemy of the “good,” however, says Citko. “Expecting POLST to solve all the advance care planning problems that currently exist is unrealis-

tic,” she says. “Problems existed before POLST, and many continue to exist after POLST. POLST creates a system that allows us to more easily identify problems, and thus, develop solutions and measure progress.” ■

REFERENCE

1. Hickman, S, Nelson C, Perrin N, et al. A comparison of methods to communicate treatment preferences in nursing facilities: Traditional practices versus the physician orders for life-sustaining treatment program. *Journal of the American Geriatrics Society* 2010;58(7):1241-1248.

SOURCES

• **Judy Citko**, JD, Executive Director, Coalition for Compassionate Care of California, Sacramento. Phone: (916) 993-7740. E-mail: jcitko@CoalitionCCC.org.

• **Susan W. Tolle**, MD, FACP, Director, Center for Ethics in Health Care, Oregon Health & Sciences University, Portland. Phone: (503) 494-4466. E-mail: tolles@ohsu.edu.

• **Amy Vandembroucke**, JD, Executive Director, National POLST Paradigm Program, Center for Ethics in Health Care, Oregon Health & Sciences University, Portland. Phone: (503) 494-9550. E-mail: vandenbr@ohsu.edu.

Some existing laws are barriers to POLST

Some existing state laws are hindering implementation of POLST programs, such as Delaware’s, which only covers out-of-hospital do-not-resuscitate (DNR) orders that require that people be terminally ill, according to **Amy Vandembroucke**, JD, executive director of the National POLST Paradigm Program at Oregon Health & Sciences University’s Center for Ethics in Health Care in Portland.

“If you try to adapt that law and use POLST under it, like some states have done, you pick up any ‘baggage’ related to that law,” explains Susan W. Tolle, MD, FACP, director of Oregon Health & Science University’s Center for Ethics in Health Care in Portland. That means that many frail elders, who very much want to return to the hospital for some interventions but do not want cardiopulmonary resuscitation (CPR) or intensive care unit care, cannot have a POLST form because they are not terminally ill.

“They are very frail, but no one is signing paperwork saying they have six months left to live. They are likely to have a sudden event which determines that, but we don’t know what that event is and when it will be,” says Tolle. “Frail elders often very much want POLST, and health care professionals were filling it out for that population. It makes sense that they

would want it, but it didn't match an old law in place about out-of-hospital DNR orders."

Delaware has a POLST program in place, but is having problems with implementation due to existing state law on out-of-hospital DNR orders that are only limited to CPR. "Most people who are POLST-appropriate have advanced illness or frailty, and we wouldn't be surprised if they died in the coming year," says Tolle. "If they are in full arrest, are not breathing, and have no pulse, they are not likely to survive an out-of-hospital resuscitation. Depending on just what their medical problems are, the rates can be lower than 1%."

In some states, existing laws have made it difficult for a surrogate to complete a POLST form. "When somebody has taken the time to designate an appropriate person through an advance directive or health care power of attorney document, it is another way for the patient to decide what care they want at the end of their life," says Vandenbroucke. "In some cases, there are barriers to surrogates being able to sign a POLST form for that patient and make that decision."

Many states have started a POLST program, but it's not in every hospice program or long-term care facility, due in part to the need for broader educational outreach. "That would not be true in Oregon or West Virginia, which have overcome all the regulatory impediments and conducted broad statewide education. There is nothing that keeps those states from implementing it everywhere," says Tolle. "But most other states are not completely penetrated yet."

A few state laws say that an advance directive always takes precedence over a POLST form, while most states say the most recent document takes precedence. "A 10-year-old advance directive may not be what you want now because your health status or life situation have changed a great deal," says Tolle.

A change in diagnosis or medical condition may mean the patient no longer has the same desires for level of treatment he or she specified in an advance directive, such as the patient making a much better recovery from a massive stroke than anyone ever guessed, or becoming a lot sicker and wanting to stay with their family during their final weeks of life. Since the POLST form is a medical order, it is easily updated or revoked to accommodate changes in patient status and preferences.

If state law requires that the advance directive takes precedence and the patient becomes unable to make decisions for him- or herself, a surrogate can't make changes that the patient would have wanted because only the patient can revoke or revise the instructions in the advance directive, explains Tolle.

"When people complete an advance directive, they often don't look at it again for a decade or more. They can get a bit trapped in a pathway they had not intended," she says. "The intent of the POLST program is that it's entirely voluntary. You can fill it out any way you want to, and you can always change your mind." ■

Ethics of prescribing choices in forefront

Addiction, untreated pain are both concerns

The relief of suffering, including suffering from untreated pain, is fundamental to the idea of ethical practice in medicine, according to Nancy Berlinger, PhD, a research scholar at The Hastings Center in Garrison, NY. "The development of palliative medicine as a subspecialty, with parallels in nursing and other clinical professions, and evidence of improved outcomes through the integration of palliative modalities into standard medical treatment, support the idea of access to pain relief as a basic right of patients," she says.

However, it is well established that some medications that are effective in pain are potentially addictive and that some pain medications are misused — for example, diverted from their intended beneficiary to another party; or abused, as when they are consumed at higher dosages or in different ways than prescribed, adds Berlinger.

Recently, a number of states have implemented electronic prescription monitoring programs, allowing physicians to determine if a patient has been prescribed opioid analgesics from other physicians in the recent past. "This information should be factored into the clinical assessment of the patient in determining the appropriateness for

EXECUTIVE SUMMARY

While some pain medications are potentially addictive and in some cases are misused or abused, undertreatment of pain also remains a significant concern. To address ethical concerns, physicians can:

- Factor data from electronic prescription monitoring programs into their clinical assessment.
- Carefully monitor patients to assure that medications are being taken as directed.
- Obtain an ethical consultation if drug-seeking is suspected.

initiating a trial of opioid therapy,” advises **Ben A. Rich**, JD, PhD, professor and School of Medicine Alumni Association Endowed Chair of Bioethics at University of California — Davis Health System. “Careful monitoring and follow-up appointments are essential to assuring that these medications are being taken as directed, and that they are producing both reduced pain and increased functionality in order for their benefits to outweigh the risks.”

The term “drug-seeking” is generally used to describe a patient who makes false claims about pain in an effort to persuade physicians to prescribe opioid analgesics for which there is no legitimate medical need, notes Rich. “Viewed outside the special parlance of pain medicine, there is nothing strange or insidious about people with certain medical conditions seeking drugs known to be effective in treating or managing them — just as we engage in ‘food-seeking’ behaviors when we are hungry,” he says.

Patients might engage in such behavior because of a substance abuse disorder, for recreational use of such medications, or to divert them for financial reasons, however. “Another complicating factor is that there is no litmus paper test for distinguishing between patients with real pain who might benefit from such medications and individuals who seek them for illegitimate purposes,” says Rich. “The preferred approach involves taking a detailed medical history, conducting a physical examination, and, whenever possible, accessing medical records for the patient.”

Complicating factors

Patients requesting pain medication present in various settings, including the emergency department, primary care, outpatient specialty care, and inpatient care. “The context in which a patient presents may influence — fairly or unfairly — how a provider sees this patient,” says Berlinger. “Is this a person in pain to whom my ethical obligation is clear — namely, to treat the pain, and the person, appropriately?”

Physicians often struggle with their obligations to a person whose addiction to pain medication is a consequence of long-term medical treatment for physical pain, or when they strongly suspect that drug diversion is occurring. “Pain is exceedingly complex. It is not always possible to make a hard distinction between patients who request pain medication to treat pain and ‘drug-seeking’ patients who request medication with the intent to misuse or abuse it,” says Berlinger. The patient whose

behavior suggests “drug-seeking,” such as having duplicate prescriptions from different providers, might also be a patient with an underlying medical condition that is known to cause significant pain, for example.

In some cases, someone may be stealing the patient’s medication or has coerced the patient into diverting medication, or there might be a need to revisit the patient’s medication plan or to help the patient adhere to it.

“Professionals who work in hospitals should be able to consult with their institution’s ethics service about ethical challenges in the care of patients suspected of drug-seeking,” advises Berlinger. “Ethics consultation, or a social work intervention, may also be helpful when a professional suspects that a patient’s pain is being undertreated because the patient’s medication supply is being diverted.” (*See related story, p. 41, on ethical responses.*) ■

SOURCES

- **Nancy Berlinger**, PhD, Research Scholar, The Hastings Center, Garrison, NY. Phone (845) 424-4040, ext. 210. Fax: (845) 424-4545. E-mail: berlingern@thehastingscenter.org.
- **Gregory L. Eastwood**, MD, Professor of Bioethics and Humanities, Past President, State University of New York Upstate Medical University, Syracuse, NY. Phone: (315) 464-8454. E-mail: eastwood@upstate.edu.
- **H. Steven Moffic**, MD, Milwaukee, WI. Phone: (414) 352-1985. E-mail: rustevie@mac.com.
- **Ben A. Rich**, JD, PhD, School of Medicine, University of California—Davis Health System. Phone: (916) 734-6010. E-mail: barich@ucdavis.edu.

Consider ethics with responses to drug-seeking

The challenge of “drug-seeking” patients is commonplace in clinical settings for adolescents and adults, and can even present in pediatric settings via the proxy desire of a parent to use the child’s addicting medication, says **H. Steven Moffic**, MD, a former professor of psychiatry and family and community medicine at the Medical College of Wisconsin in Milwaukee and author of *The Ethical Way: Challenges and Solutions for Managed Behavioral Healthcare* (Jossey-Bass, 1997).

“Ethical responses to drug-seeking patients get at the heart of potential ethical dilemmas for physicians in trying to care for our patients,” says Moffic. “That is, how do we try to provide beneficial treatment with as little harm as possible?” Here

are possible responses to a “drug-seeking” patient and ethical considerations:

- **The physician can refuse to prescribe.**

Significant undertreatment for chronic addiction can be as risky as contributing to the ongoing addiction or overprescribing the amount of medication, warns Moffic. “If the patient takes too little of a medication they are addicted to, they are at risk for severe withdrawal symptoms, some of which are even life-threatening, like seizures,” he says.

A refusal to prescribe is appropriate when a physician is presented with clear and convincing evidence that a patient has no legitimate medical need for such medication, or despite the need, fails or refuses to take the medication as directed, according to **Ben A. Rich, JD, PhD**, professor and School of Medicine Alumni Association Endowed Chair of Bioethics at University of California — Davis Health System.

“Arguably, there should be a similar refusal when a patient demands antibiotics for a condition that will not respond to them,” says Rich. “However, there is an important distinction between refusing to prescribe an opioid and refusing to provide other options for addressing a legitimate pain problem. Opioids, after all, are just one among many modalities of treatment for pain.”

Patients who categorically resist a nonopioid therapy are raising a red flag that they are more interested in the drug than in relief for their pain, with the exception of patients with sickle cell disease, says Rich. “They have well-recognized pain crises that require strong medications for relief on an urgent basis,” he says. “Their knowledge of pain medications and their insistence on prompt treatment often causes physicians to label them as drug seeking when they are really just desperate for relief.”

A 2011 Institute of Medicine report, *Relieving Pain in America*, indicates that undertreatment of pain is persistent and pervasive. “We also now know that inadequately treated pain can become a lifelong problem for patients and their families,” adds Rich.

Rich notes that the term “pseudoaddiction” was coined to identify patients whose pain is so severe and whose care has been so inadequate that they behave in ways that suggest they are “drug-seeking” in the illegitimate sense. “But they are, in actuality, acting rationally as genuine patients desperate to find a physician who will provide them with the analgesia that their condition requires in order for them to have an acceptable quality of life and level of function,” he says.

- **The physician can terminate the physician-patient relationship.**

Occasionally, a physician will consider “firing” a patient suspected of drug-seeking behavior. “Barring a patient from receiving medical services is ethically problematic, and potentially unethical, for several reasons,” says **Nancy Berlinger, PhD**, a research scholar at The Hastings Center in Garrison, NY. It may constitute abandonment if the facility was the patient’s only source of health care.

“It is likely to ‘turf’ the problematic patient to another provider, as cutting off a patient who is abusing or misusing drugs does not, itself, address the cause of the drug-seeking behavior,” says Berlinger. “In particular, it is likely to kick the problem to the nearest public ED, which, because it functions as a community benefit, cannot easily ‘fire’ patients.”

The professional who is considering “firing” a patient suspected of drug-seeking should instead develop an adequate and realistic care plan for this patient, recommends Berlinger. This might involve discussing addiction directly with the patient, and consulting with specialists in addiction medicine and the treatment of prescription medication abuse.

- **The physician can give the patient a referral.**

Any patient who shows signs of an addiction disorder should be referred to an appropriate specialist, but the problem is that in some locations there is a dearth of specialists in addiction medicine, says Rich.

“In a pinch, consultation with an addiction specialist is an option,” says Moffic. “If one suspects the patient is self-medicating an underlying psychiatric disorder, like depression or bipolar, then a psychiatrist should be consulted.”

It is important to recognize that patients who have or might be at risk for an addiction disorder can still present with serious pain issues that need to be treated along with the addiction, Rich underscores. “When the patient’s situation is complicated and challenging, referral to a pain medicine specialist and/or a specialist in addiction medicine would be appropriate,” Rich says.

Time-pressed physicians sometimes get into a habit of prescribing pain medications simply because it’s easier to do so, says **Gregory L. Eastwood, MD**, professor of bioethics and humanities at State University of New York Upstate Medical University in Syracuse. “What should be done in many of these situations is to provide a referral, but that is easier said than done,” Eastwood says. “Services are not always readily available all over the country.” ■

Ethics of high-tech, high-cost interventions

Advance planning needs improvement

It is important that the medical community understands that the cardiology and cardiac surgery communities are confronting end-of-life issues and the need to make appropriate treatment decisions based on an assessment of the likelihood that it will make a difference in a positive way, usually in a frail, sick, elderly patient's life, argues **Patrick O'Gara, MD, FACC**, president-elect of the American College of Cardiology and executive medical director of the Carl J. and Ruth Shapiro Cardiovascular Center at Brigham and Women's Hospital in Boston.

"There is a lot of ongoing research to determine the point at which patients become too frail and too sick to derive benefit from these new technologies," he says. "We are very sensitive to this issue and determined to make sure we don't travel headlong down the technological highway. We are very keen to make sure that these innovations are studied in the context of their appropriate application."

It's always easier to do something than to stop and ask whether it's the right thing to do, says O'Gara. Heart failure teams have grappled with this for a long time when trying to determine if someone is a good candidate for transplant, relying on both physiological markers and an assessment of the family dynamic, he adds.

"Percutaneous aortic valve replacement looks like fabulous technology, but still anywhere from 30% to 50% of patients die within three years of having the procedure done," he says. "There are people who die with aortic stenosis, and there are

EXECUTIVE SUMMARY

The cardiology and cardiac surgery communities are confronting end-of-life issues and the need to make appropriate treatment decisions, based on an assessment of the likelihood that it will make a difference in a positive way in a patient's life.

- Expectations of patients and referring physicians are sometimes unrealistic.
- The decision-making process ideally occurs well before patients become too sick to understand the discussion.
- Physicians should discuss end-of-life planning with patients who have left ventricular assist devices or are being considered for these.

people who die because of aortic stenosis, and we wish to pick out the latter group."

Many patients sent to cardiac surgeons are elderly, frail, and have multiple comorbidities for which an intervention like this is not likely to allow them to either live longer or live better, however. "We don't offer the procedure under those circumstances," says O'Gara. "We are trying to codify the decision making around it so that it's done for the right reasons, and not just because it can be accomplished technically."

Palliative care not always offered

High-tech, costly interventions also involve issues of distribution of resources, especially when considering these interventions at end of life or for patients who have limited life expectancy, are elderly, and/or have arguably reduced quality of life, says **James N. Kirkpatrick, MD**, an assistant professor of medicine in the Cardiovascular Division and in the Department of Medical Ethics and Health Policy at the Hospital of the University of Pennsylvania in Philadelphia.

"The expense involved in these technologies is thought to contribute to health care costs that do not have justified benefit. These issues can be compounded when the intervention is considered futile," says Kirkpatrick. "Interventions which are inexpensive and futile, such as simple blood tests, do not raise the same questions as interventions which are costly and futile." Of course, there is a question as to how to define futility, he acknowledges. "'Won't work' can be defined in terms of not having any physiological effect, as when a patient is already dead, or probabilistically, as when an intervention has a chance to work but only a small one," says Kirkpatrick.

A futile intervention could also be one in which there is a physiological effect, but the outcome cannot produce an acceptable quality of life. "In these situations, we begin to think about cost/benefit in terms of the cost and chance of different types of benefit, rather than just the magnitude of physiological benefit," says Kirkpatrick. These considerations require more nuanced discussions prior to implant, casting the benefits of a device in terms of the patient's overall values and goals, he adds. Palliative care practitioners are experts in these discussions, but need to partner with clinicians who are experts in the device technology, says Kirkpatrick.

"Although we don't have data to inform us, I suspect palliative care is not routinely being offered in most centers, either as an alternative to [transcath-

eter aortic valve implantation] TAVI or [ventricular assist devices] VADs, or along with TAVI and VADS. Palliative care is not the same thing as hospice and does not necessarily preclude interventions,” says Kirkpatrick. Patients who are turned down for TAVI and VADS are probably sent back to referring clinicians with the presumption that they will receive appropriate palliative care, he explains, but this might not happen as much as it should.

Specialists and referral centers have the expertise in disease- and device-specific management, but primary clinicians and generalists usually have the longitudinal relationships, adds Kirkpatrick.

“We are left in a difficult spot trying to figure out whose responsibility it is to discuss palliative care,” he says. “Often, these folks are desperate to feel better and will grasp at whatever technology provides hope. In these cases, palliative care focused on symptom relief may be what they most need, whether or not they are candidates for high-cost interventions.” (See related story, p. 44, on managing unrealistic expectations.) ■

SOURCES

• **James N. Kirkpatrick**, MD, Assistant Professor of Medicine, The Hospital of the University of Pennsylvania, Philadelphia. Phone: (215) 662-7726. E-mail: James.Kirkpatrick@uphs.upenn.edu.

• **Paul S. Mueller**, MD, MPH, Consultant and Chair, Division of General Internal Medicine/Professor of Biomedical Ethics, College of Medicine, Mayo Clinic, Rochester, MN. Phone: (507) 538-6341. E-mail: mueller.pauls@mayo.edu.

Public expectations often unrealistic

A patient with severe, debilitating chronic illness who has a heart attack might be sent to a center miles away from his home and family for last-ditch efforts that aren't likely to reverse the tide.

“We struggle at times with cardiac emergencies, to make the right decision in cases when it doesn't seem to be appropriate, when the expectations of the family, the referring physicians, and everyone else are at odds with our sense of the utility of performing highly invasive procedures,” says **Patrick O’Gara**, MD, FACC, president-elect of the American College of Cardiology and executive medical director of the Carl J. and Ruth Shapiro Cardiovascular Center at Brigham and Women’s Hospital in Boston.

“We need to educate our aging population about what is realistic,” he urges. “We practice medicine in an era where there are often no limits in terms of what people expect. This is something we have to face as a society.”

This scenario raises pressing ethical issues with informed consent, argues O’Gara. “It is one thing to delineate the expected benefits and the potential complications of a procedure,” he says. “It is another thing to make sure one explains this in terms that can be understood by the patient and the family, and frame it in terms of what the long-term outcome might be, and allow people enough time to really understand the limitations and possible benefits of the procedure.”

Ideally, this decision-making process occurs well before patients become sick to the extent that is hard for them to understand the nuances of this discussion, says O’Gara. “If one is heading down the pathway of a ventricular assist device or a percutaneous aortic valve, the time to have this discussion is months before they become sicker, so the process can be iterative and people can be educated,” he says. “But that isn’t always possible. Sometimes people get sick overnight, and they come in and we have to make the best decisions we can.”

Paul S. Mueller, MD, MPH, consultant and chair of the Division of General Internal Medicine/Professor of Medicine and Biomedical Ethics at the College of Medicine, at Mayo Clinic in Rochester, MN, says the draw of the “treatment imperative” is very real for clinicians and patients. “This may differ by institution. But it’s hard to say ‘no’ to a promising technology,” says Mueller. “We offer palliative care when such treatments and technologies are not likely to benefit the patient, and when using them is not consistent with their healthcare-related goals.”

Mueller says clinicians should discuss end-of-life values and preferences with patients for whom they are considering life-extending technologies, before the technology is used. “Unfortunately, advance care planning is not where it should be and there is room to improve,” he says, adding that Mayo Clinic physicians talk about end-of-life planning with patients who have left ventricular assist devices (LVADs) or are being considered for them, rather than waiting until the last days of life when they may no longer have decision-making capacity.

“Such advance care planning ensures that clinicians carry out their wishes, rather than guessing,” says Mueller. “We are actually looking at the our TAVI patients to see which ones have engaged in advance care planning. We have already examined the same in our LVAD patients. All of our LVAD patients undergo palliative care consultation.”

Patients might not have thought about their values and preferences, says Mueller. “Discussing them, ideally along with loved ones, will clarify for

clinicians what to do if the technology is unsuccessful and the patient loses capacity to make decisions on their own,” he explains. ■

Tax incentives don't appear to increase organ donation

Would you expect that offering state tax incentives or credits would increase organ donation? In fact, researchers found little difference in the annual number of living organ donations per 100,000 population between the 15 states that had enacted some sort of tax benefit as of 2009 and states having no such policy at that time, according to a 2012 study.¹

Funds allocated as tax breaks for donors could be better used in a pool of money for donor assistance for things that might arise in the course of donation, such as unexpected expenses for transportation, childcare, utility bills, and meals away from home, argues **Mary Ellen Olbrisch**, PhD, professor of psychiatry and surgery and director of education and training in clinical health psychology at Virginia Commonwealth University in Richmond. Olbrisch is the designated living donor advocate for the liver transplant program at the VCU Medical Center.

“During the psychosocial evaluation of prospective organ donors, we are obligated to discuss and explore financial issues, including the possibility that the donor has been offered some financial incentive or payoff for organ donation by the recipient,” she says. “Now, donor advocates are even expected to inform donors that the buying and selling of organs is a federal crime. This is an extremely sensitive topic that has to be handled with tact and diplomacy.”

EXECUTIVE SUMMARY

New research shows that state tax incentives or credits don't seem to increase organ donation. Some ethical considerations:

- Donors' personal expenses are often uncompensated.
- Incentives can reimburse donors for out-of-pocket expenses related to donation.
- If the parties wish to conceal financial arrangements or motivations, little can be done to uncover these.

Most donors are willing to make great personal sacrifices to help the person they are helping, both in terms of putting their own health at risk and some personal expense due to time off from work, most often uncompensated, Olbrisch explains. “Most prospective donors will simply tell you there is no financial arrangement. Some will be offended that you have suggested there might be,” she adds. “On rare occasions, one learns that a vulnerable person is being manipulated with the promise of payment for an organ.”

If the parties wish to conceal financial arrangements or motivations, little can be done to uncover these. “However, I believe that for the most part if finances are a barrier, individuals do not come forward as donors, and a promised tax incentive will not be enough to bring them forward,” Olbrisch says.

People who are donating out of care, love, and compassion, however, may actually be turned off if told that as an added bonus, they will get a tax break for their donation, says Olbrisch. “Behavior that is intrinsically motivated can be decreased or devalued if externally reinforced. Donors want to see themselves as good people doing the right thing,” she explains. “If they are put in the position to see themselves as people getting a tax break, it detracts from the image of themselves as caring, loving, compassionate people.”

A tax credit would be more valuable to the donors, as they would get a dollar-for-dollar reduction in their taxes rather than getting a few cents on the dollar that a deduction in taxable income provides, argues **John P. Roberts**, MD, professor and chief in the Division of Transplant Services at University of California, San Francisco Medical Center. “I don't think that there any ethical issues with these incentives. What the incentives are doing is reimbursing the donor for out-of-pocket costs occurring related to donation,” he says. “Personally, I think organ donors should be offered lifetime health insurance for donation.” ■

REFERENCE

1. Venkataramani AS, Martin EG, Vijayan A, et al. The impact of tax policies on living organ donations in the United States. *Am J Transplant* 2012;12(8):2133-2140.

SOURCES

- **Mary Ellen Olbrisch**, PhD, ABPP, Professor of Psychiatry and Surgery, Clinical Psychologist, Department of Psychiatry, Virginia Commonwealth University, Richmond. Phone: (804) 827-0053. E-mail: molbrisch@mcvh-vcu.edu.
- **John P. Roberts**, MD, Professor and Chief, Division of Transplant Services, University of California, San Francisco Medical Center. Phone: (415) 353-9321. E-mail: John.Roberts@ucsfmedctr.org.

Payment reform could mean more ethical care

Possible expanded role for bioethics

Many providers and health systems are unaware of the opportunity to leverage payment reform to develop or align community-based resources in order to provide better care and more support to patients post-discharge under the Patient Protection and Affordable Care Act (PPACA), according to **James Corbett**, JD, MDiv, a fellow at Harvard Medical School's Division of Medical Ethics and Vice President of Community Health and Ethics at Steward Health Care System in Boston, MA. "They may not connect that payment reform presents a tremendous opportunity," he says.

As payment reform leads providers away from the fee-for-service model to a model defined by global payment systems and sharing in patient cost reduction with insurers, providers and systems need to understand the community and the home as part of the continuum of care, stresses Corbett, and fully account for the social, behavioral, and environmental determinants of health. "Toward that end, at Steward, we are now sending pharmacists into the home of some of our most vulnerable patients to get a full sense of not just what the patient says they are taking, but also what their living conditions and medicine cabinets tell you. In the past, patients were told to go to the local pharmacy," he says.

New opportunities

Care management is expanding outside the walls of the hospital and primary care office, says Corbett. "There is also a lot of activity around self-education and social support networks impact in disease management," he says. "Our job extends

EXECUTIVE SUMMARY

Physicians have an opportunity to leverage payment reform to take advantage of existing and new community-based resources to support patients post-discharge, which could result in more empathic and ethical care.

- There are now multiple financial incentives to avoid discharging patients too quickly.
- Care management is expanding outside the walls of the hospital and primary care office.
- There is an emphasis on self-education and support networks for disease management.

beyond our walls, and much of that is driven by payment reform."

Corbett says that patients who are discharged and live alone are one of the groups of patients at highest risk for readmission. "Is that a medical issue? Not if you think of medicine as narrowly defined, but the kind of thinking that our jobs stop at the point of discharge is a thing of the past," says Corbett. Steward Health Care System is now rolling out a program to deliver healthy meals to prevent unhealthy eating from increasing the likelihood of avoidable readmissions in at-risk congestive heart failure patients, for instance.

"We knew that some patients are more likely to continue to eat high-sodium diets than others, which can lead to an avoidable readmission for heart failure patients," says Corbett. "If I can prevent a readmission by delivering healthy meals to someone for a month, I can show how that is much more cost-effective than not hitting certain readmission targets." This is the kind of program that couldn't be fully funded previously, says Corbett, but moving from the fee-for-service model to global payments has changed that.

"Payment reform finally gives us the opportunity to do many things that folks always thought could be useful, but couldn't be financially sustained in the past," he says. "More and more providers are saying, 'If I can avoid an avoidable readmission or unnecessary emergency room visit by doing these social-based initiatives, and if I can measure that and show the cost is cheaper than the hit you are going to take with a preventable readmission or unnecessary emergency room visit, then we can develop and sustain these types of programs.'"

Ethicists at the table

Ethicists need to get more involved with health care operations, argues Corbett. "Ethicists are often on the sidelines, if they are only addressing traditional ethics committee issues. I don't want to discount that — it's very important," he says. "But I am concerned that the space for ethics committees, which are generally advisory in nature, is narrowing, and that this could limit the impact of ethicists."

Ethicists need to understand the ethical implications of health care finance and the importance of operational ethics, advises Corbett. "No longer can we say that the ethicist's chief domain is in the ethics committees alone," he says. "That is far away from where the policies and protocols are being

developed that impact patient care. Let's get ethicists at the table where these decisions are made, including the C-suite."

For this to occur, however, ethicists are going to need some skills that haven't traditionally been considered as part of their domain, says Corbett. "As payment reform and accountable care organizations change our way of thinking, the role of ethicists had better change with it," he argues. While payment reform provides a powerful opportunity for better patient care, there are still some inherent risks to vulnerable patients that ethicists need to be able to understand and proactively prevent, explains Corbett. "Ethicists are a powerful backstop against unethical care, but they've got to become accustomed to broadening their traditional role," he says. (See related story, p. 47, on financial incentives.) ■

SOURCE

• **James Corbett**, JD, MDiv, Division of Medical Ethics, Harvard Medical School, Steward Health Care System LLC, Boston, MA. Phone: (617) 419-4735. E-mail: james.corbett@steward.org.

Financial incentives present opportunity

There are currently 328 accountable care organizations (ACOs), up from 164 in 2001, according to a 2012 report from Oliver Wyman, a New York-based company that consults with health care institutions looking to set up ACOs.

"ACOs are surging. This is a new way of providing care that is going to continue to expand across the country and will help us to reshape the type of care we are giving," says **James Corbett**, JD, MDiv, a fellow at Harvard Medical School's Division of Medical Ethics and Vice President of Community Health and Ethics at Steward Health Care System in Boston, MA. "The challenge now in health care is that we are on fee-for-service for some people, and risk contracts for others. It is an exciting time as we move toward more preventative care, but we are not fully there yet."

Physicians and systems providing care need to understand this new terrain of collaboration and alignment, stresses Corbett. "This is a dramatic change for hospitals. Those that were holding out hope that they wouldn't have to go in this direction are going to have to fall in line, and quickly," he says.

In addition to payment reform and ACOs, hos-

pitals also have other financial incentives to avoid discharging patients too quickly, such as avoiding Centers for Medicare & Medicaid (CMS) penalties for avoidable readmissions that occur within 30 days. "Systems will no longer get paid for discharging patients too quickly. Patients being on their own once they leave the hospitals will become a thing of the past quite soon," Corbett says. Instead, systems will have to figure out how to keep patients in the hospital long enough so that they are not readmitted, while at the same time ensuring that there are social support networks and other resources in place in the community that will support the patient post-discharge. "Hospitals won't thrive without doing that well," says Corbett.

Payment reform and CMS penalties for avoidable readmissions present an opportunity for providers to provide a different type of post-acute supportive care, which could be better both for the patient and the bottom line, he says.

"Even if the hospitals aren't getting paid for a certain initiative, there may be value in it. If it helps prevent a re-admission on a non-fee-for-service insurance model, there is an inherent cost savings there," Corbett says. "As you can imagine, the incentive to reduce readmission leads to more coordinated care outside the hospital, along with better outcomes for the patient, which is why many hospitals are honing in on it." ■

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

- Oversight of human egg donors
- Caring for undocumented patients
- Ethical approaches to combat obesity
- New challenges with advance care planning

CME QUESTIONS

1. Which is true regarding Physician Orders for Life Sustaining Treatment (POLST) programs?
 - A. The tool turns an advance directive into actionable medical orders, allowing seriously ill patients to specify choices about certain interventions.
 - B. Advance directives are ideally used only for patients with advanced illness or frailty.
 - C. POLST forms are not typically used for patients with advanced illness or frailty.
 - D. Comfort measures are not always provided to patients with POLST orders.
2. Which is true regarding ethical issues involved with prescribing pain medications, according to **Ben A. Rich, JD, PhD**?
 - A. Careful monitoring and follow-up appointments are essential to assuring that these medications are being taken as directed.
 - B. Electronic prescription-monitoring programs should not be factored into the clinical assessment of the patient in determining the appropriateness for initiating a trial of opioid therapy.
 - C. A refusal to prescribe is not appropriate, even when a physician is presented with clear and convincing evidence that a patient has no legitimate medical need for such medication.
 - D. There is no evidence that inadequately treated pain can become a lifelong problem for patients.
3. Which is true regarding incentives for organ donation, according to a study published in the *American Journal of Transplantation*?
 - A. State tax credits significantly increased organ donation, but a deduction in taxable income had no effect on the number of donors.
 - B. State tax incentives or credits don't appear to increase organ donation.
 - C. No states have enacted any sort of tax benefit for organ donation currently due to ethical concerns about this practice.
 - D. There is clear evidence that tax credits significantly increased organ donation.

EDITORIAL ADVISORY BOARD

Consulting Editor: **Arthur R. Derse**
MD, JD

Director and Professor
Center for Bioethics and Medical Humanities
Institute for Health and Society
Medical College of Wisconsin
Milwaukee, WI

John D. Banja, PhD
Associate Professor
Department of
Rehabilitation Medicine
Emory University
Atlanta

Marc D. Hiller, DrPH
Associate Professor
Department of Health
Management and Policy
University of New
Hampshire
Durham, NH

**J. Vincent Guss, Jr.,
BCC, D.Min**
Journal of Pastoral Care
Editorial Board for the
Association of Professional
Chaplains
Director of Medical Bioethics
Kaiser Permanente West Los
Angeles Medical Center
Los Angeles, CA

Paul B. Hofmann, DrPH
President
Hofmann Healthcare Group
Moraga, CA

Melissa Kurtz, MSN, MA, RN
Bioethics Consultant
The Montefiore-Einstein
Center for Bioethics
Bronx, NY

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.