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Make yourself relevant to clinical areas: Meet providers' needs for ethical guidance

Don't limit activities to ICU

As a bioethicist, is your approach too theoretical or removed from the practical issues that face clinicians? "Clinicians generally want someone who can relate to the *practical* nature of the ethical dilemmas facing them, patients, and families, even if the fundamental principles are conceptual," says **Katherine Wasson**, PhD, MPH, director of the Bioethics & Professionalism Honors Program at Loyola University's Neiswanger Institute for Bioethics in Maywood, IL. "Being able to translate the conceptual foundations of bioethics into practice is vital."

If bioethicists cannot do this effectively, clinicians may view them as unhelpful or irrelevant, warns Wasson.

"The bioethicist being visible, involved, approachable, and accessible throughout the entire hospital, and all the different clinical services, is vital to making the bioethicist relevant to all clinical services," says **Marianne L. Burda**, MD, PhD, a Pittsburgh, PA-based ethics consultant and educator. "All clinical areas have unmet needs for ethical guidance. Therefore, the bioethicist's activities should not be limited to a few areas of the hospital, such as the intensive care unit [ICU] and other critical care areas."

Bioethicists can promote greater awareness of ethics issues in all clinical areas, including subspecialties, by leading case discussions and pro-

EXECUTIVE SUMMARY

Clinicians have unmet needs for ethical guidance due to lack of time, insufficient staffing of formally trained bioethicists, or because they view bioethicists as irrelevant or unhelpful. To build relationships with clinical areas:

- Offer ethics grand rounds and educational sessions.
- Spend time in clinical areas that aren't regularly exposed to bioethics.
- Present on ethical issues within a subspecialty at national meetings.

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viding informal ethics education on units, argues Burda. "Taking bioethics to the clinical area is one very effective approach," she says. "These types of activities include participating in rounds and spending time with the different clinical areas that are not always exposed to the bioethicist on a regular basis, such as anesthesia, cardiology, and radiology."

Clinicians often lack time to attend ethics educational activities, and there may be a lack of support from clinical and administrative leadership or insufficient staffing of formally trained bioethicists, says Burda. In some cases, there is no paid bioethicist or only one bioethicist for a large facility.

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EDITORIAL QUESTIONS

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"Physicians should continue to have training in ethics in all stages of their career from medical student to attending," says Wasson. She suggests these approaches:

- Offer to serve on a community hospital ethics committee;
- Provide ethics education for clinicians of all types;
 - Ask what ethical issues clinicians have encountered in their practice and discuss ways of addressing them, such as surrogate decision makers and their choices for incompetent patients; and
 - Present on ethical issues within a subspecialty at national meetings. "This is a key way to raise awareness and encourage discussion among those clinicians in the subspecialty," says Wasson. "It denotes that the organization thinks ethics is an important area to be included and addressed."

Build relationships

Ask clinicians who are ethics committee members and clinicians on hospital committees if they are willing to be educational contacts, suggests Burda. "The more involved the bioethicist is in different clinical areas, the more contacts they can develop," she says. "These contacts can explain the medical aspects of cases to the bioethicist when needed." For instance, a bioethicist's pharmacy or oncology contacts can explain why a particular drug is not an acceptable substitute for treatment for a particular cancer.

Bioethicists working at a hospital or academic medical center can build relationships with clinical colleagues by offering ethics grand rounds and other educational sessions to various departments, says Wasson. "Classic clinical topics include informed consent, confidentiality, ethical decision-making, ethical issues at the beginning and end of life," she says. "Bioethicists also can use contemporary topical issues such as medicine and social media or direct-to-consumer genetic testing to engage clinical groups."

At Beth Israel Deaconess Medical Center in Boston, a monthly Ethics Case Conference open to all staff offers a forum for examining cases. "The conference has the dual aim of inviting peer discussion about how these cases were handled by our ethics consultant and learning from these cases about how we might improve the ethical aspect of care, education, and staff support for all of our clinicians," says **Wendy McHugh**, RN, MS, a clinical nurse ethicist.

The conference attendees come from all disci-

plines, with an interactive forum led by a panel of providers involved with the case and an ethicist. “Because it is so difficult for front-line staff to leave their units to attend case conferences, our ethics support service has instituted monthly ethics rounds in 20 different locations,” reports McHugh.

During these informal rounds, an ethicist meets with staff from a particular unit to reflect on current or recent situations involving challenging ethical issues. “Rounds are designed to be interdisciplinary and to foster team collaboration in difficult situations,” says McHugh. “We have rounds in all nine of our ICUs, one of our outpatient clinics, some of our specialty wards and, on a quarterly basis, with our hospitalist group.” Recent discussions covered ways to prevent moral distress, brainstorming ways to approach difficult medical decision-making conversations, or when it may be helpful to consult the palliative care team or the legal department.

“We are also available for a one-time ethics round on any unit to discuss a challenging clinical situation or topic,” says McHugh. The hospital’s Ethics Liaison Program is a way of engaging a larger and more broadly representative group of staff in the medical center’s ethics activities, she adds. Ethics liaisons are selected by department or division chiefs, and serve renewable year-long terms.

“They are invited to a monthly meeting to discuss clinical cases, serve as a contact for the Ethics Support Service within their area, create a project that addresses an ethical issue within their department, and annually review ethics activities or needs within their clinical or administrative area,” says McHugh. “We currently have 60 liaisons. They are encouraged to attend all the ethics educational offerings in the area.”

Training and skills

Lack of understanding and poor communication between clinicians and bioethicists can result in misunderstandings about goals for patient care by all involved parties and medical errors, warns Burda. To communicate effectively with clinicians, Burda recommends taking these steps:

- Attend continuing medical education courses to learn more about the medical issues encountered in the clinical setting;
- Take advantage of grand rounds and lectures at the health care institution or other institutions to learn more about different diseases and medical problems; and

- Obtain training in medical terminology and health care.

“Likewise, clinicians should have a basic understanding of ethics terminology, principles, and concepts to enhance communication with bioethicists,” says Burda.

While bioethicists don’t necessarily have to be “fully fluent” in medical terminology, a certain level of familiarity is important to communicate with those in the medical world, says Wasson. “One element that bioethicists can contribute to clinical ethical discussions is noting when there is too much jargon being used, and asking for clarification,” she adds. “Patients and families often do not understand medical jargon, and it can impede communication on that level.” ■

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Combating obesity raises ethical concerns

Physicians have obligation

Obesity may be the most difficult and elusive public health problem this country has ever encountered, according to a 2013 Hastings Center Report.¹ The report, which argued that combating obesity requires changing patterns of food and beverage commerce, personal eating habits, and sedentary lifestyles, got a “very hostile response,” says **Daniel Callahan**, PhD, the report’s author and

EXECUTIVE SUMMARY

Physicians don’t always bring up the topic of obesity due to concerns about stigmatizing patients, insufficient time, and lack of training. To combat obesity, physicians should:

- Consider ethical obligations to discuss obesity.
- Offer counseling or refer the patient to a physician who can do so.
- Support informed decision-making about food choices.

senior research scholar and president emeritus of the Hastings Center in Garrison, NY. “A number of people complained not only about my article, but also that we were having a discussion about obesity at all. They said, in effect, it was stigmatizing those of us who are obese.”

The fact that some 67% of people are either overweight or obese, and that this figure has remained static over the years, is evidence that a new approach is needed, argues Callahan. “We have to start with the premise that obesity is a serious problem medically and socially,” he says. “We’ve been working in this country for well over 25 years now to deal with the problem of obesity, but have made no real progress at all.”

Talking about health hazards was an effective approach to combat smoking, but this approach has not been as effective with obesity, says Callahan, noting that some programs consider getting 10% of participants to lose weight and keep it off as a success. “I find there is a very strong flavor that runs through the whole field of public health, with the exception of smoking, that, ‘Whatever the problem, don’t blame the victim,’” he says. “In one sense, that is a very valid idea. If you demean the people who have the condition, then they won’t come in for treatment.”

However, the concept of personal responsibility cannot be discounted altogether, says Callahan. “We’ve got to find some way to get obesity taken seriously which does not stigmatize those who are already obese, but as a prevention strategy, to go after the people becoming obese and stop it before it goes too far and becomes more or less irreversible,” he says.

Several studies have shown that physicians rarely bring up the topic of obesity with overweight patients.²⁻⁴ “It is not something they tend to talk with patients about,” he says. Doctors might not feel obesity is a high priority, might find obesity difficult to talk about, or might lack time and training to counsel patients effectively.

“We need to find ways of breaking through this reluctance on the part of physicians and provide them with training to do a good job, or to effectively suggest someone else for the patient go to for help,” Callahan says. “It’s a difficult conversation to have, but talk about it we must.”

Callahan considers it an ethical obligation of physicians to point out to patients that they are obese, even if the patient is probably already aware of it, and to say to the patient that it is important he or she should do something about it. In addition, the physician should offer counseling if he or she

can provide this effectively or, otherwise, should refer the patient to another physician.

“This can be a bit more delicate with specialists who are treating a patient for some other condition, and note the obesity,” acknowledges Callahan. “If I went to my orthopedist for my painful shoulder, it would be remiss of her not to point out what looks like a melanoma on my face. The same would be true of obesity. ‘If you haven’t already, you should talk with your regular doctor about that.’”

A personal choice?

While cigarettes and alcohol may be viewed as harmful products — and, thus, differentially taxed or banned — food as a generic class cannot be similarly addressed, says Desiree Lie, MD, MSED, clinical professor of family medicine and course director for the Professionalism and the Practice of Medicine course at the Keck School of Medicine of the University of Southern California in Los Angeles.

Obesity now accounts for almost 21% of U.S. health care costs, and an obese person incurs medical costs that are \$2,741 higher than if he or she were not obese, which translates into \$190.2 billion per year, according to a recent study.⁵

The ethical question of whether being obese is a personal choice or a health threat to self and society with a high cost — and, hence, amenable to public mandate or legislative control — is the basis of the challenge for clinicians and public health scientists, says Lie.

“Add to that the stigma of obesity, and the bias and stereotyping that obese persons encounter, and the push-back becomes even greater,” she says. “Education about its consequences remains the mainstay to combat the obesity epidemic. It needs to begin early — right from infancy. To be effective in the long term, physicians should make ‘becoming obese’ truly a personal informed choice made by patients.”

Research on the role of food marketing in long-term adverse effects on health, and legislative action to support informed decision-making about foods, such as food labeling and restriction of soda size, needs to continue, urges Lie. “This story and debate needs to be constantly in the public eye, because otherwise the food lobbyists will have their day,” she says. “It would be good, for example, if the Surgeon General’s office continued to make this issue visible.” ■

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MDs in “ethically untenable” position with undocumented patients

Bioethicists can start conversation

If an undocumented patient presents to an emergency department, the hospital will likely meet its obligations to stabilize the patient as required by the Emergency Medical Treatment and Labor Act, but what happens after that?

“The problem is what happens *after* somebody is stabilized. Undocumented patients are far more likely than other populations to lack health insurance, and they don’t have access to Medicaid,” says

EXECUTIVE SUMMARY

Bioethicists can communicate the ethical responsibilities of providers across the continuum of care when caring for undocumented patients, as well as facilitate discussions about this issue during medical or interdisciplinary grand rounds. Some concerns include:

- Hospitals are unable to find rehabilitation and skilled nursing facilities to treat undocumented immigrants who are not eligible for Medicaid.
- Patients with long-term injuries have been medically deported.
- In some cases, nephrologists cannot dialyze immigrants without coverage until they require emergent dialysis.

Wendy E. Parmet, JD, associate dean for academic affairs and Matthews Distinguished University Professor of Law at Northeastern University School of Law in Boston, MA. One problem is that hospitals are often unable to find rehabilitation and skilled nursing facilities that will treat undocumented immigrants who are not eligible for Medicaid. In some cases, patients with long-term injuries requiring significant amounts of care have been subject to medical deportation. “We have seen hospitals arrange for the transport of some of these people back to their country of origin, which raises significant ethical dilemmas,” says Parmet. “Hospitals are hiring air ambulances to send them back. It’s clearly ‘dumping,’ but they are not on the street, and that’s why we are not getting the uproar.”

John Henning Schumann, MD, associate professor of medicine and director of the internal medicine residency program at the University of Oklahoma School of Community Medicine in Tulsa, once cared for a Chinese immigrant who came to the hospital paralyzed from a stroke and had no family or friends to help. “There was no ability to discharge him to anywhere safe. The hospital contracted with a company to medically evacuate him to China at a cost of over \$50,000, paid for by the hospital.”

Schumann says that patients invariably wish to stay in the United States, but without a follow-up care plan in place, “the hospitals are doing what they see as their ethical best — and have the expensive receipts to ‘prove’ that what they’re doing is ‘ethical’ — providing expensive transport to facilitate safe aftercare of such patients.”

In some cases, nephrologists cannot dialyze immigrants without coverage until they are much sicker and require emergent dialysis, so patients can’t do the maintenance required to keep them from returning to the emergency department in an acutely ill state. “It’s really a very strong ethical dilemma for providers. They are unable to provide what they know is appropriate care,” says Parmet. “From a fiscal point of view, it is pennywise and pound foolish.”

“Need to speak up”

The Patient Protection and Affordable Care Act (PPACA) does not directly address ways of caring for undocumented individuals, who are excluded from the mandate to buy insurance on exchanges unless they file tax returns and can thus be penalized, and are also excluded from the upcoming

Medicaid expansion in most states. Parmet notes that the PPACA reduces payment to hospitals for uncompensated care on the assumption that a greater percentage of the population will be insured.

“There is certainly strong reason to believe that immigrants will be a larger share of the uninsured after the PPACA is fully implemented, especially in those states where Medicaid is expanded,” she adds. “But for the hospitals having less resources for providing care for the uninsured, it could actually exacerbate the problem.”

There is more money in the PPACA for community health centers, which often provide care regardless of an individual’s immigration status, notes Parmet, but some individuals may require a higher level of care than the centers can provide.

“Some of these issues also apply to documented immigrants. Under our federal laws, many categories of immigrants aren’t eligible for Medicaid, so they can’t get coverage for long-term care. They might even be insured for short-term care, but it’s not a really robust policy,” adds Parmet. “Suddenly they’re in a car crash and need months in a rehab facility, and their insurance doesn’t cover it.”

The ethical considerations are straightforward, says Schumann. “We are oath-bound to care for all patients, regardless of color, creed, nation of origin, financial status, language skill, or immigration status,” he says. “We should aspire to this ideal. We often fall very short.” Parmet says that current policies put providers in an “ethically untenable” situation. “Providers need to speak up,” she urges. “The ethical principles need to be absolutely clear so hospital administrators and public policy makers understand that it’s a violation of medical practice to ask providers to act in ways beneath the standard of care.”

Bioethicists can play a role in communicating the ethical responsibilities of providers across the continuum of care, suggests Parmet. “The responsibility for treating a patient population should not be left to the hospital alone, and certainly not to emergency departments alone,” she says. “As we move toward Accountable Care Organizations, we should be thinking of this less as the ethical obligation of the hospital and more about groups of providers having responsibility for patients across the spectrum of need.” (*See related story, p. 54, on how bioethicists can address care of undocumented patients.*) ■

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Plight of undocumented patients: “A difficult position”

Hospital ethics committees can place the care of undocumented patients on their discussion agenda periodically, and can facilitate discussions about this issue during medical or interdisciplinary grand rounds, according to a 2013 report.¹ “This could take the form of grand rounds, having the matter put on the agenda of the senior management team or board of directors, or presentations to the Medical Advisory Committee or any other forum which might exist in the organization,” says **Thomas Foreman**, DHCE, MA, MPIA, director of the Department of Clinical and Organizational Ethics at The Ottawa Hospital in Ontario, Canada. “At that point, they can advocate for the creation of an organizational approach to the issue.”

Both organizations and individual providers have the ability to provide care to undocumented immigrants, argues Foreman. “What they don’t have is the ability to receive reimbursement for the care they provide,” he says. “There is nothing that prohibits the provision of care to undocumented immigrants. It simply isn’t funded — and, ethically, that is significant.”

The inability of undocumented immigrants to access health care raises important ethical questions not just for providers but also for the organization and society, according to Foreman. “There is huge hypocrisy in this issue. There are millions of people living in conditions that most Americans would find to be unacceptable,” he says. “The reality is, people become ill regardless of their legal status. When it suits us, we embrace them. When it becomes more challenging or might cost us something, we deny them. That is a problem ethically, and the health care system finds itself in the middle of that.”

Undocumented immigrants are using costly emergency departments due to an inability to access primary care services, which means providers have

no opportunity to care for the patient holistically or build a relationship, adds Foreman.

“This clearly has negative consequences not only for patients but also for providers, who really feel like their hands are tied. Most have gone into the profession with a desire to help, and when they see barriers to being able to help, this presents ethical challenges for them,” says Foreman. “Many physicians really struggle with this. They realize that they can only address crises as they come up and not avert them. That is absolutely not the way health care should be provided.”

Bioethicists might also find themselves in a difficult position in raising this issue as individuals. “The challenge is that because we don’t have a profession, we don’t have the ability to speak as a body. As an individual, I can’t force a conversation, but as a professional body, I might be able to,” he says. “Also, most bioethicists are beholden to those institutions for their jobs. So how big of a thorn do you want to be?”

One possible solution involves hospitals in the region sharing the burden of providing unreimbursed care to undocumented immigrants, suggests Foreman. However, bioethicists might find it difficult to bring up this issue, as there are no clear-cut solutions.

“This is a classic ethical dilemma,” he says. “Either the system has to accept a reduction in revenues or profit, or the undocumented immigrants need to go away. When you think about it in those terms, we have two bad options: Reducing revenues to organizations that need to be sustainable or denying care to people who need it. There is no good solution to this, which is why many people don’t want to talk about it at all.” ■

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More training might be needed on industry gifts

Exposure to a gift restriction policy during medical school was associated with reduced prescribing of two out of three newly introduced psychotropic medications, according to a recent study.¹ Physicians who attended a medical school with an active conflict-of-interest policy were less likely to prescribe lisdexamfetamine over older stimulants and paliperidone over older antipsychotics. Among cohorts of students who had a longer exposure to the policy or were exposed

to more stringent policies, prescribing rates were further reduced.

“We were surprised by the large effect sizes we observed. While we had anticipated that the policies would have some effect on physician prescribing practices, we did not anticipate them having as large of an effect as they did,” says Marissa King, PhD, the study’s lead author and assistant professor of organizational behavior at Yale University School of Management in New Haven, CT.

Pharmaceutical companies have clear incentives to encourage physicians to adopt and prescribe their products, which are not aligned with the goal of providing an unbiased education, notes King. “Therefore, there is little role for pharmaceutical companies in early physician education,” she says. If medical schools are committed to providing an unbiased education, they should implement comprehensive policies to limit interactions between pharmaceutical companies and aspiring physicians, she argues.

“Ideally, ethics education should be a part of comprehensive conflict of interest policies,” says King. “Once physicians leave the academy, it is important that they have the tools to address negative potential conflicts of interest that arise when interacting with industry representatives.”

Physicians have an obligation to seek to optimize the health of their patients, and clinical decisions should be based on sound evidence-based science rather than information provided by industry representatives or sources that have an interest in maximizing the use of their products, argues Douglas S. Diekema, MD, MPH, an attending physician in the ED at Seattle Children’s Hospital and director of education for the Treuman Katz Center for Pediatric Bioethics at Seattle (WA) Children’s Research Institute.

“Medical students, residents, and practicing physicians should be aware of the many ways in which

EXECUTIVE SUMMARY

Physicians who were exposed to a gift restriction policy during medical school were less likely to prescribe a newly marketed psychotropic medication, according to a recent study.

- Comprehensive policies can limit interactions between pharmaceutical companies and aspiring physicians.
- Conflict-of-interest policies should include ethics education.
- More stringent policies further reduced prescribing rates.

industry attempts to influence their clinical decision-making,” he says.

This occurs not simply in the form of gifts, but by way of research grants, consultation opportunities, invitations to industry sponsored events, including CME events, and even some published articles that appear in the medical literature, says Diekema.

“Physicians have an obligation to be aware of these practices, to be aware of how easily they can be influenced, and to be on guard against that influence,” he adds. “Training programs should include educational programming that focuses on these issues.” ■

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Will health care reform affect informed consent?

Physicians will discuss cost of treatment

Physicians will need to give more thought to whether and how to discuss the costs of care with patients as a result of health care reform,

EXECUTIVE SUMMARY

Health care reform could mean that physicians will need to give more thought as to whether and how to discuss the costs of care with patients. Some ethical considerations:

- Universal, standardized coverage makes it easier to determine patients’ costs.
- Ignoring patients’ out-of-pocket costs could lead to poor compliance.
- Use of patients decision aids could result in a more consistent informed consent process.

according to **Mark A. Hall**, JD, professor of law and public health at Wake Forest University in Winston-Salem, NC.

“Before reform, discussing treatment costs was unmanageable because patients’ insurance situations varied so widely,” he explains. “Now, with coverage becoming more universal and more standardized, it is more feasible to know what portion of treatment costs, roughly speaking, patients might have to pay.”

Out-of-pocket costs obviously are important to patients in deciding what treatment is best and most feasible, and ignoring patients’ costs leads to poor compliance and less effective care, argues Hall. “Therefore, physicians bear some responsibility for considering treatment costs, in some fashion, when discussing treatment options with patients,” he says.

The Patient Protection and Affordable Care Act (PPACA) won’t necessarily adversely affect the informed consent process, says **Andrew Flescher**, PhD, associate professor of preventive medicine at the Center for Medical Humanities, Compassionate Care, and Bioethics at State University of New York, Stony Brook. “The question of whether or not a patient is made fully aware of what procedures he or she will undergo, once they are approved, is separate from the extent to which such procedures will, in the first place, continue to be as easily approved as they have in the past,” he explains.

Flescher says that the PPACA rightly incentivizes health care providers, especially hospitals, to be more efficient in health care provision, by rewarding them when they furnish evidence that they are achieving better outcomes, reducing the amount of iatrogenic deaths, and repeating fewer tests as those just conducted at nearby community hospitals.

“But it does not disincentivize health care providers from fulfilling their ability to keep patients as autonomous agents in their care, privy to being made aware of exactly what will be done to them and how,” says Flescher. “Now, perhaps in a larger, indirect sense, the populace will be less informed, or rather more confused, about what health care services in the future will be harder for them to access. But this doesn’t have to do with ‘consent,’ per se.”

In any case, says Flescher, it is the burden of insurance companies, not physicians, to inform their enrollees comprehensively as to what expectations they should have about coverage.

A provision in the PPACA authorizes the creation of a program to develop certified patient decision aids for use during the informed consent process to promote shared decision-making. “There have even

been recent suggestions that Medicare reimbursement be contingent on use of a decision aid,”¹ says **J.S. Blumenthal-Barby**, PhD, MA, assistant professor of medicine and medical ethics at Baylor College of Medicine in Houston, TX.

Use of decision aids may result in a “more consistent and ethically robust” informed consent process, says Blumenthal-Barby, but one of the challenging ethical questions is whether these decision aids should include information about the costs of the options.

“There is an ethical argument to be made from a ‘reasonable person’ standard of disclosure that most patients would deem such information material. Yet including cost information is difficult, since costs will vary depending on individual patients’ insurance coverage,” she says. “And, cost information could sway patients away from a choice that they would otherwise make and that is in their best interest.” ■

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Minimum criteria ensure consistent evaluation

Living donors are evaluated in a consistent fashion.

There is “an enormous disparity” between the number of patients with end-stage organ failure and the number of organs available for transplantation, resulting in patients dying on the waiting list, according to **Christie P. Thomas**, MD, professor in the Division of Nephrology at University of Iowa Health Care in Iowa City and chair of the Organ Procurement and Transplantation Network’s

(OPTN) Living Donor Committee. “This has led to attempts by various societies to increase both deceased and living organ donation, which can raise new ethical concerns,” he says. “There are always safety and privacy concerns for the recipient of the organ, whether it comes from a living or a deceased donor.”

There are similar safety and privacy concerns in the evaluation and acceptance of living donors, but there are additional concerns about informed consent, ensuring that there is no inducement or coercion of the donor and that there is no financial gain or other “quid pro quo” for the donor in exchange for the donation, explains Thomas.

“Societal needs for more organs have resulted in live donors stepping up to fill the gap between supply and demand. Living donors place themselves at risk for the sake of another human being, despite the lack of benefit to themselves,” says Thomas.

Living donation will never be without risk, and given the pressure to increase donation, the transplant community must strive to keep living donation as safe as possible, he urges. “We must ensure that the living donor is well-informed, is aware of the short- and long-term risks of donation, and that donation is truly voluntary,” says Thomas.

New mandatory policies

The OPTN’s new mandatory policies that all transplant centers must follow became effective in February 2013. These cover all aspects of the living donation process, from informed consent through evaluation to follow-up. “These new policies are designed to maintain and enhance safety for living donors, and should make the living donation process a more consistent experience for them,” says Thomas.

Transplant centers that have the best interests

EXECUTIVE SUMMARY

The Organ Procurement and Transplantation Network’s minimum criteria ensure that all living organ donors are evaluated consistently, and address concerns about safety, privacy, and informed consent. The new policies seek to:

- Ensure there is no inducement or coercion of the donor.
- Ensure there is no financial gain for the donor in exchange for the donation.
- Identify conditions or circumstances that result in the candidate being excluded from donation.

of their patients on the waiting list are usually the same centers that evaluate and consent living donors and perform their donor surgeries, notes Thomas. “While this can introduce a conflict between the well being of the living donor and the needs of the transplant candidate, centers have multiple ways to manage this conflict,” he says. First, every center provides the living donor candidate with an independent donor advocate who is knowledgeable about the risks and benefits associated with the donation process.

“The independent donor advocate assists the potential living kidney donor with the evaluation process, and promotes the best interests of and advocates for the potential living donor,” he says. Second, every living donor interacts individually with many health care professionals, who approach the living donor with a different perspective and a different goal. All members of the team must be satisfied that the living donor is acceptable.

Finally, the new policies that govern all aspects of living donation set minimum criteria that all centers must follow during all phases of the living donation process, which ensures that living donors are evaluated in a consistent fashion. “This set of policies also categorizes particular conditions or circumstances that, if identified in a living donor candidate, will result in the candidate being excluded from donation,” adds Thomas. ■

Focus on ethics of social networking

Patient/physician relationship is issue

Of 600 residency program directors and medical school admissions officers surveyed, 64% reported being somewhat or very familiar with

EXECUTIVE SUMMARY

More than half of residency program directors and medical school admissions offices surveyed stated that unprofessional information on websites could compromise applicants' admission. Some ethical considerations:

- Inappropriate postings can adversely affect patients' perception of credibility and reliability.
- Clear guidelines on use of social networking sites in the selection process should be provided.
- Physicians' postings might reflect poorly on the profession.

searching individual profiles on social networking sites, 9% reported routinely using social networking sites in the selection process, and 53% stated that unprofessional information on applicants' websites could compromise their admission into medical school or residency.¹

“Some might consider it surprising that a majority of respondents thought it was acceptable to use such information in the selection process, but this is clearly the norm today,” says **Carl I. Schulman, MD, PhD**, the study's lead author and associate program director for the surgical residency program at the University of Miami. “The study's findings probably underestimate the true impact of social networking sites on selection.”

“What should be considered when assessing the professionalism of a potential applicant? Should what one does in their personal life influence the selection process?” he asks. “There are certain things that are not allowed to be asked during an applicant's interview, which would most likely be easily discovered through modern social networking sites.”

What is appropriate for physicians to post on a social networking site? How much influence should a professional organization, college, or employer have outside of the work environment? “These are ethically challenging questions,” says **Rosalind Abdool, PhD(c)** a fellow at the Centre for Clinical Ethics at St. Joseph's Health Centre in Toronto, Canada. “Some may argue that this is a relatively new concept. However, questions of professionalism outside of employment have been raised for decades.”

For example, many professional colleges have strict standards about the kind of behaviors and relationships that are appropriate outside of expected or standard interactions between professionals and their patients, which can even extend once the clinical relationship has ended.

Observing one's clinician participating in *perceived* reckless behaviors can influence a patient to believe that the clinician lacks good judgment, which the patient might believe adversely influences the clinician's ability to treat and care for him or her. “Although the reactions may not always be accurate, this can have an enormous impact on trust, credibility, and reliability,” says Abdool. “This is why judgment is extremely important when considering what to post and what views to express in a social media setting.”

Transparency needed

Many medical schools lack formal policies on social media use, notes **Kayhan Parsi, JD, PhD**,

professor of bioethics and health policy/graduate program director at Loyola University Chicago's Neiswanger Institute for Bioethics and Health Policy in Maywood, IL. "Is it appropriate for students to tweet things that are obscene or inappropriate even though they aren't breaching confidentiality? It may be that we should start cultivating these norms with medical students who are in training," he says.

Abdool says it is not ethically problematic for medical schools and residency programs to inquire further, through Internet searches, about potential candidates. "Exercising good judgment regarding what to post publicly shows a concern for trust, credibility, and reliability, which is the kind of character that medical schools and residency programs look for in future physicians," she explains.

Medical schools and residency programs should be fully transparent regarding their use of Internet searches to inform candidate applications, however, says Abdool, and candidates should be made aware that this process could ultimately affect their chances of being selected for medical and residency programs. "The ethical importance and value of professionalism and public perception should be made explicit in medical schools, especially how they pertain to social networking," she says. "Professional judgment should also be discussed, and how one's actions outside of the profession can impact the fiduciary relationship between a professional and his or her patient."

Clear guidelines should be offered to applicants for medical schools and residencies, recommends Schulman, so they at least know that this information could be used in the selection process. "The same issues will clearly affect practicing physicians," he says. "It is important for all professionals to be aware that their online information can shape the way they are viewed by other physicians, hospitals, and patients."

Maintain boundaries

Historically, physicians could maintain sharper boundaries with regard to their personal and professional lives, says Parsi, "but with the proliferation of social media, those kinds of boundaries have really gone out the window. If images you post seem incongruous with the identity of a physician, professional societies or medical boards might look upon that as not the best representation of health care."

Parsi says connecting with patients on professional networking sites is "a little bit more nuanced. It offers a different kind of professional boundary

issue than Facebook, which is typically a more social networking site."

Parsi says that physicians need to keep their personal and professional identities separate online, but even with accounts that are for personal use only, physicians must consider whether their postings will reflect poorly on the profession. "Even there, you are still perceived as a physician, and anything can be reposted or forwarded," he says. "If patients see their physician behaving in a way that is unprofessional, it could undermine their trust not only in the physician, but also the profession of medicine." ■

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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.

COMING IN FUTURE MONTHS

- New challenges in neuroscience
- Cognitive enhancement drugs
- Why end-of-life wishes aren't always met
- Update on ethics consultation standards

CME QUESTIONS

- Which is true regarding obese patients and ethical obligations of physicians, according to **Daniel Callahan, PhD**?
 - Physicians have no ethical obligation to discuss a patient's obesity.
 - Informing patients of health hazards is more effective with obesity than it is for smoking.
 - The physician should offer counseling or refer the patient to another physician who can provide it.
 - It is unethical for a specialist to advise patients to discuss obesity with their regular doctor.
- Which is true regarding the Patient Protection and Affordable Care Act (PPACA) and undocumented patients, according to **Wendy E. Parmet, JD**?
 - Providing transport to medically deport patients is the most ethical approach.
 - The PPACA directly addresses ways of caring for undocumented individuals.
 - No undocumented individuals are excluded from the mandate to buy insurance.
 - There is more money in the PPACA for community health centers, which often provide care regardless of an individual's immigration status.
- Which is true regarding health care reform and the informed consent process, according to **Mark A. Hall, JD**?
 - Physicians have an ethical obligation *not* to discuss the costs of care with patients.
 - Physicians will need to give more thought to discussing cost of care.
 - Physicians bear no responsibility for considering treatment costs, in any fashion, when discussing treatment options.
 - Health care providers will be disincentivized from keeping patients as autonomous agents in their care.
- Which is true regarding exposure to a gift restriction policy during medical school, according to a study published in *BMJ*?
 - Exposure to a gift restriction policy had absolutely no effect on prescribing practices.
 - Exposure to a gift restriction policy was associated with reduced prescribing of newly marketed psychotropic medications.
 - Longer exposure to the policy resulted in increased prescribing of newly marketed medications.
 - Stringent policies were linked to increased prescribing of newly marketed medications.

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

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- 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.
- 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%.
- 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.
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