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AHC Media

Fourth state allows physician aid in dying: Is it an affront to palliative care?

Publicity stirs debate over end-of-life care

With Vermont becoming the fourth state to allow physicians to prescribe lethal doses of drugs to terminally ill patients who request prescriptions, along with Oregon, Washington, and Montana, it is possible that other states will follow suit or increase advocacy efforts.

"Legalization in Vermont has both positive and negative implications for end-of-life care," says **Robert Macauley**, MD, medical director of clinical ethics at Fletcher Allen Health Care, and professor of pediatrics at the University of Vermont in Burlington.

"In terms of the positive, the debate surrounding physician-assisted dying has thrust end-of-life issues into the public consciousness. It has made possible nuanced and thoughtful conversation," he says. "In terms of the negative, I worry that the surrounding publicity may cause some people to reduce palliative care to physician-assisted dying only."

At a recent community educational event in Vermont about end-of-life care, the majority of the questions related to physician-assisted dying, says Macaulay, and seemed to overlook the fact that palliative care is a much broader concept. Macauley hopes bioethicists will take advan-

EXECUTIVE SUMMARY

Vermont, Oregon, Washington, and Montana now allow physicians to prescribe lethal doses of drugs to terminally ill patients who meet certain criteria and request lethal prescriptions. Some ethical concerns:

- Publicity over physician aid in dying could result in misconceptions about end-of-life care.
- Patients often don't realize that palliative care is a much broader concept than physician aid in dying.
- The laws don't necessarily change the practice of individual physicians, who are free to conscientiously object.

tage of opportunities to emphasize that no one — neither physician nor patient — is obligated to utilize physician-assisted death, and that symptom management, advance care planning, and patient empowerment can often resolve the concerns that prompt patients to inquire about hastened death.

"I firmly believe that 'Doctor, will you help me hasten my death?' is not a yes or no question, based on the moral position of the physician," says Macaulay. "Regardless of whether one believes that physician-assisted dying is moral or not, such a question should prompt further inquiry as to what is driving the patient to make such a request and in what ways the physician can be of assistance."

Keith M. Swetz, MD, MA, associate professor of medicine at Mayo Clinic in Rochester, MN, says that while the legalization of physician-assisted dying in four states has received much publicity, it doesn't necessarily change the fundamental goals of medicine.

"That is to provide the best care to the patient that you can during a time of need. If one state or another chooses to enact a law, that doesn't change that," he says. "A major reason for people pushing through laws that deal with physician-assisted dying really has to do with control and not inadequate care."

Just because a law is passed doesn't necessarily mean the practice of individual physicians will change, adds Swetz. "Oregon and Washington have their systems in place, and Montana is still wrestling with how to enact the law," he notes. "It's important to note that physicians have the right to conscientiously object to anything they personally see as being objectionable."

A slippery slope

"I think most palliative care providers see physician-aided dying as an affront to palliative care," says Swetz. "Under what circumstances would physician-aided dying be desired? If a patient's symptoms are managed and the patient is not suffering quality-of-life issues, then generally the request is the person's own preference or their desire to die on their own terms." (To view the American Academy of Hospice and Palliative Medicine 2007 position statement on physician-assisted dying, go to http://www.aahpm.org/positions/default/suicide.html.)

The 2011 documentary film *How to Die in Oregon* covers the state's Death With Dignity Act, including interviews with many people who opted for physician-aided dying. Swetz says that he was struck by the fact that many individuals featured in the movie had a clear lack of palliative care. "The film has a very strong focus on individual rights, versus other ethical systems that would look at the good of the person and the community," he adds.

Some providers have made efforts to differentiate palliative care from euthanasia, notes Swetz, and to show that palliative care is not associated with the hastening of death in any way.

"Outside of the United States, there are still concerns that not aggressively intervening on life-threatening illness and focusing on palliation only

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EDITORIAL QUESTIONS

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may be viewed as allowing to die, which some see as 'passive euthanasia,'" Swetz adds, "It is an important role of the bioethicist to point out that there is a moral difference in killing and allowing to die."

In most cases, palliative care has the ability to reach beyond end-of-life care and focus on caring for a patient throughout the course of illness, says Swetz, adding that this is a key educational role that all health care providers, particularly those in bioethics, have an opportunity to promote.

"There is a concern that as physician-aided dying becomes more mainstream, that people may question the motives that can occasionally be in conflict with one another," Swetz says. "When these issues are brought up, there is a natural tendency to lump things together. But they are not the same."

Swetz notes that there is still a very strong sentiment against using appropriate opioids to help people to be comfortable. "That issue still needs to be worked on. Being that there are legal prescriptions with the specific purpose of hastening death, people who do not know the facts may blend the two together," he says.

Cost-containment efforts

Some Oregon patients have claimed that their health insurance would not pay for expensive chemotherapy treatments to treat advanced cancer, but agreed to pay for physician-aided dying and associated medications. "It can be a slippery slope," says Swetz. "This becomes a question of whether we are going to legislate cost containment by having these policies available. Even if we are not, people might perceive that physician-aided dying is associated with trying to contain costs."

Patients and family members who are offered palliative care are sometimes concerned that providers aren't being aggressive with treatment because of cost-containment issues. "There is a concern that society may think of palliative care as another measure to contain costs and ask, 'Is this option being given to me because people don't want to spend money on my medical care?'" he says. "It could be totally untrue, but it can be a perception issue."

Any patient's request for hastened death is an opportunity to enter into a meaningful dialogue and address a person's fears or unanswered questions, underscores Swetz.

"If a patient requests physician-aided dying, there is often an unmet need or suffering on some level which may not be optimally treated," he says. Such requests allow clinicians — whether palliative care providers, nurses, or clinical ethicists — to ask why a person is making such a request and to explore if there are other alternative treatments that can meet a person's goals of care without only providing a lethal prescription.

"From an ethical perspective, I think it is critical for clinicians and ethicists to acknowledge the biases that come with holding personal moral beliefs, while striving to inform and empower patients to make their own decisions," says Macauley.

This means presenting patients with all relevant and legal options, and at the same time, acknowledging that no patient or physician is obligated to take part in physician-assisted dying, even if it is legal. "In states like Vermont that have legalized physician-assisted dying, there continue to be significant ethical issues," says Macauley. "The conversation is shifting from whether it should be legalized, to how the medicine should be practiced now that it has been." ■

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Ethicists' recommendations aren't always accepted

Clinicians, patients may misunderstand team's role

A terminally ill patient was in multi-organ failure in an intensive care unit (ICU), and the family opposed the primary physician's recommendation for a Do Not Resuscitate (DNR) order, which was based on her benefit-to-burden analysis of cardiopulmonary resuscitation for the patient. A subcommittee of the ethics committee was assembled, and met with the family and representative members from the primary clinical service and from the ICU.

"The ethics team ultimately supported writing a DNR order even without family consent, based on the patient's best interests," reports **Martin L. Smith**, director of clinical ethics at The Cleveland (OH) Clinic. "Many hours by multiple members of the ethics team were spent on this consult. In the end, the primary physician chose *not* to write the DNR order."

Role is advisory

Given the advisory role of ethics consult services, an ethics consult team needs to anticipate that its recommendations won't necessarily be accepted or followed. Typically, after appropriate information-gathering and analysis, the team provides ethically supportable and recommended strategies and options, says Smith.

"The consult process, depending on the case and its complexity, can be very time-consuming and labor-intensive," says Smith. "But ethics consultants need to routinely remind themselves that after all that hard work, their role remains advisory." The primary stakeholders in the case — usually the patient, family, physician, and other clinical team members — are ultimately responsible for their own decisions and are free to ignore the advice of ethics consultants.

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, says patients and clinicians might have to be reminded that the bioethicist's role is typically advisory. "We are not there to go in and make moral pronouncements. We are really there to offer a range of ethically appropriate options," he says. "We are really facilitators, at the heart of it."

While a question such as, "Who is the appropriate surrogate decision maker for this patient?" is fairly straightforward, consults become considerably more complex when the bioethicist is asked to facilitate a resolution regarding a conflict between the family and the clinical team.

If a terminally ill patient is in an ICU setting and has undergone an aggressive treatment regimen, and the clinical team has come to a point at which they believe there is nothing else the team can do medically for the patient, the clinical ethicist might recommend a palliative care approach. "If the patient's family wants to push forward, the attending always has the discretion to follow our recommendation or not," says Parsi. "We are like any other consultant in that sense. But if they choose *not* to follow the recommendation, they should have a very good reason, and indicate such in the record."

In some instances, a family member perceives the ethics consultant as having a conflict of interest simply because he or she is employed by the institution. "We have to be very careful to clarify what our role is — that of an impartial third party," says Parsi. "We are there to facilitate dialogue and come to some sort of consensus. We are not there to be the ethics police, or address one view unilaterally."

Clinicians misunderstand role

Some clinicians, based on previous experiences with an ethics consult service, believe that ethics consultants will "take over" the case, to the detriment of the clinical team members' relationships with the patient or the family. "Clinicians who have less power or authority in health care's traditional hierarchy, such as nurses or resident physicians, may feel intimidated or threatened by an attending physician if ethics assistance is requested," says Smith.

If ethics consultation can make a positive contribution to patient care and patient outcomes, says Smith, then under-utilization of an ethics consult service means that patients and their families are being denied a valuable resource. "At the Cleveland Clinic, we have initiated what we call 'embedded ethicists' with many of our clinical services," says Smith. This means that one of the team's bioethicists participates in a clinical team's routine meetings, inter-disciplinary meetings, patient-focused meetings, care discussions, and decision-making.

"We have done this successfully and effectively with our neurology colleagues, with most of our organ transplant services, genetics, pediatrics, and heart failure," Smith says. "Over time, trusting relationships with clinicians are built. Clinicians come to see the positive contributions we can make to their thinking, decisions, and patient care."

Bioethicists also participate in routine inter-disciplinary rounds in most of the organization's ICUs. As a result, over time, bioethicists become well known by attending physicians, fellows, and residents; by bedside nurses and nurse managers; and by physical therapy, occupational therapy, social work, pastoral care, and case managers. "Mutual trust, understanding, and respect are established," says Smith. "There is little or no hesitancy to request ethics assistance when needed."

EXECUTIVE SUMMARY

Clinical ethicists typically play an advisory role, and their recommendations aren't always accepted or followed by the clinical team. To facilitate resolution of conflicts, ethicists can:

- Remind clinicians that the bioethicist's role is typically advisory.
- Inform patients that the ethics consultant is an impartial third party.
- Be ready to explain how they arrived at their recommendations.

Not about winning

If conflict over patient care isn't successfully resolved, a communication breakdown and loss of trust between any of the parties can occur. "This can stall progress on behalf of the patient, and damage the working alliance with the clinical team, patient, and family," says **Jane Jankowski**, LMSW, MSB, a clinical ethicist and assistant professor at Alden March Bioethics Institute at Albany (NY) Medical College.

In some cases, a patient's discharge from the hospital to a skilled care facility is held up because the patient will not consent to a recommended treatment. The family and clinical team can become frustrated if Jankowski recommends that the patient's preference on the matter should be honored.

"And I get it; this can delay a hospital discharge. There is a lot of pressure to move patients through the system these days," says Jankowski. However, if that patient understands the risks and benefits of what he or she is declining, as well as the consequences, Jankowski is not likely to recommend overriding a patient's well-reasoned refusal in order to satisfy the preferences of others or pressure to expedite a hospital discharge.

As a clinical ethicist, Jankowski expects to be questioned about why she arrived at the recommendation she did, and is prepared to explain her reasoning. "When there is strong opposition, I find that the most productive response is listening to other views on the situation, and validating the concerns of the team," she says. "This helps the consultation remain a shared, inclusive process."

Flexibility, self-reflection, and a willingness to acknowledge errors are key. "It is important to focus on the purpose of the consultation," says Jankowski. "It is about the patient, not about winning or losing a debate over a theoretical dilemma. This is real — it is someone's health and welfare at stake." ■

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Physicians face ethical balancing act with pain management

MDs asking for opioid contracts, urine tests

Due to suspicions that some patients are "drug-seeking," and the fear of being accused of improper subscribing of pain medications to substance-abusing patients, some physicians are asking patients to sign opioid contracts or take urine tests before agreeing to prescribe pain medications.

Prescription opioid use skyrocketed from 2000 to 2010, but the identification and treatment of pain has failed to improve, according to a recent study.[1]

Matthew Daubresse, MHS, the study's lead author and a research data analyst at the Johns Hopkins Bloomberg School of Public Health's Center for Drug Safety and Effectiveness in Baltimore, says the findings were surprising, especially given that there was no significant change in the proportion of doctor's office visits with pain or in the proportion of pain visits treated with pain relievers.

"Clinicians and patients should be fully aware of the trade-offs between different pain relievers," says Daubresse. "There are important risks associated with use of prescription opioids. Clinicians have an ethical obligation to be aware of these risks, and reserve use of these drugs only when clinically indicated." In September 2013, the Food and Drug Administration announced new labeling changes and post-market study requirements for extended-release and long-acting opioid analgesics.

The study's findings also demonstrate the ethical implications of efforts to improve the identification and treatment of pain, says Daubresse, as these efforts may have contributed to an over-reliance on prescription opioids and reductions in the use of safer alternatives to opioids like ibuprofen and acetaminophen.

EXECUTIVE SUMMARY

New research suggests that efforts to improve the identification and treatment of pain may have contributed to an over-reliance on prescription opioids. If patients are asked to sign opioid contracts or take urine tests before pain medications are prescribed, physicians should:
• Let patients know that drug testing is part of the care provided, and why this is so.
• Inform patients about the consequences of a positive test result in advance of any testing.
• Establish a uniform practice pattern.

Robert L. DuPont, MD, president of the Institute for Behavior and Health in Rockville, MD, says physicians have an ethical responsibility to their patients and to their communities when the medicines they prescribe may harm their patients or others. "Giving addicts drugs of abuse is not helping them. Addiction is a disease of much suffering," says DuPont. "A substantial percentage of prescribed controlled substances is diverted for nonmedical use. This misuse produces addiction and deaths, including overdose deaths."

DuPont says drug testing helps physicians identify patients who are not actually using the drugs prescribed for them, and patients who are using other drugs of abuse. "Patients identified as drug abusers, or addicts, deserve and need help," he says. "Drug testing can help physicians move that process along to better outcomes for their patients and their communities."

Physicians sometimes unwittingly provide potentially addicting and deadly drugs to patients who lie to them. "Drug testing is a useful tool to help physicians do a better job," says DuPont. "It is desirable for physicians to let patients know that drug testing is part of the care provided, and why this is so. The patient should also be informed about the consequences of a positive test result in advance of any testing."

Obligation to limit harm

Physicians have ethical obligations to try to relieve their patient's pain *and* to limit preventable harm when prescribing pain medication, says **Nathan Allen**, MD, assistant professor of medicine and medical ethics at Baylor College of Medicine in Houston, TX. "Systematically, the medical profession has not been highly successful in meeting these twin obligations," he says. "Many patients' pain is managed sub-optimally. Prescription pain medication misuse has become a rapidly growing problem in the United States."

Urine drug testing presents these ethical challenges, says Allen:

• Physicians' ethical obligations as fiduciaries for their patients require them to place their patients' interests before their own, generally speaking.

"For [physicians'] self-interests to be legitimate or given significant weight, they should be both highly impactful, reasonably probable, and the mechanism for addressing them as minimally impactful on the patient as possible," he says. "Legal and regulatory concerns are highly impactful, but they are both unlikely for a physician in general and highly unlikely in any single patient encounter." *(See related story, p. 127, on whether opioid contracts are fundamentally unethical.)*

• Minority patients are at greater risk of not receiving appropriate pain management, and may be more likely to be given urine drug tests than non-minority patients.

"This forms a justice consideration, as urine drug testing may risk accentuating disparities in care further," says Allen.

• Patient autonomy is threatened, whether pain medication is provided or not.

Providers risk impeding patient autonomy if they unilaterally determine that the risks of prescribing pain medication outweigh the benefits in a patient with addiction, and the same is true if providers offer a medication that an addicted patient may not be able to refuse. "How physicians balance these concerns is a tricky ethical challenge," says Allen.

• There is a threat to the trust underlying the doctor-patient relationship.

"Physicians risk using urine drug testing to find out 'Which patients are lying to me?' rather than to identify patients at risk of harm and who may need treatment for another serious disease — drug addiction," says Allen. If urine drug testing is going to be used, then it is important to establish a uniform practice pattern, and disclose to the patient in advance that testing will be done and how it will be used.

Daubresse emphasizes that opioid contracts and urine tests represent only a few of the many tools available to physicians to address the ethical and practical issues related to providing analgesia.

"Other tools include risk assessments, clinical judgment, the World Health Organization's analgesic ladder, and prescription drug-monitoring programs," he says. "Physicians must decide which of these tools is most appropriate for the patient being seen, using his or her own moral compass." ■

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Are opioid contracts fundamentally unethical?

Patient don't always understand terms

Some physicians are asking patients to sign opioid contracts or take a urine test as a precondition to prescribe pain medications, but are these practices fundamentally unethical? This depends partly on when and how these practices are utilized, and whether some patients may be disproportionately targeted because of their socio-economic background, ethnicity, or mental health conditions, says **Anita Ho**, PhD, associate professor at the Centre for Applied Ethics at the University of British Columbia and director of ethics services at Providence Health Care in Vancouver, Canada.

Opioid contracts seek patients' agreement to various sets of behaviors as conditions for receiving treatment, especially when the patient has a history of addiction or is suspected of being drug-seeking. "Establishment of clear expectations and goals of care is important for any successful and respectful treatment process," acknowledges Ho. "Nonetheless, ethically speaking, there may be questions of whether some patients are signing these contracts voluntarily."

Some patients may be in such desperate need for pain relief that they would sign the contract despite disagreeing with or not understanding the terms laid out in the contract. "It is also important to note that opioid contracts are typically not legally binding," says Ho. "Even if the patients do not adhere to the contract terms, hospitals and professionals cannot abandon patients if they are in urgent care need."

Urine tests may help clinicians to get a more objective assessment of patients' requests for pain medications, given that pain is a subjective experience and that drug-seeking behavior is not always easy to detect. "However, asking patients to take urine tests may send the message that we don't trust their intention or truthfulness," says Ho. "It can give the stigmatizing impression that one is guilty until proven otherwise, and thus harm the therapeutic relationship."

Physicians who don't already know a patient may be the most inclined to use these practices, since they have not yet established a therapeutic alliance or don't know the patient's history. "Careful screening is certainly clinically important. But there is a very fine line between identifying at-risk patients to ensure safe prescription practices and discriminating against them," says Ho. "Physicians need to be mindful of potential biases."

Moreover, opioid contracts and urine testing can have a stigmatizing effect, especially since physicians don't generally ask patients with other conditions to prove that they have been or will be adhering to treatment plans before providing care. "The Institute of Medicine reports that the majority of people with pain use their prescription drugs properly," says Ho.[1] "Nonetheless, they are often stigmatized or denied access because of the misdeeds of the small number of drug-seekers."

In attending to the risk of drug misuse, physicians also need to consider the potential harm that may ensue as a result of undertreatment of pain. Ho suggests these practices:

- **Physicians can explain the public health concerns regarding iatrogenic addiction, and the rationale behind various practice guidelines.**
- **Physicians can incorporate patients' perspectives on when their pain is most acute; what pharmacological and other strategies they have tried; their concerns regarding the use of addictive medications; and their experiences and perspectives on preventing or treating addiction.**

"Such exploration can help to build rapport and promote open understanding of the responsible and responsive prescription process," says Ho. "It can also facilitate the patient's own responsibility in being forthcoming with his or her own history and concerns."[2] ■

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Ruling likely to make genetic testing more affordable

Ethical questions arise from Supreme Court decision

Despite the Supreme Court's June 2013 ruling that DNA is a product of nature and not patent-eligible, "the debate over intellectual property claims in genetic testing is not over," says **Amy**

L. McGuire, JD, PhD, Leon Jaworski professor of biomedical ethics and director of the Center for Medical Ethics and Health Policy at Baylor College of Medicine in Houston, TX.

Companies are still free, under the Myriad ruling, to patent complementary DNA.[1] "Although the Supreme Court raised the bar for patents for diagnostic methods in *Mayo v. Prometheus*, it remains uncertain whether methods claims will be upheld more broadly," says McGuire. Since the Supreme Court ruling, Myriad has filed a lawsuit against Ambry Genetics and Gene by Gene for patent infringement. The two companies have counter-sued Myriad, alleging antitrust violations for continuing to enforce patents that are invalid and maintaining a proprietary database of pathogenic gene variants.

"The Myriad case should make room for more competition in the genetic testing industry, thereby lowering prices and making genetic tests more accessible to larger segments of the population," says McGuire. "This would be a positive advance in the field of genetics."

However, until these residual intellectual property issues are resolved, companies may be reluctant to enter the market, and the benefits of the Myriad case will not be fully realized, says McGuire.

Laura Lyman Rodriguez, PhD, director of the Division of Policy, Communications, and Education at the National Institutes of Health's National Human Genome Research Institute, says the Court's decision has important ethical implications.

"This was a very significant decision," she says. "It was very important for the basic human genome sequence to be in the public domain and, therefore, available for everyone to use. Whether for research developments or to inform therapeutic developments, the maximum public benefit can be achieved."

The hope is that clinical sequencing of genomes can be integrated as a tool in the care of individual patients. "It will be very helpful to ensure that the fruits of the human genome project can really be brought to bear for the benefit of all patients, so roadblocks won't be put up," says Rodriguez.

If whole genome sequencing wasn't possible because parts of the sequence were blocked due to patents, it would be too expensive to perform routinely in clinics and would be more likely to be available only to wealthy individuals, says Rodriguez. "This helps to ensure the basic information is out there for all."

The Supreme Court's June decision was not a foregone conclusion, says Rodriguez, noting that the federal circuit court that heard the original appeals found twice that the patents were valid. "The Supreme Court had looked at [the case] in June 2012. Rather than making a decision, they asked the federal circuit to look at it again based on the *Mayo v. Prometheus* decision, and they confirmed their prior findings," she says. Ultimately, the Supreme Court agreed with the Friend of the Court brief that the Department of Justice filed, stating that naturally occurring gene sequencing was not patentable.

As for the question of how whole genome sequencing can be used clinically, Rodriguez says "there is a lot of debate about drawing those lines, on whether we can use it at this point to make informed medical decisions or actually develop targeted therapies," she says. Another issue on the horizon involves test interpretation, as some results are meaningless, some mean that a patient's risk of disease goes up to a greater or lesser extent, and some are definitive. "One of the things we are concerned about is who owns the databases, and the knowledge about all the individual variants that are necessary for clinicians and laboratories to actually interpret the test," says Rodriguez.

Another unanswered question is whether test information should be in the public domain so that everyone can learn from it. "That gets to the question of whether everyone can have better quality care, by virtue of every physician being able to look at the comprehensive set of information about different genetic sequences, and determining what those might mean for their patients," says Rodriguez. ■

EXECUTIVE SUMMARY

The Supreme Court's recent ruling that DNA is a product of nature and not patent-eligible is expected to lower prices and make genetic tests more accessible to larger segments of the population. Some ethical concerns:

- If whole genome sequencing is too expensive, it would be available only to wealthy individuals.
- There is debate as to how whole genome sequencing should be used to make informed medical decisions.
- Having test information in the public domain could improve overall quality of care.

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Social media changing patient-MD relationship

No "absolutely correct" answer to some questions

Social media provides both significant opportunities and risks in medical practice, says **David H. Brendel**, MD, PhD, a Belmont, MA-based psychiatrist who writes extensively about the ethics of online technology use in clinical practice. Brendel is the recipient of an award for teaching medical ethics in 2011 from the Academy at Harvard Medical School.

"In the absence of clear medico-legal guidance about physician use of social media and best practices on whether and how to interact with patients using these technologies, careful ethical deliberation is essential," he says. "A pragmatic weighing of risks versus benefits is generally the best approach." Clinical ethicists who are knowledgeable about the dilemmas involving social media usage can help physicians think through these challenging new questions affecting their practice.

One important question is whether physicians should learn information about their patients by conducting searches using patients' names on Google or LinkedIn, by reading patients' online blogs, or by following them on Twitter. "My research and published articles have suggested that there is no absolutely correct answer to these questions in the absence of thoughtful, nuanced consideration of the pros and cons," Brendel says.

If this type of physician usage of social media reveals potentially life-saving information, such as reading a patient's blog describing an imminent suicidal or homicidal plan, then online searching for patient information could be ethically permissible or even required in some limited situations. "On the other hand, if physician usage of online technologies is likely to result in compromising patient privacy or other core values, then it must be avoided and prohibited," says Brendel.

Related questions arise as to whether physicians should obtain informed consent before conducting an online search for patient information, and whether the information should be disclosed to the patient and/or entered in the medical record. Brendel says the most prudent approach is to avoid conducting these kinds of online searches unless careful deliberation, possibly including consultation with peers or an ethics committee, reveals that potential benefits to clinical care far outweigh risks to patient privacy and to the public's trust in the medical profession as a whole.

"Physicians should be aware of the learning opportunities — and the serious privacy risks — that have been generated by the escalating availability of social media technologies," he cautions.

More informed patients

The degree of connectivity provided by current technology, when used incorrectly or carelessly, can threaten the relationship between physician and patient, warns **Jeanne M. Farnan**, MD, MHPE, assistant professor in the section of hospital medicine at The University of Chicago (IL) Pritzker School of Medicine.

Social media has provided patients immediate access to information and advice that has never before been available, and this is informing the therapeutic relationship. "Patients use of social media is consistently on the rise, with many accessing the Web for health concerns, often finding communities with which to share experience and stories," says Farnan. "This results in a more informed patient, with which physicians have the potential to have a higher level conversation about care and decision-making."

However, social media has taken the doctor-patient relationship out of the physical structure of the office and into a world where professional and personal boundaries are quite indistinct. "Several ethical concerns and considerations plague physician use of social media, specifically to use in interactions with patients," says Farnan.

Examples of inappropriate behaviors include inappropriate patient-physician relationships, sharing information that threatens confidentiality, and physicians displaying questionable behaviors online. In April 2013, the American College of Physicians and the Federation of State Medical Boards jointly

EXECUTIVE SUMMARY

Social media provides significant opportunities in medical practice, but ethical concerns include inappropriate use, which threatens the relationship between physicians and patients.

- A pragmatic weighing of risks versus benefits is generally the best approach.
- Online searching for patient information may be ethically permissible in some limited situations.
- Social media gives patients the ability to have immediate access to information and advice.

issued a policy statement on online medical professionalism. (To view the policy statement, go to http://bit.ly/ZR5Xvt.)

"Suggestions include maintaining personal and professional interactions by establishing clear guidelines for when and how communication can take place, being aware of the digital image that is presented by the physician in all digital behaviors, and cognizance of representation of self and the profession," says Farnan.

Bioethicists can provide guidance to medical students and practicing physicians on the ethical implications of digital behavior on the physician-patient relationship. "In addition, they can lead the discussion of what conduct is becoming of a physician in this new environment, and explore what exactly is professional behavior in the new digital realm," Farnan says. ■

SOURCES

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Ethics of minors' access to emergency contraception

Informed consent is issue

After years of controversy, the Food and Drug Administration (FDA) approved the over-the-counter status of emergency contraception without age restriction in June 2013. Therefore, a prescription is no longer necessary for minors to obtain emergency contraception.

"Based on my experiences taking care of young women and adolescents, I support the over-the-counter status of emergency contraception and the advanced provision of this safe medication for minors," says **Julie Chor**, MD, MPH, assistant professor in the Department of Obstetrics and Gynecology at The University of Chicago (IL). "That being said, I understand that those who oppose these practices may have several concerns."

Doctor-patient relationship

Minors are legally permitted to consent to contraceptive services in 26 states and the District of Columbia, and specific categories of minors are able to consent to contraceptive services in 20 additional states.[1] "With regards to parental rights and concerns about a minor's ability to make sound decisions about her reproductive health, the majority of states recognize by law that minors are capable of making such decisions," says Chor. "Furthermore, minors frequently do discuss these decisions with a trusted adult."

Young women may not understand how emergency contraception works and how it is different from nonemergency contraception. "Part of what underlies this concern is that minors may not be able to give fully informed consent to use emergency contraception — or even nonemergency contraception. Some people believe that parental consent is necessary, precisely for this reason," says **Lisa Campo-Engelstein**, PhD, assistant professor at the Alden March Bioethics Institute and Department of Obstetrics and Gynecology at Albany (NY) Medical College in New York.

Impinging on young women's access to emergency contraception increases the likelihood of unintended pregnancy, according to Chor, and prohibiting physicians' ability to prescribe emergency contraception for young women is an intrusion into the doctor-patient relationship. "Young women should be able to seek counsel from their providers regarding sensitive topics such as reproductive health," she says. "Physicians, in turn, must be able to provide counsel and medical care deemed appropriate based on their encounters with patients."

Prescriptions in advance?

Is it ethical for physicians to write prescriptions for emergency contraception in advance? "In general, the idea of prescribing in advance rather than when it's needed tends to overcome the rationale for having prescription drugs in the first place. Normally, drugs

EXECUTIVE SUMMARY

Patient autonomy and parental rights are two primary ethical concerns involving access to emergency contraception, which was recently approved with over-the-counter status without age restriction.

- Young women may not understand how emergency contraception works and how it is different from nonemergency contraception.
- Some believe that parental paternalism is justified because parents are best situated to make decisions for their children.
- Some argue that young women's reproductive autonomy should be upheld, even if they are younger than 18.

are prescription-only drugs because it is considered appropriate to have physician input and monitoring," says **G. Kevin Donovan**, MD, MA, a pediatrician and the director of the Pellegrino Center for Clinical Bioethics at Georgetown University Medical Center in Washington, DC.

Donovan says that the greatest ethical concerns involve the possibility that emergency contraceptives might be prescribed in advance to children. "There are some medical concerns about that. The FDA would not customarily allow a drug to be marketed for children if it hasn't undergone testing in children, and neither of the classes of emergency contraceptives have been," says Donovan.

If there is no physician relationship and no monitoring done by a physician, this means there likely won't be any monitoring for sexually transmitted diseases either, says Donovan. Furthermore, a patient might delay medical care for an unrecognized ectopic pregnancy. "There are also social concerns, especially the lack of parental input and the likelihood that both young teens and women may decide to use these in a serial fashion as a substitute for normal preventative contraception," he adds.

Donovan notes that the marketing site for an emergency contraceptive points out that prescriptions are available to men as well. "Any older man who is preying on a child, could have these available in advance without having to discuss it with a physician," he says. Donovan notes that there have not been well-documented problems with access to emergency contraception. "I'm not sure where the argument is that it has to be done in that fashion," he says. "It seems that the questions of access have been more theoretical and ideological rather than actual."

A committee opinion from the American Academy of Pediatrics supports advanced provision of emergency contraception.[2] According to a 2011 review of the literature on advanced provision of emergency contraception for women older than the age of 24, young women who receive advanced provision use emergency contraception sooner when needed and do not have increased sexual risk-taking behavior or negative effects on continued contraceptive use.[3]

"Advanced provision and access to emergency contraception has *not* been demonstrated to result in increased sexual risk behavior," says Chor. "Furthermore, physicians prescribe medications in advance frequently — for example, giving a pain medication as needed."

Reproductive autonomy

When weighing children's autonomy versus parental obligation to nonmaleficence and beneficence toward their children, some believe that parental paternalism is justified because parents are best situated to make decisions for their children, says Campo-Engelstein. In contrast, some argue that young women's reproductive autonomy should be upheld, even if they are younger than 18.

"Because sexuality and reproduction is such a personal matter, as well as a controversial political matter, some claim that reproductive decisions are best made by individuals themselves and not by their parents or others, such as health care providers or the government," says Campo-Engelstein.

Some may see the request for a preventive prescription for emergency contraception as an example of mature and responsible behavior that is further evidence that young women are capable of making reproductive decisions for themselves, she adds.

"Given that half of all pregnancies in the U.S. are unintended and that close to half of all unintended pregnancies end in abortion, allowing prescriptions for emergency contraception could reduce the

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prevalence of abortion," adds Campo-Engelstein. "Discussions about emergency contraception with health care providers could also lead to more overall responsible reproductive behavior." ■

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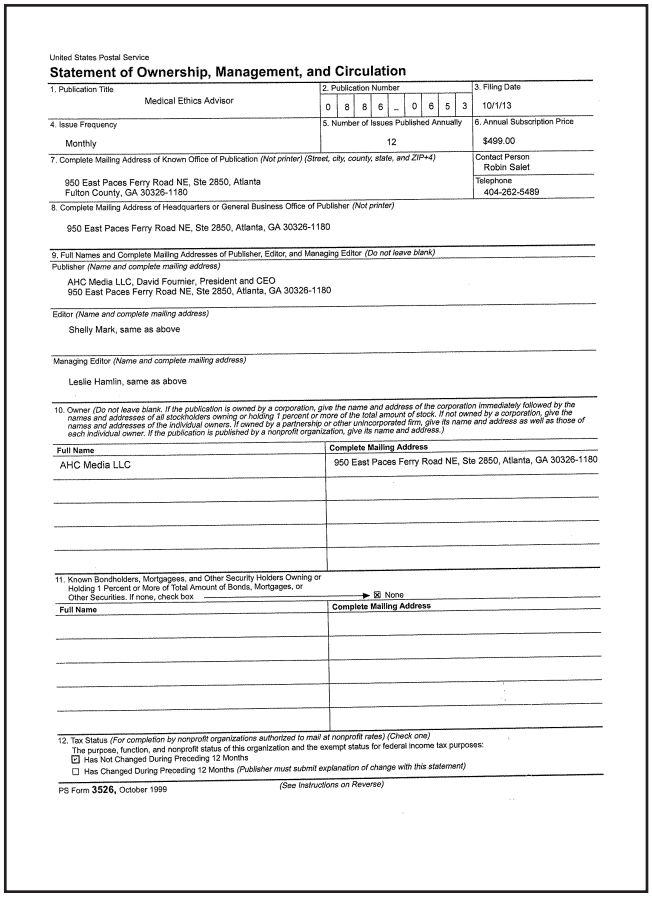

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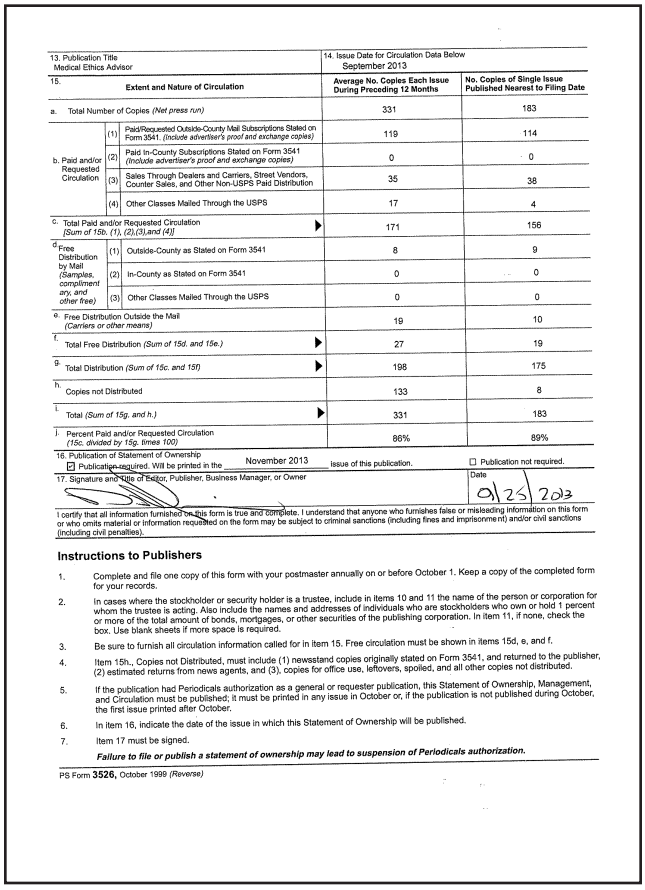

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