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What will be the fate of 'Terri's law'? Playing politics with family conflict

Ethical duty of caregivers to help families come to a resolution, expert says

As legal arguments about the fate of Florida resident Terri Schiavo continue to work their way through the state's court system, the new law allowing Gov. Jeb Bush to intervene in her case is prompting much debate in bioethics circles.

In October, the Florida state legislature passed a law allowing the governor to intervene and order artificial nutrition and hydration maintained in cases where a patient in a persistent vegetative state does not have a living will. The law was tightly crafted to affect the long-standing legal dispute between Schiavo's husband, Michael, and her parents, Robert and Mary Schindler.

Terri Schiavo, 39, has been in a persistent vegetative state since 1990 when she suffered brain damage following a heart attack. She did not have a living will, and there are no written indications of her wishes. Since her injury, her husband has claimed his wife would not want to be kept alive and sought, with the support of her physicians, to have her feeding tube removed.

The Schindlers dispute their daughter's diagnosis — claiming she responds to their voices with facial expressions and could improve with treatment — and have challenged her husband's right to terminate her life support.

Over the last 13 years, both sides have challenged each other in court, with the original probate court ruling in Michael Schiavo's favor after an independent, court-appointed physician testified that Mrs. Schiavo was in a persistent vegetative state, incapable of conscious thought, and would never recover. An appeals court supported this decision, and the state Supreme Court and U.S. Supreme Court have refused to hear the case.

On Oct. 15, Ms. Schiavo's feeding tube was withdrawn in accordance with a court order obtained by her husband following the conclusion of the legal proceedings. But six days later, the state legislature took action, passing the law, and the governor ordered artificial food and hydration be resumed.

Michael Schiavo has challenged the constitutionality of the new law. But even if the law is struck down, much damage has been done, say medical ethicists.

Who should decide?

"The question for me is, is this the way we should make public policy?" asks **Robert M. Arnold**, MD, director of the Palliative Care Service at the University of Pittsburgh Medical Center and a member of the center's ethics committee and ethics consultation service. "We as a society have previously said that the courts are the appropriate arena to resolve disputes of this kind. Why was that not honored in this case? Regardless of how you feel about the circumstances, it seems to me that if the legislators believe it is wrong in her case, why is it not wrong for everyone in her situation?"

A landmark Missouri legal case, *Cruzan v. Director, Missouri Department of Health*, in 1988, established the right of people to choose to have life-sustaining medical procedures stopped or withheld. However, the U.S. Supreme Court, in its ruling, required "clear and convincing" evidence of the person's wishes, which effectively opened the way for the establishment of living wills and advance directives.

Laws in most states allow spouses to serve as the surrogate medical decision makers when their husband or wife is left unable to communicate or make decisions for themselves and has not signed an advance directive. If a person does not have a spouse recognized by the state law, other close family members are usually authorized to make decisions on that person's behalf, says **Stuart J. Youngner**, MD, director of the Center for Biomedical Ethics at Case Western Reserve University in Cleveland.

"I think where this case becomes difficult is you have two people who have high standing as surrogates. The husband probably has higher legal standing — he would in Ohio — but parents are not inconsequential people," he says. "This is a family dispute that has been translated into all of these other things. And that is the big tragedy here."

Since the courts have decided that there is no evidence that Mrs. Schiavo will recover, no evidence that she would have wanted to continue to be kept alive, and no evidence that her husband is not acting in what he believes to be her best interests, Youngner questions how the legislature justified interference in this single case.

"It has been well accepted that if there is no evidence about what she would have wanted, then you go with the person who is at the top of the list [according to state law] of who may serve as a surrogate decision maker," he says. "That is the law. 'Here are the people who can make that decision, and this is the order.' If you don't want to honor the decision, then why have the list?"

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The Florida governor and legislature have responded to political pressure by right-to-life advocates who oppose termination of life support measures under any circumstances, Younger notes, and have not made a thoughtful attempt to consider the interests of Schiavo, her family, or other Floridians who might be affected by their actions.

"The legislature did not say, 'Let's just take a halt here until we really determine what she wanted, or do a better job of determining what she wanted.' If this case had been about the husband wanting to keep the feeding tube and her parents said no, do you think Bush would have gotten into it?" he says. "When you watch TV and see the activists talking about this, you hear what the real issue here is. They are calling it a victory for life — not a victory for autonomy and not a victory for family decision making — a victory for life."

Arnold also believes that lawmakers played politics with the family's conflict.

"From what the legislators have said about the decision, it does not appear that they are very well-educated about what the experience (of being in a persistent vegetative state) might be like or the previous ethical and clinical writings about these situations," he notes. "I just find it very sad and very tragic."

It also is sad, Arnold says, that more could not be done to prevent the family from being torn apart in a dispute over their loved one's condition, he adds.

Family members often may have disagreements about how to proceed in pursuing care for a critically ill or injured person, and it is part of the ethical duty of the patient's physician and other caregivers to attempt to help families come to a resolution they can both live with, he says.

"In many cases, you try to look at how you can make sure everyone involved feels heard, and that they feel supported, and try to see if you can find common ground," Arnold says. "Sometimes, in these situations, you can set up some intermediate plans that are not what everyone thought was right, but gives providers options and ways to proceed."

For example, in decisions about terminating life support, perhaps some family members want more time to see if the person's condition will change, or another opinion, or some other measures taken. Even if such actions aren't desired by the surrogate decision maker, or recommended by the clinicians, they might allow the ultimate decision to be resolved without causing more pain and injury to the family, he says.

"That might have been pursued in this case, I don't know," Arnold notes. "But as bioethicists, we sometimes look at these big cases and the disputes they involve, and forget the more common issue of what can be done to keep these family disputes from happening."

Even if the Florida law is found to be unconstitutional, health care providers should let this case remind them of the need to be aware of family needs and conflicts and address them before they are irreparable, he adds.

"I would hope that the result of this would be a perceived need by the Florida legislators to better understand the issues involved, and a perceived need by this woman's doctors and social workers to see whether there was anything that could have been done to help a family that was literally being torn apart and struggling," he concludes. "Regardless of what your point of view is, everyone in this case is struggling to do the best they can. The question is, what has the health care system done, or ethics mediators done, to see if there could be common ground and to try to keep this from being taken over by forces less concerned with the needs of the family and more concerned with other issues." ■

AMA ethical guidance: E-mail, health web sites

E-mail only in established relationships

As new information technologies continue to make person-to-person communications easier and more varied, they also are transforming the way that health care can be provided.

Patients frequently now make appointments and receive information from their physicians via e-mail, and some even get second opinions from on-line web sites.

CEJA Guidelines for Internet Use

E-mail recommendations

1. E-mail correspondence should not be used to establish a patient-physician relationship. Rather, e-mail should supplement other, more personal encounters.
2. When using e-mail communication, physicians hold the same ethical responsibilities to their patients as they do during other encounters. Whenever communicating medical information, physicians must present the information in a manner that meets professional standards. To this end, specialty societies should provide specific guidance as the appropriateness of offering specialty care or advice through e-mail communication.
3. Physicians should engage in e-mail communication with proper notification of e-mail's inherent limitations. Such notice should include information regarding potential breaches of privacy and confidentiality, difficulties in validating the identity of the parties, and delays in responses. Patients should have the opportunity to accept these limitations prior to the communication of privileged information. Disclaimers alone cannot absolve physicians of the ethical responsibility to protect patients' interests.
4. Proper notification of e-mail's inherent limitations can be communicated during a prior patient encounter or in the initial e-mail communication with a patient. This is similar to checking with a patient about the privacy or security of a particular fax machine prior to faxing sensitive medical information. If a patient initiates e-mail communication, the physician's initial response should include information regarding the limitations of e-mail and ask for the patient's consent to continue the e-mail conversation. Medical advice or information specific to the patient's condition should not be transmitted prior to obtaining the patient's authorization.

Guidelines for health web sites

1. Physicians responsible for the health-related content of an on-line site should ensure that the information is accurate, timely, reliable, and scientifically sound, and includes appropriate scientific references.
2. The provision of diagnostic or therapeutic services through interactive on-line sites, including advice to on-line users with whom the physician does not have a pre-existing relationship or the use of decision-support programs that generate personalized information directly transmitted to users, should be consistent with general and specialty-specific standards. General standards include truthfulness, protection of privacy, principles of informed consent, and disclosures such as limitations inherent in the technology.
3. When participating in interactive on-line sites that offer e-mail communication, physicians should follow guidelines established in Opinion 5.026, "Use of Electronic Mail."
4. Physicians who establish or are involved in health-related on-line sites must minimize conflicts of interest and commercial biases. This can be achieved through the development of safeguards regarding funding and advertising that require disclosure and honesty. It also requires that physicians not place commercial interests ahead of patient health; therefore, physicians must not use health-related on-line sites to promote unnecessary services, refer patients to entities in which they have ownership interests, or sell products outside of established ethical guidelines. (See Opinions 2.19, "Unnecessary Services"; 8.032, "Conflicts of Interest: Health Facility Ownership by a Physician"; 8.062, "Sale of Non-Health-Related Goods from Physicians' Offices"; and 8.063, "Sale of Health-Related Products from Physicians' Offices.") Promotional claims on on-line sites must conform to Opinion 5.02, "Advertising and Publicity."
5. Physicians who establish or are involved in health-related on-line sites that use patient-specific information must provide high-level security protections, as well as privacy and confidentiality safeguards.

Source: American Medical Association, Chicago.

But while these advances have enormous potential to improve access to care, it's important that medical professionals address potential ethical and legal complications new technologies pose.

Last month, the American Medical Association's Council on Ethical and Judicial Affairs (CEJA) published two reports offering guidance to physicians on the appropriate use of e-mail and health-related on-line sites.[1,2] **(See CEJA recommendations, above.)**

"These are the first in a series of reports that we are planning that address ethical uses of emerging technologies," explains **Michael S. Goldrich**, MD, chair of the CEJA and a practicing otolaryngologist in Highland Park, NJ. "We wanted to address the increasing potential for medical care to be delivered at a distance. Primarily, we are beginning to look at the practice of telemedicine, but we also realized that there was some groundwork that needed to be done first."

There are a number of communication technologies that have become more frequently used

SOURCE

- **Michael S. Goldrich**, MD, American Medical Association, Council on Ethical and Judicial Affairs, 515 N. State St., Chicago, IL 60610.

in doctor's office and in other health care settings — fax, e-mail, interactive web sites — that need closer examination, he says.

The CEJA wanted to examine how different communication methods are being used and how these uses may affect the physician-patient relationship.

In their research, they discovered a wide variety of practices:

• Some physicians use e-mail to recruit new patients and communicate a variety of clinical and diagnostic information this way, while others use e-mail exclusively as a method to reserve appointments or communicate routine, nonsensitive information.

• Institutions sponsor or participate in interactive web sites to provide a wide variety of health information to patients and the public. Some web sites provide general information, but some provide — or attempt to provide — detailed, individual medical advice.

"The quality of the sites varies a great deal. Some are maintained by physician's groups or other institutions to offer information to patients, while others were started by various e-business ventures," Goldrich says. "Some provide information tailored for specific patients while others offer more general medical information, but that sometimes crosses the line and gets into more what we would consider to be patient care and advice."

The guidelines developed by the CEJA are meant to give individual physicians guidance about how these information technologies can be used ethically and to enhance their relationships with patients.

In general, the CEJA recommends that e-mail between physicians and patients be limited to correspondence between a doctor and an already established patient, and that the physician — in a face-to-face meeting with the patient — explain the limitations and vulnerabilities of e-mail communications and determine whether e-mail might be an appropriate means of communicating with that patient.

The physician and patient also should determine what kinds of information can be communicated via e-mail, whether the patient's e-mail address is secure, and what personnel on the physician's end will have access to the patient's e-mail messages.

For example, a patient who uses an e-mail account at his place of employment might need to understand that his employer might have access to messages he receives at work and, thus, any medical information contained in them.

Several on-line sites now are offering medical advice on-line — both to established patients and to nonaffiliated members of the public, Goldrich notes.

For example, individuals can seek on-line consultations at Johns Hopkins Radiosurgery (www.hopkinsmedicine.or/radiosurgery), or inquire about a second opinion at the Cleveland Clinic's site, e-Cleveland Clinic (http://eclevelandclinic.org). At e-Cleveland, people may upload medical records and diagnostic test results for a second opinion. This involves entering a secure site and filling out an on-line questionnaire that documents patients' medical conditions.

Provided appropriate measures are put in place, these methods of patient encounters are not necessarily as problematic as they might appear, Goldrich adds.

"These are examples of technologies developed that are appropriate to the existing practices of the institution," he notes.

At a major center such as Johns Hopkins or the Cleveland Clinic, a patient's medical information may be sent to someone in a specialty area, such as radiology, or reviewed by the chairman of the department of medicine in order to confirm a diagnosis or get another opinion about a treatment option. This is not so different from a patient seeking similar input through the on-line site.

"Some patients travel an entire day's journey for a consultation at such a center, while this method might allow them to get the same information without a long journey," he says.

As long as appropriate procedures have been established, both methods should be equally sound, he notes. It's important for providers to consider the specific benefits and limitations of each kind of technology and develop policies and procedures concerning their use that reflect that understanding, he says.

Emerging technologies have the potential to facilitate and ease communication between patients and physicians, and to eliminate access barriers to people in remote areas for whom traveling is difficult or impossible.

But it is the responsibility of the American

Medical Association and other medical societies to determine the ethical issues that individual technologies may present and educate their members about how to address the issues, he says.

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ACOG issues opinion on elective cesareans

The decision should depend on many factors

Over the past decade, obstetricians have noted an interesting phenomenon — more women rejecting the concept of a natural birth and requesting elective cesarean deliveries, sometimes called "patient-choice cesareans" or "cesareans on demand."

According to many OB/GYNs, there are a number of factors fueling this trend.

"I think we are seeing a lot of people influenced by pregnant celebrities and Hollywood," notes **Adelaide Nardone**, MD, FACOG, an OB/GYN practicing and medical advisor to the Vagisil Women's Health Center in White Plains, NY. "Pregnancy is now in vogue, so to speak. When I was pregnant, I didn't tell anyone until the month before the birth. Now, women are baring their bellies and showing them off. And I think women are also following another celebrity trend of having elective C-sections so they feel in control of when the baby arrives."

Many women also are requesting cesareans in the belief that a surgical delivery will help them avoid pelvic support problems or sexual dysfunction later in life, Nardone adds, although clinical evidence supporting this belief is slight.

Women also may ask for a cesarean because they are afraid they won't be able to endure the pain of labor and want to avoid it altogether, she adds.

Over the past four or five years, some OB/GYNs have supported allowing women who otherwise would have no reason to have the surgery to choose a cesarean as their delivery method. Others, however, believe that selecting a surgical procedure over a natural process, without a compelling medical need, is unethical. **(See "Should your hospital allow C-sections on demand?" in the September 2002 issue of *Medical Ethics Advisor.)***

New committee opinion

Responding to the controversy, the ethics committee of the American College of Obstetricians and Gynecologists (ACOG) has issued an opinion to guide doctors in making decisions about surgical treatments when there is a lack of firm evidence for or against a procedure.[1]

Where medical evidence is limited, the opinion states, there is no one answer on the right ethical response by a physician considering a patient's request for surgery. The decision on whether to perform an elective cesarean will come down to the physician's evaluation of a number of ethical factors, including the patient's concerns and the physician's understanding of the procedure's risks and benefits.

For example, in the case of an elective cesarean delivery, if the physician believes that cesarean delivery promotes the overall health and welfare of the woman and her fetus more than does vaginal birth, then he or she ethically is justified in performing the surgery. Similarly, if the physician believes that performing a cesarean would be detrimental to the overall health and welfare of the woman and her fetus, he or she ethically is obliged to refrain from performing the surgery. In this case, a referral to another health care provider would be appropriate if the physician and patient cannot agree on a method of delivery.

The last point is a particularly important one for many OB/GYNs, Nardone says.

"Many of them are facing enormous pressure from their patients to do this, but they don't believe it is right," she notes. "I think the ACOG opinion very strongly states that they are not required to do this at a patient's request and that, if they believe the procedure not to be in the patient's best interest, it is permissible to refer them to someone else."

The opinion also states that OB/GYNs are under no ethical obligation to initiate discussions about elective cesareans as an option for delivery, if they believe the procedure is not indicated, she adds.

"The statement clearly says, 'In the absence of

significant data regarding the risks and benefits of cesarean delivery, the burden of proof should fall on those who are advocates for a change in policy in support of elective cesarean delivery [i.e., the replacement of a natural process with a major surgical procedure]'," she notes. "There is no obligation to initiate a discussion about a procedure the physician does not consider medically appropriate."

Questions about risks and benefits

With advances in technology and technique, the risks of a cesarean delivery to a woman without other health problems are very low, and comparable to an uncomplicated vaginal birth, proponents of elective cesareans claim.

Many studies indicate higher rates of complications from cesarean surgery, but these data are not completely reliable because they often compare women who had cesareans for a medical reason with women who had uncomplicated vaginal births, and other variables might have influenced the complications.

And limited data indicate women who have had cesareans may suffer fewer problems with pelvic floor support and sexual functioning later in life.

However, Nardone notes, newer studies indicate that this may not be the case at all.

"We don't have enough data yet to reliably say why some women suffer vaginal prolapse, incontinence or sexual dysfunction later in life," she says. "Genetic factors may come into play. There may be environmental or behavioral factors. It may be that just carrying a pregnancy to term causes the same changes in the female body that lead to these complications later."

As more healthy women with uncomplicated pregnancies are allowed to choose cesareans on demand, large-scale retrospective studies should be initiated to determine true comparisons of the risks and benefits, both Nardone and ACOG say.

Decisions should be individualized

It's important for obstetricians and their patients to realize that decisions about cesareans must be made with the woman's long-term interest in mind and that what might be appropriate for one woman may not necessarily be OK for another, Nardone says.

"Personally, I believe that a vaginal birth is preferable unless there is some compelling reason to perform surgery," she says. "Nature has provided a way for birth to occur, the vagina is an organ that is particularly suited to this process. However, there are times when an elective cesarean is appropriate."

A patient may have coexisting health problems that would complicate a vaginal birth, such as a chronic infection, high blood pressure, or a previous pelvic injury, she says.

And in some cases, she might consider a cesarean purely for patient choice, she adds. The point being, she emphasizes, is that such decisions must be made after a substantive discussion with each individual patient.

"You can't say that you support it in all cases or that you don't," she says. "The decision must be made in each individual case."

If, for example, a patient pregnant with her first child at age 45, had used assisted reproductive technology, and felt this was her only chance to have a child, might be a more appropriate candidate than a younger woman who intended to have more than one baby, she explains.

"If the first woman said to me, 'This is going to be my only child. I don't want to take any chances, please just take the baby,' I might consider it," she says. "But if a woman is 30 and tells me she intends to have two or three kids, then there is no way I am going to perform a section on her first pregnancy without some compelling reason."

Although the complication rates for vaginal and cesarean births may be similar, women who have had cesareans are at higher risk for some complications with subsequent pregnancies.

The conditions placenta previa and placenta accreta are more common in women who have had prior cesareans, she says.

Women who have had at least one cesarean have a 4% chance of developing placenta previa or placenta accreta in a subsequent pregnancy. Placenta previa is the term for a "low-lying" placenta that covers all or part of the internal opening of the cervix. Placenta accreta is a placenta that attaches itself too deeply and too firmly into the wall of the uterus. The conditions most often occur in the second and third trimesters of pregnancy. They may cause serious morbidity and mortality to both fetus and mother. They also can lead to vaginal bleeding in the second and third trimesters.

After four cesareans, the chance jumps to 10%. It is difficult for many women to have a vaginal birth after an initial cesarean due to the risk of uterine rupture.

SOURCE

- **Adelaide Nardone**, MD, FACOG, Vagisil Women's Center, Combe Inc., 1101 Westchester Ave., White Plains, NY 10604.

Additionally, approximately 7% of women who have placenta accreta die.

"You can't just look at that pregnancy and what the woman's wishes are; you have to be sure you look at the long term and what her goals are in terms of having a family," she says.

It's also important for both patients and physicians to realize that, even if they agree on an elective section, nature may have other ideas.

"Most OB/GYNs would not perform an elective C-section before 39 weeks," she notes. "But, many women don't make it that long. They go into labor at 37 weeks or 38 weeks. What do you do then? If they come to the hospital and they are already nine centimeters dilated, do you stop that labor and do a C-section? Labor is very unpredictable. You might have someone get to the hospital and the baby has already started to enter the birth canal. At that point, it is very risky to stop the labor and attempt a section. I would find that unthinkable."

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SARS presents challenges to hospitals, public health

Weighing ethics and public safety

If an outbreak of severe acute respiratory syndrome (SARS) were to occur in the United States this year, our health care and public health systems might have a significantly harder time detecting and containing spread of the virus than the countries that experienced cases last year, experts say.

But a recent federal preparation plan developed by the Centers for Disease Control and Prevention (CDC) in Atlanta offers guidance on how health officials can balance individual freedoms and safety at the same time.

"I think it is a very valuable document for people to look at, to digest, and to consider the implications of what they are proposing and what steps may be necessary should an event similar to what occurred last year in Asia and Canada occurs here," says **Steven Opal**, MD, professor of medicine and infectious diseases at Brown Medical School in Providence, RI. "It gives people a good point of reference and allows time to reflect on how difficult it would be to control the situation here in the United States, an the sometimes draconian measures that might be required should a serious outbreak occur."

The CDC's draft plan (available on its web site at: www.cdc.gov/ncidod/sars) advocates a tiered approach in SARS preparations for health care facilities and local public health officials. The first tier, in effect as long as there are no currently reported cases of SARS transmission anywhere in the world, involves enhanced surveillance for possible SARS based on clinical symptoms combined with epidemiologic links between suspect patients and areas of the world that reported cases in the last outbreak.

Hospitals are encouraged to ensure their clinicians, particularly in outpatient clinics and emergency departments, are alert for possible signs of SARS in patients who present for care. They are also urged to develop close contacts and communication procedures with local public health officials so that information can be shared quickly.

For example, because spread of SARS was so closely tied to health care facilities in the last outbreak, it now is recommended that hospital providers report any potential cases to the public health department. The public health department also should be on heightened alert for any evidence of clusters of respiratory illnesses, particularly among health care workers from the same facility.

Once SARS cases have been reported again, the CDC recommendations gradually ramping up the number and intensity of precautions to be taken.

If SARS is reported again anywhere, for example, hospitals are urged to implement a plan for isolating patients with respiratory symptoms from other patients in hospital and physician waiting rooms. If SARS transmission is evident in a particular community, the CDC plan advocates a system of voluntary quarantine by the cancellation of public events and gatherings and requesting that contacts of people with SARS confine

themselves to their homes.

"In the United States, containing SARS will be more difficult than in countries with have a state-supported health care system and a more autocratic view of controlling their citizens," Opal says. "I was amazed at how well the WHO [World Health Organization] and other countries were able to keep a lid on this. Whether we could do the same here in the U.S., with [the risk of] violating people's civil rights and trying to control the population and the spread of pathogens in the community, is less clear."

In the United States, a fragmented, private health care system and a patchwork of public health quarantine laws, which vary state to state, will make a coordinated response to SARS very difficult, Opal predicts.

Public health officials will largely have to rely on good communication with the public to ensure its willingness to comply with containment measures, he adds.

"You are going to have to have a measured approach consistent with the level of the outbreak in order to try to do this with an informational and voluntary process as opposed to coming through with the National Guard forcing people to stay in their homes," he says.

Put a plan in place

It's important that U.S. health care systems have a plan of action in place so that they can respond calmly and logically should a SARS outbreak occur, adds **Michael Vaughn**, president and CEO of Nashai Biotech LLC, a technology transfer company that has major operations in both Nashville, TN, and Shanghai, China.

Vaughn was traveling in southern China in November of 2002 during the time of the initial SARS outbreak there.

"At that time, it was referred to as severe upper respiratory flu," he notes.

Over the course of his trip, Vaughn had his temperature taken 30 times in four days, encountered a panicked public encouraged to wear small face masks at all times, and SARS reporting enforcement measures that threatened the execution of anyone who had SARS and failed to report to authorities, or failed to report if their neighbor had SARS.

China's experience should be a lesson to the United States about the need for advance planning that provides appropriate precautions but minimizes panic, he says.

"Communication, or the lack thereof, will determine how successful the U.S. policy for SARS is implemented when we have an outbreak," Vaughn notes. "The public should be informed, with reinforced education via the media, on the basics of public health hygiene, especially during the flu season. The message should include references to the possibility of a serious outbreak of SARS, or a terrorist weaponization of an infectious agent, and emphasize the need to wash our hands, cover when sneezing and coughing, and see a doctor or nurse when we have flulike symptoms."

If they feel informed, the public will respond appropriately, he says. But if they don't trust the messages they are given or feel that information is being withheld, then panic and overreactions may result, Vaughn adds.

If the CDC's plans are implemented effectively, then an outbreak here should be able to be contained relatively quickly, says Opal.

The SARS virus, so far, is an example of a pathogen that can be contained by relatively easy means, he notes. Unlike influenza or tuberculosis, it appears to be spread primarily through human contact, or by contact with a contaminated object. And it appears that people are most at risk of transmitting the virus when they are having severe symptoms.

"It could have been much worse," he says. "Severe influenza or measles would have been worse. With this disease, the sicker you get, the more contagious you are. It puts health care workers at risk, but it makes it less likely that it will spread out of control before you realize what is going on, the way other respiratory viruses can. With other viruses, people are transmitting it before they even know they are sick, but that has not been the case with SARS. Very strict isolation and control measures will work. The [challenge] is how to best implement them so that people will comply."

The real nightmare scenario for hospitals and other health providers is the re-emergence of SARS in the middle of winter, prime season for a number of respiratory ailments, including influenza and respiratory synctial virus.

There currently are no rapid diagnostic tests available for SARS. Blood samples must be sent to public health authorities for testing and are most accurate if taken after the patient has been sick for some time.

As a result, a SARS patient could be at a hospital for days before a definitive diagnosis of suspect SARS is made. Determining whether suspect cases should be isolated individually and when or whether they can be safety cohorted, will be a key

SOURCES

- **Steven Opal**, MD, Professor, Brown Medical School, Brown University, Box G-MHRI, Providence, RI 02912.
- **T. Michael Vaughn**, President and CEO, Nashai Bioetch, 209 10th Ave. S., Suite 332 Nashville, TN 37203.

challenge for health care facilities, Opal says.

"It is very likely that people with undiagnosed respiratory illnesses will have different diseases and they may end up transmitting them to each other if they are cohorted together," he explains. "It will be a major challenge for health care systems, colleges, and the military — anywhere people are together in a closely defined space."

Like Vaughn, Opal says it is essential for hospitals and public health authorities to work together to develop effective communication plans and strategies that can convey accurate, reliable information to the public in the event an outbreak occurs.

"With China, it was difficult enough trying to quarantine people in certain municipalities and regions. I think in the U.S., you can just imagine how difficult it would be," he says. "Let's face it, you are talking about violating people's civil rights and freedom of movement. It will be difficult to do without significant buy-in from the community that quarantine and isolation is the logical thing to do — and that they are not being persecuted. It would be interesting to see how this would work. I hope we don't have to find out."

The anthrax attacks that began in September 2001 provided a glimpse at how public perceptions can overtake clinical realities and cause significant problems, Opal adds.

"With people receiving mixed information about anthrax and the ensuing huge demand for Cipro, it became obvious that you want to have a very specific message that the local department of health, local doctors and health care administrators are going to give to the public," he says. "The messages have to be accurate and consistent. It is vital to get people to buy into the plan because you may be asking them to voluntarily defer themselves from school or work or stay home, etc."

In addition to making plans for managing patients, medical centers and universities also should consider policies for reminding faculty and staff that travel to SARS-affected areas could have consequences, not just for their health, but for their activities abroad and their freedom of movement and activity once they return home, he adds.

"At Brown, we have a number of people who travel to endemic areas for research or to visit family," he notes. "They need to be aware that if they travel there during the time a travel advisory is in place, they are subject to the same public health protections as the citizens of that country. If they are quarantined and not allowed the fly home, then that is just the situation they are in. And if they choose to travel to an affected area, then they may be asked to take a leave of absence for a period of time when they return. That is something people need to be made aware of."

The CDC's effort has helped craft a national response that should be effective yet preserve as much local autonomy as possible, Opal says.

"I think they did us a favor by having us consider national guidelines on what you should do, as opposed to each state coming up with their own system, which could yield quite dissimilar plans, with some being overkill and some underkill," he says. "Now we have federal guidelines. You don't have to follow them, but you know what they suggest and you can decide how to implement them in the most appropriate way locally to deal with local situations." ■

SARS audio program updates guidelines

Leading epidemiologists say a global return of severe acute respiratory syndrome (SARS) — which wreaked havoc on the health care systems that had to deal with it — is almost inevitable. The current overriding concern is that SARS will resurface as a seasonal illness along with influenza and other respiratory infections. Indeed, it would be a surprising development if the emerging coronavirus did not return, said **Julie Gerberding**, MD, MPH, director of the Atlanta-based Centers for Disease Control and Prevention (CDC).

"As an infectious disease expert, I can say in my experience, I've never seen a pathogen emerge and go away on its own," she said. "I think we have to expect that somewhere, some time, this coronavirus is going to rear its ugly head again; and that's the whole purpose of all this preparedness effort."

What would happen *today* if a patient with suspect or probable SARS showed up at your emergency department (ED)? To help you prepare for

the threat, Thomson American Health Consultants offers the upcoming audio conference: **The Resurgence of SARS: Why Your Hospital May Not Be as Prepared as You Think**, Dec. 9, from 2:30-3:30 p.m. ET.

Let our experts help you answer that and many other critical questions with practical tips and solutions to detect first cases and protect other patients and health care workers.

Our speakers include **Allison McGeer**, MD, director of infection control at Mount Sinai and Princess Margaret Hospitals in Toronto. A veteran epidemiologist, she worked firsthand with SARS patients and occupationally infected workers during the prolonged outbreak in Toronto. Hear the lessons learned by somebody who has dealt with this novel emerging pathogen.

If SARS returns, EDs certainly will be on those front lines. To provide valuable guidance and critical insight in that setting, **Susan E. Shapiro**, PhD, RN, MSN, CEN, will outline valuable tips and procedures, in addition to addressing and clarifying recently updated CDC recommendations for SARS.

Shapiro is a postdoctoral fellow in risk assessment and intervention research with individuals and families at Oregon Health and Science University School of Nursing in Portland. A career ED nurse and nurse manager before recently completing a doctoral program, she is the Emergency Nurses Association's representative to the CDC's SARS task force.

Educate your entire staff for one low fee including 1 hour of CE, CME, or critical care credits for all attendees. You may invite as many participants as you wish to listen for the low fee of $249.

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NEWS BRIEF

Canada's drug shortage from U.S. Internet sales?

A Canadian pharmacists' group is blaming the burgeoning trade in prescription-drug sales to U.S. patients for reported instances of local drug shortages, *The Wall Street Journal* reported on Nov. 3.

Barry Power, a director of the Canadian Pharmacists Association, told the newspaper his organization has been hearing from members across the country that supply problems are cropping up more often and lasting longer than before the Internet pharmacies set up shop.

While Canada's federal health ministry says it doesn't have any evidence that the on-line pharmacies are causing shortages, a senior official acknowledged last month that swelling cross-border sales raise that risk.

In a letter to provincial regulators, pharmacy associations and medical groups, Health Canada Assistant Deputy Minister **Diane Gorman** said the federal agency "regards this as a very serious matter."

The letter requested any "information regarding early indications of drug supply problems" or "trends regarding drug supply, safety concerns, or impacts on human resources, which may pose risks to Canadians' health."

The Canadian International Pharmacy Association, which represents Canadian pharmacies offering U.S. mail-order service over the Internet, estimates that total sales by its members will reach roughly $800 million this year, with more than $1 billion in sales projected for 2004. The association says Canada currently has between 120 and 140 Internet pharmacies, compared with 10 in 1999.

Several large pharmaceutical companies, including Pfizer Inc. and GlaxoSmithKline PLC, said they would limit sales of patent-protected prescription drugs to Canada over concerns that

COMING IN FUTURE MONTHS

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Canadian Internet pharmacies are re-exporting the drugs to the United States.

One of the latest companies to do so is Eli Lilly & Co., which started limiting drug sales to Canadian pharmacies in late October. ■

CME instructions

Physicians participate in this continuing medical education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. **The semester ends with this issue.** You must complete the evaluation form provided and return it in the reply envelope provided to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CME Questions

21. What actions did the passage of "Terri's Law" in Florida allow?
A. A woman's husband to withdraw artificial nutrition and hydration from his wife, who is in a persistent vegetative state.
B. The state's governor to intervene and reinstate artificial nutrition and hydration in a woman in a persistent vegetative state, despite the wishes of her husband and a court order.
C. The withdrawal of a feeding tube from a woman who is brain-dead.
D. None of the above

22. What body recently issued guidelines about the use of e-mail and on-line health sites by physicians and patients?
A. The American Medical Association's Council on Ethical and Judicial Affairs
B. The American Cancer Society
C. The American Hospital Association
D. The American College of Medicine-American Society of Internal Medicine

23. When should e-mail be used to communicate information between patients and physicians?
A. When there is an established relationship between a patient and that physician.
B. When a face-to-face encounter has been held that establishes both parties willingness to communicate by e-mail and stipulates the type of information that will be conveyed.
C. When both the patient and physician have considered what security measures and necessary to ensure the confidentiality of the information contained in the messages.
D. All of the above

24. According to the recent opinion by the ethics committee of the American College of Obstetricians and Gynecologists, elective cesareans:
A. Always should be offered as an option to pregnant patients.
B. Are never appropriate.
C. Can be considered by physicians, who should use their best clinical judgment about whether such a procedure is in the best interests of both the woman and her fetus.
D. None of the above

Answers: 21-B; 22-A; 23-D; 24-C.

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