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Med students learn when to label it an ethical dilemma

Recognizing true ethical questions an important skill

How and when, during the course of a medical student's education, should the subject of ethics be taught is a matter of much discussion. One program at the University of Iowa's (UI) Carver College of Medicine adds an additional basic element — teaching med students how to tell if an ethical problem is really an ethical problem.

"Sometimes, a problem arises and it too quickly is labeled an ethical problem," says Lauris Kaldjian, MD, PhD, an assistant professor of internal medicine who teaches second-year medical ethics at the UI medical school. Kaldjian and some ethicist colleagues — Robert Weir, PhD, the Richard M. Caplan Endowed Chair in Biomedical Ethics and Medical Humanities at UI; and Thomas P. Duffy, MD, professor of internal medicine at the Yale University School of Medicine — looked at this paradox and developed what they call a clinical approach to ethical reasoning.

"We were interested in integrating medical understanding and ethical understanding," says Kaldjian. They used the orderly way medical professionals think and applied that to situations that might appear at first glance to be ethical questions, when they're really something else.

"There are situations that arise that people might think the only way to solve is through ethical thinking or an ethics consultation, when they might simply require talking to the patient a little more," he adds.

Going beyond theory

Ethical reasoning and decision making often are considered cultivated professional skills, but a group of researchers at Stanford University found that undergraduate medical programs in ethics tend to focus on teaching bioethical theories, concepts, and major ethical issues such as in vitro fertilization and euthanasia, rather than how to put those principals and theories into clinical practice. (See resource at end of article.)

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“Not surprisingly, many students and clinicians experience considerable difficulty in using what they know about ethics to help them make competent ethical decisions in their day-to-day clinical practice,” the Stanford group found.

Using what they already know, Kaldjian says, is an important factor in learning to practice good clinical ethics.

“In medicine, we have an orderly way of

thinking,” he explains. “There’s much about the practice of medicine that is truly unregulated, but there are also guidelines that encourage us to practice within standards of care.

“Those standards are individualized by patients and providers, so it is hard to regulate. Our approach honors the fact that every physician brings to ethical reasoning their own set of priorities and set of values.”

Kaldjian says removing the mystery behind ethics helps make ethical decision making more meaningful to the medical student. Because medical students are accustomed to — and encouraged to seek the single correct answer to any question, making ethics-based decisions can be unsettling to them, he observes.

The approach he and his colleagues have developed capitalizes on both a systematic way of organizing information and incorporating the clinician’s knowledge, skills, and attitudes.

“By capitalizing on the way clinicians think, we believe this approach provides a practical means to articulate ethical justifications for challenging clinical decisions,” he says. “Such articulation allows the ethical basis of a difficult decision to become transparent.

“Transparency, in turn, allows clinicians to communicate and document an explanation for a course of action, and it is likely to facilitate consensus based on a shared understanding of values and goals or, at least, clarify causes of lingering disagreements.”

Breaking down the process

Determining whether the clinician is, in fact, facing an ethical decision is the first skill he or she must become comfortable with, Kaldjian says. What appears to be an ethical problem may be a lack of communication or trust, or insufficient medical information, and determining the difference will let the clinician know better what comes next.

“The situation may need something as common as communication or a family meeting. Maybe the doctors haven’t done their work as well as possible,” he suggests. “Maybe the patient just wants care on his or her own terms, so it requires the physician to do more homework, another literature review, and then suggest a wider range of options.” (For a simple, step-by-step approach to determining if an ethical problem exists, see box on p. 39.)

“We needed a scheme that made sense to

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A Clinical Approach to Ethical Reasoning

1. **State** the problem plainly.
2. **Gather** and organize data.
 - Medical facts
 - Medical goals
 - Patient's goals and preferences
 - Context
3. **Ask:** Is the problem *ethical*?
4. **Ask:** Is more information or dialogue needed?
5. **Determine** the best course of action, and support it with reference to one or more sources of ethical value:
 - **Ethical principles** — Beneficence, non-maleficence, respect for autonomy, and justice
 - **Rights** — Protections that are independent of professional obligations
 - **Consequences** — Estimation of the goodness or desirability of likely outcomes
 - **Comparable cases** — Reasoning by analogy from prior cases
 - **Professional guidelines** — e.g., AMA Code of Ethics, *ACP Ethics Manual*, *BMA Handbook*
 - **Conscientious practice** — Preserving the personal and professional integrity of clinicians
6. **Confirm** the adequacy and coherence of the conclusion.

Source: Lauris Kaldjian, MD, PhD; Robert Weir, PhD; and Thomas P. Duffy, MD.

clinicians, so it was useful to borrow the trajectory of reasoning we use as clinicians and apply that to clinical ethical reasoning," Kaldjian explains.

Ethical reasoning, he says, merges the core set of values demanded by the medical profession and the personal values (as our "moral selves," Kaldjian describes it) of individual clinicians.

"Everyone is familiar with the term 'differential diagnosis,'" he points out. "A differential diagnostic evaluation [of a possible ethical issue] includes the possibilities of poor communication, strained interpersonal relationships, or incomplete exploration of medical alternatives."

Though the clinical ethical reasoning approach has not been subjected to feedback evaluation from students, Kaldjian says he is encouraged by what he has been observing.

"Our overall impression [from students'

responses] is that people agree this style of reasoning is accessible and reasonable," he says. "It basically gives them a structure. If clinicians have hard time with anything, it's when they're presented information in a disorganized manner. If it's chaotic, it's difficult to make sense of it, so this gives them a scheme that echoes or parallels what we're already used to."

Roles of patient and family

Because what often is mistaken for an ethics-caused impasse is actually a shortfall in communication, clinicians should learn how to draw patients and families into discussions when questions about care arise. Patients and families should be made aware that physicians' training and values may cause them to respond to a clinical presentation in one way, while the family's or patient's values and understanding may cause them to see things differently, and what may initially seem to be an ethical problem can be remedied with discussion and more information.

Family members should listen carefully when a doctor makes a recommendation and ask the doctor to explain the rationale for the approach if one is not forthcoming, suggests Kaldjian — an approach that will keep communication open rather than leading to an assumption that the physician and patient are in complete disagreement.

"Medical ethics is not only about asking and exploring questions but also about decision making," he says. "In clinical care, you can't just sit back and have a discussion with no follow-up action."

Kaldjian says it is important that students be taught that there is more than one way to determine a right or wrong answer, and it's important that they are able to explain their reasons for making the decisions they do.

"Maybe a patient refuses what the physician believes to be the best recommendation," he says. "But if the recommendation was made too quickly, without enough discussion, and rejected, the physician may think there's an ethical conflict when really there just needs to be additional dialogue."

Sometimes, involving a third party — a staff ethicist, chaplain, social worker, or another physician — can help move discussion along, particularly if there appears to be a lack of trust between the clinician and patient.

Kaldjian and his co-authors stress the clinician's own ethical integrity and the need for preserving it when ethical conflicts do arise.

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Physicians must engage in “conscientious practice,” they wrote, allowing them to deliver care without compromising their own personal and professional conscience.

Resource

• Myser C, et al. Teaching clinical ethics as a professional skill: Bridging the gap between knowledge about ethics and its use in clinical practice. *J Med Ethics* 1995; 21:97-103. ■

Growing pains for special-needs youth

How to transition from pediatric to adult care

Ensuring age- and condition-appropriate medical care for young patients with special health care needs is challenging enough, but one aspect of their care that may not receive the attention it merits is the effect on a child when he or she is forced to transition from pediatric to adult care.

“The process of moving from pediatric to adult-oriented medicine is an important and necessary process in the lives of all adolescents and young adults, especially those with disabilities and special health care needs,” according to **John G. Reiss**, PhD, of the Institute for Child Health Policy at the University of Florida in Gainesville.

Reiss, who has done extensive research on health care transition, and colleagues at the University of Florida and Georgetown University recently completed a study on health care transition, the

findings of which appeared in the January issue of *Pediatrics*.

More children crossing threshold

In 2002, the American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physician/American Society of Internal Medicine issued a consensus statement on health care transitions for children with special needs and at that time, reported that nearly 500,000 children with special health care needs migrated from pediatric to adult care each year.

This marks a tremendous change from a generation ago, when most children with severe disabilities died before reaching maturity, the consensus panel authors wrote. Today, most young people with special medical needs survive to adulthood and must move from their pediatric clinician — in many cases, the physician they have grown most familiar and comfortable with — into adult care.

“Many adolescents and young adults with severe medical conditions and disabilities that limit their ability to function and result in complicating social, emotional, or behavioral sequelae experience difficulty transitioning from child to adult health care,” the consensus panel found. “There is a substantial number whose success depends on more deliberate guidance.”

Reiss and his colleagues, in the more recent study, looked at health care transition from the perspectives of the patient, the provider, and the patient’s family. The health care issues facing the children involved in the study were chronic diseases such as asthma, cancer, cerebral palsy, AIDS, sickle cell anemia, developmental disabilities, birth defects, and ongoing effects of trauma and head injuries.

Among the barriers to successful transitions from pediatric to adult health care is lack of preparation, Reiss says.

“[Health care transition] was found to be abrupt, with little or no preparation before transfer from pediatric to adult-oriented providers,” Reiss states. “In many instances, age — rather than indicators of maturity or independence — was used as the trigger for transition.”

The 2002 consensus panel recognized this problem, as well, and incorporated into its consensus statement — which was adopted as policy by all three bodies — a finding that, just as the Individuals with Disabilities Education Act requires a plan for education transition, health

care providers should plan for health care transition for patients with special needs.

The panel determined that pediatric providers should create written health care transition plans by the time their young patients reach age 14. The plans should spell out what services should be provided, by whom, and how they will be paid for. They also should be updated annually and whenever a transfer of care occurs, the panel report states.

A well-timed transition from child-oriented to adult-oriented health care, the panel concluded, allows young people to optimize their ability to assume adult roles and functioning. While for many children with special health care needs, this change will mean a transfer from a child to an adult health care professional; whereas, for others, it will involve an ongoing relationship with the same provider but with a reorientation of clinical interactions to mirror the young person's increasing maturity and emerging adulthood.

"Other suggestions involved helping the young person become an expert in his or her own medical condition, improving his or her understanding of the difference between pediatric medicine and adult-oriented medicine, providing young adults with opportunities to practice independent disease management, navigating the adult health care systems, and promoting peer-to-peer information sharing," Reiss says his team's study found.

From more supportive to less supportive

Reiss states, among many of the young patients he and his colleagues studied, the differences between adult and pediatric care were unsettling.

Among the things the patients and their families did not like about growing into adult care was the expectation of independence they found in adult-oriented medicine, compared to the supportive, family-centered approach they'd experienced with their pediatric providers.

"Young adults and their families also were reluctant to leave familiar and trusted health care providers and settings," Reiss says. "The supportive nature of pediatrics was observed to foster dependence in the young adult, which made transition to [adult-oriented providers] difficult."

Reiss and his team found the young patients' cognitive abilities had an influence on how well they were able to transition from pediatric to adult care. Those with impaired cognitive ability,

but who are able to live independently, transitioned successfully with some additional support. Patients with severely impaired cognitive ability had significantly more problems with transition.

Patients, families, and providers who participated in focus groups for Reiss's study told researchers young people whose conditions are progressive in nature and likely to cause death at a young age should probably not transition to adult-oriented care unless the change is desired by the family.

Transition happens in stages, families say

Reiss says participants in his study saw transition as a three-stage process that begins with "envisioning a future," progresses through an "age of responsibility," and concludes with the "age of transition."

"Envisioning a future" begins as soon as the disability or special health need is identified. Families said envisioning their children growing to adulthood helped them promote future planning. Participants recommended the transition process begin early. One parent told Reiss, "[The pediatric specialist] was a very firm believer in the children taking responsibility for their own health care. So, when Bobby was 2½ years old, he started answering his own questions when we came to clinic and, as a family, we started rehearsing those questions and answers on the way to clinic."

"Age of responsibility" is the second stage delineated by participants. It is during this stage that family members lay the foundation of future independence by teaching and giving responsibility to the child to carry out tasks of daily living and medical self-care. Examples include talking with health care providers, ordering and taking medications, and developing positive medical habits and routines.

The "age of transition" is the point at which the child draws on the groundwork laid during the previous two stages, and makes the transition to adult-oriented care.

But whether they observed stages of transition, participants told Reiss there was one almost universal factor in children's move from pediatrics to adult medicine: age. Most pediatric systems generally use the ages of 18 or 21 as the limit for providing services. Age limits were also related to service providers' expertise and comfort with providing certain services, Reiss says. Examples identified by participants included the refusal of

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pediatric anesthesiologists to provide anesthesia services to adult patients in children's hospitals and the licensing guidelines for pediatric nurse practitioners that limit treatment to individuals younger than 25.

Consensus panel suggestions

The 2002 consensus panel on health care transitions drew up a list of six suggestions to help ensure that the transition from pediatrics to adult-oriented care — and the transition from young child to young adult — is eased, rather than made more difficult:

- A young person with special health care needs should have an identified health care professional who attends to the unique challenges of transition and assumes responsibility for current health care, care coordination, and future health care planning.
- Identify the core knowledge and skills required to provide developmentally appropriate health care transition services to young people with special health care needs and make them part of training and certification requirements for primary care residents and physicians in practice.
- Prepare and maintain an up-to-date medical summary that is portable and accessible, to provide a common knowledge base for collaboration among health care professionals.
- Create a written health care transition plan by age 14 together with the young person and his or her family. At a minimum, this plan should include what services need to be provided, who will provide them, and how they will be financed. This plan should be reviewed and updated annually and whenever there is a transfer of care.
- Apply the same guidelines for primary and preventive care for all adolescents and young adults, including those with special health care needs, recognizing that young people with special health care needs may require more resources and services than do other young people to optimize their health. Examples of such guidelines include the American Medical Association's *Guidelines for Adolescent Preventive Services (GAPS)*, the National Center for

Education in Maternal and Child Health's *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, and the U.S. Public Health Service's *Guidelines to Clinical Preventive Services*.

- Ensure affordable, continuous health insurance coverage for all young people with special health care needs throughout adolescence and adulthood. This insurance should cover appropriate compensation for health care transition planning for all young people with special health care needs, and care coordination for those who have complex medical conditions.

Resources

- AAP, AAFP, ACP-ASIM Consensus Panel. A consensus statement on health care transitions for young adults with special health care needs. *Pediatrics* 2002; 110:1,304-1,306.
- Reiss JG, Gibson RW, Walker LR. Health care transition: Youth, family, and provider perspectives. *Pediatrics* 2005; 115:112-120. ■

AMA disavows anti-gay discrimination comments

President's remarks taken out of context

The president of the American Medical Association (AMA), who became the target of criticism from gay and lesbian groups after comments defending a medical school's decision to ban a gay student group were attributed to him in a newspaper article, asserts that his views were misrepresented.

John C. Nelson, MD, MPH, FACOG, FACPM, president of the 250,000-member AMA, was interviewed by the *Journal News* of White Plains, NY, in mid-February, and was asked about New York Medical College's decision to ban a gay student group. The article quoted Nelson as likening the ban to Brigham Young University's ban on caffeine on campus and its suspension of football players accused of rape.

The executive director of the Gay and Lesbian Medical Association, Joel Ginsberg, issued a statement charging that Nelson's comments compared the gay student group to something trivial, like the use of soft drinks, and to criminal activity, such as rape.

Nelson was quoted in the article as saying the AMA does not support the ban of the group at

the medical school, but that the students' rights to be on campus had to be balanced against the private, Catholic church-affiliated school's right to set policy.

AMA refutes discrimination accusations

J. James Rohack, MD, chairman of the AMA's board of trustees, issued a statement in which he did not mention Nelson's name or the attributed quotes, but strongly voiced the AMA's "zero tolerance for discrimination in any form."

"We are greatly disturbed that a recent newspaper article failed to document this commitment," he stated in comments posted to the AMA's web site. "Respecting the diversity of patients and the physicians who care for them is a fundamental value of the medical profession and reflected in numerous AMA policies."

"Contrary to the offending report, the AMA does not support banning a gay and lesbian medical student group at New York Medical College," Rohack continued. "The AMA encourages all medical schools to give great consideration to the benefits that arise from diversity, and help raise awareness among our physicians-in-training about the unique needs of their future gay and lesbian patients."

Nelson, a Mormon whose children attend Brigham Young, the Mormon-affiliated university he allegedly used as his example in the newspaper article, said in comments he posted to the AMA web site that his views "were grossly misrepresented" in the newspaper article.

"Let me be perfectly clear — the AMA is opposed to discrimination for any reason, and I am opposed to discrimination for any reason," he said. "The examples I used were taken out of context and twisted to portray a negative attitude toward gays and lesbians — an attitude which I do not share."

Nelson pointed out that he helped establish the AMA's Commission to End Healthcare Disparities and that he frequently speaks on the need to eradicate inequality in health care.

"I apologize to anyone who may have been offended by what they read. Please be assured that the article does not represent my views or the policies of the AMA," Nelson concluded.

The *Journal News* issued a statement in which its managing editor said the paper taped the interview with Nelson, stands by the resulting story, and that neither the AMA nor Nelson had requested a correction to the article. ■

Center takes on pediatric bioethics

Some ethical issues pertain only to kids

There are some ethical issues that are universal — end of life decisions, competency, and refusal of treatment, to name a few. But the questions involved — and their answers — seem to carry added weight when the patients are children.

"It's always been interesting to me that people who are comfortable with bioethics in adults, when faced with an identical issue in children, almost don't know what to do with it," says **Douglas Diekema, MD, MPH**, director of the Center for Pediatric Bioethics at Children's Hospital and Regional Medical Center in Seattle.

The center is in its infancy, with Diekema in the process of assembling a staff and getting some work coordinated and under way. Startup funding for the center, provided by Children's Hospital and a federal grant, was announced in December.

Some issues different, some the same

Many situations that prompt ethical questions occur in both adult and pediatric patients; others are unique to an age group.

"The primary differences can be seen when it comes to decision making," Diekema says. "In adults, the principle of autonomy plays a role.

"With a competent adult, you go to him or her to find out what they want. The equation changes when you're talking 3-, 12-, or 17-year-olds," he continues.

A 3-year-old is absolutely dependent upon his/her parents for health care decisions. Problems arise when health care providers don't think the parents are acting in the child's best interests, Diekema points out.

On the other hand, while 17-year-olds are not considered legally competent to make major health care decisions on their own, they probably have some degree of knowledge and opinion on the course their health care should take.

"That child may not agree with what [the] parents want, and in those cases, you have a unique situation where you have a patient who can make decisions, but doesn't have legal competency to," explains Diekema.

Genetic testing is another area of study that will be addressed through the center, he says, and

it's yet another example of ethical decisions that may be influenced by the age of the patient.

When screening for Huntington's disease, an incurable, inherited, degenerative neuropsychiatric disorder that affects the body and mind, "the literature is fairly clear that if you screen an adult for Huntington's, it's really up to that person as to whether they want to know or not." But what if the patient being tested — for whom testing is being considered — is a child?

Symptoms of Huntington's most commonly begin between the ages of 35 and 50, although onset may occur any time from childhood to old age.

"It's a whole different question when you are talking about a 5-year-old or a newborn whose parents want the child screened," says Diekema. "You're having the parents make that decision for a child, for a disorder that has no treatment, when there's no medical reason for finding out."

If parents want a child tested, it can be argued that they're robbing their child of a future opportunity to make that decision for him or herself, and saddling the child with the knowledge of bleak future health when there is currently nothing that can be done to avoid it.

"That's a situation that's relatively unique to pediatrics," Diekema observes.

Confidentiality is another area that can take on a different complexion when children are involved.

"It is an issue when an adolescent is in the hospital with a sexually transmitted disease, the parents are at her bedside, and [the patient] is telling us not to tell the parents why [the patient is] being treated," Diekema says, describing a particularly touchy position physicians and nurses might find themselves in. "[The patient is] a minor, but an adolescent minor, so what is the duty of confidentiality?"

A federal advisory group is expected at any time to recommend that all newborns in the United States be screened for 29 rare medical conditions, including sickle cell anemia and lesser-known diseases. The proposed screening has already sparked debate over how useful the findings would be, particularly when the conditions are untreatable.

Involvement in research at issue

Children's involvement in clinical trials and other research has long been a contentious issue. Because children are physiologically and psychologically different from adults, their responses to

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medications, procedures, and devices will not be the same as adults', and adults are not suitable stand-ins for children when the medications, procedures, and devices being studied are for use in children.

Because children are legally incapable of granting informed consent, their participation in studies is obtained by gaining parental permission and the assent of the child, to the extent his or her age allows the child to understand and agree.

A study published in *The Journal of Clinical Ethics* last year shows that when equipped with enough information, some adolescents age 13 to 16 can make health care decisions as well as adults — further muddying the lines clinicians use to determine who should decide treatment when the patient is an adolescent. Does the ability of an adolescent to decide weigh more than the fact that the adolescent still is a child and has parents who legally have the authority to decide?

Concentrated study

The center's planners and director say it will fill a gap in the study of pediatric bioethics.

According to **Treuman Katz**, retiring president and CEO of Children's Hospital, the Center for Pediatric Bioethics "will promote the highest standards of medical ethics and protections of patient rights in pediatric research and health care."

A key part of that goal will be centralizing some of the work being done now in pediatric medical ethics, Diekema points out.

"Right now, if you look around the country, there are dozens of people who are doing pediatric bioethics — either writing, speaking, or doing consulting — but there is no concentrated group that represents a study center for interdisciplinary collaboration and collegial work," he says.

Work at the center will be divided among four areas, Diekema continues. Primarily, the center will be the home of research of theoretical and empirical bioethics, some database studies, and some philosophical writing.

The center also will promote education, developing educational components that can be used at Washington as well as at other institutions. Another product of work at the center will be clinical services at Children's Hospital.

The fourth area of concentration, and probably the last to be developed, will be an advocacy program to develop local and national policy on pediatric bioethics.

"With the educational component, there are obvious education applications for our own institution, but I hope that in a consulting role we will be able to share that regionally and, hopefully, nationally," says Diekema. "The clinical services to the hospital will expand what the hospital already has in terms of consultative services and the ethics committee."

The advocacy arm of the center will encompass monitoring of informed consent clinical testing, patient care, and research.

"I can also see a sort of public policy advocacy role, with some of that coming naturally out of research," he says.

The design of genetic therapies is another burgeoning field that will likely be researched

at the center, including the issues that arise when clinical tests of genetic therapies include children.

There are other, peripheral topics that have not been paid enough attention but that the center might tackle, Diekema says, including the effects that being uninsured have on children and their lifelong health.

"There's abundant data that shows that when kids don't have insurance, they end up with worse health, which means they go into adulthood less equipped to compete in the marketplace and thrive as adults," he points out.

The interdisciplinary nature of bioethics makes the center a good jumping-off point for study of the direct and peripheral issues of pediatric bioethics, Diekema believes.

"This is a wonderful opportunity we have for very creative work," he says. "One of the things that make bioethics somewhat unique is that it really is an interdisciplinary endeavor, involving medical historians, physicians, nurses, researchers, and academics.

"The best work combines endeavors, and that's where work in a center can be very valuable." ■

U.S. Supreme Court to review PAS law

Oregon's Death with Dignity Act under federal fire

A Bush administration challenge to the nation's only physician-assisted suicide law will be reviewed by the Supreme Court later this year.

Oregon is the only state that allows people who meet specific criteria to take their own lives with the help of physicians, without legal recriminations to the physician. The Bush administration and some members of Congress oppose the law on grounds that prescribing a lethal drug for purposes of suicide violates the federal Controlled Substances Act. Last year, the Ninth U.S. Circuit Court of Appeals ruled that then-U.S. Attorney General John Ashcroft, the plaintiff in the ongoing case against the law, cannot sanction or hold doctors criminally liable for prescribing overdoses under Oregon law.

The Bush administration has appealed, and the Supreme Court has agreed to review Oregon's law. Legal experts say the outcome could affect the future of other such laws, should they be proposed in other states. Currently, Oregon is the

only state with a physician-assisted suicide law on the books.

Oregon's Death with Dignity law was enacted in 1997. It allows mentally competent adults to take their own lives with the help of a physician if certain conditions are met: The individual must declare his or her intentions in writing, must be diagnosed with a terminal illness, and must take the prescribed lethal drug on his or her own after a waiting period. The lethal drug must be taken orally. Oregon prohibits lethal injection, "mercy killing," and active euthanasia.

Aside from concerns that the law violates federal drug control laws, opponents to the physician-assisted suicide law argue that it encourages suicides, or that physicians or family members might use it to push vulnerable ill people to kill themselves.

According to Oregon's Department of Human Services, 171 people used the Death with Dignity Act process to end their lives between 1998 and 2003. Most of those people (80%) were terminally ill with cancer, followed by amyotrophic lateral sclerosis (Lou Gehrig's disease) and HIV/AIDS.

The Supreme Court has ruled in previous cases that there is no constitutional right to assisted suicide, but has not declared the practice illegal. Public opinion polls seem to indicate support

among those polled for physician-assisted suicide; however, laws similar to Oregon's have failed when proposed in other states, and the majority of states outlaw any form of euthanasia.

In attempting to thwart the Oregon act under federal law, Ashcroft proposed that physicians who prescribe drugs for patients to use to kill themselves would lose their right to write prescriptions.

Under the federal Controlled Substances Act, the use of controlled drugs is generally prohibited, except when prescribed for legitimate medical purposes. Oregon law proponents say a state-controlled and physician-monitored assisted suicide is a legitimate medical purpose; opponents say suicide is not ever a legitimate medical purpose. ■

MDs who observe executions challenged

Two recent complaints to medical boards dismissed

Recent challenges to the medical licenses of physicians who participate in state-ordered executions have been dismissed, but the physicians and ethicists who claim that participation violates the American Medical Association (AMA) code of ethics vow to keep up the complaints.

Two highly publicized recent cases have brought attention to the fact that states that impose capital punishment require the participation of — or at least observation by — licensed physicians when executions are carried out, and there are those in the medical community who want doctors to stay out of executions.

Opponents say physician participation violates physician ethics on two fronts — the AMA ethics code and the Hippocratic oath.

The AMA code states that “a physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution.”

The AMA code goes on to spell out what the AMA considers to be “participation”: actions that would directly cause the death of the condemned

(administering the lethal injection, for example); an action that would assist, supervise, or contribute to the ability of someone else to carry out the execution (placing a catheter, or merely being present, if a physician's presence permits the execution to be carried out); or an action that would automatically cause an execution to be carried out.

The AMA code states that a physician's mere presence, unless it is in a nonprofessional capacity or at the voluntary request of the condemned person, constitutes a violation of the code. The AMA code does not support or denounce capital punishment itself, but merely addresses physician participation.

Some critics add that participation in executions violates the classic version of the Hippocratic oath, which includes the lines, “I will give no deadly medicine to anyone if asked.” That wording has been removed from most modern versions of the oath. Most medical schools, but not all, require graduates to recite some form of the oath, also called the “good doctor” oath.

Regardless, physician's licenses, which are granted by the states they practice in, do not hinge on either the Hippocratic oath or the AMA ethics code; however, some state medical boards require physicians to adhere to the AMA code, and in states that make that requirement and also require physician attendance at executions, there is tension, legal and medical experts say.

Challenges dismissed

Late last year, a small group of physicians and ethicists lodged a complaint with the Georgia state medical board against a physician, Hothur Sanjeeva Rao, MD, who had assisted with executions by attending (Georgia requires the presence of two physicians at executions to verify death) and, in one case, by assisting in placing a catheter after numerous lay attempts by prison staff had failed.

The medical board dismissed the complaint in December, and the Georgia Department of Corrections has initiated legislation that would stop future challenges to doctors' licenses if they participate in executions as required by state law.

Ernie Fletcher, MD, a Kentucky physician, was

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at the center of another challenge over participation in executions — this one, initiated by some of the same death penalty opponents who lodged the complaint against Rao, arose because Fletcher is the governor of Kentucky and signed a death warrant in November for a convicted double murderer. Kentucky's Board of Medical Licensure ruled in January that it found no merit to the complaint and that Fletcher was acting as governor, not as a doctor, when he ordered the execution.

The AMA and state medical associations can, upon finding that a physician has violated an association code, revoke the physician's membership in the organization. But neither the AMA nor state medical associations can revoke licenses. Corrections officials say that the primary effect they have seen from the complaints is that physicians who once were willing to observe executions, as required in those states, are opting out now to avoid possible challenges.

The group challenging physician presence or participation in executions has indicated it will continue to seek out physicians who participate in executions and lodge complaints against them. Corrections officials liken the complaints to those lodged against physicians who perform abortions in states where abortion is legal — the complaints are still lodged and cause physicians discomfort and inconvenience, but abortions are legal, and doctors who perform them legally are not in danger of losing their licenses. ■

Few minorities participate in clinical trials

Lack of trust pervasive

Mistrust of the medical and science communities may be discouraging non-Caucasian cancer patients from enrolling in clinical trials, a research group has discovered.

Several studies in recent years have borne out researchers' anecdotal knowledge that non-Caucasian cancer patients are less likely than their Caucasian counterparts to enroll in clinical trials, so a team at the Hospital of the University of Pennsylvania in Philadelphia conducted research to find out in what ways the two groups differ in their views on clinical study.

Charles Wood, MD, a radiation oncologist at the Hospital of the University of Pennsylvania

SOURCE

- **Charles Wood, MD**, Radiation Oncologist, Hospital of the University of Pennsylvania, Philadelphia.

in Philadelphia, led a study that found non-Caucasians and Caucasians are equally interested in learning about clinical trials and their outcomes, but non-Caucasians are less likely to enroll in a trial unless the chances are high that it would benefit them.

He presented the findings of his group's study at the American Society for Therapeutic Radiology and Oncology (ASTRO) annual meeting last October.

"By identifying attitudes affecting enrollment, I'm hopeful that physicians will be able to better overcome barriers that would otherwise keep patients from enrolling in clinical trials," Wood says.

Enrollment of adult cancer patients in clinical trials is low for all groups, but particularly for minority populations. Only 2%-3% of all patients diagnosed with a particular disease enroll in clinical trials; therefore, Wood points out, the information gathered may not be generalizable to the entire population.

Wood's team surveyed 166 cancer patients in 2003 at two radiation oncology clinics about their attitudes toward clinical trials. Sixty-five percent of the patients surveyed were Caucasian, and African

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. After completing this activity, you must complete the evaluation form provided at the end of each semester 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. ■

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CME Questions

13. The model of clinical ethical reasoning stresses the importance of conscientious practice, which:
 - A. Preserves the personal and professional integrity of clinicians.
 - B. Estimates the desirability of outcomes.
 - C. Employs reasoning by analogy from other cases.
 - D. Protects the desires of the patient.
14. Which of the following, according to research into how special-needs pediatric patients transition from pediatric care to adult care, is/are stages of that transition?
 - A. Envisioning a future
 - B. Age of responsibility
 - C. Age of transition
 - D. All of the above
15. Which of the following argument(s) supports not testing a young child for Huntington's disease?
 - A. It burdens the child with the knowledge that he/she has an incurable disease.
 - B. It is not medically necessary.
 - C. Doing so denies the child the option of deciding on the test for himself/herself.
 - D. All of the above
16. The U.S. Attorney General is challenging Oregon's physician-assisted suicide law on the grounds that:
 - A. The law is morally wrong.
 - B. The law is in violation of federal controlled substances laws.
 - C. The Supreme Court has already declared the law unconstitutional.
 - D. it encourages suicide.

Answers: 13-A; 14-D; 15-D; 16-B.

Americans made up the majority of the other 35%.

Researchers found that while both Caucasians and minorities were interested in learning about clinical trials, Caucasian patients were more likely to gather information on trials from the Internet (31% vs. 11%) and were more apt to talk with their doctors about clinical trials (50% vs. 34%). Non-Caucasian patients were more likely to talk about clinical trial enrollment with other patients (25% vs. 12%). In addition, more minority patients believe they have been subjected to a clinical trial without their knowledge (22% vs. 9%).

Patients also differed on their expectations of clinical trials. More minority patients indicated that they would need a greater than 50% chance of benefiting from the trial (64% vs. 45%); however, there were no differences between the two groups on their outlook on potential side effects from the treatment.

Wood's team theorizes that minority patients may have an increased level of mistrust toward the medical and scientific community, and this may in turn affect their willingness to enroll in clinical trials. To combat this atmosphere of mistrust, Woods says, physicians need to improve their abilities to explain the realities, risks, and benefits of clinical trial enrollment to all of their patients.

"The manner in which enrollment in clinical trials is discussed with patients of all races must

be sensitive to particular patient's underlying fears, concerns, and potential distrust of the medical community," according to Wood. "Non-classical methods of enrollment on clinical trials may need to be employed to ensure that there are adequate numbers of minority patients studied."

ASTRO is the largest radiation oncology society in the world, with more than 7,500 members who specialize in treating patients with radiation therapies. ■