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Withdrawing life support from PVS patients: Do ethics change for age?

Case center of debate over guardian's perceived haste to withdraw support

The case of an 11-year-old Massachusetts girl, Haleigh Poutre, who suffered severe brain trauma last year as the result of abuse and is now in the custody of the state, has opened up discussion on withdrawing life support in pediatric patients who are diagnosed as being in a persistent vegetative state (PVS).

However, one pediatrician says the debate is not so much among clinicians, but among policy-makers.

"The only discussion and debate is among politicians," says **Robert Nelson**, MD, PhD, associate professor, anesthesiology and critical care at the University of Pennsylvania, who practices at The Children's Hospital of Philadelphia. "I don't think there's a lot of professional disagreement [on the criteria for PVS and withdrawal of life support]. The point comes down to whether you think it's reasonable."

Though the emotional impact often is different when deciding to end life support for a child vs. an adult, according to **Steven Leuthner**, MD, MA, assistant professor of pediatrics and bioethics at the Medical College of Wisconsin Center for the Study of Bioethics, "from an ethical perspective, I don't know that the decisions should be very different."

"The main difference between an adult and a child is that the adult might have had an opportunity to say what they would want to do if they were in the situation of PVS, and unfortunately with children they don't have the capability to say what they would want to do," says Leuthner. "But if you have an adult who has never expressed their wishes, that's no different from a child, and then you turn in both cases to whatever surrogate decision maker who is there."

Massachusetts case turns on PVS and guardianship

Poutre was hospitalized Sept. 11, 2005, with bruises, broken teeth, and a sheared brain stem. Authorities charged her adoptive mother

and stepfather with assault, alleging the child was beaten with a baseball bat. She was placed in the custody of the Massachusetts Department of Social Services (DSS), and several days after her hospitalization, doctors told her custodian that she was in a vegetative state and had no hope of recovery, a spokesman for DSS said at the time.

On Sept. 17, DSS stated in court documents, the child's "intracranial pressure increased, and she was diagnosed as having a stroke of the entire right side and most of the left side of her brain."

DSS asked a court for permission to remove her feeding tube and ventilator on Sept. 19, according to a redacted brief made public by the Supreme Judicial Court. The agency drew fire from critics who said it acted too swiftly; DSS issued statements defending its action, saying the department wanted to have all options available so that it could act in the child's best interest as her condition demanded.

On Oct. 5, a juvenile court ruled life support could be withdrawn. The girl's stepfather, who could face murder charges if the child died, appealed the decision to the state supreme court, which ruled in January that he could not have a say in her medical care due to his conflict of interest, and upheld the decision to allow withdrawal of life support. The child's adoptive mother committed suicide after being charged in the abuse case.

The day after the state supreme court ruled that the agency could withdraw life support, DSS announced the girl was breathing on her own and may have shown signs of regaining responsiveness. She was moved to a rehabilitation hospital in late January for additional evaluation.

Medical experts have long said that eye and body movement are not enough to determine whether a person is or is not in PVS. The Terri Schiavo case famously showed millions of lay people and lawmakers a woman who exhibited some body movement and who, though blind, was believed by family members to follow their movements with her eyes.

After being weaned from her ventilator, Poutre reportedly moved her eyes and hands — in the presence of DSS Commissioner Harry Spence — but doctors said those could be random, reflexive motions. Spence, in early February, said he would postpone removal of the child's artificial nutrition and hydration (ANH) until her condition was more conclusively evaluated.

Nelson says that in cases such as Poutre's, details are crucial.

"Is she in PVS or is she neurologically devastated? In situations where patients wake up, no one claims they were in PVS — they were neurologically devastated," he explains. "If a neurologist I trusted told me a [pediatric patient] was in PVS, I would treat that child differently than if he or she were neurologically devastated. The details are important."

Nelson said while a child in PVS can be diagnosed within a month, if doubt exists, waiting is "prudent."

The mechanism of injury is important to any decision to wait, as well, Nelson and Leuthner both say. A traumatic brain injury may leave

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room for some degree of recovery; injury due to asphyxiation does not yield such outcomes.

"Traumatic brain injury [outcome] can be hard to predict, but I generally tell parents a month is long enough [to tell]," Nelson says. "With asphyxial injury, you can tell in a week."

Then, he says, parents and physicians waiting to make treatment decisions have to ask what they are waiting *for.*

"Why are you waiting? What outcome are you waiting for?" he says.

Medical experts who have weighed in on the Poutre case have acknowledged that it is more difficult to make such calls when the patient is a child. While some have said regardless of the patient's age, the decisions should be based on the same criteria, at least one doctor publicly stated she would wait a year before removing life support from a child.

The American Medical Association code of ethics addresses the initiation and withdrawal of ANH without making a distinction based on age: "Treatments such as mechanical ventilation and artificial nutrition and hydration should be provided only with appropriate authorization from a patient, a surrogate, or a court. Once initiated, life-sustaining treatments may be ethically withdrawn upon request of the patient, or a surrogate or court acting on the patient's behalf."

Conflicts of interest cloud decision making

In the case of Haleigh Poutre, authorities and the court determined that her abuser, while her adoptive stepfather, had too great a conflict of interest to determine her care. If she lived, even on life support, he could not be charged with her death.

Lacking other family guardians, Poutre was placed in the custody of the state. Though there is a long, well-established legal tradition of the state making life or death medical decisions for children in state custody, critics point to a spectrum of potential conflicts in the Poutre situation — because DSS has acknowledged missing earlier signs that the child was being abused by her parents, would the agency be biased toward keeping her alive? Would the cost of keeping her alive prejudice the state to seek to end her life? The governor of the state has called for an investigation into the case; since DSS reports to the governor, is it still an independent guardian with only the child's best interest at heart?

The American Academy of Pediatrics (AAP) Committee on Child Abuse and Neglect and Committee on Bioethics issued in 2001 a position paper entitled "Forgoing life-sustaining medical treatment in abused children," (*Pediatrics* 2000; 106:1,151-1,153), in which it advises: "A guardian *ad litem* for medical decision making should be appointed in all cases of child abuse requiring [life-sustaining medical treatment] in which a parent, guardian, or prosecutor of the alleged abuser may have a conflict of interest."

In the Poutre case, some argue, the guardian appointed could also be considered to be a prosecutor of the alleged abuser.

Also, the AAP committees advise, "Decisions to forgo [life-sustaining medical treatment] for a critically ill child whose injuries are the result of abuse should be made using the same guidelines as those used for any critically ill child."

Leuthner suggests that if state law says withdrawing ANH in a patient who is in PVS is permitted, then if the patient or the patient's guardian and physician believe to do so is in the patient's best interest, age should probably not prevent that action.

"Once a child is declared PVS, ethically I think it is very reasonable to argue not to keep him or her in that state forever," he says. ■

SOURCE

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- **Steven Leuthner**, MD, MA, associate professor, pediatrics and bioethics, Center for the Study of Bioethics, Medical College of Wisconsin, Milwaukee. Phone: (414) 456-8296.

Recognition of patients' spiritual needs grows

Patient's spiritual beliefs important to treatment

Spirituality is recognized as a factor that many patients say contributes to their health; but now experts — even some who previously had doubts — are embracing patients' and their own spirituality as an essential part of treatment.

"Spirituality can affect how patients and health care providers perceive health and illness, and how they interact with each other," says **Christine M. Puchalski**, MD, director of the George Washington Institute for Spirituality and Health (GWISH) at The George Washington University Medical Center. "We need additional research and evidence as to the benefits of spirituality in health care, but we did a consensus with the naysayers — physicians, psychiatrists — and the group concluded that spirituality is essential to health care, and not just an amenity."

Puchalski describes spirituality as the "values, beliefs, practices, relationships, and experiences that lead one to an awareness of God or the divine or a transcendence and a sense of ultimate value and purpose in life."

Spirituality is found in all cultures, and is expressed in people's search for ultimate meaning through participation in religion and/or their belief in God, family, naturalism, rationalism, humanism, and the arts.

A spiritual or religious base can provide a seriously ill patient with immeasurable support when confronting unanswerable questions like, "Why me?" and "Why now?"

"Clinically what happens is that illness and stress can cause people to question their ultimate meaning," says Puchalski.

Attention to spirituality important to patients

Addressing the audience at a recent conference on Spirituality and Healing in Medicine, Puchalski pointed out that the nation's largest physician and nurse associations have addressed the importance of spirituality to patient care.

The American College of Physicians' ethical standards state that physicians "should extend their care for those with serious medical illness attentiveness to include psychosocial, existential, or spiritual suffering," and the American Nurses Association code of ethics states, "An individual's lifestyle, values system, and religious beliefs should be considered in planning health care with and for each patient."

The Dalai Lama even addressed the spiritual aspect of caring for the sick, Puchalski says, when he said, "Deprived of human warmth and a sense of value, other forms of treatment prove less effective. Real care of the sick does not begin with costly procedures, but with simple gifts of affection, love, and concern."

FICA: Taking a spiritual history

F — Do you have a spiritual belief or FAITH? Does it help you cope? What gives your life meaning?
I — Are these beliefs IMPORTANT to you? Do they INFLUENCE you?
C — Are you part of a spiritual or religious COMMUNITY?
A — How would you like your health care provider to ADDRESS these issues with you?

Source George Washington Institute for Spirituality and Health

Treating a patient's spiritual distress sometimes bears similarities to treating physical distress; for example, one important part of addressing spiritual distress is to take a spiritual history.

Taking the time to document a patient's spiritual history can provide an important complement to his or her medical history.

Prompted by the mnemonic FICA, clinicians can find out what motivates, inspires, and supports a sick patient. (See table above.)

Puchalski points out data indicating that physicians can feel comfortable broaching the subject with patients. A study of pulmonary patients at the University of Pennsylvania revealed that most (66%) said their trust in their health care providers increased if they were asked about their spiritual beliefs.

Not surprisingly, Puchalski says, inquiries about spirituality were most welcome by patients who were very seriously ill or dying (94%), and those suffering from or just diagnosed with a chronic or serious illness (91%).

Don't medicate spiritual distress

Though treating a patient's spiritual side in some ways can mimic treating his or her physical condition, Puchalski says health care providers must guard against medicating away a patient's spiritual distress.

"It's a question of healing vs. cure," she explains. "The medical system is cure-oriented. We want to make a good diagnosis and fix it.

"But a lot of healing is in the context of the incurable [condition], and so healing may mean

helping the patient be at peace, to tap in to hope, and to find value in their life."

Spiritual distress, unlike physical pain, should not be masked with medications, she advises.

"It has to be experienced. It's not like physical distress. There is so much we can do to help the patient move through spiritual distress and reach peace," she points out.

Theoretical, ethical framework helps guide

Puchalski lays out a spiritual and ethical framework that involves compassionate, patient-centered care and the biopsychosocialspiritual model, which holds that spirituality and medicine should go hand in hand because of the personal nature of the practice of medicine.

"Compassionate care has long been addressed in professional standards [set forth in medical and nursing codes]," she says. "That 'caring presence and attention to suffering.'"

Patient-centered care consists of shared decision making, respect for the patient's values and beliefs, and the involvement of a larger community of caregivers. Because a patient's understanding of illness and health is impacted by his or her spiritual, religious, and cultural beliefs, illness can trigger questions about the meaning and purpose of the patient's life.

A physician's understanding of the patient and his or her spiritual beliefs can be important to the patient's response to treatment, and to the course of treatment. For example, Muslim faith dictates that the patient be alert at the time of death; Jehovah's Witnesses do not believe in receiving blood transfusions.

"You try to work within the belief system of the patient, and incorporate their spiritual practices as appropriate," Puchalski suggests. "Identify his or her resources of strength — what gives them hope and faith, what their support community is.

"Research shows that patients' spiritual beliefs impact their recovery from illness, how they cope with illness, their will to live, their resiliency to stress and the adverse effects of stress on their quality of life, and the mind-body connection."

Medical schools in the United States are recognizing the medical role of spirituality. From 1992 to 2004, the number of medical schools offering courses in spirituality and health went from three schools out of 141 to 102 out of 141. More than half (58%) offer more than one course, and the courses are required at 70% of schools.

Topics addressed in the courses include spirituality and end of life, childbirth, chronic illness, and surgery; coping with stress in patients and health care workers; taking a spiritual history; ethical guidelines; suffering; spiritual models; how different religions and cultures view ethical issues in health care; the role of ritual, prayer, and customs in health care decision making; and the spirituality of the health care provider. ■

SOURCE

- **Christine M. Puchalski**, MD, director, The George Washington Institute for Spirituality and Health, The George Washington University Medical Center, Washington, DC. Web site: www.gwish.org.

PAS ruling settles some questions, others left open

Opponents say doctors will abuse powers

Though the Supreme Court's recent ruling in *Gonzales v. Oregon* says more about physicians' authority to write prescriptions than about the right of states to pass laws permitting physician-assisted suicide (PAS), proponents of Oregon's Death with Dignity law welcomed the ruling as a victory for physician discretion and patient autonomy.

Groups opposing PAS, however, plan to take their fight to Congress, where efforts are under way to draft legislation making it a federal crime for doctors to prescribe lethal doses of federally controlled drugs to assist suicide.

"The court held that the use of federally controlled drugs for the purpose of assisting suicide is not 'drug abuse' because the physician is not facilitating drug addiction, but instead seeking to kill," stated **Dorothy Timbs**, legislative counsel for the National Right to Life Committee's Robert Powell Center for Medical Ethics, in a statement released shortly after the ruling in January. "This is a shocking conclusion since one of the things that we most fear in drug abuse is danger to the life of the addict."

On the other side of the argument, **Barbara Coombs Lees**, president of Compassion &

Choices, an organization supportive of assisted suicide, called the ruling "a watershed decision for freedom and democracy in the U.S." that "reaffirms the liberty, dignity, and privacy Americans cherish at the end of life."

The *Gonzales* case arose from Oregon's 1997 passage of the Death with Dignity law permitting physicians to assist in the suicide of certain terminally ill patients by prescribing life-ending doses of drugs.

Congress failed in attempts in 1998 and 1999 to pass acts aimed at prohibiting PAS and overturning Oregon's PAS law. Former U.S. Attorney General John Ashcroft issued an order in 2001 that physicians not prescribe federally controlled drugs for PAS, countered by a federal court injunction that put Ashcroft's order on hold. The subsequent lawsuit, *Ashcroft v. Oregon*, became *Gonzales v. Oregon* when Ashcroft left office and was succeeded by Alberto R. Gonzales.

Oregon physicians wrote 325 prescriptions for life-ending drug doses between 1998 and 2004, the Oregon Department of Human Services reports. Of the 325 patients who received prescriptions, 208 patients used them.

Medical communities divided

The American Medical Association (AMA) did not file an *amicus,* or "friend of the court" brief, taking either side in *Gonzales.* AMA ethics code required physicians to respect patients' end-of-life directives regarding the administration or withholding of treatment, and to ease suffering to the extent possible. But AMA delegates have in the past passed policy statements holding that PAS is "inconsistent with the physician's role as healer."

The California Medical Association did file briefs in support of Oregon in the *Gonzales* case, out of concerns that if the attorney general prevailed, the federal government would gain authority over the states in determining the practice of medicine.

David Stevens, MD, director of the Tennessee-based Christian Medical and Dental Association, undoes patient protections that have existed "since the time of Hippocrates."

"Before Hippocrates, patients couldn't know for sure if their doctor would heal them or kill them," says Stevens. "The ethical foundation of medicine is crumbling under the court's jackhammer."

RESOURCES

- **National Right to Life Committee**, 512 10th St. NW, Washington, DC 20004. Phone: (202) 626-8800. E-mail: NRLC@nrlc.org.
- **Christian Medical and Dental Association**, PO Box 7500, Bristol, TN 37621. Phone: (888) 230-2637.
- **Compassion & Choices**, PO Box 101810, Denver, CO 80250. Phone: (800) 247-7421.
- **Sandra Johnson**, JD, LLM, professor, Saint Louis (MO) University School of Law, Saint Louis (MO) University Center for Health Care Ethics. Phone: (314) 977-2791.

He predicts that the *Gonzales* ruling will energize efforts to pass laws permitting PAS in other states. The 6-3 ruling, written for the majority by Justice Anthony Kennedy, not only held that Ashcroft exceeded his authority under the Controlled Substances Act in issuing his order prohibiting use of controlled drugs for PAS, but also affirmed states as the primary regulators of medical practice. Kennedy was joined by Justices John Paul Stevens, Sandra Day O'Connor, David Souter, Ruth Bader Ginsburg, and Stephen Breyer in the majority decision.

Justices Clarence Thomas and Antonin Scalia and Chief Justice John Roberts dissented. Scalia wrote, "Virtually every relevant source of authoritative meaning confirms that the phrase 'legitimate medical purpose' does not include intentionally assisting suicide."

Sandra Johnson, JD, LLM, professor of health care law and ethics at Saint Louis University School of Law and the Saint Louis University Center for Health Care Ethics, says the *Gonzales* case gives PAS efforts in other states "a significant boost," but "leaves the door open for Congress to enact legislation prohibiting physician-assisted suicide."

Johnson says the Supreme Court's ruling should afford physicians some protection from the federal prosecutions some have faced over prescribing controlled substances to patients in pain.

NLRC's Timbs, however, says those patients are the ones at risk under PAS laws.

"This sets a dangerous precedent for all vulnerable Americans, especially those with disabilities and life- or health-threatening illnesses," she insists. "Drugs should be used to cure and relieve pain, never to kill." ■

Abstinence-only education problematic, group says

Group urges comprehensive sexual health education

The Society for Adolescent Medicine (SAM) has issued a position statement rejecting current administration policy promoting abstinence-only education for young people, urging U.S. educators to present abstinence as one important option in an overall sexual health prevention strategy.

"We believe that current federal abstinence-only-until-marriage policy is ethically problematic, as it excludes accurate information about contraception, misinforms by overemphasizing or misstating the risks of contraception, and fails to require the use of scientifically accurate information while promoting approaches of questionable value," the authors write in "Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine," released in January in *The Journal of Adolescent Health* (2006; 38:83-87).

Lead author **John Santelli**, MD, MPH, of the Heilbrunn Department of Population & Family Health, Mailman School of Public Health, Columbia University in New York, writes that abstinence from sexual intercourse represents a healthy choice for teen-agers, and acknowledges that teen-agers remaining abstinent, at least through high school, is strongly supported by parents and even by adolescents themselves.

"However, few Americans remain abstinent until marriage, many do not or cannot marry, and most initiate sexual intercourse and other sexual behaviors as adolescents," he writes. "Abstinence as a behavioral goal is not the same as abstinence-only education programs. Abstinence from sexual intercourse, while theoretically fully protective, often fails to protect against pregnancy and disease in actual practice because abstinence is not maintained."

SAM urges the abandonment of abstinence only as a basis for health policy and programs, calling the presentation of abstinence-only or abstinence-until-marriage messages as a sole option for teen-agers "flawed from scientific and medical ethics viewpoints," providing misinformation and withholding information needed to make informed choices.

In addition, the SAM paper suggests, federally funded abstinence-until-marriage programs discriminate against gay, lesbian, bisexual, transgender, and questioning youth, as federal law limits the definition of marriage to heterosexual couples.

Abstinence-only vs. SAM recommendations

Under Section 510 of the Social Security Act, originally enacted in 1996, abstinence education is defined by an eight-point description as an educational or motivational program that:

- has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
- teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;
- teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
- teaches that a mutually faithful, monogamous relationship in the context of marriage is the expected standard of human sexual activity;
- teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
- teaches that bearing children out of wedlock is likely to have harmful consequences for the child, the child's parents, and society;
- teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
- teaches the importance of attaining self-sufficiency before engaging in sexual activity.

The society's position, summarized in the paper, is that:

- Abstinence is a healthy choice for adolescents. The choice for abstinence should not be coerced. SAM supports a comprehensive approach to sexual risk reduction including abstinence as well as correct and consistent use of condoms and contraception among teens who choose to be sexually active;
- Efforts to promote abstinence should be provided within health education programs that provide adolescents with complete and accurate information about sexual health, including information about concepts of healthy sexuality; sexual orientation and tolerance; personal responsibility; risks of HIV and other STIs and unwanted pregnancy; access to reproductive health care; and benefits and risks of condoms and other contraceptive methods;

• Individualized counseling about abstinence and sexual risk reduction are important components of clinical care for teen-agers;

• Health educators and clinicians caring for adolescents should promote social and cultural sensitivity to sexually active youth and gay, lesbian, bisexual, transgendered, and questioning youth. Health education curricula should also reflect such sensitivity;

• Governments and schools should eliminate censorship of information related to human sexual health;

• Government policy regarding sexual and reproductive health education should be science-based. Governments should increase support for evaluation of programs to promote abstinence and reduce sexual risk, including school-based interventions, media efforts, and clinic-based interventions. Such evaluations should utilize rigorous research methods and should assess the behavioral impact as well as STIs and pregnancy outcomes. The results of such evaluations should be made available to the public in an expeditious manner; and

• Current U.S. federal law and guidelines regarding abstinence-only funding are ethically flawed and interfere with fundamental human rights. Current federal funding requirements as outlined in Subsections A-H of Section 510 of the Social Security Act should be repealed. Current funding for abstinence-only programs should be replaced with funding for programs that offer comprehensive, medically accurate sexuality education.

Position paper lauded, criticized

Advocates of comprehensive sexual health education praised the SAM paper, calling abstinence only "bad science."

"We have 8 million young people under the age of 19 who are sexually active, yet 79% of junior high and 45% of high school teachers fail to teach about condoms. No wonder we have the highest rates of teen pregnancy and sexually transmitted disease in the developed world," says **James Wagoner**, president of the national organization Advocates for Youth.

"The [SAM] report is not anti-abstinence. It clearly supports abstinence as a strategy to protect young people's sexual health. But the report makes clear that, to be effective, abstinence education needs to be delivered in a comprehensive context along with information on condoms and birth control."

Supporters of abstinence-only education, however, disagree.

"With skyrocketing STD rates and conclusive research, which shows that contraception does not offer protections against all STDs, we need to be wise in the counsel we give young people," says **Jessemyn Pekari**, communications director for the Abstinence Clearinghouse, headquartered in Sioux Falls, SD. Abstinence Clearinghouse's position is that abstinence is not "a healthy choice," it is 'the only healthy choice" for the sexual health of adolescents, she says.

Reference

Santelli J, et al. Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine. Available on-line at www.jahonline.org/article/PIIS1054139X05004672/abstract. ■

SOURCE

- **Society for Adolescent Medicine**, 1916 NW Copper Oaks Circle, Blue Springs, MO 64015. Phone: (816) 224-8010. Web site: www.adolescenthealth.org.

Accepting, rejecting patient gifts: A delicate proposition

Motive, value, appearance all come into play

If a grateful patient presented you with one of his Aunt Mary's special fruitcakes during the holidays, it was probably pretty obvious that such a gift presents no ethical dilemma.

But what if your patient is injured in an accident that later comes with a sizable monetary settlement, and wants to share a portion of the award with you out of gratitude for his medical outcome?

So long as the gift is not *too* large — and you had nothing to do with it in terms of giving court testimony or depositions — you are probably ethically in the clear to accept the gift, according to the American Medical Association's Council on Ethical and Judicial Affairs (CEJA); but other authors on the subject feel the line is much more difficult to draw.

Use good judgment, consider motives

CEJA largely leaves the acceptance or declination of gifts from patients or their families to physicians up to the physician — with some cautionary advice.

"Gifts from patients may be an important means for some patients or their family caregivers to express gratitude for the care a physician has provided," the CEJA opinion states. "However, physicians should be aware that gifts may be offered for many different reasons, and that acceptance of certain gifts may compromise the patient-physician relationship."

Likewise, turning down a gift might have a negative consequence to the patient-physician relationship, the council notes.

Gift giving and receiving is a complex interaction of relational rules. Depending on the relationship and the intention, to reject a gift might offend the giver; on the other hand, accepting a gift intended to secure preferential treatment may be required to maintain the appropriate respect and objectivity key to the patient-physician relationship.

The council's bottom line recommendation? There can be no set rule for most situations. "Physicians need to think carefully and exercise judgment when deciding whether to accept or refuse a gift," according to the CEJA opinion.

In deciding whether to accept a gift, a physician should consider the giver's motive. Often, the gift springs from generosity, simply because the patient derives pleasure from giving gifts. The gift might be a sign of appreciation only, not as a means of influencing the physician-patient relationship. In those cases, CEJA suggests, gifts are a "manifestation of goodwill" and not a threat to the professional relationship.

When gifts are a means of influencing care, however, there could be a threat to the patient-physician relationship. If the gift is refused, the patient might be offended; if the gift is accepted and the desired effect (favorable treatment, etc.) is not achieved, the patient might become resentful; or, accepting the gift might cause the clinician to feel obligated and to question his or her ability to make treatment-appropriate recommendations.

Value not the determining criteria

A hundred-dollar gift certificate from a patient of limited means can represent a gift of much greater relative value than a million-dollar faculty chair donated by a wealthy client. Therefore, judging the value placed on the gift by the giver is an important factor in deciding whether to accept it. A large gift from a wealthy donor may not be considered by the patient to be of much value, but might be interpreted by the physician, or his colleagues, as a request for special treatment. The reverse may be true of a gift from a less wealthy patient that may seem insignificant to the physician, but represents a large gift with serious meaning from the patient.

A commonly quoted rule of thumb is to ask oneself, "Would I feel comfortable if my colleagues or the public were to know about this?"

What does it mean when patients give their doctor a gift?, asks British physician **Sean A. Spence**, MD, who wrote on the topic in the *British Medical Journal* in 2005. In "Patients bearing gifts: Are there strings attached?" (2005; 331:1,527-1,529), Spence suggests that even though many gifts merely convey a "thank you" sentiment from the patient, within the medical practice, the main argument against accepting gifts from individual patients is the need for justice and equity when dealing with all patients. "So, even in the most sincere interaction, the doctor is on a slippery slope when accepting a gift," Spence writes.

Keeping a record of all gifts offered or received and discussing the matter openly with colleagues promotes transparency, Spence adds.

Another author, **Laurie J. Lyckholm**, MD, writes in the *Journal of the American Medical Association* that regardless of the intent of the giver, a large or expensive gift to a physician "is a serious boundary transgression." She suggests accepting or acknowledging the gift appropriately, to let the patient know the sentiment is appreciated, but to then direct the gift to a charity or foundation. This is true whether the gift is a $1 million gift from a wealthy patient or a $100 gift from a patient who is not well off. ("Should physicians accept gifts from patients?" *JAMA* 1998; 280:1,944-1,946.)

One author who believes physicians should not accept gifts at all from patients is **Charles Weijer**, a professor at Dalhousie University in Nova Scotia, who wrote in the *Western Journal of Medicine* that "gift giving debases the true value of the care that physicians give to their patients."

"The gift of life is simply too precious to be acknowledged by a bottle of scotch, no matter

the make or vintage," he concludes. ("Gifts debase the true value of care." *West J Med* 2001; 175:77.) ■

JCAHO issues sentinel event alert on medication accuracy

Aims to reduce errors in medication reconciliation

The nation's largest hospital accreditation organization has issued a new warning aiming to reduce harmful incidents arising from inaccurate delivery of medications. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued a new *Sentinel Event Alert* in January that urges intensified attention to the accuracy of medications given to patients as they transition from one care setting to another or one practitioner to another.

The alert specifies that medication reconciliation should occur whenever a patient moves from one location to another location in a health care facility (for example, from a critical care unit to a general medical unit); or from one health care facility to another or to home; and/or when there is a change in the caregivers responsible for the patient. When effective medication reconciliation does not occur, patients may receive duplicative medications, incompatible drugs, wrong dosages, or wrong dosage forms, among other potential errors. The medication reconciliation process also provides an important opportunity to assure that the patient is receiving all medications necessary to his or her care and to eliminate any medications that are no longer needed by the patient.

The U.S. Pharmacopeia in 2005 received more than 2,000 voluntary reports of medication reconciliation errors, and a 1999 Institute of Medicine report estimated that more than 7,000 deaths occur each year in hospitals alone due to medication errors. JCAHO's sentinel event database also identifies medication errors as one of the most frequently occurring threats to patient safety. The database reveals that 63% of the reported medication errors resulting in death or serious injury were due to breakdowns in communication, and approximately half of those would have been avoided through effective medication reconciliation.

The fact that medication reconciliation errors continue to occur, despite repeated warnings and rigorous standards, prompted the Joint Commission to issue the new alert on medication reconciliation to the more than 15,000 health care organizations it accredits.

"A systematic approach to reconciling medications must be the foundation for all efforts to prevent drug errors," says **Dennis S. O'Leary**, MD, JCAHO president. "As challenging as this effort may be, it will be well worth the investment for caregivers and patients alike."

To reduce the risk of errors related to medication reconciliation, JCAHO recommends that health care organizations:

- Put the list of medications in a highly visible place in the patient's chart and include essential information about dosages, drug schedules, immunizations, and drug allergies;
- Reconcile medications at each interface of care, specifically including admission, transfer, and discharge. The patient and responsible physicians, nurses, and pharmacists should be involved in this process;
- Provide each patient with a complete list of medications that he or she will take after being discharged from the facility, as well as instructions on how and how long to take any new medications. The patient should be encouraged to carry this list and share it with any caregivers who provide any follow-up care;

In addition, as part of its current national patient safety goals, the Joint Commission also specifically requires that each accredited health care organization:

- Implement a process for obtaining and documenting a complete list of the patient's current medications upon admission. This includes a comparison of the medications the organization provides to those on the list. The patient should be asked to describe or confirm any prescription medications, over-the-counter medications, vitamins, herbs or other supplements that he or she takes;
- Communicate a complete list of the patient's medications to the next service provider when the patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization.

The warnings about medication reconciliation

CE/CME answers

9. A; 10. D; 11. B; 12. C.

are the latest in a continuing series of *Sentinel Event Alerts* issued by the commission. Much of the information and guidance provided in the alerts are drawn from the sentinel event database, which includes detailed information about both the adverse events and their underlying causes. The complete list and text of past issues of *Sentinel Event Alert* can be found on the Joint Commission web site at www.jcaho.org. ■

Americans for quarantine not forced compliance

SARS-hit countries more likely support enforcement

If faced with the threat of SARS, avian flu or another epidemic, most Americans would consider quarantine a good idea — but they wouldn't approve of strong enforcement. That is one American attitude toward quarantine described by Harvard public health researchers who studied U.S. attitudes about quarantine.

The study also indicates weak faith in the government's ability to manage an epidemic, according to study author **Robert Blendon**, MD, professor of health policy and management at the Harvard School of Public Health. Blendon says in light of his findings that only 40% of Americans trust the government to cope with a disease outbreak so how officials manage future emergencies will be crucial.

The Harvard study compared U.S. attitudes to those of people in Hong Kong, Singapore, and Taiwan, where quarantine was used during SARS outbreaks in 2003. While residents of SARS-hit countries support arrest for those who violate quarantine, Americans surveyed say they strongly support quarantine as a preventive measure; however that support falls when asked if they would support arresting people who did not comply with the quarantines.

Respondents who opposed quarantine were concerned about overcrowding, infection, and inability to communicate with family members while quarantined.

The survey asked about support for three measures that public health officials could take to protect the health of the public and prevent the spread of a contagious disease: masks, required temperature-taking, and quarantine.

In areas of Asia where most respondents had worn a mask in public, there was a higher level of support for requiring everyone to wear one. In Hong Kong and Taiwan, approximately 90% of the public reported wearing a mask in public in the past two years to protect themselves against becoming ill. Support for requiring masks ranged from a high of 96% in Taiwan to a low of 53% in the United States. However, when people were told that they could be arrested for noncompliance, support for this measure in Hong Kong fell to a level similar to that of the United States and Singapore.

There was a high level of support (99%-84%) in Taiwan, Singapore, and Hong Kong for requiring everyone to have their temperature taken to screen for illness before entering public places during an epidemic. But again, when told that people who refused could be arrested, support for this measure declined.

Strong majorities in each of the countries favored quarantining people suspected of having been exposed to a contagious disease. In the United States, compulsory quarantine, under which those who refuse to comply could be arrested, was supported by 42% of the public across all demographic groups. African-Americans were significantly more likely than whites or Hispanics to move from initially favoring the measure to no longer favoring it when told they could be arrested for noncompliance. This difference across racial groups held after age, sex, income, education, and urbanity were adjusted for.

The findings from the Harvard study are available on-line at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.25.w15. ■

COMING IN FUTURE MONTHS

- When to call for an ethics consult
- When you disagree with your patient's choice
- Defining 'quality of life'
- Beyond Vioxx — when good meds go bad

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. ■

CE objectives

After reading each issue of *Medical Ethics Advisor*, you will be able to do the following:

- discuss new information about hospital-based approaches to bioethical issues and developments in the regulatory arena that apply to the hospital ethics committee;
- stay abreast of developments in bioethics and their implications on patient care, risk management, and liability;
- learn how bioethical issues specifically affect physicians, patients, and patients' families. ■

CME Questions

9. Young children with severe brain injury may have a slightly increased chance of recovering some brain function if:
A. the injury was caused by trauma.
B. the injury was caused by asphyxiation.
C. the injury was caused by a toxin.
D. None of the above

10. In taking a patient's spiritual history, a clinician may be reminded by the mnemonic FICA, which stands for:
A. Faith, Inspiration, Comfort, Action
B. Faith, Ideals, Christianity, Advice
C. Family, Importance, Community, Assistance
D. Faith, Influence, Community, Address

11. The Supreme Court's ruling in *Gonzales* assures states that laws on physician-assisted suicide can't be overturned by Congress.
A. True
B. False

12. The Harvard School of Public Health study examining attitudes toward quarantine during times of epidemic found what factor to most negatively impact support for mandatory quarantine?
A. loss of privacy
B. lack of contact with loved ones
C. threat of arrest
D. risk of infection

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