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When patient and provider disagree; 'Letting' patients make 'bad' choices

Ethics committees can help when patient and caregiver disagree

If you ever find yourself struggling with the ethical implications of permitting a patient to make a bad medical decision, maybe you should think semantics before you weigh ethics.

Courts rule tirelessly that competent patients have the ability to make their own decisions, regardless of consequences. That being a given, do physicians really "permit" patients to make choices? And who decides whether that choice is "bad?"

At what point does the physician surrender to patient autonomy and be satisfied that he or she has fulfilled his or her ethical obligations?

"It's my observation that the mere description of a patient's decision or choice as 'unwise' indicates the caregiver and the patient have different values and/or the caregiver doesn't fully understand the patient's reasons for making a decision viewed as inappropriate," points out **Paul B. Hofmann**, DrPH, FACHE, president of Hofmann Healthcare Group in Moraga, CA.

"Similarly, talking about permitting a patient to make an unwise choice is value-laden because the word 'permitting' is used rather than the word 'respecting.'"

According to Frankfort, IL, attorney and physician **William Sullivan**, DO, JD, many court cases have been dismissed when the patient has suffered a bad outcome after not listening to physicians' advice.

"The problem is that the decision a patient makes must be 'informed,'" Sullivan says. "The legal issues that arise when such cases are litigated are whether the patient was competent and whether the patient was given enough information to make an informed decision. The ethical question that arises is, 'At what point are patients responsible for adverse effects of the decisions they make?'"

Being comfortable that a patient is making an informed decision and being comfortable with the decision itself, most agree, can be two very different things.

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Patient choice impacts patient well-being

Hofmann says the decisions patients must make range from the innocuous (what to eat, what to wear for comfort) to the very serious (whether to abandon life-sustaining care or pursue possibly futile treatment).

"The choices or decisions by patients range from mundane to the very vital decisions that have profound impact on their well-being," such as when a pregnant woman elects to proceed with a pregnancy when all tests indicate the likelihood of harm to the mother and unlikelihood of the fetus surviving make that decision irrational, he says.

"The reason disagreements occur among

patients, family members, or caregivers is often a failure to understand the underlying rationale for the patient's choice," Hofmann explains.

"Probably the most common explanation is that the caregiver — a nurse or physician — has not taken the time or made the investment to really understand the basis for what he or she perceives to be an inappropriate, unwise choice."

One obstacle to that understanding is language, and Hofmann says this doesn't just mean two people speaking different languages.

"The fact is that caregivers use relatively technical and almost unintelligible — from the patient's perspective — language, so the patient may misunderstand what the caregiver says in regard to treatment options," he says. "This can be a problem with the caregiver not providing a clear explanation of the issues involved in making a decision."

Another impediment to good decision making — meaning, informed decision making — is the impact of illness, trauma, depression, dementia, and/or medications, Hofmann says. Busy caregivers may fail to recognize or appreciate the consequence these conditions or medications may have on the patient's ability to make a clear, informed decision.

"When a patient makes what is perceived to be an unwise or inappropriate choice, one possible explanation is that he or she does not have what might legally be defined as full decision-making capacity — either temporarily or on a long-term basis," he says. "The amount of medications he or she is receiving, the level of depression he or she may be experiencing because of trauma and illness, the impact of the trauma or illness itself, and temporary or progressive dementia all can complicate and may interfere with what caregivers believe to be a problem in terms of the decision-making process."

Caregiver's emotions affect decisions

Anger, guilt, and other emotional factors can influence a patient's choices, but Hofmann is quick to point out that that doesn't just mean the patient's emotional state.

Surrogates acting on behalf of the patient can be influenced by their feelings, as can caregivers.

"I was meeting with a task force that is working to improve end of life in the intensive care unit, and I am really proud of work this group has done; they've done marvelous work, but the fact is that this hospital still has physicians who are in denial when it comes to conceding that there's nothing they can do to extend the life expectancy and

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Editorial Questions

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improve the quality of life in some of their patients who are terminally ill," Hofmann says.

"And that is reflected in their unwillingness to even talk with a patient or his or her family about a DNR [do not resuscitate] order, because they view death as defeat, as failure. They believe, especially the subspecialists, that if 'I can keep the patient's lungs going, or if I can keep the patient's kidneys going, or his heart pumping. . .' They say, 'I can reverse this problem.' But if a patient has cancer that has metastasized and multiple organ failure you might be successful in your limited scope [heart, lungs, kidneys], but the patient's well-being is being compromised because of one or more physicians who are unwilling to let go."

Finally, the health care provider and the patient might simply have legitimate, deep differences in values. Those need to be acknowledged, Hofmann says, and it's up to the caregiver to say "our differences are too great, so we need to arrange for you to be in the care of someone else."

Ethics committee helps minimize dilemmas

Ethics committees are valuable resources for minimizing and even preventing patients from making uninformed choices, and in addressing situations in which patients and their caregivers are at odds over those choices.

"The staff should be trained to be both culturally competent, not just culturally sensitive," suggests Hofmann. "They need to recognize the tendency of caregivers to push for decisions in a shorter time frame than many patients or surrogates are comfortable accepting, and need to allow more time to pass to avoid the possibility of forcing premature decisions being made."

Often, he says, in dealing with end-of-life decisions staff members have difficulty understanding why a patient or surrogate is having difficulty making a decision about withholding life-sustaining treatment.

A way to help ensure patients and surrogates have balanced information when it comes to making end-of-life decisions is for health care providers to emphasize — before those decisions have to be made, if possible — that if it becomes necessary to enforce a DNR order, that the patient is not abandoned at that point.

"I think that it is not emphasized enough, when a painful conversation is held about a DNR order, that if the conversation is held in a way that emphasizes that the patient won't be abandoned, will be made comfortable, the likelihood of what the caregiver believes to be the most appropriate choice is greater," says Hofmann.

Again, understandable communication is key. Hofmann says conventionally, end-of-life conversations between physicians and family members or surrogates begin with the physician telling the family what the diagnosis and prognosis are; instead, he says, physicians should start by asking the family what they understand the diagnosis and prognosis to be.

"Listening to and learning where the patient and surrogates are creates a crucial context for the physician's presentation and discussion," he explains. "If they listen to where the patient or surrogate is along the continuum of understanding, the greater the likelihood that the physician will be able to convey the information that he or she was intending to convey.

"By not inviting them to describe where they are [in understanding the patient's condition], the physician makes some very inappropriate assumptions and raises the likelihood that there will be tense conflicts over choices."

Another example: asking, when a surrogate is approached about withdrawing or withholding a ventilator, "What do you want us to do?"

That question puts the decision in the context of what the surrogate wants, rather than what the patient would want, when the choices might not be the same; if the surrogate is the patient's child, for example, he or she might not want the parent to die, whereas the parent's wish would be to avoid the ventilator.

"The right question is, 'What do you believe the patient would want?,' and it's a huge distinction, because it allows the surrogate to demonstrate respect for the patient's wishes," he says. "It feels different to say, 'My mother would want this' than to say, 'I want this.' It's a huge difference in acknowledging and respecting the patient's wishes."

Finally, Hofmann says, ethics trainers should make extensive use of role-playing to help ethics

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committees and others become more aware of effective ways to mediate and resolve complex ethical dilemmas that arise at the end of life.

"When a patient's decision is at variance with what the physician would do, you have to recognize the triumph of autonomy," Hofmann points out. Lingered doubt about a patient's choice is one reason that such conflicts demand an ethics consult.

"That's why these multidisciplinary resources have been established, because irreconcilable differences occur — so how might they be reconciled and mediated in a way to bring resolution in such a manner that the legitimate needs of the participants are met," he explains. "I think if we are oblivious to the crucial needs of the caregivers [when conflicts arise] in a naïve attempt to be completely responsive to patients and families, we do great disservice to the caregivers on whom patients and family members depend for their well-being. We have a moral imperative to be sensitive to the needs of the caregivers, and I see the ethics consult as part of that." ■

Texas act formalizes ethics committee role in disputes

Drafters say act is still somewhat misunderstood

The Texas Advance Directives Act (TADA) was enacted several years ago after a consensus of health care providers in that state agreed that there was a need to come up with a process to resolve ethical disputes that can arise at the end of life in a way that would foster dialogue and avoid courts of law whenever possible. The act, signed into law by then-Gov. George W. Bush, made substantial changes to state law regarding end-of-life and medical futility (renamed "medically inappropriate treatment"); while considered groundbreaking by many, it has come under fire as the result of some recently publicized end-of-life cases.

"We recommended over 20 substantive changes to Texas law regarding end of life and agreed on new definitions of terms and a new form of a living will that allows patients to reject or request life-sustaining treatments," says **Robert L. Fine**, MD, FACP, director of the Baylor Health Care System office of clinical ethics in Dallas. Fine was a member of the multidisciplinary task force that drew up the law. "It's unique in the country, but it's still misunderstood."

One element of TADA establishes a process for resolving disputes among family members, patients, and health care providers, and formalizes the role of the ethics committee when disputes arise. Importantly, in cases in which there is a dispute over withdrawal or continuation of life-sustaining treatment, once all aspects of the law are satisfied, health care providers are immune from legal liability.

Thomas W. Mayo, JD, director of the Southern Methodist University Cary M. Maguire Center for Ethics and Public Responsibility and co-chair of the Parkland (TX) Hospital and Children's Medical Center ethics committees, says TADA "started with the idea that physicians and patients earnestly deliberate and negotiate prior understanding of the limits of care, so that they could reach an agreement that if the patient developed a terminal or irreversible condition, it would be known whether the patient would or would not want certain treatments."

This requires dropping the natural tendencies on both sides to avoid talking about possible bad outcomes, he points out.

The Texas law favors a joint decision-making arrangement, with attempts to negotiate and reach common ground when there are disagreements.

From that point, if agreement is not reached, an ethics consultant or other resource in the hospital or community is invited into the discussion. Failing then to reach an agreement, the ethics committee is required to become involved.

"Once the ethics process is played out, two things can happen. If the physician is unpersuaded by the outcome, he or she transfers the patient to another physician," Mayo explains. "If the patient or surrogate is unpersuaded by the outcome, he or she can request transfer to another care setting with the support of the transferor and transferee."

If transfer is not possible, and all other aspects of the TADA have been observed, the disputed medi-

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cal intervention need not be provided to the patient; and if the health care providers in these cases have satisfied the procedural requirements of the statute, they are immune from all forms of legal liability.

The triggering event that sets the process in motion is when an attending physician refuses to honor an advance directive or a treatment decision made on behalf of the patient.

"You have to scrupulously observe these various due process protections to get the legal protection provided in the statute," Mayo says. The process is initiated by physician disagreement with a patient's treatment decision, and not by the hospital, and it requires, by law, an ethics committee review.

"And, although an ethics committee review is required, one or more informal consults usually occur before the formal consultation, even though they're not required. The formal one is the one that satisfies all the due process requirements of the statutes," explains Mayo.

The patient or his or her surrogate is entitled to 48 hours notice of the consult, can attend the meeting, and can receive a written overview of the process. In addition, the surrogate is entitled to a list of providers willing to accept transfer, and an explanation of the ethics committee outcome.

"In a classic right-to-die case, if a physician or surrogate disagrees with the outcome of the ethics committee review, the hospital shall assist the physician in arranging for transfer to another physician, another care setting within the institution, or to another institution," Mayo says. "In a reverse right-to-die (medical futility) case, where the family member is asking that everything be done and the doctors think it is inappropriate, if the ethics committee agrees that the disputed treatment is appropriate, treatment must be continued pending transfer. After 10 days, the hospital is not required to continue the disputed treatment unless it is extended by a court, if there is a reasonable chance of affecting a transfer."

Habtegeris case draws conflict

Fine and Mayo say the goal of the Texas statute is to promote a process that is participatory and collaborative, rather than adversarial, within a context that recognizes that death cannot be postponed indefinitely and that eventually, withdrawal of life-sustaining treatment may be appropriate.

Two recent Texas cases have tested the TADA process. In the case of Sun Hudson, a baby born with a lethal dwarfism condition with no known

treatment or cure, he was placed on a ventilator while his doctors researched his diagnosis. Ultimately, his doctors recommended withdrawing life-sustaining measures, providing comfort treatment, and allowing the condition to take its natural course.

The child's mother, however, rejected that decision, demanded treatment to continue, and insisted that the child's father, the "sun god," would cure him.

Fine says the hospital ethics committee met with the mother, agreed to try to transfer the child, but was unable to arrange a transfer. She was notified of the decision of the ethics committee, the 10-day limit for continuing the life-sustaining treatment was set, and though the mother did win an additional 14-day extension (via a restraining order), the process was allowed to continue and the child was allowed to die.

In the case of Tirhas Habtegeris, the same process occurred; the 27-year-old woman was diagnosed in August 2005 with multiple masses caused by angiosarcoma and was treated with palliative chemotherapy to alleviate her symptoms. In November 2005, she was readmitted and placed on a ventilator. After an evaluation, her doctors recommended to her family that the ventilator be withdrawn and she be given comfort care only. At that point, the versions of Baylor health care providers and the family diverge; Baylor says she was unconscious due to disease and necessary pain measures, but her family describes her as awake and alert. The family refused the ethics committee's decision regarding withdrawing life-sustaining treatment on religious and cultural grounds, counseling attempts failed, and transfer was unsuccessful. After 10 days, the ventilator was removed and Habtegeris died within a matter of minutes.

Since her death, Habtegeris has become a hot-button example, both for those who say life-sustaining treatment is removed for the wrong reasons and for those who say her case is an example of a process that offers patients the best care at the end of life.

With legal responsibility, education needed

Asked if the state created skill sets or educational requirements for ethics committee members when it formalized the role of ethics committees, Fine says that was one area on which the task force couldn't reach consensus.

"Ethics committees vary from institution to institution, and when we developed the law, some

of us advocated that we define ethics committee membership and a skills set, but we couldn't agree on that, and it's still being discussed," says Fine.

He points out, however, that most of these "core cases" take place at large tertiary hospitals such as Baylor, which has 35 to 40 people on its ethics committee who span the institution and community, meet and study regularly, and receive ethics training.

"We encourage aggressive self-education programs for all members of our committees, and at every meeting we have an educational component," explains Mayo.

Mayo says that from 2001 to 2005, Texas hospitals experienced 592 formal statutory ethics consultations, and an equal number of non-formal consults. Of those 592, 490 were end-of-life cases, one-fourth were explicit futility cases, and of those 12 advanced to the point of the family receiving the 10-day notice of termination of medically inappropriate treatment. The rest, Mayo says, were resolved without dispute. ■

Patients deserve info on quality-of-care cases

Regulations prohibit sharing of details

Medicare recipients who have a complaint about their quality of care have a means of reporting their complaints — but it's unlikely they will find out the details of investigations of their complaints, according to the American Health Quality Association (AHQA), which has launched an effort to enact major reforms in the complaints system.

The Centers for Medicare and Medicaid Services (CMS) investigates complaints by Medicare beneficiaries about quality of care by contracting with quality improvement organizations (QIOs) in each state to actually conduct the investigations.

However, CMS prohibits QIOs from telling the complainants details of investigations involving physicians without permission from those physicians. Without permission, QIOs can only tell complainants whether their complaint was confirmed; they cannot reveal what went wrong or why.

AHQA, which represents the national network of QIOs, is proposing that QIOs inform beneficiaries of findings, launch a national campaign to promote more timely and direct patient feedback

to providers, and help providers correct confirmed problems reported by consumers.

AHQA: Tell beneficiaries what happens

According to CMS, QIOs have two methods of resolving clinical quality-of-care beneficiary complaints: medical record review and mediation.

When a case is reviewed for quality issues, one of two determinations is made — either "no substantial improvement opportunities are identified," or "care could have been better."

The Medicare patient is not given details uncovered by the QIO. In cases where it is deemed that care could have been better, the QIO reviewer determines if care was "grossly and flagrantly unacceptable," failed to follow accepted guidelines or usual practice, or could reasonably have been expected to be better. Again, while CMS permits complainants to be kept informed as to the progress of the sometimes months-long investigation, no specifics involving physicians are disclosed.

Cases for which no improvement opportunities are identified or where better care could have been expected can be considered for mediation if the person filing the complaint wants to pursue mediation. Due to the serious implications of cases in which care was grossly or flagrantly unacceptable, or where care failed to follow accepted guidelines or usual practice, those cases are not eligible for handling through mediation.

Medical record review is the traditional option to resolve a quality-of-care complaint under Medicare. When the QIO receives a written complaint about the quality of services received by a Medicare beneficiary, a doctor of matching specialty will review the medical record. When the review is complete, the QIO notifies the complainant of the final disposition of the complaint.

AHQA is proposing that the findings of QIO investigations of complaints be given to Medicare beneficiaries who file complaints, along with information about actions taken to prevent the problem from recurring. The proposal would make QIO findings in complaint investigations inadmissible as evidence in malpractice suits.

"This approach strikes a proper balance," says **David Schulke**, AHQA executive vice president. "It isn't just Medicare that must appreciate that consumer concerns are important indicators of quality breakdowns. Providers, too, must learn to actively welcome consumer concerns, and take timely action to improve care so there is no need

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to bring in the QIO.”

“The role of the Medicare QIO program should be to protect the entire population of Medicare beneficiaries, and to support improvement of America’s health care system,” says **Jonathan Sugarman, MD, AHQA** past president and the CEO of Qualis Health, a QIO in Seattle.

“Unfortunately, the current Medicare beneficiary complaint system as regulated by CMS has not been implemented in a manner that focuses on rapid resolution of disputes and systematic improvements in care, and has not kept up with our evolving understanding of quality improvement.”

For example, Sugarman points out, CMS does not regularly analyze and report the specific types of quality-of-care concerns that are identified by QIOs, depriving QIOs the opportunity to share data on the quality complaints confirmed nationwide.

“AHQA’s proposal encourages increased transparency to complainants, remediation of systems problems, and prompt referral to appropriate authorities when willful and reckless actions are identified, and it also supports prompt and candid communication between patients and practitioners when complaints arise,” Sugarman adds.

Policy part of modernizing QIOs

AHQA’s call to reform the beneficiary complaint program follows the association’s adoption in 2005 of a new policy to assure that all QIOs conform to the highest standards for business practices, governance, and public accountability. The new code of conduct — formally adopted by more than two-thirds of QIOs — sets standards for board and executive compensation, diversity, travel expenses, and conflicts of interest.

To implement AHQA’s proposals for reform of the beneficiary complaint process, Congress will

need to revise the law governing operation of the QIO program. Responding to beneficiary complaints is a small part of current QIO initiatives, which focus mainly on proactive efforts to improve care by providing technical assistance to hospitals, physicians, nursing homes, and home health agencies. Congress will examine how to modernize the QIO program after receiving a report on the program from the Institute of Medicine.

Details clear the air, may prevent lawsuits

Some efforts at reducing medical errors and contentious malpractice lawsuits hinge on getting information into the hands of those who believe they have suffered a breach in quality of care, not in withholding that information. The Sorry Works! Coalition has been successful in getting several states to pass legislation urging health care providers and hospitals to openly investigate allegations of medical errors, and to share their findings with complainants.

Theorizing that many lawsuits arise out of frustration over not receiving answers about what happened or assurances that measures are taken to prevent repeat occurrences, Sorry Works! and efforts like it work to educate health care providers that openly addressing errors — or allegations of error — can do more to ensure a good outcome than a room full of lawyers. Like the AHQA proposal, Sorry Works! plans contain protections for physicians and other providers so that the information shared cannot be used against them in malpractice actions. ■

Group wants ban on role of physician in executions

Anesthesiologists refuse to participate in execution

Spurred by the controversy that arose over a court order compelling physicians to participate in prisoner executions, the California Medical Association is sponsoring legislation seeking to eliminate any role of physicians in future executions.

The proposed legislation is in response to attempts to compel anesthesiologists to take an active role in the execution of San Quentin State Prison inmate Michael Morales in February 2006.

Stated simply, says California Medical Association Chief Executive **Jack Lewin, MD**, “Physicians should be treating people’s illnesses, not participating in their executions.

“Participating in an execution goes against longstanding principles of professional ethics and is a violation of the Hippocratic Oath: First, do no harm,” he says.

According to a 2002 study of state statutes and execution protocols, published in the *Ohio State Law Journal*, seven states require active participation in executions, such as making sure intravenous lines are in place or making sure the prisoner is dead. Four states simply require physicians to be present at executions.

In the Morales case, a federal judge ruled that to ensure Morales did not suffer undue pain during his execution, San Quentin officials could choose to either administer fatal levels of sedatives exclusively, or have an anesthesiologist present so that Morales was unconscious from a sedative before he received the standard mix of paralytic agents and heart-stopping chemicals.

Although two anesthesiologists hired by the state had agreed to participate by verifying that appropriate protocol was followed, they backed out before the execution could take place when they reportedly learned their role would include ensuring that the execution was painless by monitoring the patient’s unconsciousness while the fatal dose of paralytics was administered. The physicians decided that their participation would be “ethically unacceptable.”

Corrections officials chose to let Morales’ execution order expire for that date rather than administer a fatal dose of sedatives; Morales’ execution is scheduled for a later date.

The American Medical Association (AMA) Council on Ethical and Judicial Affairs released a statement following the ruling by the federal judge requiring physician participation in executions by lethal injection, saying the judge “has disregarded physicians’ ethical obligations.”

AMA ethics preclude participation

The AMA code of medical ethics addresses physician participation in executions involving lethal injection in ethical opinion 2.06, which states in part, “An individual’s opinion on capital punishment is the personal moral decision of the individual. 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 defines “participation” as either an action that would directly cause the death of the condemned; an action that would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; or an action that could automatically cause an execution to be carried out on a condemned prisoner.

That includes, according to the AMA, prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

In the case in which the method of execution is lethal injection, the AMA says the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.

Proposed bill takes no stand on executions

The California bill that would address physician participation in court-ordered executions does not take any stand on capital punishment itself, only the participation or presence of physicians at executions. The bill would change state law to state that the department of corrections “shall not utilize a physician and surgeon to assist with or otherwise participate in the execution.”

The American Society of Anesthesiologists recognizes the AMA’s ethical guidelines regarding

SOURCES

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- **American Medical Association**, code of ethics regarding capital punishment available on-line at www.ama-assn.org/ama/pub/category/8419.html.
- **Jack Lewin, MD**, chief executive, California Medical Association, 1201 J Street, Suite 200, Sacramento, CA 95814. Phone: (916) 444-5532.

physician participation in lethal injections, but does not take a position on capital punishment because it is not a medical practice, the society said in a statement released regarding the California case. ■

AMA: 21 states ‘in crisis’ from closing practices

Tennessee, Guam newest on list; Texas removed

John Ameen, one of only two practicing obstetrician/gynecologists in rural Monroe County, TN, is considering abandoning the obstetrics arm of his practice because the cost of medical liability insurance has become more than he can afford.

The Tennessee Medical Association (TMA) cites Ameen as a prime example of why the American Medical Association (AMA) has added Tennessee to its list of “in-crisis” states, where the high cost of patient care and medical liability insurance is driving doctors to close or move their practices, cutting patients’ access to medical care.

As of March 2006, the AMA listed 21 states as being in crisis.

From 1995 to 2005, Tennessee physicians have seen liability premium increases as high as 127% to 212%, according to AMA figures. The TMA says Ameen’s experience is, unfortunately, all too common. Ameen, in a letter to the association, says his insurance cost \$26,000 when he moved to the state in the 1990s, but had more than doubled — to \$59,000 — by 2005. He said he was forced to borrow money to make his quarterly premium at the end of the year.

While premium costs have increased, reimbursements from TennCare — the state’s health care program — have dwindled, and now average only 25% of billed charges.

Phyllis Miller, MD, president of the TMA, described the situation in that state as “a perfect storm” of financial factors that alone make practicing medicine in Tennessee difficult, but together make it impossible for more and more practitioners.

Miller says the costs are causing some physicians in her state to close their practices or relocate to other states, leaving fewer doctors for the patients left behind.

“Doctors have to pay their bills and pay their employees, just like everyone else, or they cannot keep their doors open,” says AMA President J.

Edward Hill, MD.

AMA data from 2004 show that of the state’s 95 counties, 81 have no residing neurosurgeon in patient care, 49 have no residing orthopedic surgeon in patient care, 47 counties have no residing emergency physician in patient care, and 42 have no residing obstetrician/gynecologist in patient care.

Doctors, lawyers differ on solutions

While physician groups support legislating caps on damages that juries may award, opponents of medical malpractice reform, including the national Trial Lawyer Association, say capping non-economic damages (so-called “pain and suffering” awards) would do nothing to reduce high insurance rates.

In a prepared statement, the American Bar Association (ABA) takes a stand against reform that would cap non-economic damages, saying, “Supporters of this approach . . . argue that placing caps on these awards will lead to reductions in doctors’ malpractice insurance premiums. The ABA strongly refutes any such contention because neither empirical data nor experience with tort reform efforts within the states in the past have shown any established link between limiting non-economic damages and affordability of malpractice insurance policies.”

For the fourth consecutive year, malpractice reform legislation is being considered by the Tennessee general assembly. The legislation’s main points seek a cap of \$250,000 on non-economic rewards, a sliding scale for attorney fees to ensure that more money goes to the injured patient, and requirements that each lawsuit contains an affidavit from a medical expert certifying a specific malpractice occurrence.

Sponsors say passage of such a bill will require supporters of the reforms to produce new, compelling data showing that the changes have worked elsewhere and could work in Tennessee.

In addition to Tennessee, the AMA’s in-crisis list includes Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, New Jersey, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Washington, West Virginia, and Wyoming.

The AMA points to medical liability reforms that include a reasonable limit on non-economic damages as proven ways to protect patients and preserve access to medical care. A medical liability crisis in Texas resulted in sweeping reforms enacted in 2003, and voters passed a constitu-

tional amendment to head off potential court challenges. Since then, the AMA reports, access to care has been increasing, claims are down, physician recruitment and retention are up, and new insurers are entering the increasingly competitive Texas medical liability market, creating more choices for physicians. As a consequence, last year the AMA removed Texas from the list of crisis states.

The AMA in March also added the territory of Guam to the medical liability crisis map as an area showing signs of trouble, with a limited number of physicians practicing some specialties, no physicians available in others, and the closest alternative about eight hours away in Hawaii. Guam has only one civilian hospital serving a largely rural population of 160,000. A number of physicians have left the territory, and local doctors cite the medical liability environment as the key challenge to attracting and retaining physicians to meet existing needs. ■

Supply of physicians will be adequate through 2020

Threat of too few doctors not real, study suggests

Bleak reports threatening that there will be too few doctors to manage the growing elderly population are wrong, according to researchers at Dartmouth Medical School's Center for the Evaluative Clinical Sciences (CECS). In a recently published study, they argue that if employed efficiently, the current supply of physicians and medical students will be adequate through 2020.

The Association of American Medical Colleges (AAMC) and others, warning that population and economic trends will necessitate a greater and greater supply of physicians, have called for expanded enrollments at medical schools. But **David Goodman**, MD, professor of community and family medicine and of pediatrics at Dartmouth Medical School, and his CECS colleagues assert that shifting the current work force to more efficient practice styles would avert the need to train additional physicians.

"Spending millions of dollars annually to expand our capacity to train physicians will not only create an oversupply, but will also divert health care dollars from care that has been shown to improve the health and well-being of patients," writes Goodman.

Instead of expanding the number of physicians

being trained, Goodman and his team write, efforts should be aimed at increasing the efficiency of medical practice and directing resources to care that has proved to be effective. They cite as an example the large interdisciplinary (or multispecialty) group practice, a structure that has been in place in many parts of the United States since early in the 20th century, as a model of both clinical excellence and efficiency.

One such practice, the Mayo Clinic in Rochester, MN, is widely viewed as one of the most outstanding providers of medical care in the United States, despite using fewer doctors and fewer resources in managing patients with chronic illnesses compared to other academic medical centers, they point out.

Using the Medicare claims database to examine the experience of chronically ill people who received most of their medical care at academic medical centers, the researchers calculated the physician work force inputs per patient during their last six months of life. Their analysis found that the full-time equivalent physician input per 1,000 chronically ill patients varied by a factor of five, from about six per 1,000 to almost 30 per 1,000.

For example, patients treated at the Mayo Clinic used fewer than nine physicians on average, among the lowest in the country, while patients treated at New York University Medical Center, another medical school-affiliated facility, used 28.3 physicians per 1,000 in the six months before death.

Goodman says the results seem to support the idea that "less is more, and that quality of care, rather than quantity, is the critical factor."

The research focuses on the management of severe chronic illness because it is the area where health care resources are most heavily used—about half of Medicare's budget goes to the care of chronically ill Americans. Additionally, the need for such management is expected to increase as the population ages and baby boomers acquire a growing number of ailments.

Prior studies by CECS have demonstrated that in some parts of the country, people with severe chronic illnesses receive more physician care in visits, hospitalizations, and procedures than people who live in areas with fewer physicians per capita. But contrary to popular belief, patients who have more doctor visits and treatments do not realize a benefit. Instead, Goodman points

CE/CME answers

13. D; 14. B; 15. A; 16. B.

out, evidence shows they may actually be harmed by unnecessary medical care. If all medical practices adopted the practice style and resource use of efficient providers, he continues, patient care would cost less and patients would be less subject to interventions that could do more harm than good.

The argument for expanding the physician workforce is based on a faulty assumption, according to the authors. Proponents reason that the practices of the highest-intensity medical centers where many more doctors and resources are used in providing medical services at the end of life, should be the standard for the country as a whole.

“Instead of financing further growth in our medical education system, resources might be better directed to reorganizing delivery systems that have already demonstrated that they can deliver good care at relatively low cost,” the authors write. The study appears in the March/April 2006 issue of *Health Affairs*.

AAMC: Problem is not unequal distribution

The AAMC, in a fact sheet distributed with its 2005 position advocating more medical school admissions, notes that while there are serious problems with the geographic distribution of physicians, their forecasts indicate a much bigger problem.

The AAMC asserts that what it foresees as an increasing shortage will only make the distribution inequities worse, especially in areas already underserved.

“We don't disagree that there are variations that we need to understand and that there are inefficiencies in the system,” says **Edward Salsberg**, AAMC associate vice president and director of the AAMC's

Center for Workforce Studies. “But that doesn't change our position that we'll face a shortage in physicians, and that even if we can improve efficiency, there's strong evidence that we need to increase U.S. medical schools' production.” ■

NEWS BRIEF

Controversial cadaver exhibit on display

A controversial exhibit featuring preserved, **A**posed human bodies will be shown by the Houston Museum of Natural Science and Baylor College of Medicine through September, despite some complaints that the display is exploitative. “Body Worlds 3: The Anatomical Exhibition of Real Human Bodies” features whole-body “plastinates” — bodies preserved with reactive resins, silicon rubber, and epoxy. The exhibit includes more than 200 authentic specimens, including organs and whole body specimens. Plastination was developed as a means of preserving bodies for medical study, but its developer responded to public interest in the process by creating the first in a series of public exhibitions. The sponsoring organizations say the exhibit allows viewers to see the complex interconnection of muscles, tendons, and blood vessels in the human body, and medical experts from the Baylor College of Medicine will provide consultation, docent training, and educational programming support in collaboration with the museum for the duration of the exhibit. Body Worlds creators say more than 6,500 donors, including 142 from the United States, have bequeathed their bodies to the Institute for Plastination in Heidelberg, Germany, for public and educational use. For more information, go to www.bodyworlds.com. ■

SOURCES

- **David Goodman**, MD, professor, community and family medicine and pediatrics, Dartmouth Medical School, Hanover, NH. E-mail: david.goodman@dartmouth.edu.

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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

13. Which of the following can impede a patient's decision-making capabilities?
A. dementia
B. misunderstanding of complex medical terms
C. medications
D. all of the above
14. A federal judge in California ruled that the department of corrections had only one option in the Michael Morales execution — to have anesthesiologists in attendance to ensure Morales was unconscious when he received the lethal injection.
A. True
B. False
15. Scrupulous adherence to the requirements of the Texas Advance Directives Act is necessary to trigger what statutory benefit to health care providers?
A. immunity from legal action
B. reduced liability insurance
C. retention of licensure
D. EMTALA compliance
16. Current law gives the Centers for Medicare and Medicaid Services the power to investigate complaints filed by Medicare patients, but not to take any action when the complaints are found to be true.
A. True
B. False

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