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## Schiavo's legacy: Has anything really changed one year later?

*Right of refusal unchanged; public interest in end of life increased*

Just over a year ago, Terri Schiavo was the center of worldwide attention in several different roles — severely brain-injured bulimic, daughter and wife trapped in a public family fight, fuel for debates over right to life vs. right to refuse, and subject of endless talk show discussion. To many, her case was the most important battle between the camps, one urging a "culture of life" and the other just as adamant that people should be allowed to choose how and when they will die.

Schiavo died March 31, 2005, but Schiavo as a cause is still alive. At the one-year anniversary of her death, politicians, legal experts, medical professionals, and ethicists are assessing what, if any, difference the fight over Terri Schiavo made in the landscape of patient autonomy, right to life, assessment of brain functioning, and the role of the government in personal medical decisions.

"The Schiavo case didn't change the law. It didn't change medicine. It didn't change bioethics." That's the conclusion reached by **George J. Annas**, JD, MPH, a professor in the Boston University (BU) schools of law, medicine, and public health. BU dedicated its annual health law conference — held exactly one year to the day after Schiavo's death — to looking back at the political, medical, ethical, and legal lessons learned from the case.

The biggest impact the Schiavo case had, Annas says, was political. Schiavo became an icon to groups that urge preservation of life whenever possible and to opposing organizations that warn of attacks on patient autonomy, a struggle that led Congress to cross a line that many Americans say was out of bounds.

### **Congressional intervention remains controversial**

Experts who spoke with *Medical Ethics Advisor* and others who addressed the BU conference largely concur that, whether or not they agree with Congress stepping in to force the case into federal court, intervention was perhaps the most controversial aspect of the Schiavo case.

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**Rep. Barney Frank** (D-MA) helped lead the opposition in the House to the emergency federal statute that moved the Schiavo case into federal court after state courts had repeatedly upheld Michael Schiavo's right to have his wife's artificial nutrition and hydration, which had kept her alive for 13 years after she fell into a persistent or permanent vegetative state (PVS), withdrawn.

Other members of Congress, led by Sen. **Bill Frist** (R-TN), a heart-lung surgeon, were determined to intervene to keep Schiavo alive until her condition could be re-evaluated; opponents fought unsuccessfully to block the emergency statute. But those in Congress who fought for the bill as well as those who opposed it soon realized

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they hadn't accurately gauged public opinion, Frank says now.

"In my entire career, I have never seen the political community so misjudge public opinion," says Frank. "The public's reaction was overwhelmingly, 'You guys did what?'"

Frist, who famously weighed in during debate over the bill with the opinion that Schiavo appeared "responsive" in a home video given to him by her family, told the *New York Times* in April that he now realizes the public does not want Congress involved in individual cases.

An ABC News poll conducted in March 2005 and again in March 2006 found that Democrats, Republicans, and independents were equally likely to say removing Schiavo's feeding tube was the right thing to do. Sixty-five percent of Republicans and the same percentage of Democrats said it was the right thing to do; 25% of Democrats said it was the wrong thing to do, and 29% of Republicans said it was wrong.

Frank says the "egregious" Schiavo statute and subsequent negative public reaction cause him to conclude that such an intervention won't happen again in Congress. But some political science scholars have suggested that given the influence and pressure brought to bear in some right-to-life and patient autonomy cases, the Schiavo case might not be the last time Capitol Hill intervenes in an individual case.

At the state level, however, new laws are going on the books that **Cynda Rushton**, DNSc, RN, FAAN, clinical nurse specialist in ethics at Johns Hopkins Children's Center in Baltimore, says are likely the result of the Schiavo case.

"I think an impact has been that we've seen a number of states attempting to enact conscientious objection legislation [permitting health care providers to refuse to deliver medical care that is in conflict with their own values]," says Rushton. "It's clearly linked to this case, this kind of conflict, situations that challenge individuals' core values and what they think is appropriate at the end of life."

## Right of refusal unchanged

Experts say the right of patients or their designated surrogates to refuse treatment was firmly established before Schiavo, and remains so despite the bitter court fight between Schiavo's husband — who was her legal surrogate — and her parents, who adamantly opposed the withdrawal of hydration and nutrition on religious grounds and personal beliefs.

While the Schiavo case was not the first time a family's dispute over withdrawing care from an incompetent patient has been taken to court, Schiavo drew more attention because of publicity generated by her parents and by organizations polarized over the issues of refusal of treatment and right to life.

"In the prior cases, the families were very private," says **Ronald Cranford**, MD, professor of neurology at the University of Minnesota Medical School and faculty associate of the Center for Bioethics at the university, a nationally recognized expert on PVS. Cranford examined Schiavo on behalf of the court as the case wound its way through Florida state courts. "The conflict is privacy for the family vs. educating people on the issues."

Ultimately, however, the Schiavo case was a simple one that just went badly for one family, and in doing so, drew the public into the argument. Cranford points out that before the Terri Schiavo case arose, patients and their surrogates could legally refuse care; that was not changed by any of the court challenges during Schiavo's life or by any legislation after her death.

BU professor **Wendy K. Mariner**, JD, LLM, MPH, concurs that laws giving patients the right to refuse lifesaving or life-sustaining treatments are unchanged; though she points out that the Schiavo case wasn't about whether patients can refuse, but about knowing what an incompetent or unconscious patient would want.

While the case might not have changed the rules for patient self-determination, Rushton says, it did change how people think about those rules and those decisions.

"I think one of the impacts is it sort of brings front and center the issues of private vs. public decision making. I think people felt a great deal of regret about the impact on the people who were involved — her family and her husband — and I also think we're left with the ambiguity that is always part of trying to make good decisions in individual cases," Rushton says.

She says one shortcoming Schiavo's case highlighted is the failure to consider the role of personal religious beliefs in the process.

"We see how important good facts are in [the decision-making process], but I think this shows us again that you can't argue faith with fact, and so we need to be thinking of models that engage both spirituality and intellect," she suggests. So while there may not be any legal or ethical difference between taking patients who can't breathe on their own off a ventilator and removing feed-

ing and hydration tubes from those who can't eat or swallow on their own, physicians need to be sensitive to the fact that the two actions are very different in the minds of some, whether for religious, cultural, or aesthetic reasons.

### **Polls gauge effects on public opinion**

The Schiavo case might not have changed the legalities of refusing or withdrawing treatment; but if anything, it strengthened public awareness of the issue and support for making clear one's preferences for receiving or withdrawing lifesaving or life-sustaining treatment, according to several polls conducted in recent months.

The Pew Research Center for the People and the Press conducted a poll in November 2005 to gauge attitudes about circumstances in which patients or their surrogates should be permitted to refuse treatment or request that all possible measures be taken to preserve and prolong life.

Of the 1,500 people interviewed in the Pew Center survey, 70% said there are circumstances in which patients should be allowed to die, and 22% said health care providers should always do everything possible to save patients' lives. Pew researchers say that compared to 1990 data, public attitudes on those issues are unchanged despite the Schiavo controversy.

Eighty-four percent of those surveyed said they approve of laws allowing terminally ill patients to decide whether to be kept alive through medical treatment, and 74% said that if a terminally ill patient is unable to communicate, his or her closest family member should decide whether to continue treatment. Fifteen percent said relatives should not be allowed to make such decisions.

While most people supported the idea of stopping medical treatment in some circumstances, fewer said they would opt to stop medical treatment if they themselves were the patients; 43% said that if faced with a condition in which there was no prospect of improvement and difficulty functioning they would still tell their doctors to do everything possible, while 42% said they would ask that treatment be halted.

When asked specifically about the Schiavo case, 72% of those polled said Congress should have stayed out of the case, and 17% said Congress did the right thing by moving the case into federal court.

The ABC News survey conducted in March 2006 found that American's views on the Schiavo case were unchanged from shortly before her

death; 64% of the 1,000 people surveyed said they support the decision to remove Schiavo's feeding tube; a poll conducted at the time the tube was removed in March 2005 showed that 63% of those surveyed agreed with the decision.

Another measurable effect of the Schiavo debate has been the jump in the number of people requesting information on living wills, durable power of attorney, and health care proxies. The U.S. Living Will Registry, which registers living wills for electronic access by doctors, family members, and surrogates, reports that visits to its web site increased from about 500 per day before the Schiavo case gained prominence to as many as 50,000 a day when the case was at peak public interest. (**See related story "Can surrogates really know patients' wishes?" on p. 53.**)

## **How to approach the EOL discussion**

Ethicists have speculated in print and in talks since Schiavo's death about how — and if — physicians can prevent family disagreements over ending or starting life-sustaining care in cases where there is no indication for recovery.

"Could an ethics consult have helped in Schiavo? Maybe not," says Cranford. "There were a lot of cultural differences, conflicts between the parents and spouse. But a consult early on might have helped."

While some clinical ethicists disagree, Cranford advocates involving non-medical intervention with clergy, social workers, or others whose input might be meaningful to the patient or surrogate if it would help work out disputes.

"I would urge [to the family] the use of aggressive palliative care, to ensure the patient's comfort even to the point of coma," he says. "That lets you get rid of treatment and equipment that doesn't do any good," resulting in a less stressful atmosphere for the family.

Rushton says physicians' and institutions' approach to end-of-life discussions with families is important to how the family accepts and processes the information they're given.

"[At Johns Hopkins] we changed our approach to end-of-life discussion several years ago, away from a 'do not resuscitate' model, which is the model of abandonment, to a model that emphasizes what we will do, rather than what we are taking away," she says.

Other suggestions for having end-of-life conversations with family members who are contemplating ceasing life-sustaining treatments include:

- Avoid using the word "futile" — to family members it can sound as if their loved one is not deemed worthy of effort. Likewise, the term "withdrawal of care" may be interpreted to mean the patient will be abandoned;

- Keep the conversation patient-focused, not centered on the family or the health care providers;

- Ask family members what their understanding of the patient's condition is before presenting clinical information, so that the conversation starts at that point;

- Demonstrate empathy for the family's grief, and avoid the appearance of rushing the patient or surrogate to a decision;

- Acknowledge conflicts, encourage discussions of the differences between hoped-for and likely outcomes;

- When the discussion is about stopping artificial nutrition and hydration, using the term "gastric tube" instead of "feeding tube" removes some of the social connotations of being "fed," and may make the response less emotional.

"I think the good that has come out of [the Schiavo case] is the increased awareness of end-of-life issues, but I think it still leaves some unan-

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- **The Pew Research Center for the People and the Press**, 1615 L Street, NW, Suite 700, Washington, DC 20036. Phone: (202) 419-4350. Survey report, "Strong Public Support for Right to Die: More Americans Discussing — and Planning — End-of-Life Treatment," Jan. 5, 2006, available on-line at [www.peoplepress.org/reports](http://www.peoplepress.org/reports).
- **ABC News**, "More Than Six in 10 Still Support Decision in Schiavo Case" poll, March 27, 2006, available on-line at [www.abcnetwork.com/Health/PollVault/story?id=1771492](http://www.abcnetwork.com/Health/PollVault/story?id=1771492).

swered questions as to how we as health care professionals can practice with integrity when we have very distinct personal values about the boundaries of end-of-life care," says Rushton. "How do we not abandon patients as we exercise our own values?" ■

## Can surrogates really know patients' wishes?

*Just more than half of surrogates get it right*

Making end-of-life decisions for incapacitated patients most often falls to surrogates chosen by the patients, or to next of kin. But a recent review of the literature indicates that surrogates are only slightly better than physicians at making decisions that the patient would make if he or she were able.

Terri Schiavo's dilemma — being the center of a struggle over end-of-life decisions between her husband, who Florida state courts recognized as her legal next of kin for decision-making purposes, and her parents — has prompted many Americans to sign living wills and talk to their next of kin about what end-of-life care they want or do not want.

But according to **David Wendler**, PhD, of the National Institutes of Health's Department of Clinical Bioethics, a review of studies that provide data on how accurately surrogates predict patients' treatment preferences indicates that while those discussions are certainly better than doing nothing, surrogates in the studies predicted patients' treatment preferences with 68% accuracy.

Surprisingly, they did even worse after discussing treatment preferences with the patient.

### **Surrogates get it right sometimes**

The analysis, conducted by Wendler and colleagues at the National Institutes of Health and Johns Hopkins University, examined 151 role-playing scenarios that were presented to 2,595 patient/surrogate pairs.<sup>1</sup> The "patients" in some cases were healthy subjects asked to assume they were incapacitated and others who were actual patients not at the end of life.

In the studies, the next of kin or surrogate decision makers were asked to decide whether the patients would want certain medical interventions, often ones that physicians deemed necessary to

keep the patients alive. The patients were asked, independently, what their preferences would be.

A sample hypothetical scenario was: "You recently suffered a major stroke, leaving you in a coma and unable to breathe without a machine. After a few months, the doctor determines that it is unlikely that you will come out of the coma. If your doctor had asked whether to try to revive you if your heart stopped beating in this situation, what would you have told the doctor to do?" Patients and surrogates were free to choose to accept or reject the proposed treatment.

Leaving the decision up to doctors resulted in a rate of 63% accuracy at predicting what the patient would want. Surrogates or next of kin fared only slightly better at 68%.

Of the 16 studies reviewed, 12 assessed the errors surrogates made when they misjudged patients' preferences. Three studies found that they erred by choosing interventions that the patients said they would not want. One study found that surrogates erred by withholding interventions the patients would want, and eight studies found no consistent trend in surrogates' miscalculations.

The studies showed only one percentage point difference in the accuracy of patient-chosen surrogates (69%) and legally assigned surrogates (68%).

"In general, we thought the way to explain people not being as accurate as you hope they are was that they are unwilling or reluctant [to make the decisions]; but we found you really can't say one way or the other," says Wendler.

### **Talking about preferences doesn't help**

It would be natural to assume that if patients and their surrogates talk about preferences beforehand, the surrogates' decision making would be more accurate.

Natural, maybe — but wrong, according to the two studies that examined whether discussion improved accuracy.

One study found no change in accuracy, while the other found a slight but statistically significant worsening of surrogates' accuracy after they talked with patients about their wishes.

"It was a little surprising that talking didn't change accuracy, and we don't really know why that is," says Wendler. "Our hypothesis is that the kinds of discussions you can have tend to be very general and not sufficiently rich to capture the complexity of real cases."

Wendler says patients should be encouraged to

think about what is important to them and what they envision happening in certain circumstances.

"A lot of time, it's not clear," he says. "If you like to talk, read, and walk, then would it be acceptable to you to be on a ventilator? Also, medical probabilities are involved [in real-life situations], and doctors can't tell you what those are for sure."

According to **Cynda Rushton**, DNSc, RN, FAAN, clinical nurse specialist in ethics at Johns Hopkins Children's Center in Baltimore, a positive benefit to emerge from the Schiavo case is that the number of people who are considering the importance of designating health care agents and preparing living wills has jumped dramatically.

"We are encouraging living wills and for patients to converse with their surrogates early and often," she says.

Rushton says a study conducted at Johns Hopkins, which examined the process of selecting and communicating with surrogates, found that while many had definite ideas they wanted surrogates to adhere closely to, others said they wanted family members to do what they thought was best under the circumstances.

Maryland is in the process of revamping its advance directives, to encourage people to indicate how they want their living wills interpreted — literally or by surrogates applying their best judgment at the time.

Wendler says surrogates were most accurate in making decisions in situations where the patient was in good health before becoming ill and the intervention was relatively sure to return him or her to good health.

"They're good at predicting in those situations, because that's easy," he says. "If you're a healthy 50 year old and you get pneumonia and you need to be on a respirator but will recover, everyone

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will say 'yes' to that.

"The ones that give you trouble are the [exercises] where you start radically changing their cognitive state. That's when the preferences aren't as clear and surrogates misestimate it. But also, people have doubts about what their own preferences would be in those circumstances, for example, if they have Alzheimer's.

"For me this suggests that we need more data on what people really care about," says Wendler. "Argument points to using next of kin [for end-of-life decisions], but if you find out that the next of kin is not that accurate, then you have to ask yourself what the impact is for using family members as surrogates, and whether the impact is positive or not. Legislating [next of kin as surrogates] is a reasonable way to go, but you never know. These are hard decisions to make, and it may be a burden."

## Reference

1. Shalowitz DI, Garrett-Mayer E, Wendler D. The accuracy of surrogate decision makers: A systematic review. *Arch Intern Med* 2006; 166:493-497. ■

## Investigation begins on allegations of euthanasia

*Did hospitals fail to follow evacuation plans?*

The criminal investigation of hospitals and health care providers in New Orleans has cast an unusual light on a group whose primary mission is to heal. The attorney general for Louisiana has described allegations that hospital workers, including at least one physician, euthanized patients trapped by floodwaters following Hurricane Katrina in August 2005 as "credible."

A spokeswoman for Attorney General Charles Foti told *Medical Ethics Advisor* in April that investigators are awaiting a state Supreme Court ruling on access to witnesses before announcing whether — or, more likely, what — founded allegations have been uncovered, and if charges may arise from what occurred in three hospitals and a handful of nursing homes in the four to six days following Hurricane Katrina.

Kris Wartelle, spokeswoman for Foti, acknowledges that a criminal investigation has been ongoing since September into allegations that

hospitals, doctors, and administrators may have played a role in the deaths of more than 200 patients at Tenet Healthcare Corp.'s Memorial Medical Center, at Lindy Boggs and Touro hospitals, and at five nursing homes in the New Orleans area.

Most of the allegations that have been disclosed in court records center around the actions of the Tenet hospital, Memorial, which included an independently owned long-term acute-care facility, LifeCare Hospital. The 317-bed Memorial hospital had 260 patients when the hurricane struck, with another 82 mostly frail patients in the LifeCare facility. At least 45 patients died at Memorial, Tenet said in prepared statements released in late 2005.

The allegations that staff at Memorial euthanized patients several days after the hurricane struck — after enduring days without electricity or clean water in temperatures in excess of 100 degrees Fahrenheit and with little or no medicine or operational equipment — began appearing within days after the hurricane hit.

No official details were disclosed by Foti's office, which announced a criminal investigation within weeks of the storm. But because of the actions of Tenet, the allegations against the Memorial Medical Center recently were unsealed in federal court. Allegations involving other hospitals and nursing homes had not been made public at presstime.

Foti's office issued more than 70 subpoenas to Tenet employees and officers in December, after Tenet issued a statement to its employees saying that they did not have to talk with investigators.

An announcement in the case was delayed in March and April by a petition filed in the state Supreme Court by the lawyer for one Memorial doctor, Anna Pou, asking that Pou's conversations with Tenet attorneys and other hospital officials in the days after the storm be protected under attorney-client privilege. If successful, it would mean investigators could not ask the lawyers what Pou told them about patient deaths at Memorial.

Pou is alleged to have been seen carrying several syringes. While witness descriptions in court records don't specify what was in the syringes or whether they saw Pou administer injections, Pou's attorney says in filings with the court that she is a suspect in allegations of patient euthanasia.

Hospital employees and Tenet have described the harrowing days after the storm — patients

dying of natural causes or due to lack of supplies, looters threatening the hospital campus, and hospital staff being torn between wanting to evacuate and being told to stay behind with patients.

### **Scrutiny on evacuation failure**

Wartelle says the investigation is focused not only on individuals and hospitals, but on whether the hospitals and nursing homes failed to follow evacuation plans, which might have saved more patients.

"We are looking at every death in every hospital and nursing home during and after Katrina," says Wartelle. "We're looking at specific allegations as to whether euthanasia occurred, whether the circumstances warranted it or not, because regardless, euthanasia is illegal in the state of Louisiana."

Throughout the investigation, she says, there has always been more than one "person of interest," and not all were doctors and nurses.

"As part of this whole umbrella of an investigation, we were charged with looking at everything," she explains. "The attorney general wanted to come up with a report to give to the governor, to the department of human services, and to elected officials, to talk specifically in terms of what should have been done in evacuation."

One outcome likely will be to close a loophole in state law that requires hospitals and nursing homes to have evacuation plans, but does not specifically require that they follow those plans.

"That's what we're looking at — they have to have a plan, but they don't have to follow it, and we want to see what they did to make sure patients got out of harm's way," says Wartelle. "We want to find out what went wrong in all regards, and how to make it better."

The only criminal charges filed as of early April relating to patient care or abandonment during and after the hurricane are those filed against the owners of St. Rita's Nursing Home in St. Bernard parish near New Orleans. Mable B. Mangano and Salvador A. Mangano, Sr., owners of the nursing home, were charged in September with 34 counts of negligent homicide for abandoning nursing home residents who later drowned in the flooding that followed the hurricane.

Tenet Healthcare, based in Dallas, issued a statement several months ago stating that it was not a target of the investigation by Foti's office. Wartelle says that after Foti issued the 73 subpoenas to Tenet employees, the hospital corporation cooperated with investigators. ■

# Rate of physician-assisted suicide in Oregon stable

*More ask for prescriptions than actually use them*

The number of Oregon residents who ended their lives in 2005 by employing the state's legal physician-assisted suicide law was twice the number that it was in 1998, the first year after the law was passed.

But the 2005 figure — 38 — is essentially unchanged from 2004, meaning that for four years in a row the number of lethal prescriptions taken under the state's Death with Dignity law has remained stable.

The Death with Dignity Act makes it legal for physicians to prescribe life-ending drug doses for terminally ill patients. The act, condemned by organizations opposed to physicians facilitating suicides, withstood its most serious challenge thus far when the U.S. Supreme Court ruled in January that the U.S. attorney general could not prosecute physicians who write the prescriptions under federal anti-drug abuse laws.

The challenge presented by the suit, *Gonzalez v. Oregon*, apparently did not influence the number of prescriptions written or the number used in 2005, state public health officials said when the figures were released. The U.S. Supreme Court's ruling did not address the legality of physician-assisted suicide, only whether doctors writing prescriptions under the law were violating federal anti-drug laws.

Every year since the law was passed, the number of patients who actually used the prescriptions to end their lives has been fewer than the number of prescriptions requested, a sign proponents of the act say that many patients merely want the option to end their lives to be available.

The numbers since 1998, according to the Oregon Department of Public Health, are:

- 1998: 16 suicides, 24 prescriptions written;
- 1999: 27 suicides, 33 prescriptions written;
- 2000: 27 suicides, 39 prescriptions written;
- 2001: 21 suicides, 44 prescriptions written;
- 2002: 38 suicides, 58 prescriptions written;
- 2003: 42 suicides, 67 prescriptions written;
- 2004: 37 suicides, 60 prescriptions written;
- 2005: 38 suicides, 64 prescriptions written.

According to state figures, the majority (84%) of physician-assisted suicides in 2005 involved cancer patients. The 64 total prescriptions were

written by 39 physicians. Most (89%) said their primary end-of-life concern was an inability to participate in activities important to them. ■

## Why do workers just say 'no' to flu shots?

*Looking at those who decline and sign*

Infection control professionals adopting policies requiring workers to sign declination statements if they forgo influenza vaccination can expect to run into a persistent group of "refuseniks" with varied reasons for their recalcitrance.

At least that's the experience reported at Wake Forest University School of Medicine in Winston-Salem, NC, where declination statements have been part of an aggressive flu immunization program for several years. But even as health care immunization rates soar to 70% and beyond — figures most hospitals would view with abject envy — there remains that troubling 25% or so who just say "no" on their declination statement.

"I would say for the most part it is basically the same group," says **Scott Spillmann**, MD, a medical epidemiologist at Wake Forest. "We are trying to peel back the layers of the onion. Fear of side effects is the most [common reason]. People are still worried about getting the flu, though we tell them you cannot get the flu [from the vaccine]. There are still a group of people who are just afraid of injections. They just don't want the needle, period. And if they can avoid a needle, they will. Some people are morally opposed. Others will give multiple reasons. The biggest thing that doesn't relate to medical [contraindication] is, they just don't want it."

That is the reality with a voluntary world, and adopting a mandatory policy is a "hot potato" that is a little too fraught with intrigue for the hospital administration's taste, he adds. Thus, the hospital continues to push a multifaceted flu immunization effort that requires workers to sign off on declination statements, an approach recently recommended by the Centers for Disease Control and Prevention (CDC).

The Wake Forest declination statement says directly that, "I realize I am eligible for the flu shot and that my refusal of it may put patients, visitors, and family with whom I have contact at risk should I contract the flu."

"For those who just don't want the vaccine we

ask them to basically state that 'I know I may be putting myself and others at risk,'" Spillmann says.

Declination statements are only part of an aggressive program that ignores no sector of the work force. For example, a flu vaccination campaign targeted at new employees is currently yielding an immunization rate of 83%, he notes.

"There are challenges and opportunities, [but at least] epidemiologists still have job security," Spillmann jokes. "It takes inside, outside, top, bottom, everywhere, everybody throughout the organization to make this happen. We have been able to make it a part of our culture. Our very top leaders are very supportive."

In describing his program recently in Atlanta at the CDC's National Immunization Conference, Spillmann shared an anecdote about flu vaccine decisions and patient consequences.

"In the children's unit a few years ago, the [health care workers] said basically in a block vote that, 'We are not getting the vaccine,'" he says. "Then they had cases where their patients contracted influenza. The next year, they all got [vaccinated]. So it was a learning experience. They saw what the results were based on their actions. Fortunately, the children survived, but it was still unnerving." ■

## Sexual misconduct requires firm stance

*Patients may misinterpret touching, comments*

Sexual misconduct or harassment of patients in health care can be a major liability risk and probably happens more than you think, say a risk manager and attorney who are experienced in dealing with such issues. Concerns often go unreported until a lawsuit is filed, they say, and many health care workers don't realize how their seemingly innocuous actions can be perceived as misconduct by patients.

**Deborah S. Stephens, RN, BSN, JD, CPHRM**, risk manager at Spectrum Health in Grand Rapids, MI, and **Bridget Tucker Gonder, RN, BSN, JD, CPHRM**, associate legal counsel for the health system, say health care workers can get into trouble when they forget that patients are not as familiar with medical procedures as they are and are not used to being touched intimately as a routine matter.

"They're accustomed to doing procedures, even intimate procedures, and not even thinking twice about it," Gonder says. "To the clinician, it's nothing at all, but the patient is wondering why he's lifting her gown up."

For instance, Gonder describes a scenario that happened at Spectrum, in which a male electrocardiogram (EKG) technician entered an emergency department treatment room to perform an EKG on a woman. The man pulled down the sheet covering the woman, opened her gown, and started putting leads on her chest. The woman later complained that she felt sexually violated.

"It was probably the 50th time he had done that, that day. He just saw it as another patient and he was going through his routine," she says. "The patient had never been through this and was very much upset that a man just walked in and bared her breasts and started touching her."

### **Real risk for health care employers**

Stephens and Gonder estimate that they have handled about 20 allegations of sexual misconduct or harassment of patients over the past 10 years, and they sense that the frequency is on the increase. While they cannot discuss individual cases at Spectrum, they note that there is significant potential employer liability from sexual misconduct.

The employer can be accused of negligence, malpractice, breach of fiduciary duty, infliction of emotional distress, assault, negligent hiring or retention, battery, and negligent supervision. And, of course, there is the risk of negative publicity if sexual misconduct is reported at your facility.

Gonder cautions risk managers not to assume that current policies and procedures are sufficient to address sexual misconduct and sexual harassment. Most health care organizations have a policy on sexual harassment, but few have policies that specifically address sexual misconduct involving caregivers and patients.

A policy on sexual misconduct should ensure a consistent approach to handling allegations that protects the patient and the accused employee, Stephens says. Much of Spectrum's policy addresses the manner of notification, how people will be interviewed, and it stresses the importance of allowing the employees to adequately defend themselves.

While many allegations are grounded in misunderstanding or carelessness by the caregiver, there are instances of true sexual misconduct in health care settings, Stephen and Gonder stress.

Risk managers must be on the alert for sexual predators and those professionals who let their own emotional needs and problems lead them into serious misbehavior.

"There is no doubt that people take advantage of the situation to prey on patients," Stephens says. "There are some who do it because they have their own problems, such as addictions, and there are some who are just predators and see an opportunity."

It also is important to know that sexual misconduct — both actual misconduct and cases of misunderstanding — is not strictly male or female, Gonder says. "We've had elderly males wake up and say they were sexually assaulted by a female nurse, and the investigation revealed that she was inserting a Foley catheter. We had another where the nurse was checking a groin dressing and she pulled up his gown and said, 'Things are looking good down there!'" she recalls. "That was misperceived by both him and his wife — maybe more so by his wife." ■

## Ethicists discuss ties between HCWs, pharma

*Professionals can become biased, distracted*

Conflicts of interest created when health care professionals form ties with the pharmaceutical industry are a mixed bag, according to experts from the Veterans Health Administration's (VHA) National Center for Ethics in Health Care.

On one hand, physicians who accept compensation from pharmaceutical companies might be unduly biased toward those companies; they might not be influenced, but because their patients and peers know of the relationships, their reputations might be adversely affected.

On the other hand, consulting or serving as a speakers' bureau member for a pharma company can allow health care professionals to bring new insight and breadth to their work, benefiting their patients and their institutions, according to **Michael Cantor**, MD, JD, chair of the National Ethics Committee (NEC) and clinical director of the geriatric research, education, and clinical center at the VA Boston Health Care System. (The NEC is responsible for analyzing and reporting on health care ethics topics that relate to the VHA.)

Cantor was one expert who participated in a

teleconference on the National Ethics Committee report "Compensation to Health Care Professionals from the Pharmaceutical Industry," an examination of the ethical implications of gifts to individual health care professionals from pharmaceutical companies, and how institutions and physicians should address those concerns.

The NEC report examines relationships between health care professionals and the pharma industry in which the medical professionals are compensated for services, such as consulting and speaking, and how those relationships might compromise objectivity, integrity, and patient and peer relationships.

However, says **Ken Berkowitz**, MD, FCCP, chief of the ethics consultation service at the VHA's Center for Ethics in Health Care, conflicts posed by relationships between the pharmaceutical industry and health care professionals "is not a problem that is unique to VA."

"If I remember the data correctly, I think either two-thirds or three-fourths of all CME [continuing medical education] in the country is pharmaceutical-sponsored, which is a staggering statistic when you think about what we really want from our education," Berkowitz said in the Feb. 28 teleconference. (A transcript of the conference is available at [www1.va.gov/vhaethics/download/Transcripts/NET2-28-06.doc](http://www1.va.gov/vhaethics/download/Transcripts/NET2-28-06.doc).)

Of concern are not just arrangements that yield large amounts of money or other valuable compensation for the professional; the report indicates that objectivity and judgment are affected no matter how much — or little — money is involved.

Cantor says the ethical problems reach beyond loss of objectivity. Diverting more time to secondary, pharma-sponsored activities can alter the professional's priorities and loyalties, he suggests.

The NEC report does not address compensation relating to research or clinical trials; those areas are the subject of a report being prepared by VHA researchers for future release.

The NEC report is available at [www1.va.gov/vhaethics/download/reports/Compensation\\_2006.pdf](http://www1.va.gov/vhaethics/download/reports/Compensation_2006.pdf).

For more information on the VHA National Center for Ethics in Health Care, e-mail [vhaethics@hq.med.va.gov](mailto:vhaethics@hq.med.va.gov). ■

### CE/CME answers

17. D; 18. A; 19. B; 20. B.

# NEWS BRIEFS

## Association addresses spirituality, medicine

With a growing body of research examining how spirituality and religion may affect health, the *Southern Medical Journal* becomes one of the first major medical association journals in the United States to dedicate regular coverage to the subject. The Southern Medical Association's Spirituality/Medicine Interface Project will provide its members guidance in addressing the importance and effects of spirituality to their patients through regular quarterly journal articles, web-based seminars, and conferences.

Edward J. Waldron, executive vice president of the Southern Medical Association, says the addition of quarterly coverage of spiritual issues to the 100-year-old association's journal will address a need for physicians to understand "how faith and religion may modulate their patients' responses to disease." For more information about the Southern Medical Association's Spirituality/Medicine Interface Project, go to [www.sma.org/spirituality](http://www.sma.org/spirituality). ■

## Ontario transplant act triples organ donations

Legislation enacted by the Ontario government in January 2006 requiring hospitals to report every death to the government-established Trillium Gift of Life organ donation network (TGLN) resulted in the donation rate in the province tripling in the law's first 10 weeks, the network reports.

The new section of the TGLN act requires "routine notification and request" (RNR) by the province's 13 type A hospitals for every death at the hospitals. TGLN says RNR ensures that accurate identification can be made of potential organ donors quickly, and their families can be given the opportunity for donation.

The new law is not without opposition, however. Some opponents to the act argue that the government is exerting undue pressure on Ontario residents to agree to organ donation, particularly in cases in which there is disagreement over the definition of brain death. ■

## Patients recount 'ideal' physician behaviors

Patients at the Scottsdale, AZ, and Rochester, NY, Mayo Clinics have helped researchers identify seven behaviors that make up "ideal" physicians, and what the study team learned is that medical students need work in the area of interpersonal relationships — also known as bedside manner.

The 192 patients surveyed detailed their best and worst experiences with Mayo physicians, and from these anecdotes, researchers found these to be the behaviors that describe an ideal physician:

- confident;
- empathetic;
- humane;
- personal;
- forthright;
- respectful; and
- thorough.

Of the seven traits, "thorough" was the one named most often. The authors of the study, published in *Mayo Clinic Proceedings* in March ([www.mayoclinicproceedings.com/abstract.asp?id=1675](http://www.mayoclinicproceedings.com/abstract.asp?id=1675)), say patients can sense if their physician is rushed or not giving them his or her full attention. Study authors say their findings suggest new doctors receive training in interpersonal skills. ■

### COMING IN FUTURE MONTHS

■ Polyheme: Ethics of emergency trials

■ Pandemic policies: Can they work?

■ Benefits of third-party prayer

■ Does 'Medicare for All' equal more access to care?

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## 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

17. Following the death of Terri Schiavo, polls indicate that a majority of Americans disapproved of Congress intervening to send the case to federal court, with opinions:

- A. divided along political party lines
- B. reflective of religious affiliation
- C. differing based on age and other demographics
- D. apparently unaffected by political affiliation, religion, or demographics

18. Wendler, et al, found that which of the following is most likely to be the reason surrogates did a worse job of predicting patient wishes after discussing preferences with the patient?

- A. Discussions are typically general and not as detailed as the actual event would be.
- B. Surrogates put their own values ahead of what the patient wanted.
- C. Patients were reluctant to talk about end-of-life decisions.
- D. Physician input clouded the discussion.

19. According to the Louisiana attorney general's office, if it is determined that patients were euthanized in New Orleans hospitals by hospital staff following Hurricane Katrina, the circumstances under which the euthanasia occurred would make a difference in whether charges are filed.

- A. True
- B. False

20. In conducting end-of-life discussions with family members, patients, and/or their surrogates, ethics consultants generally agree that it is useful to use the word "futile" to reassure family members that no more can be done for their loved one.

- A. True
- B. False

## On-line bonus book for MEA subscribers

Readers of *Medical Ethics Advisor* who recently have subscribed or renewed their previous subscriptions have a free gift waiting — *The 2006 Healthcare Salary Survey & Career Guide*.

The report examines salary trends and other compensation in the hospital, outpatient, and home health industries.

For access to your free 2006 on-line bonus report, visit [www.ahcpub.com](http://www.ahcpub.com). ■