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IN THIS ISSUE

- Heart attack after two-hour wait termed 'homicide' . . . cover
- PVS patients as medical research subjects 135
- Change in wording adds to debate over Oregon's 'Death with Dignity' act 136
- Hospitals saying 'it's time to quit' smoking 138
- Issues with pulling supplemental oxygen 140
- NIH scientists quitting over conflict of interest rules . . . 141
- Medical societies weigh in on case of LA doctor 141
- Nurse presence growing on ethics committees 142

Also included:
2006 Index of Stories
CE evaluation

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Death in the ED: Heart attack after two-hour wait termed 'homicide'

Fingers point at hospital, staff, and overtaxed emergency system

The death of a 49-year-old woman from a heart attack after waiting two hours to be seen in the emergency room of a Waukegan, IL, hospital has been ruled a homicide following a grand jury inquest. The grand jury's finding in September against Vista Medical Center East is believed to be the first of its kind, and state prosecutors were still weighing the evidence and their options in late October.

The July 28 death of **Beatrice Vance** is viewed as a wakeup call on a number of fronts:

Was there a violation of the Emergency Medical Treatment and Active Labor Act (EMTALA), brought on by inadequate triage and/or failure to reassess her condition during such a lengthy wait?

Was there discrimination based on race? (Vance was black.)

Does blame lie with the triage nurse, emergency department physicians, hospital protocol, or, as many medical bloggers have suggested, an overtaxed emergency medicine system?

The hospital is not commenting on the case, and the state attorney's office was still mulling the complexities of the grand jury inquest decision at presstime.

"We are looking into it, trying to determine what happened and what the facts are, and we'll review that before deciding how to proceed," says **Daniel Shanes**, a Lake County state's attorney's office prosecutor.

The inquest results also go to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Illinois Department of Public Health.

Under Illinois law, a coroner's inquest is a legal public inquiry into the manner of death. The coroner and six jurors sit in a quasi-judicial fashion, and medical, investigative, and legal evidence is presented to determine the manner and circumstances surrounding a death, including foul play, hazardous conditions, or death due to an unknown cause. An inquest is not a criminal or civil court proceeding, but an investigative and recommendation process.

Lake County Deputy Coroner **Robert Barrett** stated that his find-

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ing, following investigation of Vance's death, was that she died of a heart attack caused by a blocked artery, but that "delayed and inadequate treatment" contributed to her death.

Illinois does not have a statute recognizing negligent homicide as a criminal offense, says Shanes. Reckless homicide is an offense reserved only for deaths caused by motor vehicle accidents. The choices as to cause of death considered by the jurors were homicide, suicide, accidental death, and death due to undetermined causes.

In reaching its decision, the jury ruled that Vance's death, while directly attributed to a heart attack, was also the result of "gross deviations from the standard of care that a reasonable person would have exercised in this situation."

According to the coroner's investigation, Vance

had waited almost two hours for a doctor to see her after complaining of classic heart attack symptoms — chest pains, nausea, and shortness of breath. The coroner found that the hospital follows two protocols for patients suspected of having heart attacks, from the American Heart Association and the American College of Cardiology, and that Vance's symptoms clearly fell into both.

The inquest jury also heard evidence of protocols, including recommendations that patients apparently suffering from a heart attack should be put on cardiac monitoring immediately and have an electrocardiogram done within 10 minutes of arrival at the hospital, neither of which was done in Vance's case, the coroner reported.

Shanes said the coroner's report states that Vance arrived at the emergency room at 10:15 p.m. July 28 and was seen by a triage nurse at 10:28 p.m., who classified her condition as semi-emergent. Her daughter, a licensed practical nurse, was with her, and tried at least twice to have her mother seen by a physician; at 12:25 a.m., two hours after triage, an emergency room nurse called for Vance to be seen, but got no response. Vance was unconscious and pulseless, and efforts to resuscitate her failed.

The Illinois State Medical Society in October had no official comment on the Vance case other than their director of media relations, **Laurie Peacock**, reaffirming the belief that "patients deserve the care they need."

"We'll be monitoring the situation surrounding Beatrice Vance's death," Peacock added.

ACEP: Learning opportunity

The American College of Emergency Physicians (ACEP) says the case elicits questions about what emergency patients should do if their condition worsens while they are in the waiting room.

"First, my heart also goes out to the family of Beatrice Vance," says ACEP President **Rick Blum**, MD, FACEP. "Emergency physicians and nurses are dedicated to saving lives, and we treat more than 110 million patients each year."

Though Blum refrained from speculating about the facts surrounding Vance's death, he said emergency physicians "have been sounding an alarm for years about the growing crisis in our nation's emergency departments."

"We issued a national report card on the state of emergency medicine earlier this year [*The National Report Card on the State of Emergency Medicine*, available at www.acep.org, click on

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National Report Card], and the Institute of Medicine released three major reports in June about the fragmentation and lack of capacity to deal with day-to-day emergencies, let alone an act of terrorism," he said.

Blum points out that while patients with chest pains, stroke symptoms, or other life-threatening emergency go to the front of the line in an emergency department's triage process, sometimes patients come in with mild symptoms that worsen during their wait and should not hesitate to seek help from a nurse. However, Vance's daughter told investigators she tried repeatedly to alert nurses about her mother's worsening condition.

Blum also commented on a concern voiced by health care providers concerned with the ripple effect the homicide finding might have.

"[E]mergency physicians and nurses go into emergency medicine to save lives," he says. "To criminalize their efforts would be a terrible mistake and have a severe chilling effect on people going into the medical field." ■

Should PVS patients be medical research subjects?

Defining what death means

Discussion about the merits and drawbacks of using patients in a persistent vegetative state (PVS) as subjects for experiments in xenotransplantation gathered some notice in ethics circles when the commentaries appeared in October, but

according to one ethicist, that aspect of PVS research is unlikely to see serious debate until more is known about the neurologic state.

A discussion in a recent ethics journal centers on whether PVS patients should, with prior consent, be enlisted as research subjects for animal-to-human solid organ transplants and other studies, as well as whether there should be provisions for people to declare when they want to be considered "dead" — suggesting that some might choose that their bodies be declared legally dead if they are diagnosed permanently vegetative, and for their "breathing cadavers" to be used for medical research.

Such suggestions are deemed unpalatable by most in medicine and society, as even one strong proponent states.

"Firstly, it may be put forward that the general public will not welcome such a shift in policy," wrote Belgian researcher An Ravelingien, in a 2004 article.¹ Among Ravelingien's more controversial arguments is that PVS patients could be considered already dead, and if so, should not be referred to as "patients" so as not to overly humanize them.

"If permitting willed body donation in case of PVS implies that we go against some of the most fundamental convictions on life and death matters held by relatives, physicians, and the general public, our suggestion could cause public distrust and outrage," writes Ravelingien.

Consent to the unforeseeable?

But **Steven Curry**, PhD, a University of Melbourne (Australia) philosopher, writes in the October issue of the *Journal of Medical Ethics* that suggestions such as Ravelingien's — to declare PVS patients as dead — won't work because public opinion would not allow it.²

That is not to say that people who want their bodies to be used for research, if they themselves enter a permanent vegetative state, should not be allowed to, Curry suggests.

"Those who are in a PVS will not ever wake up; they feel no pain or discomfort and have no continuing interest in their own survival... these patients must also have a right to risk that life for the common good," Curry writes.

Among the benefits to using PVS patients for long-term study of transplants is that, unlike so-called "brain dead" patients, who can only survive a finite period on life support, PVS patients often live many years.

"On the one hand, there are powerful ethical and

medical reasons for proceeding with research into the transplantation of non-human organs into human patients; whereas on the other, there are equally powerful ethical reasons for blocking whole organ transplant experiments," according to Curry.

But **Kathy Kinlaw**, MDiv, acting director of the Emory University Center for Ethics in Atlanta, says that such debate is premature, because there is still much that is not known about PVS — including whether it is a *permanent* vegetative state or a *persistent* vegetative state. "Persistent," some experts say, suggests that the state is long-lasting, but perhaps not permanent.

"There is good reason to talk about [PVS patients' role in medical research], but I wouldn't want it to move too quickly forward," says Kinlaw. "There is so much discussion on PVS and whether we have an accurate way of diagnosing it, whether there is potential for reversal, and when it truly becomes permanent, then it raises a lot of other questions."

Before debate over introducing PVS patients into research on other diseases, Kinlaw suggests, comes discussion on how PVS patients might teach medicine about PVS.

There are similar discussions in the end-of-life arena, Kinlaw says, regarding patients who are near death, unable to donate their organs and tissues for transplant, but who want to somehow contribute to ongoing medical research.

"In those cases, like with PVS, there has to be much discussion around how we make sure the patients are very carefully protected," she explains. "The ideal would be an adequate method to inform and somehow get consent to the process."

Agreeably, the informed consent aspect is a major obstacle among those who advocate research involving PVS patients, because a healthy adult is unable to know whether he or she would be in that state eventually, and if so, what procedures or studies might be involved.

The consent for research issue is one factor in Ravelingien's advocacy that the process not be for people to consent to being research subjects if they enter a vegetative state, but to determine when they can be declared dead and their bodies donated to research not requiring a living subject's consent.

"The concept of prior consent from a patient in PVS is fairly problematic," says Kinlaw. "So we would be moving toward surrogate consent. There are large concerns about that that I would have, about its appropriateness."

SOURCE

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A family member acting as surrogate for a patient in PVS would likely be very troubled by a decision to permit research on a body that is still alive, even if the surrogate knew the patient would be interested in contributing to research in some way, Kinlaw suggests.

"What happens for the relationship between the PVS patient and their family if the nature of the research is somewhat invasive, or it requires that the patient be removed [from where the family can visit or see the patient] for periods of time or permanently?" asks Kinlaw. "That is not dissimilar to when a patient is near death, and the patient were removed physically from the site. There's a real question of how that interrupts the patient-family relationship."

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2. Curry S. Living patients in a permanent vegetative state as legitimate research subjects. *J Med Ethics* 2006; 32:606-607. ■

Debate over change to 'Death with Dignity' act

Physician-assisted suicide now physician-assisted death

What's in a word? Lots, when the issue is physician-assisted suicide, or — as it's now known in Oregon, physician-assisted death.

The state with the landmark statute allowing dying patients to ask their physicians for medication they can choose to take to end their lives has changed the term for the act from "suicide" to "death" in its official references to people using the act, which state health and human services officials say makes it more consistent with the law.

Denver-based Compassion & Choices, an

advocacy group supportive of the act and the terminology change, further reported on its web site that the references to physician involvement will be removed wherever possible, with the Oregon Department of Public Health retiring the term entirely and instead referring to “persons who use the Oregon Death with Dignity Act.”

Advocates of the law argued that terminally ill patients who choose to end their lives are not the same as people who choose suicide under other conditions. The term “physician-assisted death” will now be used in reports and on the state’s web sites.

The Death with Dignity Act (DWDA), passed in 1994 and signed into law four years later, specifically states that its provisions do not “constitute suicide, assisted suicide, mercy killing or homicide,” but deaths that took place under the provisions of the act have been both commonly and officially referred to as physician-assisted suicide, or PAS.

New term: Accurate or deceptive?

Compassion & Choices hailed the terminology change, even as Oregon Right to Life’s director described the change as a “euphemism” to make the idea easier to accept.

“Eliminating the emotionally laden and inaccurate word ‘suicide’ from state references to the DWDA is a major leap forward in clarifying the public’s perception of the distinction between suicide and a terminally ill patient’s choice for a peaceful and dignified death,” Compassion & Choices stated in prepared comments released in October.

Then again, says Euthanasia Prevention Coalition spokesman **Alex Schadenberg**, “In other words, assisted suicide ceases to be assisted suicide if you stop calling it assisted suicide? What’s next?”

SOURCE

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- **Physicians for Compassionate Care Educational Foundation**, P.O. Box 6042, Portland, OR 97228. Phone: (503) 533-8154. Web site: www.pccef.org.

There is no state Death with Dignity “program” in Oregon. Patients and physicians do not register or otherwise notify the state prior to implementing the act. The decision to request a prescription for lethal doses of medication is left up to patients (provided they are competent) and physicians. The state Department of Human Services collects information about patients who participate each year, and issues those data in an annual report.

In 2005, 39 physicians wrote a total of 64 prescriptions for lethal doses of medication, the department reports. Thirty-two of the 2005 prescription recipients died after ingesting the medication; of the 32 recipients who did not ingest the prescribed medication in 2005, 15 died from their illnesses, and 17 were still alive as of the end of that data year.

Charles J. Bentz, MD, FACP, president of the Portland, OR-based Physicians for Compassionate Care Education Foundation (PCCEF), suggests the Oregon Department of Public Health was “bullied” by proponents of the Death with Dignity Act into changing references to “suicide” to “death.”

“Rather than using the phrase ‘physician-assisted suicide’ to describe this practice, the state agency will now use the vague and misleading language favored by one side in our statewide debate on assisted suicide,” Bentz states.

PCCEF states that it opposes PAS on the grounds that it undermines trust between physicians and patients, changes the physician’s role “from the traditional role of healer to that of the executioner,” and devalues the lives of vulnerable and dying patients.

Kenneth Stevens, MD, vice president of PCCEF, says using the term “physician-assisted suicide” accurately describes this choice of death.

“Physician-assisted suicide is the standard phrase for describing the act of writing a prescription for a patient with the intent that the patient will take that medicine for the sole purpose of causing their death,” he says. “It is the standard phrase in the medical, legal, and scientific literature.”

A 2005 survey of 1,000 physicians revealed that a clear majority (57%) believe it is ethical to assist an individual who has made a rational choice to die due to unbearable suffering, while 39% believe it is unethical, according to New Jersey pollster HCD Research and the Louis Finkelstein Institute for Social and Religious Research. The survey report is available at www.jtsa.edu/research/finkelstein/surveys/pas.shtml.

To read Oregon’s Death with Dignity Act in full, go to www.oregon.gov/DHS/ph/pas/index.shtml. ■

Hospitals telling smokers that 'it's time to quit'

Smoke-free hospitalizations

Patients hospitalized at University of Rochester (NY) Medical Center might not be able to kick the habit during their hospitalization, but staff will no longer be aiding their addiction.

The hospital recently joined many others in becoming an entirely smoke-free campus, so that medical staff "can get out of the mode of helping people to the front door so they can have a smoke," says **Robert J. Panzer**, MD, FACP, chief quality officer for the medical center.

Hospitalized patients who are smokers present a number of practical challenges, from merely being ill tempered and nervous to unhooking themselves from monitors and making their way outside to smoke, heedless of their recovery and the smoke-free campus the hospital might have created.

Do most cardiac patients who smoke know, deep down, that they should quit? Do their doctors and nurses urge them to stop smoking, and does the hospital make it abundantly clear that smoking is not permitted in the building and, in more and more cases, anywhere on hospital property?

The answer to all those questions is, of course, "yes," but while a health crisis and hospital stay might be a wake-up call to some smokers, many others are not able to make the break. Coming down hard on the patient in that situation, a patient educator says, is unlikely to accomplish anything.

So what can health care providers do to prevent their patients from smoking while in the hospital? According to some smoking cessation educators, the answer sometimes is nothing.

"Patients are not allowed to smoke in our hospital," points out **Rafael Maldonado**, health educator for University Hospital in San Antonio. "But they do."

That's the reality, Maldonado says — even though they know they should not smoke, and everyone around them and treating them tells them to stop, the simple fact of being hospitalized does not mean the end of smoking for some patients.

In those cases, Maldonado says, the most ethical approach is the connection with the patient at

the point where he or she is on the "change scale," the spectrum that ranges from complete unwillingness to change all the way to absolute readiness and motivation to change.

"I strongly believe it's far more important to just say, 'If you're ready to quit, I can coach you through it,' as opposed to saying, 'You have to quit' and trying to kind of slap them on the hand," he explains.

Health crisis might not be enough to quit

For many patients, particularly cardiac or cancer patients, hospitalization is a wakeup call, alerting them to the need to make serious lifestyle changes. Those patients, Maldonado says, are ready to begin the process of quitting. For others, the lifelong habit might be shaken by a health crisis, but not enough to prepare them to quit.

"We have a few patients who, even if they are on monitors, and even though we do not have any smoking areas on the hospital grounds, will unhook themselves from the monitors, and go outside to the farthest point they can — which might be 3 feet from the door — and they will smoke," Maldonado says. "They have been smoking so many years, and now they're confronted with physicians telling them they can't smoke. They're going through withdrawals, and on top of everything else they're coping with [during their hospitalization], they can't cope with the withdrawal."

Hospitals across the United States address smoking with their patients, typically at admission. In some cases, there is continued contact with patient educators throughout the stay; in others, the patient receives printed materials and initiating contact with smoking cessation advisors is left to the patient.

Panzer says University of Rochester Medical Center chose the date of the Great American Smokeout to implement its campus-wide no smoking policy.

"We are not going to permit patients to smoke while they're inpatients, period," he says. "We can't control what they do when they leave, but we're not going to give them leave to go out there [and smoke] while they are inpatients."

University Hospital-San Antonio is trying a new initiative, funded by a Robert Wood Johnson Foundation grant. Maldonado and other educators in the four-hospital system are trying to identify as many smokers as possible, and maintain

direct contact with them throughout their hospitalization.

The health educators rely heavily on the medical and nursing staff — particularly nurses — to work with each patient who smokes, at whatever point on the change continuum he or she might be.

Every contact can be an opportunity for teaching, Maldonado explains.

“We identify smokers when they are admitted, and begin treatment and a quit plan for them while they are in the hospital,” he says.

Under the grant, the educators are targeting heart patients. The first step — identifying smokers — is deceptively difficult, he points out.

Many smokers will answer “no” when asked if they use tobacco products — some to avoid saying “yes,” and some because, at that particular moment of a health crisis, consider that they have stopped.

“When they arrive at the hospital, we get patients from all levels of the stages of change, from ready to not ready, to those who aren’t sure,” Maldonado continues. A large number of patients consider themselves as having quit at the point of admission, but realistically and statistically, their percentage of relapse is very high.

University of Rochester Medical Center’s program screens patients for tobacco use within the year prior to admission, and then steers them to a nicotine replacement therapy pathway.

“The best way to handle cigarette addiction is to move [the smoker] toward cessation with nicotine replacement, if suitable,” Panzer says.

Take advantage of all teachable moments

No matter where the patient is in willingness to quit, Maldonado and the hospital education staff address that person’s individual needs.

If a patient is ready to quit, he or she begins cessation therapy in the hospital. (Patients or their insurers pay for the smoking cessation therapy, and grant monies cover those who can’t pay.)

“Those who aren’t ready, we still address them,” Maldonado says. “We give them information and educate them as much as possible. We can start getting them to at least think about why they should quit.”

A study published in 2000 in *Preventive Medicine* examined patient compliance with hospital smoking policies and the effects of hospitalization on patients’ subsequent smoking.¹ Hospitalization can precipitate nicotine with-

SOURCE

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drawal, the authors noted, but also offers willing quitters an opportunity to stop smoking.

In that study, the authors found that one-quarter of smokers admitted to smoke-free hospitals said they smoked during their hospital stay; 55% reported nicotine cravings within 48 hours of admission. Abstaining from tobacco during the hospital stay was a strong indication that abstinence would continue after discharge, the authors added.

Patients wrestling with nicotine withdrawal are very vulnerable to relapse, so it is important to help them understand what is happening and why their bodies are reacting in that way.

“We try to help them understand, too, where the physician is coming from, that he or she is not just this person ordering you to stop smoking,” Maldonado explains. “Most doctors want patients to have stopped smoking two weeks before an incision is made, because they want the patient to be at their healthiest status ever.”

An inpatient smoking cessation program, such as the one at University Health, starts with educating the clinical and support staff, with an eye toward making whatever the method be easy and efficient.

“We understand that nurses are overloaded with work, so all we ask is that they help us identify patients who smoke, and then turn them over to me,” Maldonado explains. “Then, we take every opportunity to educate the patients as much as possible.

“Every moment is a teachable moment, regardless of what stage of change they are.” ■

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Pulling supplemental oxygen creates struggle

Guide addresses how to respond to patient request

The right of competent, informed patients to reject lifesaving therapies has been affirmed by courts at every level, but a group of ethicists at the University of Pennsylvania wondered whether the line is as clear when it comes to supplemental oxygen.

Scott Halpern, MD, PhD, senior fellow with the Center for Bioethics at the University of Pennsylvania Health System and a fellow in the division of pulmonary, allergy, and critical care, has co-authored a guide for providers whose patients request removal of oxygen.

“Informed patients with decision-making capacity have well-established rights to forgo any and all forms of life-sustaining therapy,” says Halpern. “However, there is no clear definition of what constitutes a life-sustaining therapy.”

While life-sustaining therapy is often thought of as invasive therapies, such as mechanical ventilation, kidney dialysis, or tube feeding, non-invasive high-flow oxygen is also life-sustaining in patients with advanced lung, heart, or cancer-related diseases, he points out.

“Many of these patients would lose consciousness and die within hours or even minutes if their supplemental oxygen was withdrawn,” Halpern says.

Halpern and co-author **John Hansen-Flaschen**, MD address concerns physicians who have not undergone specific training in critical care may have about withdrawing oxygen, including how to balance the burdens and benefits of supplemental oxygen; whether withdrawing oxygen might appear neglectful; how to determine whether patients retain decision-making capacity; when it is acceptable to use sedation in lieu of oxygen; and concerns about patients’ motivations for discontinuing oxygen.

Experience leads to four-step approach

Both Halpern and Hansen-Flaschen, who serves as chief of Penn’s division of pulmonary, allergy, and critical care medicine, arrived at the guidelines, published in September in the *Journal of the American Medical Association*,¹ through experience.

Both Halpern and Hansen-Flaschen recount experiences where they received requests from patients to stop their flow of supplemental oxygen, resulting in death. Halpern was first faced with the request to withdraw oxygen as a first-year medical resident, when an awake and alert patient suffering from advanced lung disease and cancer asked to end the oxygen supplement. One morning, the patient said he’d “had enough” and tugged on his mask, but was too weak to remove it and asked for Halpern’s help. Halpern recalls that he debated the request with the attending physician, who was concerned that the patient would experience air hunger and fear after oxygen was removed, necessitating high doses of sedating drugs, and worried this might constitute a form of euthanasia.

Hansen-Flaschen received a similar request from a homebound outpatient who suffered from advanced lung disease. The patient could no longer get out of bed and his quality of life had seriously deteriorated, and he asked to stop his oxygen and for Hansen-Flaschen to help him avoid a sense of suffocation afterwards.

“I had to ask myself, is this participating in a patient’s death or is it simply respecting a patient’s request?” Hansen-Flaschen explains. “Plus, there’s no way to predict an individual’s response to removing supplemental oxygen and how much they will suffer.”

Advances in medicine mean that many more patients with end-stage diseases are living longer, and technology permits high-flow supplemental oxygen to be used both in the hospital and at home, often providing a limited quality of life.

“So this is yet another ethical dilemma in medicine born of technological advancements,” observes Halpern.

Halpern and Hansen-Flaschen offer a four-step approach to help physicians meet requests to end supplemental oxygen and to overcome the concerns such requests create:

- Physicians should assure themselves and other health care professionals involved in the patient’s care, as well as the patient’s family members and close friends, that supplemental oxygen is a form of life-sustaining medical treatment. As such, requests to discontinue oxygen should be honored with the same judiciousness as requests to withdraw other forms of life support;
- Physicians should ensure that patients requesting the terminal withdrawal of oxygen are

SOURCE

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free from undue influences, including family member's wishes, economic considerations, or treatable depression;

- Physicians should ensure that the patient has the capacity to make medical decisions by documenting that patients show consistency, understanding, and rationality in making such requests;

- Physicians should ensure that patients and their family members understand the difficulty of predicting patients' experiences after oxygen withdrawal.

Reference

1. Halpern SD, Hansen-Flaschen J. Terminal withdrawal of life-sustaining supplemental oxygen. *JAMA* 2006; 296:1,397-1,400. ■

Scientists quitting NIH over conflict of interest rules

Survey shows 40% not happy with loss of income

Ethics rules aimed at curbing conflicts of interest of National Institutes of Health (NIH) employees should have a positive impact on public opinion of NIH credibility, a survey of agency employees revealed; at the same time, almost 40% say they are leaving or considering leaving due to the restrictions on their ability to earn outside income.

Despite the indications that the new ethics rules, issued in August 2005, could mean a mass exodus of current employees and difficulty attracting replacements, NIH director **Elias A. Zerhouni**, MD, says the rules are not open to revision at this time.

"Although the survey does suggest concerns about the impact of the regulations on recruitment and retention, at this time we do not antici-

pate revisions in the regulations," Zerhouni stated when the survey results came out. "We do, however, plan to proceed with the next two stages of the evaluation process."

He points out that while the survey results are consistent with anecdotal evidence of a possible impact on recruitment and retention, data from 2005 indicate NIH scientists have resigned and retired at about the same rate for the last several years. Future stages of the evaluation will survey NIH employees who have already left the agency to find out if the new ethics rules influenced their decision to go, and potential employees on whether the rules affect their decision to join NIH.

The survey asked the 8,000 NIH employees who responded (about half the workforce) for their opinions on the ethics rules and what the public's perception of the rules might be.

Almost three-fourths of the respondents said the rules would positively impact the agency's credibility with the public. More than half said the rules would have negative effects on the NIH's efforts to recruit or retain staff.

Fewer than 20% said the new rules would have a positive effect on their career outlook. Forty percent said the new rules are too restrictive.

The crackdown on outside income for NIH scientists came after agency leaders learned that scientists violated existing restrictions on lucrative private consulting deals with drug and biotechnology companies.

Under the new ethics rules, outside income from such companies is now banned, and there are tighter restrictions on employees' financial holdings and stricter disclosure requirements.

The report of the NIH survey is posted at the NIH conflict of interest web site, www.nih.gov/about/ethics_COI.htm. ■

Medical societies weigh in on case of New Orleans doc

After two months of not commenting on the arrest of Dr. Anna Pou, a Louisiana otolaryngologist accused by the Louisiana Attorney General's office of euthanizing patients at Memorial Medical Center in the days following Hurricane Katrina, the American Medical Association (AMA) and Louisiana State Medical Society (LSMS) issued statements within days of each other in late September, expressing solid

support for Pou.

Pou and two nurses, Lori Budo and Cheri Landry, were arrested and taken from their homes late at night in July. Under Louisiana law, they need not be formally charged before they are arrested, and as of press time have not been charged with crimes. However, Attorney General Charles Foti has stated that he believes his office has uncovered enough evidence for the Orleans Parish District Attorney to charge the three health care providers with murder in the deaths of four patients, who prosecutors say died from a combination of sedatives and painkillers.

In the weeks following the arrests, both the AMA and the LSMS withheld releasing any statements beyond expressing support for all medical personnel who cared for patients after the hurricane, and stating their intentions to withhold judgment pending the completion of the criminal investigation.

However, both organizations issued statements during the last week of September, and stated support for Pou — the LSMS with comments more strongly worded.

“[The] Louisiana State Medical Society is confident that Dr. Pou performed courageously under the most challenging and horrific conditions and made decisions in the best interest of her patients,” LSMS President **Floyd Buras**, MD, said. “Her recent statements regarding the events clearly show her dedication to providing care and hope to her patients when all hope seemed abandoned.”

Buras’ statement continued, stressing that Pou’s career “should not be tarnished as a result of these accusations.”

“The Louisiana State Medical Society will continue to support Dr. Pou as she has always supported her patients. The LSMS commends the valiant efforts of Dr. Pou, along with the many other dedicated health care professionals, who stayed behind to provide medical care during and following Hurricane Katrina,” Buras concluded.

Cecil B. Wilson, MD, chairman of the AMA board, stated that the AMA will closely monitor the Pou case, and that she remains an AMA member in good standing.

“The facts of this case appear complex, remain under investigation, and based on media reports, are sharply contested,” said Wilson. “The AMA is very proud of the many heroic physicians and other health care professionals who sacrificed and

distinguished themselves in the aftermath of Hurricane Katrina. We believe these physicians served as bright lights during New Orleans’ darkest hour.”

The AMA statement can be found at www.ama-assn.org/ama/pub/category/16876.html; the LSMS statement is available at www.lsms.org. ■

Nurse presence growing on hospital ethics committees

While it was not always so, nurses are now members of ethics committees in most hospitals, and are participating in consults where they traditionally were not.

“The physicians concentrate so much on the physical aspect, making sure the patient is being treated correctly, while nurses, being with the patient more and with the family more, can be a go-between, an advocate, and help broaden the view,” says **Celia Mills**, RN, BSN, PHN, PCCN, clinical manager of the ICU/CCU and medical/surgical departments at Ridgecrest (CA) Regional Hospital.

Mills has been on the ethics committee at her hospital for many years, a panel made up of half medical staff, the other half non-medical staff.

“We have always chosen people from nursing [for part of the medical staff representatives],” she explains. “I am in ICU, and it makes sense because lots of ethical issues arise out of the ICU.”

Some ethics committees, especially in smaller institutions, include only physicians and those from the philosophy disciplines.

“Voices and opinions of other disciplines that may have a more in-depth, day-to-day knowledge or simply another point of view of the case, go unheard and thus unheeded,” nurse **Penelope Chase** wrote in comments to *South Carolina Nurse* in 2004¹. “Ethics committees and services that do ethics consultations should be interdisciplinary, and need to include more nurses than is usually the norm.”

A manual developed by the American Society for Bioethics and Humanities (ASBH),

CE/CME answers

21. B; 22. C; 23. A; 24. D.

SOURCE

For more information, contact:

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"Core Competencies for Health Care Ethics Consultation," in use by hospital ethics committees nationwide, was created by a task force that included members of the American Association of Critical Care Nurses, Chase points out.

Mills says probably because nurses have been a part of ethics consults and the ethics committee at her hospital so long, "it's a very collegial atmosphere."

"Everyone is invited to speak their mind," she adds. "It's a very level playing field, one that doesn't seem very territorial."

The involvement of nurses on the ethics committee and on subcommittees convened to deal with specific cases flexes depending on the case,

she says.

"If a case involved a pregnant woman, it would involve the obstetrics department nursing-wise and physician-wise, and perhaps a lawyer and chaplain," she says.

The presence of nurses, in addition to providing broader first-hand experience with patients and their families, adds an important perspective to ethics discussions, Mills believes.

"Sometimes you can get tunnel vision [when there is] a big problem, and having someone else with a different viewpoint can really help," she explains. "Also, we still find in the older population, the physician being viewed as an authority figure, and they might not want to question him, but will ask the nurse all the questions instead, and that gives you an insight or a perspective that a physician or other person on the ethics committee."

Reference

1. Chase P. More nurse members needed for ethics consultation, ethics committees, and ethics services. *SC Nurse* 2004;11:22. ■

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CME Questions

21. Despite a reported two-hour wait in the emergency department, a Lake County, IL, coroner's inquest did not find that Beatrice Vance's death from a heart attack was the result of "gross deviations from the standard of care."
 - A. True
 - B. False
22. According to a 2005 survey of 1,000 physicians conducted by HCD Research and the Louis Finkelstein Institute for Social and Religious Research, what percentage of doctors surveyed believe it is ethical to assist an individual who has made a rational choice to die due to unbearable suffering?
 - A. 15%
 - B. 39%
 - C. 57%
 - D. 81%
23. According to Halpern and Hansen-Flaschen, when asked by a competent patient to end supplemental oxygen therapy, physicians should approach the request as they would requests to withdraw other forms of life support.
 - A. True
 - B. False
24. New conflict of interest rules at the NIH stipulate:
 - A. No outside income from biotechnology and pharmaceutical companies should be allowed.
 - B. There should be stricter disclosure requirements.
 - C. None of the above.
 - D. A & B.

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. This issue signals the end of the semester. **The semester ends with this issue.** You must complete the evaluation form provided and return it in the reply envelope provided to receive a credit letter. When your evaluation is received, a credit letter will be mailed to you. ■

CE objectives

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

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2006 Index

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Access

In crisis: AMA says 21 states 'in crisis' from liability costs, dwindling access to care APR:45

Alternative medicine

When mature minors demand alternative, questionable treatment JULY:77

What are your ethical obligations when it comes to alternative medicine? OCT:109

VA teen who sought alternative cancer treatment compromises with court NOV:125

Conflict of interest

Conflict of interest, informed consent: Learning from past mistakes JAN:5

Ethicists comment on physician compensation from pharma companies MAY:58

'Free samples from pharmas may bias other doctors, but not me' NOV:128

Medical journals repeatedly fail to disclose authors' conflicts of interest SEPT:104

Coverage

Stung by bad publicity, hospitals alter collection practices for uninsured FEB:20

Delivery models

Concierge care: Better care for a few or trickle-down benefits for everyone? AUG:89

KY surgeons, surgery center provide free operations for underinsured NOV:121

Drugs

That great prescription is worthless if your patient can't afford it JULY:81

Direct-to-consumer advertising: AMA creates advertising guidelines for new drugs, devices AUG:94

'Free samples from pharmas may bias other doctors, but not me' NOV:128

End-of-life issues

Beyond the end of life: Some ethical considerations after a patient dies JAN:10

Legalized physician-assisted death doesn't lead to mistrust of doctors JAN:10

Caregivers of terminally ill patients at home benefit from education, support FEB:13

Withdrawing life support: Ethics of withdrawing life support in pediatric PVS vs. adult PVS patients MAR:25

Practice and research on the newly dead: Consensus panel creates guidelines FEB:16

Swiss hospital to allow on-premises assisted suicides FEB:22

Decision making: Patients might not make the same choices as you APR:37

Schiavo's legacy: Has anything really changed? MAY:49

Can surrogates really know patients' wishes? MAY:53

Delivering news of brain death: Done incorrectly, damage can be profound JUNE:64

Growth in palliative care field a response to end-of-life issues JUNE:68

Earlier termination of CPR in out-of-hospital cardiac arrest cuts transports, but at what cost? SEPT:101

When a patient asks for a hastened death, look behind the question to find answers OCT:114

TADA: Texas act formalizes ethics committee role in end-of-life disputes APR:40

Ethics education

Disciplinary action against physicians may have roots in medical school FEB:18

Delivering news of brain death: Done incorrectly, damage can be profound JUNE:64

Ethics reform

FSMB toughens sexual boundaries policy FEB:21

Rhode Island mulls extending ethics codes to hospital administrators FEB:22

Informed consent

Conflict of interest, informed consent: Learning from past mistakes JAN:5

IOM says Americans not ready for presumed consent to organ donation JUNE:65

Mass casualty, epidemic

In pandemic, public health outweighs patient autonomy JAN:7

Will health care workers skip out during a disaster? JAN:8

Weigh in: Americans support quarantine during epidemic, but not forced compliance MAR:35

Probe of euthanasia allegations after Katrina not just focused on health care workers MAY:54

Ethics and pandemic influenza: The rules aren't the same as for typical flu season JUNE:61

Why do workers just say 'no' to flu shots? MAY:56

Arrest of Katrina doctor, nurses stirs up strong support for the accused

SEPT:97

ANA to study how disasters can affect standards of care and practice

NOV:129

Medical errors

JCAHO: Joint Commission issues sentinel event alert MAR:34

Bioethicist: Fear of malpractice only one barrier to disclosing medical errors SEPT:100

Organizational ethics

Trustees: Untapped resource for ethics guidance JAN:1

FSMB toughens sexual boundaries policy FEB:21

Rhode Island mulls extending ethics codes to hospital administrators FEB:22

Drive to require skilled translators in hospitals reaching more states NOV:126

Making hospital-acquired infection rates transparent: More than just numbers OCT:112

Quality investigators: Medicare patients deserve details of investigations APR:42

Pain

Growth in palliative care field a response to end-of-life issues JUNE:68

States to get report cards on chronic pain policies SEPT:105

Pediatrics

Withdrawing life support: Ethics of withdrawing life support in pediatric PVS vs. adult PVS patients MAR:25

When a patient asks for a hastened death, look behind the question to find answers OCT:114

VA teen who sought alternative cancer treatment compromises with court NOV:125

Obesity in pediatric patients: Be assertive in broaching this important topic with families SEPT:103

British parents say children with CF should be included in gene therapy trials JULY:83

Physician-assisted suicide

Swiss hospital to allow on-premises assisted suicides FEB:22

Supreme Court: Ruling settles some questions, leaves others open for Congress, states FEB:29

Probe of euthanasia allegations after Katrina not just focused on health care workers MAY:54

2005 data: Oregon's PAS rate almost unchanged since 2002 MAY:56

Professional issues

Disciplinary action against physicians may have roots in medical school FEB:18

Thanks, no thanks? Accepting, rejecting gifts from patients MAR:32

Physicians and executions: Group seeks ban on physician involvement in executions APR:43

Dwindling physician supply? Bleak reports wrong APR:46

Ethicists comment on physician compensation from pharma companies MAY:58

Sexual misconduct requires firm stance MAY:57

To tell the truth: AMA rejects therapeutic privilege, advises giving patients full story AUG:85

Critics say: Physician peer review misused to rid hospitals of whistleblowers, competition AUG:92

Placebo therapy: Unethical without informed consent AUG:95

Ron Cranford, noted neurologist, MEA adviser, dead at 65 JULY:75

Religion and spirituality

Spirituality and health: Health care's recognition of patients' spiritual needs continues to grow MAR:27

Spirituality and medicine: Benefits seen in letting patients know they can talk about faith JUNE:66

What medicine can't provide: Cedars-Sinai's traveling Torah brings blessings to the bedside JULY:80

Study shows: Intercourse prayer doesn't benefit heart patients - but are such findings valid? AUG:87

Reproductive health

Abstinence-only education: Group says ethically, clinically problematic

MAR:31

Research ethics

Trust in medical research based on ethics, disclosure JAN:4

New findings show minorities as willing as whites to participate in research studies JAN:6

Practice and research on the newly dead: Consensus panel creates guidelines FEB:16

British parents say children with CF should be included in gene therapy trials JULY:83

Ethics stifling research? Some Britons say 'yes,' but U.S. ethicists don't agree OCT:118

Special populations

CDC's new HIV testing guidelines greeted with praise, condemnation NOV:123

HIV experts say ethics bottlenecking research NOV:127

Obesity in pediatric patients: Be assertive in broaching this important topic with families SEPT:103

Dealing with abusive, unlikable patients: Be understanding, acknowledge human nature OCT:115

Surrogate decision makers

Decision making: Patients might not make the same choices as you APR:37

Schiavo's legacy: Has anything really changed? MAY:49

Can surrogates really know patients' wishes? MAY:53

Transplant ethics

IOM says Americans not ready for presumed consent to organ donation JUNE:65

Suspect donor tissue: Recipients reporting adverse effects JUNE:68

Face transplants: U.S. researchers say identifying the right recipient a monumental ethical challenge JULY:73