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IN THIS ISSUE

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No resuscitation for severely premature infants says British bioethics council

Guidelines represent accepted treatment, U.S. ethicists say

A paper released in November by a British bioethics council has generated hot debate and headlines warning "disabled babies to be killed at birth," but the guidelines set out by the Nuffield Council on Bioethics regarding the treatment of babies born severely premature are similar to those observed in many states in the United States.

"I think most neonatologists would agree that the Nuffield report is in line with standard thinking," says **Doug Diekema**, MD, MPH, an ethicist with the Treuman Katz Center for Pediatric Bioethics at Seattle Children's Hospital. "The controversy has always been over where do you draw the line [when deciding whether to resuscitate very premature babies], and I guess what makes the Nuffield report controversial is that they have tried to draw that line."

The Nuffield Council on Bioethics was established in 1991 to identify, examine, and report on ethical questions raised by advances in biological and medical research. Although the council's recommendations are not binding, it has achieved an international reputation and

Don't miss medical futility audio conference

Exploring ethical dimensions of medical futility legislation

When do you withhold or discontinue life-prolonging treatment in cases deemed medically futile? As baby boomers age, the critical issues surrounding these cases will require advance planning and establishment of guidelines.

The problem of "futility" in end-of-life care has recently come under heavy scrutiny and pointed criticism, especially by disability rights groups and advocates. Their position, which made front-page news during the Terry Schiavo case, is that persons with serious disabilities are frequently dismissed as burdensome and as having lives not worth living. **Medical Futility Practices: Are They Ethical or Discriminatory?**,

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its reports are influential in shaping health care policy and debate in Great Britain.

The report on extraordinary care for the very premature, "Critical Care Decisions in Fetal and Neonatal Medicine," provoked strong reactions when it was released, but does not suggest any measures that have not already been widely discussed and, in some countries and states, already implemented, according to ethicists.

Treatment vs. comfort care debated

The Nuffield Council's report suggests that extremely premature babies born at 22 weeks gestation or less should not routinely receive resuscitation and intensive care. The standard for babies born at 22-23 weeks should be to not resuscitate unless parents ask that it be done and physicians agree. **(See Table, "Nuffield Council Guidelines," p. 3.)**

Such extremely premature births are statistically shown to have a 1% rate of survival to discharge from the hospital. Those who do survive often develop severe disabilities due to their physiological immaturity.

"Natural instincts are to try to save all babies, even if the baby's chances of survival are low," according to **Margaret Brazier**, a University of Manchester (UK) law professor who chaired the committee that produced the guidelines. "However, we don't think it is always right to put a baby through the stress and pain of invasive treatment if the baby is unlikely to get any better and death is inevitable."

Despite the evidence of futility in resuscitating very premature infants, Brazier notes in her foreword to the report that, "Writing this report has not been easy," but "any difficulties that we have faced pale into insignificance compared with the heartbreaking choices that parents and professionals have to make in these areas of medicine."

Recognizing the agonizing decisions faced by parents and physicians when a baby is born before 25 weeks, the council framed its guidelines to provide a large "gray area" during which parents' wishes should determine care, according to **Steven Leuthner**, MD, MA, associate professor of pediatrics and bioethics at the Medical College of Wisconsin in Milwaukee and director of the fetal concerns program at Children's Hospital of Wisconsin.

"I personally look at [the Nuffield study] as not necessarily anything new, but as another group of people who agree with what I tend to agree with, and that is that you shouldn't seriously think about starting resuscitation in a [22-

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week gestation or less] baby who probably can't survive anyway," he says. "But there is a big gray window where we let parents make the choices."

The third "window," he says, comes at 25 weeks and beyond, "when we owe it to the baby to at least try."

Debate in the United States among neonatologists and ethicists is not usually over whether it is humane to resuscitate babies who stand very little chance of survival, Leuthner says, but when to make that decision.

"These are debated all the time — who should we resuscitate and who should we not?" he explains. "The [American Association of Pediatrics] has guidelines about this, here in Wisconsin we formulated guidelines, and certainly there is published medical literature suggesting cutoffs very similar to these [in the Nuffield report]."

Despite the hue and cry in the British press over what is contained in the report, Leuthner says what the council has proposed "is not a fringe issue at all in neonatology."

In fact, he says, historical guidelines were even more absolute — and likely, less accurate as a means of judging viability.

"Historically, people would make the decisions based on weight. If the baby weighed less than 500 grams, you would provide comfort care and that's all," he explains. "If the baby weighed over 500 grams, you would resuscitate."

Now decisions are based on gestational age, but influenced by guidelines, policy, and case-by-case facts. The Baby Doe law, an amendment to the 1984 federal child abuse law, is another factor. It mandates that all infants should receive treatment unless treatment is deemed "virtually futile" in terms of survival; ethicists, lawyers, and physicians continue to debate whether the law is worded in such a way that parents and physicians have some discretion in deciding whether to give or withhold treatment.

Further complicating the picture is the inaccuracy of predictive methods currently available. Diekema explains that while weight has been rejected as the sole determining factor, gestational age is an imperfect replacement tool.

"The reality is that every neonatologist has seen a baby expected to come out at 25 weeks' gestational age and it comes out considerably further along than that, or considerably less far along than that," he points out.

For all these reasons, Diekema suggests, guidelines should not try to establish a definitive "black line" demarcating an absolute age at which resuscitation should or should not be initiated, but rather, there should be standards established, around which physicians and parents can exercise discretion.

Nuffield Council Guidelines for Critical Care in Neonates

25 weeks of gestation and above — Rate of survival is relatively high, risk of disability is relatively low. The standard should be to initiate intensive care and admission to a neonatal intensive care unit.

Below 25 weeks of gestation — Discuss with parents the statistical evidence for survival and disabilities, including evidence that most babies born before 25 weeks' gestation will die.

24 weeks, 0 days to 24 weeks, 6 days of gestation — Offer intensive care and support unless parents and clinicians agree it is not in the baby's best interest.

23 weeks, 0 days to 23 weeks, 6 days of gestation — Precedence should be given to the wishes of the parents regarding resuscitation and treatment of their baby with invasive intensive care. Where parents would prefer that the clinical team made the decision about whether or not to initiate intensive care, the clinicians should determine what constitutes appropriate care for that particular baby.

22 weeks, 0 days to 22 weeks, 6 days of gestation — Standard practice should be not to resuscitate a baby unless parents request resuscitation and reiterate the request after thorough discussion with an experienced pediatrician about the risks and long-term outcomes.

22 weeks of gestation — No baby should be resuscitated except within a clinical research study that has been assessed and approved by a research ethics committee and with informed parental consent.

When intensive care is not given, the clinical team should provide palliative care until the baby dies.

Source: The Nuffield Council on Bioethics. "Critical Care Decisions in Fetal and Neonatal Medicine," November 2006.

Religious communities respond to guidelines

While some right-to-life and religious groups condemned the report, even saying it sanctions euthanasia, the Nuffield report drew support from British medical groups and religious leaders of the Church of England (Anglican) and the Catholic Bishops' Conference of England and Wales.

"This reaffirms the validity of existing law prohibiting euthanasia, and upholds the vital and fundamental moral principle that the deliberate taking of innocent human life is always gravely wrong," the Church of England and the Catholic Bishops' Conference said in a joint statement. "There is a clear distinction between interventions which are deliberately aimed at killing, and decisions to withhold or withdraw medical treatment when it is judged to be futile or unduly burdensome."

The Nuffield guidelines adamantly state that the "active ending of life" of newborn babies should not be allowed no matter how serious a child's condition.

"The professional obligation of doctors is to preserve life where they can," the authors of the report wrote.

The council's recommendations are that when deciding whether to give life support, physicians should consider parents' views, the likelihood that the treatment will significantly prolong life, and whether the child will be capable of establishing relationships or experiencing pleasure in the future. In comparison, the U.S. Baby Doe law does not take quality of life into account in requiring treatment.

The 278-page Nuffield Council report is available as a free download on-line at www.nuffieldbioethics.org/go/ourwork/prolonginglife/publication_406.html. ■

What neuroethics is and what it means are evolving

New ethics branch probes personality, soul

In its infancy, neuroethics was thought of as simply a small offshoot of the bigger field of bioethics. In the last five years, however, interest in and study of neuroethics has taken on a life of its own, spawning studies, conferences, and the establishment of a society to further the development of the field. The term "neuroethics" is believed to have been coined in the literature in the early 1990s.

While there's no doubt neuroethics is a booming new frontier in ethics, most people would be stymied if asked to pin down a definition of just what neuroethics is.

That's because, according to **Judy Illes**, PhD, senior research scholar at Stanford University's Center for Biomedical Ethics and a founding member of the Neuroethics Society founded in early 2006, neuroethics has the potential to touch so many different areas of medicine and behavior studies.

For example, who are neuroethicists?

"Neuroethicists can be medical ethicists, they can be philosophers, they can be brain and spinal cord [specialists], to be really inclusive," Illes says, offering examples. "They can be neuroscientists who have become interested in ethics. We all bring a different skill set to the table."

Two focus areas: What we do, and who we are

According to the University of Pennsylvania Center for Cognitive Neuroscience (CCN), which created and manages the on-line resource neuroethics.upenn.edu, neuroethics is concerned with the ways in which developments in basic and clinical neuroscience intersect with social and ethical issues.

"The field is so young that any attempt to define its scope and limits now will undoubtedly be proved wrong in the future, as neuroscience develops and its implications continue to be revealed," CCN suggests.

But neuroethicists relatively agree that there are two general categories of neuroethical issues — one relating to what humans can do (problems arising from neuroimaging, psychopharmacology, and physical manipulation of the brain), and one relating to what we know (philosophical advances and questions relating to behavior, consciousness, personality, and the soul).

Authors have written that neuroethics will be tasked with addressing concerns about the effects brain science and technology will have on other aspects of life — for example, the idea of personal responsibility.

"I really think that in health care a huge area of research — and, ultimately, controversy — is going to revolve around freedom of will," says **John Banja**, PhD, an ethicist at Emory University's Center for Ethics. "Neuroscientists are more and

more going to uncover and discover really impressive evidence that will show, among other things, that certain people don't have as much free will as other people do."

For example, he asks whether people who abuse drugs and alcohol, or molest children, or become serial killers do so out of free will or because their brains are "wired differently."

"So, if they're doing this because their brains are actually structured differently or are wired differently, do you penalize them for that? It's an interesting question," Banja suggests.

Neuroethics Society's first issue: Imaging

Illes says the first issue the Neuroethics Society is addressing involves functional brain imaging.

"We have been trying to locate behavior in the brain since antiquity," she says. And now, if imaging can map the brain and tell us things about ourselves — should it?

"What are the dangers of scanning brains in children and adolescents? And what if we do find something wrong — if we can't intervene, should we look for it in the first place?" Illes asks. "What does it mean to predict certain abilities or limitations in the very young? Does the child become a self-fulfilling prophesy then?"

These questions bear close resemblance to an ethical dilemma clinicians have grappled with for years — whether or how to deliver inadvertently discovered, negative health news, particularly if there's nothing that can be done. Another example is how to use the knowledge that a patient carries the genetic markers for Parkinson's disease — is the burden of knowing you bear the risk of developing a degenerative, incurable disease worth knowing, when there is a possibility you'll never get sick?

Banja says this is the two-edged sword of neuroscience advances — the need to be careful what you ask for.

"I have a hunch that this is going to be deeply interesting, especially in predictive health and being able to look at our genome and see our disposal to this illness and that illness," he says. "But all that is predicated on people wanting that information."

All these questions are why Illes and colleagues interested in neuroethics, who had previously met and talked only informally at neuroscience conferences and other meetings, decided to launch the Neuroethics Society.

"We felt it would help draw new people into neuroethics, which is a critical step for continuing to make progress in the field," she says. The fact that there is as much debate as agreement over what neuroethics is and what it can and should do "is one of the things that make it so exciting and challenging."

In the March 2003 issue of *Nature Neuroscience* (*Nat Neurosci* 2003;6:205), Illes writes that the study of neuroethics is one way to help identify and avoid how brain imaging can be exploited. For example, if imaging were to be able to identify people who are prone to aggression, but someone whose brain images revealed that marker had never been aggressive toward another person — should family and employers have that information? Or should a very young child who is determined to be prone to doing poorly at school be so categorized before he or she has even entered kindergarten?

As imaging technology becomes more advanced and able to tell us more about ourselves and what makes each brain unique, Illes says we need to consider how that knowledge and power will be used. Currently, she points out, some research studies into imaging don't have protocols directing researchers what to do if they uncover incidental findings about participants — even whether to tell the participants about incidental findings.

Manipulating vs. healing the brain

Another issue frequently mentioned in neuroethics discussions is treatment of the brain vs. enhancing or boosting the brain. A question arising from that discussion might be, where do you draw the line between treatment and enhancement?

Banja says this question is already being asked on college campuses where so-called ADHD

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drugs (those frequently prescribed for attention deficit disorders, such as Ritalin and Adderall) have become drugs of choice for students seeking an edge in attention and memorization powers.

"The question that science fiction folks never tire of asking has to do with the possibilities of cosmetic enhancement of the brain, and that's what we're already seeing on campuses, with [the ADHD drugs] becoming popular as a stay-awake-and-memorize drug," he explains. "It's preferable to caffeine because it doesn't give them the shakes. But other students, ones who aren't using the drugs, are complaining because those who do are at an advantage.

"It's just like the situation of professional athletes using performance-enhancing drugs to give them a physical edge over their opponents, only this gives you a mental edge. Should there be performance-enhancing drugs for mental performance?"

Illes says questions like these, touching on pediatric and learning issues, are of particular interest, because children's brains are so much different from adult brains.

"We tend to think of children's issues as adult issues in a little box, but they are really special issues, such as autism in terms of identifying and understanding of the disease, ADHD and the implications of additional forms of diagnosis," she points out. "And also with predicting behavior — this has tremendous implications for these kids, both in the educational strategies they'll need, and also, if we say they're 'bad,' does that make them bad?"

Implications for clinicians

The importance of neuroethics research to neuroscientists and researchers seems clear, but what about for those practicing clinical medicine?

Banja says there is much to suggest doctors "in the trenches" will benefit from neuroethics study, as well.

"Health care professionals tend to be very responsible, thoughtful, well-intentioned people, but a lot of times, some of them have trouble empathizing with people whose behaviors they can't understand," he says. "Neuroethics and neuroscience will show us that these patients act this way through no fault of their own. Health professionals will question their own attitudes about people whose behaviors they don't like. If you're angry or upset with someone who can't control their behaviors, what does that say about you?"

The struggle over disclosing inadvertent findings, such as a tendency toward developing an incurable condition, is another neuroethics issue that clinicians can expect to encounter, he adds.

Illes says neuroethics is being introduced in medical school curricula, often, as at Stanford, as a "vertical thread" element within another course, such as neuron biology.

"We are very early in this field, and already there is so much for medical students to learn," she points out. "What we are seeing is an embodiment of neuroethics into seminar series, new and existing lectures, into psychiatry coursework, and in neuron content."

(In future issues, Medical Ethics Advisor *will examine specific neuroethics issues in detail.)* ■

Nonprescription sales of Plan B still murky waters

Requests for morning-after pill may drop

The recent federal approval of nonprescription sales of the emergency contraceptive Plan B (Barr Laboratories; Woodcliffe Lake, NJ) to women and men ages 18 and older may have quieted what was a brewing controversy in emergency medicine. However, the ethical issues that gave rise to the debate still are very much in play, emergency department (ED) experts say.

The issue came to the forefront when, in July 2006, an ED doctor at Good Samaritan Hospital in Pennsylvania cited his Mennonite beliefs and refused to prescribe a morning-after pill for a rape victim. The incident touched off a national debate on emergency contraception.

Despite the recent federal approval, however, "The underlying ethical principle is still open for discussion," asserts **Mark Debard**, MD, an emergency physician at The Ohio State University Medical Center in Columbus, who wrote much of the information used in sexual assault protocols in his state's EDs.

While emergency medicine experts note that the vast majority of rape victims are older than age 18, they agree this does not make the issue moot. Some states, for example, are moving to make access to the pill in pharmacies more difficult.

John Banja, PhD, a medical ethicist in the Center

for Ethics at Emory University in Atlanta, poses these scenarios: A patient is in a rural area and can't get emergency contraception at the hospital. Or, the pharmacy closest to a patient won't provide the pill.

Banja notes that Georgia legislature has passed a law that allows pharmacists to refuse to prescribe the pill without fear of prosecution. "The assumption of widespread availability may not be correct," he says. "Just because it is approved does not necessarily mean women will be able to get the drug."

As part of their preparation for dealing with staff who object to prescribing the pill because they are opposed to abortion, Banja says it's critical to understand exactly how Plan B works.

"For pregnancy to occur, of course, three things must happen: The woman's ovaries have to secrete an egg into the fallopian tube; the male sperm has to fertilize the egg in the fallopian tube; and the fertilized egg has to implant into the lining of the uterus," Banja summarizes. "The morning-after pill can work in one of three ways: It can stop ovulation from happening, it can stop the fertilization from happening, or it can prevent the fertilized egg from implanting."

Generally, fertilization will not occur within the first 24 hours of unprotected sex, Banja says. Thus, in most rape victims in the ED, the Plan B pill is going to prevent ovulation or fertilization, he says. "To the extent it does that, we are not talking about abortion," he asserts.

Still, Banja concedes, there will be ED staff members who reject that rationale or who are opposed to any form of contraception.

Finding a balance

"We have a long-standing tradition of allowing physicians a great deal of autonomy in what they are allowed to do [or not do] within the rule of law," says Debard. "There is no question that doctors with ethical and religious scruples about not performing certain acts are not required to perform them." Thus, he says, in the case of the Pennsylvania physician, "there's no question he acted within proper professional ethics."

Still, Debard counters, "Just because he was within his ethical rights does not mean he doesn't have other ethical obligations."

Those obligations always have existed, he says. "To the point where even when doctors did not want to prescribe birth control pills because it was against their religion, they were traditionally required to provide information about others who would — in other words, how the patients might obtain that prescription," Debard says.

So, how does this translate into ED operations? "To my knowledge, such a protocol or policy rarely exists in the ED — but it probably should," Debard says. "Such a policy would acknowledge the rights of the physician not to prescribe the drug, but it also should acknowledge the patient's rights to information on how to obtain that prescription."

Finding alternatives

The approval of over-the-counter sale of Plan B has not changed the policy in the ED at Emory University Hospital in Atlanta, says **Matthew T. Keadey**, MD, medical director.

First of all, he notes, rape victims younger than 18 represent a "small volume" for his ED. "It's often a date-rape incident and alcohol-related, involving campus freshmen," he notes.

"Our position in general has been that we will provide post-exposure prophylaxis to anyone who requests it," he says. If someone in his group does not feel comfortable providing that care, "usually the staff will call me, and I will be happy to call the prescription in for the patients."

Have a backup plan

While it is admittedly difficult to delve into someone's religious belief, it is nevertheless important to know how your staff feel about these issues, says Keadey. "If there is somebody who feels, for whatever reason, uncomfortable about caring for this problem, you need to have some sort of backup plan to facilitate the care of the patient," he notes.

Banja agrees — to a point. "To the extent that

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the emergency room physician would routinely have written a prescription for a birth control pill, it should make no difference," he says. "On the other hand, suppose he is even against contraception — now, what do we do?"

Banja notes that while there is great political controversy in the United States about abortion, "women do have the absolute legal right to an abortion during their first trimester, and to the extent that the hospitals are licensed facilities and have to obey the law to maintain that license, they have to respect the rights of the patient."

However, says Banja, the ED manager should respect the conscience of the physician and allow him not to prescribe the pill. "But if I am the ED director, I will have another doctor available to fill it," he says. He "absolutely" recommends making this action part of the ED's policies and procedures.

Even in cases involving younger victims, there are ways for the victims younger than 17 to ask for Plan B, says Debard. Most states have laws that allow for the examination and care of a minor with regard to sexually transmitted diseases and pregnancy, he says. "If a sexual assault has occurred, this approach can certainly be conceived of under those circumstances," he says, "But in general, I would do it in association with the parents being present."

While the physician still would have the right to refuse care, "I think it would be a very small minority," says Debard. Even then, he says, "There would be an ethical obligation to educate the patient and their parents about where they could get the pill." ■

E-mail between patients and docs slow to catch on

Physicians concerned about billing, quality of care

Only about one in four physicians in the United States use e-mail to communicate clinical information to patients, and one reason may be a lack of effective means of billing for e-mail time. But some say they don't yet know enough about what quality of care can be delivered via patients' e-mail inboxes.

These were among findings released recently by the Center for Studying Health System Change (HSC). The report states that one in four physicians (24%) reported that e-mail was used in their practice to communicate clinical issues with patients in 2004-2005, up from one in five physicians in 2000-2001.

"Despite strong interest among policy makers and the public, most physicians are not rushing to embrace e-mail communication with patients," according to **Joy M. Grossman**, PhD, a senior researcher at HSC and coauthor of the study.

Among policy makers pushing information technologies such as e-mail for communication between patients and health care providers is the Bush administration, which two years ago formed the American Health Information Community, a branch of the U.S. Department of Health and Human Services. Additionally, 80% of e-mail-using Americans surveyed in a 2005 HarrisInteractive health care poll said they would like to be able to communicate with their doctors via e-mail.

The survey on which Grossman and her colleagues based their report polled members of the American Medical Association and American Osteopathic Association. Their findings are included in the HSC data bulletin "Physicians Slow to Adopt Patient E-mail," available at www.hschange.org/CONTENT/875/.

The authors write that while some health plans are testing potential mechanisms for obtaining payment for e-mail consultations, reimbursement at this time remains limited, posing a major barrier for physicians, the authors write. A few practices are experimenting with charging patients directly, but whether and how much patients will be willing to pay out of pocket is unclear, they add. Moreover, implementing a secure messaging system is more costly than using unencrypted e-mail, and physicians are less likely to make such an investment without payment for electronic consultations, the authors conclude.

In addition, some physicians fear e-mail will add to their workload instead of replacing face-to-face or telephone consultations. While some studies have shown e-mail can improve physician efficiency and patient satisfaction by providing more timely communication, the authors report, even less is known about the effects of e-mail use on quality of care.

Doctors in larger practices say they use physician-patient e-mail more often than physicians in smaller groups. Physicians in staff/group-model health maintenance organizations (HMOs) and medical school faculty practices reported the highest rates of adopting e-mail use (47% and 43%, respectively), followed by physicians in group practices of more than 50 physicians (29%).

In contrast, only about 20% of physicians in practices with nine or fewer physicians reported adopting e-mail use, the study found.

However, growth in e-mail adoption essentially stalled in larger practices between 2000-2001 and 2004-2005. At the same time, smaller practices with nine or fewer physicians did have statistically significant growth in e-mail use.

"The stagnant growth among large practices — traditionally early IT adopters — suggests e-mail use is not progressing rapidly," Grossman said.

While some patients are eager to communicate with their physicians via e-mail, not all patients have access to e-mail, according to the HSC. Rural, low-income, elderly, and Black consumers are among those less likely to have Internet access and, if they have it, to use e-mail, Grossman points out.

Practices with higher proportions of such patients may move more cautiously to offer e-mail consultations because of more limited patient demand and capability. Physicians in practices in nonmetropolitan areas, practices with high Medicaid and Medicare revenue, and practices with a high percentage of Black patients are less likely to report e-mail is used to communicate with patients, according to the HSC study. ■

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Age, race may influence pain management in EDs

A patient's race, age, and medical condition may affect whether or not they receive pain medications in the emergency department (ED), according to a study of adults who presented to an emergency department with musculoskeletal pain.[1]

In the study of 868 adults, researchers found that fewer opioids and discharge analgesics were prescribed for black patients than for white patients. Also, younger patients, trauma patients, and patients with chronic pain received more opioids and discharge analgesics compared to older patients and those without trauma or chronic pain.

"If you were unlucky enough to get a certain ED physician, you might get analgesia for your pain only a third of the time, compared to 90% from another," says **Alan Heins**, MD, one of the study's authors and assistant professor in the department of emergency medicine at the University of South Alabama in Mobile.

ED nurses should use protocols for rapid assessment, standing orders for potent treatments, and perform frequent re-evaluations with orders for additional analgesics if pain is poorly controlled, recommends Heins. "ED nurses are much better at standardizing care, through use of protocols and evidence-based care guidelines, than physicians," he adds.

As advocates for patients in pain, ED nurses should work to eliminate variations in pain practice, says **Janet Kaye Heins**, RN, MSN, CRNP, the study's lead author. "We must lobby with our superiors to institute standardized nursing triage and treatment protocols to improve care and reduce disparities in pain management," she says. "Findings from several studies reveal that a nurse-initiated morphine protocol for severe pain significantly reduces time to analgesia."[2]

Protocol gives nurses autonomy

At Christiana Care Health System in Newark, DE, ED nurses use a pain protocol to ensure safe and effective pain management. "This protocol provides a great deal of autonomy for our triage nurses," says **Karen Rollo**, RN, BSN, CEN, SANE-A, an ED nurse at the hospital.

As with EDs across the country, they are busy and at times overcrowded, says Rollo. "Effective and consistent pain management is, therefore, definitely a priority, since the most common chief complaint in most EDs is pain," she says.

For the protocol to be used, patients must have a documented triage assessment, including vital signs and pain level, medications, allergies, and history. Nurses give ibuprofen to patients with nonurgent complaints such as headache, toothache, earache, contusions, lacerations, minor burns, and musculoskeletal pain, when pain is at a Level 4 or less on a 0-10 scale, with 10 being the worst pain.

(Continued from cover)
an audio conference sponsored by AHC Media, with presenter John Banja, PhD, from Emory's Center for Ethics, will address how to solve the problem of "futility."

Ramifications of the Texas Advance Directives Act

Disability rights advocates have taken special aim at legislation like Texas's 1999 "futility law" (actually, the Texas Advance Directives Act), which empowers health professionals to withhold or discontinue life-prolonging treatment that they deem futile or medically unnecessary. On the other hand, many health professionals commonly report feeling unreasonable pressure to provide aggressive care that they believe is thoroughly unwarranted. They report considerable distress in feeling compelled, usually by a patient's family members, to offer treatment that they deem clinically ineffective, burdensome if not torturous for the patient, and a waste of health care dollars.

Contrasting views will be explored

This presentation will survey these contrasting interpretations and experiences of futility, and question whether it is even possible to understand "futile treatment" in a fair and ethically unambiguous way. Recommendations will be made that might prevent or mitigate psychological and organizational distress that often accompanies decisions about aggressive treatment in difficult cases. The ethical dimensions of futility will be elaborately explored as will those ideological and cultural factors that ultimately limit the degree to which ethical reflection, especially as it occurs in the United States, can "solve" the problem of futility.

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"We start with 800 mg of ibuprofen if the patient has not taken any prior to arrival or if it has been taken prior to arrival with no relief," says Rollo. If the pain level is more than 4 but less than 7, oxycodone can be given, unless patients are nauseous or have suspected sickle cell crisis, flank pain, pelvic pain, abdominal pain, or more serious traumatic injury. For patients with these complaints, or those with a pain level more than 7, the ED physician is consulted and an evaluation is required within 30 minutes for intravenous pain medication. "These patients are assisted to a triage treatment area, or to a stretcher in a hallway spot equipped with call lights if a treatment room is not available," says Rollo.

Since pain is subjective, nurses are taught to accept the level a patient is reporting, but in the event that the triage nurse suspects that the patient may be seeking drugs, such as if the assessment doesn't fit with the complaint, the nurse has the option to ask the physician to first evaluate the patient to order the appropriate medication, which may not necessarily be a narcotic. "All patients medicated at triage are strongly encouraged to wait for the full evaluation and complete treatment, even if they feel better after they are medicated," says Rollo. "The percentage who leave without completing treatment is only 2.4%."

At Jackson Memorial Hospital in Miami, triage nurses for all patients use a pain protocol with a complaint involving pain. Standing orders allow nurses to give patients a single dose of acetaminophen after a completed nursing assessment, says **Susie Tome-Manjarrez**, ARNP, an ED triage nurse.

The nurse then documents the pain assessment findings on the nursing flow sheet, including the response to medications given and any complications. "If there is no improvement when we reassess the patient's response, we expedite the patient back to the treatment area," she says.

References

1. Heins JK, Heins A, Grammas M, et al. Disparities in analgesia and opioid prescribing practices for patients with musculoskeletal pain in the emergency department. *J Emerg Nurs* 2006; 32:219-224.
2. Fry M, Holdgate A. Nurse initiated intravenous morphine in the emergency department: Efficacy, rate of adverse events and impact on time to analgesia. *Emerg Med* 2002; 14:249-254. ■

CE/CME answers

1. B; 2. D; 3. C; 4. D.

'Teach back' technique improves patient safety

Good physician-patient communication does much more than eliminate the need for repeated visits. Effective communication has been demonstrated to result in better outcomes, greater patient satisfaction, and decreased likelihood of lawsuits.

An approach called "teach back" is one that can greatly improve provider-patient communication, according to the U.S. Department of Veterans Affairs (VA) National Center for Ethics in Health Care and the National Quality Forum, which listed teaching back as one of its 30 safe practices for improving patient safety.

Asking open-ended questions (rather than yes/no questions) and repeating patients' questions or comments back to them are common tools for good communication during patient encounters. However, striking the right balance between knowing what information patients want or need and the physician's skill at delivering that information can be hard to do. The VA Center for Ethics says that a recent study found that 37% of patients reported understanding what they were told during medical visits, while the physicians of those same patients thought that 80% of the patients understood.

Asking the patient "Do you understand?" is one way to approach finding out if the patient does, indeed, understand; however, that head-on questioning can make the patient feel uncomfortable and may elicit a positive response when, in fact, the patient really is not sure he or she understands.

Teaching back is simply the practitioner asking the patient to tell what he or she understands has been discussed. For example, after going over a new medication, the physician might ask, "Now, I want to be sure I was clear in explaining this to you. Can you tell me what you understand the instructions and dosage are for your new medicine?"

The National Quality Forum found that teach-

SOURCES

For more information:

- U.S. Department of Veterans Affairs National Center for Ethics in Health Care ,"Teach back: A tool for improving provider-patient communication," at www.ethics.va.gov/ETHICS/pubs/infocus.asp.
- National Quality Forum, "Improving patient safety through informed consent for patients with limited health literacy," at www.qualityforum.org/publications/reports/informed_consent.asp.

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 credit letter. When your evaluation is received, a credit letter will be mailed to you. ■

CME 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. ■

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ing back is especially helpful when the patient has a low health literacy, has a cognitive impairment, or has limited proficiency in English.

Some suggestions from the National Quality Forum include:

• Have patients explain, in their own words, their diagnosis or the medical condition that they have sought care for;

• Describe the nature of the treatment or procedure, including the risks, benefits, and any alternatives that have been discussed;

Don't ask yes/no questions such as "Do you understand?" or "Do you have any questions?" ■

CME Questions

1. Guidelines such as those suggested by the Nuffield Council on Bioethics regarding treatment of severely premature babies remove all parental autonomy when it comes to making treatment decisions.
A. True
B. False

2. Which of the following are areas of interest to neuroethicists?
A. Brain-enhancement drugs
B. Neuroimaging
C. How to deliver news of findings to patients
D. All of the above

3. Which of the following are NOT reasons that physician-patient e-mail has not caught on quickly as a means of communication between doctors and their patients, according to the Center for Studying Health System Change survey?
A. Unresolved questions about billing
B. Unresolved questions about quality of care that can be delivered electronically
C. Physician skill at using e-mail
D. Lack of universal patient access to e-mail

4. Which of the following factors was shown in a recent study by Heins et al to affect whether or not patients receive pain medications in the emergency department?
A. age;
B. race;
C. condition;
D. all of the above.

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