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JUNE 2007
VOL. 23, NO. 6 • (pages 61-72)

Gun control: Medical ethics issue, public health concern, or political bias?

VA Tech shootings fuel debate on MD's role in curbing violence

The mass shootings at Virginia Tech in April fueled the national debate over gun control, and physicians treating those killed and injured in the rampage expressed shock at the extent of the violence.

But is gun violence a health care issue?

"I don't think there are many people who would say people with holes in them aren't a public health problem," says **Mike McCally**, MD, PhD, executive director of physicians for social responsibility in Washington, DC.

Or is simply *violence* the health care issue, with guns brought into the equation for political purposes?

"Well-intentioned physicians are confusing violence with guns; oppose the violence, but not the guns," says **Miguel A. Faria, Jr.,** MD, a retired Macon, GA, neurosurgeon and professor of neurosurgery, who has written extensively on the subject of gun control and public health.

McCally, a public health physician professor in the department of community and preventive medicine at Mount Sinai School of Medicine in New York, says while few in the medical community dispute that gun violence and violence in general are a public health problem, there is less clear evidence of a medical ethical argument for that assertion.

In 2004, 29,569 people in the United States died from firearm-related deaths — 11,624 (39%) homicides; 16,750 (57%) suicides; 649 (2.2%) accidents; and 235 (0.8%) of unknown cause/intent. In all, the death rate from accident and injury in 2004 was 167,184.[1]

Physicians on all sides of the gun violence debate agree that's too many — just like the statistics on drunk driving deaths, child abuse, and domestic violence are too high. Where opinions diverge is over the role guns play, and the role physicians should have in advocating for gun control.

Fighting a 'Wild West mentality'

Gregory Luke Larkin, MD, MS, who practices trauma and emergency medicine at Yale-New Haven Hospital in Connecticut, is squarely in favor of physicians doing anything they can to deter gun violence. He's stitched up and resuscitated more gunshot-wounded patients than he can count; he's been shot at himself, twice, in the emergency department. And he doesn't think the Virginia Tech shootings will change the number of guns and gunshot wounds he sees.

"I think when the news dies down, people will stick their heads in the sand, and will pretend it will go away, and it won't," he says. "I think it's important that people understand and not be surprised when [mass killings] happen again."

Medical Ethics Advisor® (ISSN 0886-0653) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Medical Ethics Advisor**®, P.O. Box 740059, Atlanta, GA 30374.

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Subscription rates: U.S.A., one year (12 issues), $499. Add $9.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

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The former rifle team sharpshooter says there is a place for guns, but in the hands of so much of the population is not that place.

"Given that we've tried this experiment, where people can buy guns openly, with limited restrictions and short wait times — it doesn't work," Larkin insists. "As an emergency physician in a trauma center, who has been shot at twice by patients, the evidence is clear: There is a very small part of the population that can responsibly carry a firearm and handle the implications of a semiautomatic weapon. The vast majority can't."

Larkin says America maintains a "Wild West mentality" when it comes to the right of the individual above the good of society. Privacy restrictions afforded by the federal Health Insurance Portability and Accountability Act (HIPAA) can add additional risk in some cases, he adds.

"HIPAA restrictions prohibit us from sharing mental health information that would have helped in the Virginia incident," he suggests. "We are butchering safety on the altar of the rights of the individual."

While Faria adamantly opposes asking patients if they own firearms, Larkin says he often does.

"I ask people if they have access to firearms, if they have firearms in their house, and I can admit them [to the hospital] for a short stay against their will if I think they could be a threat to themselves or others," he says. "Only recently have we realized how many patients are suicidal. We reported that of patients who come into the ED for routine stuff — headaches, asthma, sprains — about 8% have suicidal thoughts, and about 2% actually have a plan, but that's not routinely picked up by staff because they're focusing on the complaint they come in with."[2]

Larkin says it's not unusual for him to see patients come in with gunshot wounds, have their injuries treated — and sometimes their lives saved, only to return again a month or year later with another gun-related injury.

"As a physician I feel ineffective," says Larkin. "We are closing the barn door after the horses run free — we don't seem to want to invest in prevention to control injuries, but we're willing to spend millions of dollars on trauma centers to treat the consequences."

Doctors ask about guns, 'violate boundaries'

"I think the gun control issue is a political and constitutional issue, and it is very dangerous for physicians to get involved in it," says Faria. "In

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the Soviet Union, you saw the perversion of psychology so that it could be used against dissidents. It's the same thing with the gun control issue today — doctors have too much moral authority to influence their patients."

Gun violence, like any other type of violence, is a grave public health concern, Faria says.

"I was a neurosurgeon before I retired, and I was often called in the middle of the night to operate on someone who had been shot, so I know it is a problem," he says. "But the problem is the violence. Not the guns. Gun control is a political issue, not a medical or ethics issue."

Physicians should stick to health care, he insists. To do otherwise "can become a boundary violation — a physician using his influence with his patients to sell a political idea," he says.

"The American Medical Association has imposed its anti-gun bias on doctors, and for doctors to impose their bias on patients is unethical," he asserts. "Are physicians going to also inquire about the storage of household cleaning agents, or matches, and about swimming pools? More youngsters die annually of poisoning, fires, and drowning than of firearm injuries."

What's the role of physicians?

Physicians for Social Responsibility advocates against violence prevention and was involved in gun control for some time, McCally says, in an effort to have gun violence seen as a public health issue.

"Medicine deals with treating gunshot injuries, but what's the role of physicians who also have public health responsibilities and work in the public health paradigm?" he asks. "Even though we are clinicians, that argument became the argument for dealing with gun violence as a public health issue."

McCally says Physicians for Social Responsibility found its efforts in the gun control arena pitted it against the juggernaut of the National Rifle Association (NRA).

"When you get into the politics of gun control, you end up engaged with the NRA, and we've never won that," McCally says. "Now, if you could somehow position that the NRA stance is unethical, that would be a useful contribution."

In recent years, two organizations of physicians interested in the gun control issue were organized — Doctors for Sensible Gun Laws, a collaboration stemming from KeepAndBearArms.com, and Doctors Against Handgun Injury, a division of the New York Academy of Medicine.

Both organizations are currently inactive.

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Is care ever futile? Texas MDs, advocates square off

Baby Emilio Gonzales latest center of debate

If there is any state that is currently a lightning rod for issues relating to futility of care, it would be Texas. Medical professionals, right-to-life and disability rights organizations, churches, and civil liberties groups are doing battle over the Texas Advance Directives Act (TADA); many of the same parties have taken sides over a terminally ill Austin toddler whose mother is fighting a hospital's efforts to invoke the act to end the boy's life-sustaining treatments.

"There's some hard-knuckle politics going on down here," says **Robert L. Fine**, MD, FACP, who is both the director of the Office of Clinical Ethics at Baylor Health System in Dallas and one of the architects of TADA, which was passed into law in 1999 and amended in 2003. "And the Emilio

Gonzales case shows the fundamental differences, with organized medicine and the Catholic church on record as saying he is terminal, and Texas Right to Life saying he's not dying."

The struggle over Emilio Gonzales illustrates what Emory University ethicist **John Banja**, PhD, calls parties hitting an "ethical bedrock."

"You have clashing views on what is futile, and unfortunately, ethical theory is unable to reconcile that clash," says Banja, assistant director for health sciences and clinical ethics, and associate professor of clinical ethics at Emory in Atlanta.

Emilio Gonzales: Is care ever futile?

Fine stops a question about Texas' "medical futility law" to point out that the state has no such law; TADA is about advance directives, and the controversial section on withdrawal of care deemed medically futile is only one part of the act.

"Care is never futile," he says.

In the case of 17-month-old Emilio Gonzales, however, Children's Hospital of Austin has declared that its medical efforts on his behalf are futile, and that he is suffering as a result.

Emilio is believed to have Leigh's Disease, a rare, progressive, inherited neurometabolic disorder characterized by degeneration of the central nervous system, according to a statement released by the hospital's attorneys during court proceedings. He cannot breathe, eat, or swallow on his own, and can't make purposeful movements; the hospital says the child's higher-order brain functions are destroyed.

"He was imminently dying until he was placed on a ventilator," says Fine.

Acting under TADA, and with the concurring opinions of physicians and the hospital ethics committee, Children's Hospital, where Emilio has been treated since December 2006, notified Emilio's 23-year-old mother that in 10 days his ventilator would be removed. If she disagreed, she had 10 days to find another hospital willing to admit and care for her son.

She did disagree, no other hospital was willing to accept transfer, and so, with the backing of Texas Right to Life, she went to court seeking an order barring the hospital from ending its treatment of her son.

As of the time *Medical Ethics Advisor* went to print, a judge in Austin had ordered that the hospital refrain from withdrawing treatment, with a follow-up hearing scheduled for mid-May.

The Gonzales case is the latest court battle over TADA. While cases like that of Gonzales, Sun Hudson, and Tirhas Habtegiris have gathered national attention (both Hudson and Habtegiris were removed from life support over the objections of family members), Fine points out that there have been only about a few contested cases over withdrawing care from patients under TADA.

Obtaining legal immunity

Under the Texas Advance Directives Act of 1999, the following process must occur if the treatment team and institution wish to take full advantage of the provisions of the law creating a legal safe harbor for them. These provisions are as follows:

1. The family must be given written information concerning hospital policy on the ethics consultation process.
2. The family must be given 48 hours notice and be invited to participate in the ethics consultation process.
3. The ethics consultation process must provide a written report to the family of the findings of the ethics review process.
4. If the ethics consultation process fails to resolve the dispute, the hospital, working with the family, must try to arrange transfer to another provider, physician, and institution who are willing to give the treatment requested by the family and refused by the current treatment team.
5. If after 10 days, no such provider can be found, the hospital and physician may unilaterally withhold or withdraw the therapy that has been determined to be futile.
6. The party who disagrees may appeal to the relevant state court and ask the judge to grant an extension of time before treatment is withdrawn. This extension is to be granted only if the judge determines that there is a reasonable likelihood of finding a willing provider of the disputed treatment if more time is granted.
7. If either the family does not seek an extension or the judge fails to grant one, futile treatment may be unilaterally withdrawn by the treatment team with immunity from civil or criminal prosecution. (This is the "legal safe harbor" for physicians, institutions, and ethics committees, the first of its kind in the country.)

Source: Fine RL. Medical futility and the Texas Advance Directives Act of 1999 *BUMC Proceedings* 2000; 13:144-147

At Baylor, from 2001 through 2003, there were 47 futility consultations. In 43, the ethics committee agreed with the health care provider's determination that treatment was futile, and the families agreed in 37 of the 43 cases. In six cases, the family refused to withdraw treatment. Of those six, three agreed within a few days after the committee determination, two patients died during the 10-day transfer/wait period, and one patient died awaiting transfer to another provider.[1]

"When we are fighting at such a basic level of argument [the definition of what is futile], we don't have a way of resolving it," says Banja. "Both sides have good reasons, and we just can't adjudicate it."

If a parent or family member of a terminally ill patient is presented with overwhelming evidence that further treatment is not going to improve the condition of that patient, the medical providers' definition of futile might not be the same as the family members'.

"If we had clinical criteria for a pediatric patient, and his health care providers said his condition is not going to come around and it would be unwise, wasteful, and unethical to continue treating him, but his mother says, 'If there is a one in 1 million chance that he will improve, that is what I believe is owed to my child, even if he doesn't recover,' I don't know what you can say to that," Banja says.

What is reasonable?

Banja says difficult cases like that of Emilio Gonzales boil down to arguments over reasonableness.

"The idea of what is reasonable is key, and it is precisely what we disagree about," he explains. "We don't have a vision of reasonableness. To Ms. Gonzales, it is perfectly reasonable that her child continue to get care, and in fact, would be criminal for health care providers to abandon her son.

"Health care providers, on the other hand, would say that it's clinically unreasonable to treat this infant because he will die anyway, and it's ethically and financially unreasonable to prolong his dying."

The Gonzales case is very likely a struggle for his medical providers on two levels, Banja theorizes.

On one level, there are the purely biological and bioethical issues dealing with what is just and fair to Emilio and in allocating valuable health care resources that could be used to benefit others.

On another level is the "moral distress" that the case presents for those caring for him. His care providers already feel helpless because his medical condition leaves them unable to provide anything but palliative care. "Add to that a non-health care provider, his mother, who is making demands on them that they feel are not warranted and reasonable, and that adds to and mixes the psychological and emotional turmoil all the more," Banja suggests.

So what do doctors do when confronted with one of these "bedrock clashes"?

"Health care providers have to continue to drill down on the notion of reasonableness," Banja advises. "You should only invoke futility legislation when it is very, very clear that health care providers are being asked to do something that is excessively unreasonable, with an emphasis on "excessively," from various points of view — clinical, ethical [when it creates more suffering than benefit], and financial, when it is squandering health care resources we could put to better use."

Texas MDs fighting to save TADA

Fine says he and other medical professionals in Texas find themselves struggling to save a law that doesn't need fixing.

"Organized medicine doesn't think [TADA] is broken; we think it's served patients well," says Fine. "But the National and Texas Right to Life [organizations] pulled out of the consensus agreements we operated under when the law was passed in 1999, and now there's no consensus about the law. It's a tough political battle, bottom line."

Fine says Right to Life leaders told him that after outcry from its membership following the Terri Schiavo case, they could no longer support the Texas law that provides an avenue for physi-

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cians to withdraw life-sustaining treatment, even in futile cases.

"In 1999 and 2003, we operated by compromise; now there are number of competing bills, and organized medicine's [testimony that the law doesn't need changing] has been rebuffed," says Fine.

There are several bills that would change TADA from a little to a lot, Fine says. One bill would add some time between when families are told that an ethics committee will rule on continuation of care and when that committee meets and would extend the time families who object to the termination of life-sustaining care have to find a facility to move the patient to.

That bill, sponsored by state Rep. Dianne Delisi, has won tentative support from the Texas Medical Association (TMA) and Fine, but any bill making changes to the law is felt to be unneeded by those who back TADA, Fine says. Troubling to backers of the current version of TADA is a provision that would bar hospitals from invoking the law in cases of patients whose only life-sustaining treatment is artificial hydration and nutrition — a direct result, Fine says, of the Schiavo debate.

Strange political bedfellows

Rival bills would force doctors to continue treating terminally ill patients indefinitely if their families or other proxies objected to withdrawing care, and have created some unlikely alliances — the Texas American Civil Liberties Union (advocating for the disabled) and Texas Right to Life on one side, the Catholic church siding with physicians, to some extent, on the other.

"We're working with Rep. Delisi to get a favorable bill," Fine explains. "But I'm very concerned about the fate of the law. It's trapped in post-Schiavo politics."

Fine says it was his observation that before Schiavo, during the years after the Nancy Cruzan "right-to-die" ruling, there was a more cooperative atmosphere when it came to compromise and consensus on end of life and medical futility issues.

Post-Schiavo politics

"Now, after Schiavo, it's very fractured, very contentious. It's a very different atmosphere, and it's all part and parcel of the national post-Schiavo politics," he says.

Banja doesn't agree that opposition to TADA stems from Schiavo, but rather is the result of efforts on the part of those who advocate for rights for the disabled.

Bob Kafka, an organizer of the Texas branch of the anti-euthanasia organization Not Dead Yet, says he has concluded "that the essence of any futility law embraces involuntary euthanasia. The ability of a doctor to overrule both the patient and their surrogate in withdrawing life-sustaining treatment is in violation of the principle of patient autonomy."

"After hundreds of years of being told their lives are worthless, people with disabilities get the message — it's too hard to take care of them," Banja says, explaining the results of generations of discriminatory treatment. "Disability rights people say the message has been driven home that their lives are worthless, and they feel that futility laws give the able-bodied too much power to make decisions as to the worth of their lives."

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Will California follow Oregon with PAS bill?

Legislation mirrors Oregon's Death with Dignity Act

A bill that would make California the second state in the country to legalize physician-assisted suicide (PAS) has worked its way through the state assembly's Judiciary Committee, but needs to clear the state House by June 8 to be eligible for consideration this year by the state Senate.

While committee voting so far has fallen along party lines, with Democrats endorsing the bill patterned after Oregon's Death with Dignity Act and Republicans voting against it, political observers say the bill stands a better chance of passage this year than it did last year, when a nearly identical bill failed to win assembly approval.

The state's two largest physician organizations, however, remain split on the bill.

"When physicians can no longer heal the disease or alleviate the symptoms, terminally ill patients have a right to control the circumstances of their death," said **Wells Shoemaker**, MD, medical director of the California Association of Physician Groups, based in Los Angeles.

The 35,000-member California Medical Association, which like the American Medical Association has consistently opposed physicians assisting with the suicides of patients, issued a statement in March reaffirming that opposition.

"Assisting someone to die is unethical and unacceptable, and is fundamentally incompatible with the physician's role as healer," said California Medical Association President **Anmol S. Mahal**, MD.

California bill mirrors Oregon act

The Oregon PAS act was passed in 1996, and has withstood attempts to strike it down at both the federal and state levels. Oregon voters passed the act via a referendum; California Gov. Arnold Schwarzenegger has said he believes the decision on passing a PAS law should be put directly to California voters, as was Oregon's act.

The proposed California PAS law would apply to patients who are terminally ill and within six months of death, only to residents of California, and only to adult patients who can make informed decisions.

Other points of bill AB 374 include:

- The patient must be evaluated by two physicians. A consulting physician must examine the patient and confirm the attending physician's diagnosis and prognosis and that the patient is mentally capable, fully informed, and acting voluntarily and free of coercion.
- The patient must be mentally capable. Both evaluating physicians must verify that the patient is mentally capable of making and communicating health care decisions; if either physician suspects the patient's judgment may be impaired by medication or a psychiatric or psychological disorder, the patient must be referred to a licensed psychiatrist or psychologist for a psychological examination. If a patient is referred for psychological evaluation, the process stops until the psychiatrist or psychologist has determined that the patient is mentally capable. If the patient is determined to not be mentally capable, he or she will be denied the medication.
- The patient must make two oral requests and one written request for the prescription. The written request must be witnessed by two people who attest that the patient is competent, is acting voluntarily, and is not feeling coerced into making the decision.
- The California bill proposes two waiting periods: 15 days after the first oral request, at which time the written request can be made, and 48 hours after the second oral request and the writing of the prescription.
- The patient must self-administer the prescription. No one else can administer the medication to the patient.
- Physicians may refuse to participate with the act, with no requirement to participate in any part of the process. (To read the bill in its entirety, go to www.assembly.ca.gov/acs/acsframeset2text.htm.)
- The California bill shares another similarity with the Oregon act — opposition from religious and right-to-life organizations.

The president of the 16,000-member Christian Medical Association (CMA), based in Bristol, TN, says the California bill "invites patient abuse, prevents investigation of patient abuse, and covers up incidents of patient abuse."

David Stevens, MD, CEO of the CMA, adds,

"Instead of being called the Compassionate Choices Act, this bill should be called the 'Covert Abuses Act.'

"No one will ever know if patients were pressured to die because they had no health insurance, or because a greedy family member wanted to preserve his inheritance, or because a doctor or insurer calculated that suicide was more efficient than palliative care," Stevens insisted in a prepared statement. "The state health department relies on the very people who abuse patients to report their own abuse."

The CMA's statement opposing the bill is based on a number of concerns, including fear of:

- A misunderstanding of pain control. The CMA's position is that most pain can be controlled through appropriate medication and comfort care in a hospice setting, but it acknowledges that appropriate end-of-life care may include aggressive treatment of pain that, in some cases, such treatment may hasten death.
- The incapability of a doctor or other health care provider to truly determine consent of the dying individual; doctors could be forced to make highly subjective decisions that some patients' lives are no longer worth living, the CMA statement suggests.
- A lack of scientific certainty in determining the course of a patient's illness. Someone given six months to live may actually live several more years with a reasonable quality of life, the CMA position statement asserts.
- The possibility that doctors and other health care workers could find themselves "on a slippery slope that would extremely compromise medical ethics," should PAS become accepted as an ethical or appropriate activity, and arguments arise that PAS should be extended to patients who are disabled and suffering but not terminally ill.

Survey: Support for PAS among MDs

A national survey of 1,088 physicians conducted by the Louis Finkelstein Institute for Social and Religious Research, part of the New York, NY-based Jewish Theological Seminary, in 2005 revealed that a majority of those surveyed (57% percent) believe that it is ethical to assist an individual who has made a rational choice to die due to unbearable suffering. Thirty-nine percent say they believe it is unethical.

The Finkelstein survey revealed that while doctors tend to support legalization of PAS as a public policy, results were mixed when they were asked whether they would personally participate in assisting a patient. A plurality (46%) would not assist a patient for any reason, 34% would assist a patient in a few cases, and 20% would assist under a wide variety of circumstances. (To read the survey results, visit www.jtsa.edu/research/finkelstein/surveys/pas.shtml.)

Forty states have specifically outlawed PAS; six states prohibit it through common law, according to the Death with Dignity National Center in Portland, OR (www.deathwithdignity.org). Three states (other than Oregon) — North Carolina, Utah, and Wyoming — do not have laws prohibiting or permitting PAS. ■

Pandemic plans address vaccines but not ethics

Review of plans reveals holes in ethical foresight

Should a pandemic strike the United States, states and local communities are ready with protective equipment and plans for allocating vaccines. But some important ethical questions aren't addressed in state pandemic flu plans, one public health expert says, and those are the issues that might derail the best-laid disaster plans.

James C. Thomas, MPH, PhD, an epidemiologist at the University of North Carolina School of Public Health, Chapel Hill, has researched the pandemic preparedness plans of all 50 states, the District of Columbia, and the federal government, and found some critical weaknesses shared by all.[1]

"The things that are being addressed most are those having to do with vaccines, antivirals, protective equipment, and those sorts of things," says Thomas. "What's being less well addressed in the plans are how to prepare a state or a local community for the decisions that will have to be made. Right now, the decision-making plans are centralized and limited to a few issues.

SOURCES

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"Many of the issues that will be faced are going to be difficult to foresee, so what needs to be happening now is that we need to be preparing local health departments to make difficult ethical decisions."

Thomas found all the preparedness plans lacking in key ethical terminology, including accountability, autonomy, collaboration, confidentiality, and privacy.

'Opaque reasoning' leaves room for error

Some points in the pandemic plans, Thomas reasons, are set out as thoroughly as can be done ahead of time, but sometimes miss some important ethical points.

"On some questions, such as who should get the vaccines when they become available, the guidelines created by the CDC [Centers for Disease Control and Prevention] and others are available, and there have been a lot of very well-informed people who are part of those decisions," he says.

But the thought given to what to do in the time between when a virus is identified and when the antivirals and vaccines are available for it "is disproportionate to the number of issues we'll be facing."

Also, plans that call for immunizing the most vulnerable and most needed — the chronically ill, elderly, and very young, and those responsible for public health and public order — leave out some ethical questions that could prove very troubling.

"What about prison populations?" Thomas asks. "Prisoners are not high on the list of people who are needed to maintain order, nor are many of them on the list of people who are physically vulnerable. But they are in a crowded situation that they can't leave, so if the virus gets into their population, it can sweep through them."

Immigrants, undocumented people living in the country, and those without health care or in extreme poverty are among those who will likely be hit hardest, earliest, and longest by a pandemic, Thomas adds.

"When a crisis happens, it exacerbates disparities, and people who are vulnerable are, by definition, vulnerable, and they need to be given extra vigilance," he says. Working against their favor is the "two-list" model of ensuring vaccines and antivirals for the physically vulnerable and those needed for public order, both of which stand to overlook other vulnerable populations.

Thomas says many of the plans he and his colleagues reviewed employ "opaque ethical reasoning;" they carry the implied messages of "trust us and do as we say" and "ethics are self-evident, just do what is needed to preserve lives."

But many of the ethics are *not* self evident, Thomas predicts, and state and federal plans should take steps to anticipate them better and train public health providers — and all levels of government — to identify and address the ethical decision making that can be faced during a public health emergency.

Thomas says many plans recognize the need to address ethical questions, but sidestep the issue by simply stating that ethicists would need to be consulted at some point.

Lessons learned from past events

Meanwhile, other ethical questions were seldom addressed, including the diversion of resources from other public needs in order to anticipate or address the pandemic, acceptable compromises in skill levels if retired professionals are recruited to fill in for those struck by the pandemic, and preventing panic in communities and fear mongering by the media. Looking to past events and near-events is one way to anticipate and plan for potential ethical issues, Thomas says.

"The swine flu epidemic — the epidemic that didn't happen — showed us some of the risks of actions you can take if you think you see a pandemic coming your way," he says. "It highlights questions about resource allocation, about how many resources you want to put into anticipation of an epidemic, and how many resources to put into responding to an epidemic."

Communities should consider allocating public health resources ahead of an epidemic toward monitoring and communication — processes that will prove useful even if the pandemic doesn't occur as expected.

"The public needs to understand how things will be handled, so public education about allocation of resources needs to take place ahead of time," he says. "Some information will be available on-line, but how much can the Internet handle and how quickly?"

Private television stations will be a major point of disseminating official releases of information during a health emergency, but there is the potential for fear mongering by media outlets who stand to profit from advertising revenues generated when more people tune in for news on a crisis.

One of the lessons of the 1918 influenza pandemic was a credibility crisis for the government, he points out. Because World War I was drawing to a close, the federal government turned little attention to the pandemic, instead urging the public to ignore the "nuisance" of influenza and to stay focused on the war effort.

"It showed us that communication is vital, that truth and credible information is one of the key elements in maintaining order and helping people cope," he says.

The SARS outbreak four years ago gave two very different pictures of response and results, Thomas points out. Under authoritarian regimes in China and Hong Kong, there was stringent forced screening and isolation of those exposed; police were empowered to hunt down and isolate "superspreaders" of the virus, even to publicize their names; and workers in heavy contact with the public were mandated to be screened on a frequent basis. The control of the virus in those situations, Thomas relates, appeared to have been much more effective than in Canada, a far less restrictive environment.

"What compromises in professional ethics are we willing to incur if the need arises to conscript individuals into various forms of service?" Thomas asks. "One of the things that came out of the SARS analysis, especially in Canada, was the responsibility and rights of those who face risks because they are caring for those who are sick.

"If there is a 'duty to care' that is so often invoked, so too is there a duty to care for those workers, many of whom have divided loyalties between the people they care for and their own families."

Reference

1. Thomas JC, Dasgupta N, Martinot A. Ethics in a pandemic: A survey of the state pandemic influenza plans. *Am J Public Health* 2007; 97:S26-S31. ■

AAP reviews policy on circumcision

Current policy 'not where it should be'

A "flurry" of new studies suggesting that there is a link between sexually transmitted diseases and non-circumcision has led the American Association of Pediatrics (AAP) to undertake a new review of its policy on the procedure.

AAP President **Jay Berkelhamer**, MD, FAAP, told *Medical Ethics Advisor* that new evidence "has raised some concerns that the academy's current policy [on circumcision] is not positioned where it should be."

Drafted and adopted in 1999, then reviewed and reaffirmed in 2003 and 2005, the AAP's policy is to neither recommend nor discourage circumcision. The policy states:

"Existing scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision. In circumstances in which there are potential benefits and risks, yet the procedure is not essential to the child's current well-being, parents should determine what is in the best interest of the child."[1]

Berkelhamer says the recent studies, including some studies in Africa that correlate non-circumcision with new cases of HIV, have prompted the AAP to revisit the policy about a year earlier than it would have.

"We generally review policies every three years, but because of the flurry of recent articles and heightened interest, we're going back and looking at the literature and publications — and there are hundreds of them, both proponents for and against — and reviewing both the body and quality of the evidence to determine if a change is needed," continues Berkelhamer.

The review process is expected to take about six months; at the time *Medical Ethics Advisor* was going to print in early May, the academy was about halfway through the review, Berkelhamer says.

"It won't change for a while, if at all, and in the meantime, families should continue to be well educated and well informed, and make their decision on circumcision based on what is best for their child," Berkelhamer says.

NIH studies show link to HIV

The National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health (NIH), announced in December 2006 that it was shutting down two clinical trials on

CNE/CME answers

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

SOURCES

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adult male circumcision because an interim review of trial data revealed that medically performed circumcision significantly reduces a man's risk of acquiring HIV through heterosexual intercourse. The trial in Kisumu, Kenya, of 2,784 HIV-negative men, showed a 53% reduction of HIV acquisition in circumcised men relative to uncircumcised men,[2] while a trial of 4,996 HIV-negative men in Rakai, Uganda, showed that HIV acquisition was reduced by 48% in circumcised men.[3]

Both trials involved adult, HIV-negative heterosexual male volunteers assigned at random to either intervention (circumcision performed by trained medical professionals in a clinic setting) or no intervention (no circumcision). All participants were extensively counseled in HIV prevention and risk-reduction techniques.

Both trials originally were designed to continue follow-up until mid-2007. However, at the regularly scheduled meeting of the NIAID study monitoring board in December, reviewers assessed the interim data and recommended the two studies be halted early due to the strength of the evidence and so that all study subjects who had been randomized into the non-circumcision group could be offered circumcision.

"Many studies have suggested that male circumcision plays a role in protecting against HIV acquisition," NIAID Director **Anthony S. Fauci**, MD, said in announcing the suspension of the trials. "We now have confirmation — from large, carefully controlled, randomized clinical trials — showing definitively that medically performed circumcision can significantly lower the risk of adult males contracting HIV through heterosexual intercourse. While the initial benefit will be fewer HIV infections in men, ultimately adult male circumcision could lead to fewer infections in women in those areas of the world where HIV is spread primarily through heterosexual intercourse."

References

1. American Academy of Pediatrics, Task Force on Circumcision. Circumcision policy statement. *Pediatrics* 1999; 103:686-693.
2. Bailey RC, Moses S, Parker CB, et al. Male circumcision

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 **with this issue** 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. ■

COMING IN FUTURE MONTHS

- Physician code of conduct
- Finding common ground on PAS
- Gender discrimination in reproductive medicine
- Special end-of-life issues in cardiac medicine

for HIV prevention in young men in Kisumu, Kenya: A randomised controlled trial. *Lancet* 2007; 369:643-656.

3. Gray RH, Kigozi G, Serwadda D, et al. Male circumcision for HIV prevention in Rakai, Uganda: A randomised trial. *Lancet* 2007; 369:657-666. ■

CME Questions

21. According to Claassen and Larkin in the British Journal of Psychiatry, what percentage of emergency department patients presenting with a physical complaint have suicidal ideations?
A. 2%
B. 5%
C. 8%
D. 10%

22. Which of the following is/are provisions of the proposed physician-assisted suicide legislation before the California General Assembly?
A. The patient must make two oral requests and one written request for the prescription.
B. There must be two waiting periods: one after the first oral request, and one after the second oral request and the writing of the prescription.
C. The patient must self-administer the prescription.
D. Physicians may refuse to participate with the act.
E. All of the above

23. In their study of pandemic preparedness plans, Thomas et al found which of the following missing from state plans?
A. Plans for disseminating vaccines and antivirals
B. Acceptable compromises in skill levels if retired professionals are recruited to fill in for those struck by the pandemic.
C. Plans for having protective equipment on hand.
D. Priority lists for who should receive vaccines.

24. A study of circumcision and HIV among young African men revealed there was a 48% to 53% reduction in rate of HIV acquisition in men who were circumcised compared to men who were uncircumcised.
A. True
B. False