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IN THIS ISSUE

- Does patient confidentiality end with death? Depends on definition of person cover
- GWU offers first postgrad certificate in spirituality and health care 100
- EOL decisions in incapacitated ICU patients with no surrogate 102
- Medical, nursing associations hail failed prosecution of Hurricane Katrina doctor . . . 103
- Preserving patients' dignity lends value to end of life . . 103
- Massachusetts legislates universal health insurance coverage; is it enough? . . . 104
- AMA issues opinions on patenting procedures, implantable ID chips 105
- Relief of chronic pain gathers steam as human rights issue 106

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Does patient confidentiality end with death? Depends on definition of person

Ethicists present differing views on sharing information after death

One of your patients dies as the result of an AIDS-related infection. During the time he was under your care, he made it clear that he did not want his parents to know that he was HIV-positive or suffering from AIDS.

At the hospital following his death, his parents approach you and ask for details about their son's illness. Has your obligation to maintain patient confidentiality ended now that the patient has died?

The answer depends on the physician's interpretation of who the obligation is to: Is it the living, physical patient? The patient's identity and "personhood" that remains after his death? The spirit of the patient's intent?

Patient confidentiality, and the trust that it engenders in the physician-patient relationship, has been a cornerstone of medicine for centuries. The American Medical Association's (AMA) *Code of Medical Ethics*¹ states that information disclosed during the course of the physician-patient relationship is confidential to the utmost degree in life, and after death.

"At their strongest, confidentiality protections after death would be equal to those in force during a patient's life," the AMA code states. Disclosure of information after death is ethically permissible under some circumstances, according to AMA guidelines, particularly if there is imminent harm or potential risk to living individuals or the public health.

Factors the AMA urges consideration of include: the impact the disclosure may have on the reputation of the deceased, and any specific directives the patient may have made before death regarding disclosure after he or she died.

But ethicists say the question is much more complicated, and involves the belief and value systems of both physicians and their patients.

Confidentiality precedes birth, outlasts death

"Patient confidentiality can start, indeed, before the patient is ever born," according to **Bryan Liang, MD, PhD, JD**, executive director and

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professor at the Institute of Health Law Studies, California Western School of Law in San Diego. "Information on gender, genetics, and other conditions and aspects of his or her medical and social conditions are ethically subject to the same principles and protections as those of a born person."

Therefore, Liang asserts, it's the health care provider's duty to maintain confidentiality of children before and after their birth, just as the provider would an adult.

"Beyond this, of course, there is an ongoing duty of the medical professional to keep relevant social and medical information about a patient confidential on both ethical grounds and legal grounds," he continues.

Ethically, confidentiality is paramount to establishing the trust necessary for a patient to provide

full, relevant information so that the provider can meet the patient's health care needs.

"It should be emphasized that the information should be used only in the spirit it is given — for the purposes of assisting the patient in reaching his or her health care goals, which includes diagnosis, assessment and discussion of alternatives, and treatments," says Liang. "Only in very prescribed circumstances is this confidentiality permitted to be broken either ethically or legally — usually when the patient puts his or her condition at issue, such as a patient injury lawsuit [a 'waiver' situation]; in significant public policy circumstances such as a court order [a 'public duty' situation]; or in assisting an investigation of a crime or prevention of harm to an identifiable individual [a 'public welfare' situation]."

Statutorily created exceptions to confidentiality, including those under the Health Insurance Portability and Accountability Act (HIPAA), should be assessed on their facts and justified both ethically and legally before confidentiality is breached, he adds.

Liang believes that not only does confidentiality begin before birth, it lasts beyond death — and that includes the death of the physician.

"The concept of continuing confidentiality past the patient's death is both an established ethical precept, as well as imbued in law," he explains. "The trust conception and manifestation must include these beginning- and end-of-life circumstances to ensure that we, as providers, are seen as fulfilling our duty of confidentiality and will not break that duty in the event the patient is not there to object, and that each generation of patients sees that there is an inviolable rule of keeping the words spoken and information passed between provider and patient as solely between those parties."

'Death changes things'

Sara Rosenthal, PhD, director of the University of Kentucky College of Medicine Program for Bioethics and Patients' Rights and co-chair of the university hospital ethics committee, thinks the idea of confidentiality is to protect "personhood," and that after death, there no longer exists that living person whose confidences the physician protected.

"Death changes things, and you're no longer talking about a living person," Rosenthal suggests. "The point of confidentiality is to protect the person in a practical sense — for example, to protect information from employers who could use that information to socially or professionally

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- **American Medical Association** Code of Ethics, E-5.051: Confidentiality of medical information postmortem. Available on-line at www.ama-assn.org/ama/pub/category/2498.html.

stigmatize [the patient], or for example, when they are dealing with something like AIDS.”

Rosenthal, who says she has not done a thorough literature search on the subject, says she believes the question of whether — and what — to disclose after a person's death would depend on the situation.

“If confidentiality is there to protect people who are alive from having their privacy and private information disclosed, and if, when someone dies, they cease to be a person, I think the question about what information may be disclosed then comes down to the situation,” she explains. “I would say those questions are individualized. What do [the people asking for information] want to know, specifically, and what will they do with the information?”

“Would it reduce the suffering of certain family members? Or would they use the information for some sort of financial or other agenda, or is their need something real and practical, such as a question about insurance?”

In cases where a physician's duty to warn of imminent harm or potential threat comes into play, HIPAA and state laws offer protection, and in those cases, it would be unethical not to divulge information, Rosenthal says.

In the case of a surviving spouse whose husband died of complications following minor surgery, a physician disclosed that the husband had been told that the risk of potentially fatal complications was high. However, the husband had not shared that information with his wife

before the surgery. In that case, Rosenthal suggests disclosing the information was appropriate because it might relieve concerns the wife had about her husband's death following what she had assumed was a low-risk surgery.

“In that case, while it probably says a lot about the husband and wife's relationship in that he didn't confide in her, the physician might have felt an ethical obligation to relieve the questions in the spouse's mind,” she says.

Rosenthal offers an anecdote about a case in which a patient was clear in his demand that information be withheld, but physicians felt that while the case did not rise to the legal duty to warn standard, it was ethical to breach confidentiality after his death.

“There was a patient with a genetically inherited cancer. The nature of the inheritance was that it functioned like Huntington's disease — if you have the mutation, you are guaranteed to develop the cancer,” she recounts. “This patient was not a very nice man, and he had lots of adult children by several wives, so there was lots of potential for people to be at risk of having this mutation for this incurable, aggressive cancer.

“His doctor said, ‘You need to get your children tested,’ and the patient said, ‘Let them die.’ Ultimately, the patient was found dead in a hotel room, and upon his death, the physician located all the man's children, explained the situation, disclosed to them that their father had this cancer, and they all got tested.

“This was, they felt, a duty to warn situation. They tried to get permission; he said explicitly not to contact them — but the physicians did anyway because they felt their ethical obligation overrode that patient's reasons for demanding confidentiality.”

Confidentiality equals respect

To get to the core of the ethical question about if and when patient confidentiality ends, you must first separate out the idea of “protection,” a legalistic term, from the true root of confidentiality, which is respect, according to **Stuart G. Finder**, PhD, director of the Center for Healthcare Ethics at Cedars-Sinai Medical Center in Los Angeles.

“When you talk about confidentiality, you are really talking about respect, about showing some sort of deference to that person and respecting that person,” says Finder. “When someone is alive and asking you to hold a confidence, the idea is to subjugate your concerns and interests to

them and their wishes.

“But when they’re dead, how do you respect someone who no longer ‘is’?”

To answer that question, Finder says the health care professional has to look deep within his or her own understanding of what constitutes a person.

“Part of what we bump up against is how we understand who that ‘other’ is. In the case of a living patient, the brute fact of the physical body stands out — and, of course, medicine is very attentive to that body, maybe even primarily focused on it — even though who one is, in terms of how lives are actually lived and experienced, is probably much better thought about in terms of a complexity of relational and inter-relational dynamics.

“So who you are goes beyond your body. And what’s really quite interesting is that those relational dynamics associated with you or me go on [after death],” says Finder. “So even after my parents die, I am still their son and they are still my parents. I will always be my children’s father, even after I die and after they die.”

Finder says that to disclose confidential information after the death of a patient risks altering a relationship dynamic that the patient may have spent a lifetime constructing.

In considering the ethics of breaching confidences after death, Finder urges providers to look not just at the situation, but the context in which the information was learned.

“So in some cases, even if a wife wants to know information, the physician has to make a decision and review whether divulging that information would be to go against the spirit of how that information was given or who the person was, and base the decision very similarly, if not the same, as if the person were still alive,” he adds.

Talk with patients before they die

Finder says if a patient tells his physician that he wants his condition or treatment decisions kept private, that’s an invitation to the physician to talk about confidentiality.

“There are clearly situations that patients don’t want their families to know about, and they’ve made decisions based on [their relatives not knowing]. So that’s a clear invitation, I think, for the physician to say, for example, ‘I’ve been treating your HIV for five or 10 years now and support your decisions not to tell your parents, but now the questions are going to come up [as the patient enters the final stages of life]. Have you thought of what you want me to do when those questions

come up and you’re no longer here?’” says Finder.

Liang suggests the discussion of what — if anything — the patient wants disclosed after death should take place well before death is imminent.

“As there should be a standard discussion about health care proxies or living wills, there should also be a standard discussion about what the patient wishes to have disclosed, if anything, as well as to whom he or she would want this disclosure made,” he says. “It should occur early in the process, when the patient is not under tremendous stress and emotionally saturated in addressing the disease state he or she is experiencing.”

Rosenthal says that just as advance directives and wills let patients determine some aspects of their deaths and what is and is not allowed, patients can talk with their physicians about what information disclosures they are comfortable with taking place after their deaths.

“I don’t see any reason practitioners shouldn’t ask [patients about their disclosure wishes], but I don’t think there is any hard and fast rule compelling them to ask,” she adds. “I think the burden still falls to the health care provider, and they will have to weigh each situation.”

And technology may render some wishes about post-mortem confidentiality moot, Finder says, as we gain increasing ability to reassess health information from the past.

“At what point does my health information become public? People keep going back and asking why George Washington died, and whether Lincoln’s height was due to a nutritional phenomenon, so what about ordinary citizens’ health information?” Finder asks. “I think you can make an argument that researchers may have legitimacy in gaining access to our information after a period of time — maybe after six or seven generations, or a hundred years — for certain purposes. That legitimacy, however, like the justification for accessing my information now, will still be bound up with the question of how best to show respect.” ■

Postgrad certificate offered in spirituality, health care

Course brings spirituality into the medical academic

Spirituality has been tied to physical health throughout the history of cultures worldwide, but only recently has it been gaining new attention

SOURCE

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as a component of modern health care. Now, George Washington University's Institute for Spirituality and Health (GWISH) has brought the subject fully into the academic setting by offering a graduate certificate in spirituality and health care.

"Spirituality is a factor that contributes to health. It can be understood as an essential part of each human being — that part which seeks meaning and purpose in the midst of suffering, illness, stress, and life transitions," explains GWISH Director **Christina Puchalski**, MD. "Spiritual beliefs and issues can impact patients' illness and health care decision making, as well as influence diagnosis, treatment, and coping."

The certificate program that was launched during the spring 2007 semester is believed to be the first of its kind in an academic setting, according to the program's director, **Beverly Lunsford**, PhD, RN, associate director of the Washington, DC-based GWISH. The 15-semester-hour certificate program is offered on-line and targets health care providers who are already in — or on their way to — their careers.

Bringing spirituality into existing programs

Lunsford says she frequently received inquiries from medical or nursing students asking, "What kind of job will I be able to get when I finish this program?" But the program is geared not toward job seekers as much as it is to professionals already in jobs where they have identified ways that incorporating spiritual awareness can improve delivery of care.

"What we've found is that people who are in health care professions — be it end-of-life [care], nursing, or another profession — come into the program and see roles that are needed where they already are [working]," she says. Designing the program to be offered on-line rather than in the classroom allows applicants already in full-time careers to find real-life applications as they learn, she adds.

Applicants to the program must be practicing health care professionals (physicians, psychologists, nurses, social workers, chaplains, etc.) with a bachelor's degree and GPA of 3.0 or higher in a related field. The first cohort of students who began in January 2007 are primarily physicians, followed by chaplains, nurses, and social workers.

The potential for impact on the delivery of health care is twofold, Lunsford says. On one level, individual candidates will develop their own skills at integrating patient spirituality and health, and on another level, they'll be able act as leaders to bring about changes in approach at their clinical and academic institutions.

It's spirituality, not religion

An important point Lunsford makes about the GWISH program is that it is evidence-based, not rooted in religious belief.

"We view spirituality as universal to all people, and not just to people who practice a religion," she explains. "We say we look at our patients as bio-psycho-social-spiritual, but the spiritual component is not developed very fully because it's been couched as 'religious.' But spirituality is broader than religion, and [through the GWISH program], we're developing some theoretical framework for that."

The need for incorporating patients' spirituality into their health care is evidenced in a growing body of literature, Lunsford adds. More than 80% of U.S. medical schools have courses in spirituality, and many hospitals have spirituality initiatives, according to Puchalski.

Patient-centered care "must include knowing people's spiritual framework, because that determines whether they accept care, whether we make our care appropriate to their own health beliefs and practices — it truly affects the delivery of care," Lunsford says. Among the primary aims of the GWISH instruction is to enable certificate candidates to facilitate spiritual care in particular when patients and families face serious illness, chronic pain, end of life, and bereavement.

The provider's own spirituality is not ignored; in fact, one component of the program addresses how health care professionals' personal spirituality is a factor that contributes to their own professional purpose and their delivery of care.

(For information on the GWISH Spirituality and Health Care Graduate Certificate Program and how to apply, go to www.gwumc.edu/healthsci/programs/shc_c.) ■

EOL in incapacitated ICU patients with no surrogates

Some EOL decisions made without ethics consult

Physicians in intensive care settings at times make the decision to withdraw life-supporting care from patients who are incapacitated and have no surrogate decision makers or advance directives.¹ But how often does it happen?

According to investigators led by University of California ethicist **Douglas D. White, MD, MAS**, 5% of all deaths in intensive care units (ICUs) involve patients who lacked surrogates or advance directives, and when physicians considered limiting life support in those patients, they usually did so without institutional or judicial review. White's latest findings are reported in a recent issue of *Annals of Internal Medicine*.²

White points out that patients without advance directives or surrogates "pose ethical and practical dilemmas in intensive care units." Further complicating such situations, he adds, is the fact that hospital policies, professional society guidelines, and state laws on making end-of-life decisions for those patients vary widely.

White and his colleagues conducted a study that included all adults who were admitted to the medical or medical-surgical ICUs of seven hospitals in a six-month period during 2004 to 2005. The hospitals are in metropolitan areas in California, Oregon, Washington, Pennsylvania, New York, and New Hampshire.

Attending physicians at the hospitals were told they were participating in a study on the processes of care for incapacitated patients without surrogates. If the attendings indicated that withholding or withdrawing life-sustaining treatment had been considered or would have been considered if a surrogate had been available, they completed a questionnaire that detailed the patient's care, decisions that were considered, and decisions that were made.

The study rendered the hospitals, physicians, and patients anonymous to protect patient confidentiality and guard against possible physician liability.

During the study period, 3,011 patients were admitted to ICUs, and the combined mortality rate for all intensive care units was 15% (451 patients). The percentage of ICU deaths that occurred in incapacitated patients without surrogates and advance directives ranged from 0% to 27%, with an overall rate of 5.5% (25 patients).

SOURCE

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Physicians reported that in 37 incapacitated patients with no surrogate and no advance directive, they considered or would have considered limiting life support if a surrogate had been available.

In five of the 37 patients, the physicians did not consider limiting life support, but would have if a surrogate had been available. In those 5 patients, the physicians did not involve anyone else in the decision-making process.

In 10 of the 37 patients, physicians consulted other members of the patient's health care team on at least one of the life-sustaining care decisions, but did not involve hospital review committees or other attending physicians and did not seek a review by the courts.

In the other 22 cases, the attending physician sought assistance from another attending, a hospital review committee, or the courts.

White reports that five hospitals had an explicit policy about making decision for patients who were incapacitated and lacking surrogates, and in those hospitals, life support decisions were made for five of 14 patients without conforming to the oversight recommended by the policy.

The study also compared decisions made in the incapacitated patients to hospital policies and guidelines on decision making for incapacitated patients without surrogates published by the American Medical Association (AMA), American College of Physicians (ACP), American Geriatrics Society (AGS), American Thoracic Society, American College of Chest Physicians, and Society for Critical Care Medicine. State laws were researched to find laws that pertained to decisions in those patients.

Decisions made in the majority of the 37 patients did not adhere to the policies of the AMA or the ACP; however, all were consistent with the oversight suggested by the AGS.

"When patients without decision-making capacity lack a surrogate and an advance directive, it is generally not possible to know whether the decisions made are those that the patients would have made themselves," reports White. For that reason, "the process by which the decisions are made assumes greater importance," and the authors urge

further research and ethical analysis on how decisions for these patients should be considered.²

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AMA, ANA hail failed prosecution of Katrina doc

Groups concerned about fallout case could have

While a grand jury in New Orleans has cleared otolaryngologist **Anna Pou**, MD, in the deaths of patients at Memorial Medical Center in the days following Hurricane Katrina in August 2005, allegations that she and two nurses actively killed patients trapped in the hospital, some doctors fear, could deter health care providers from remaining at their posts in future disasters.

Calling Pou and other physicians and nurses who stayed with their patients through the desperate conditions that followed the hurricane “bright lights during New Orleans’ darkest hour” in a statement released after the grand jury refused to issue charges, American Medical Association (AMA) and American Nursing Association (ANA) leaders expressed concern about the actions taken against the doctor and nurses.

“[The AMA and ANA] continue to be very concerned about criminalizing decisions about patient care, especially those made during the chaotic aftermath of a disaster, when medical personnel and supplies are severely compromised,” according to the statement issued by the Chicago-based AMA and Silver Springs, MD-headquartered ANA. The two largest organizations representing doctors and nurses in the United States say such decisions and actions by providers should be investigated by licensing boards, not criminal investigators.

“During any disaster, health care providers — doctors, nurses, and others — must work together to make the best decisions that they can given available resources,” the statement continues. “This criminal prosecution will chill future responses of health

practitioners during a major disaster for fear of having their best judgments second-guessed.”

Pou and nurses **Cheri Landry** and **Lori Budo** were arrested in 2006, though they were never charged with any crimes related to the deaths of nine patients who Louisiana Attorney General **Charles Foti** said were murdered with a lethal “cocktail” (of morphine and midazolam hydrochloride). Pou said she administered medications to the patients only to relieve pain.

The Louisiana State Medical Society backed Pou from the outset and issued several statements in support of her care of patients after the hurricane left Memorial Medical Center and other hospitals isolated, flooded, and without electricity, clean water, or adequate supplies.

“The decisions [Pou] made were in the best interests of the patients under her care,” says **Amy W. Phillips**, JD, director of legal affairs for the state medical society. “We hope the grand jury’s decision will remove the chilling effect these charges have had, and encourage physicians and other health care providers to continue to volunteer during disaster and emergency situations.”

As for Pou herself, during brief comments to the media following the grand jury decision, she said her experiences since Katrina would not deter her from staying with patients should she find herself in the midst of another disaster.

“There’s no one better than those of us who were here at the hospital during Katrina,” Pou said.¹

Pou still faces civil suits filed by some families of the patients who died at Memorial, and is herself suing the state of Louisiana for relief of the legal fees she has incurred.

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1. “Grand jury refuses to indict Dr. Anna Pou” by Gwen Filosa and John Pope. *The Times-Picayune* (New Orleans), July 24, 2007. ■

Preserving patients’ dignity lends value to end of life

Expert says respect more than just courteous

Preserving a patient’s dignity is more important than some doctors think, according to a palliative care expert who points out that loss of dignity is one of the most common reasons

patients seek out physician-hastened death.

“When patients experience a radical unsettling of their conventional sense of self and a disintegration of personhood, suffering knows few bounds,” says **Harvey Max Chochinov**, MD, PhD, a Canadian palliative care expert and professor at the University of Manitoba Department of Psychiatry. “To feel sick is one thing, but to feel that who we are is being threatened or undermined — that we are no longer the person we once were — can cause despair affecting body, mind, and soul.”

Some physicians neglect dignity in care because they feel they don’t have the time to address it, or because they feel they lack the expertise, Chochinov says. In response, Chochinov has written a guide that provides an A-B-C-D mnemonic of dignity-conserving care.¹

ABCDs preserve patient dignity

Chochinov says health care providers have a profound influence on how patients experience illness and their sense of dignity. He says a lack of attention to dignity-conserving care — variously referred to as spiritual care, whole person care, or psychosocial care — can lead to patients feeling they are not being treated with respect and dignity, which can undermine their sense of worth and result in the feeling that their lives no longer have meaning or value.

Chochinov suggests bearing in mind four main ideas — attitude, behavior, compassion, and dialogue — to keep patient dignity high on the list of priorities in health care:

- **Attitude** is the attitude and assumptions health care providers have toward their patients. This can mean a predisposition to behave in a consistent way toward a particular class of people, or a tendency to react to people not as they are, but as they are conceived to be, says Chochinov. An example might be to assume that a patient with disabilities has a poorer quality of life than someone without disabilities.

- **Behavior** toward patients should be “predicated on kindness and respect.” Don’t discount the value of small acts of kindness — getting the patient a glass of water, adjusting pillows, and commenting on personal photos, greeting cards or flowers are some examples. “These behaviors convey a powerful message, indicating that the person is worthy of such attention,” says Chochinov, who adds that such acts are particularly impor-

SOURCE

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tant when the patient is suffering from advanced disease.

- **Compassion** is a “deep awareness of the suffering of another coupled with a wish to relieve it,” Chochinov’s guide states. Physicians are encouraged to examine the feelings that are evoked by their contact with patients, and to consider how it shapes their approach to care.

- **Dialogue** can be, Chochinov argues, the most important component of the framework for dignity-preserving care. The exchange of information between patient and caregivers drives the delivery of care, and should begin with acknowledging the patient as a person beyond his or her illness.

Chochinov writes that his guide has its origins in palliative care, but applies across all medicine because it’s based on empirical evidence demonstrating that kindness, humanity, and respect are core values of medicine, not just “niceties of care” to be offered when time and circumstances allow.

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Is legislating universal health coverage enough?

Massachusetts first state to guarantee coverage

With the implementation of health care reform passed in 2006, Massachusetts became the first state in the country to enact a law guaranteeing health insurance coverage to all its citizens. In the 12 months leading up to the July 1, 2007, implementation of the law, more than 155,000 Massachusetts residents had enrolled with health insurance providers —

progress that state health insurance official **Jon Kingsdale**, PhD, hails as “a big step in the long march toward near-universal health coverage.”

While health care providers say it’s too early to tell whether the measure will be of benefit in delivery of care, ethicists say one positive feature is the elimination of many preexisting conditions that previously were used to disqualify some applicants.

The Massachusetts health insurance plan is being closely watched by other states considering universal health coverage. Features of the plan include:

- Free health insurance to residents with incomes slightly above or below the poverty level;
- Insurance on a sliding-scale basis for low- and moderate-income residents who have no source of coverage;
- The Connector, a new source for coverage with different choices of affordable health insurance plans for individuals and their families;
- The requirement that adults who do not have health insurance get coverage if affordable coverage is available. Adults who do not qualify for free or subsidized health insurance or a waiver must pay a penalty.

All employers — except for very small businesses — are now required to offer their employees health insurance and pay a fair share of the cost, or else pay a penalty. Massachusetts is only the second state, after Hawaii, to mandate employer-funded health insurance.

Fines for non-compliance increase dramatically as time passes, which officials hope will spur employers and individuals to act quickly. There are no criminal penalties for not purchasing insurance.

“The new plans we offer will be more affordable for tens of thousands of Massachusetts workers who might otherwise remain uninsured because they are not able to purchase insurance directly through their employer,” says Kingsdale, director of the Massachusetts Health Insurance Connector Authority. “The fact that we are on track to surpass our projections is indicative of the need for this program, the high level of benefits it offers, strong outreach, and collaboration with many partners who have helped to simplify the enrollment process.”

However, some health care organizations remain unconvinced. They view the plan as uncomfortably similar to one proposed in the 1980s that collapsed within two years due to

funding issues.

“The requirement that most of the uninsured purchase coverage will either require them to pay money they don’t have, or buy nearly worthless, stripped-down policies that represent coverage in name only,” says **Steffie Woolhandler**, MD, MPH, co-founder of the Chicago-based Physicians for a National Health Program and a primary care physician in Cambridge, MA.

Additionally, says Woolhandler, “the legislation will do nothing to contain the skyrocketing costs of health care in Massachusetts, already the highest in the world.”

[For more information, visit the Massachusetts Health Insurance Connector Authority on-line at www.mass.gov/connector. Contact the Physicians for a National Health Program at (312) 782-6006.] ■

AMA on implantable ID chips, patenting procedures

Technology demands review, revision of ethics code

The American Medical Association has spoken out on two medical technology-related ethics issues, affirming that it is unethical to patent medical procedures and cautioning that the use of implantable radio frequency identification devices should come with a strong dose of caution to the user.

The AMA House of Delegates took action on the ethics questions at its annual meeting in June.

Patents too restrictive, delegates rule

The AMA’s Council on Ethics and Judicial Affairs (CEJA) proposed that the AMA soften its opinion that the use of trade secrets, confidentiality agreements, and patents unethically limits patient access to the protected procedures.

CEJA said its investigation into patents suggests there are legitimate reasons to patent some procedures, and that the patent application process provides adequate public disclosure of the procedures. CEJA proposed that patents on procedures be permitted under the AMA ethics code, so long as they are not used to limit access; but the House of Delegates decided to let the 1995 ethics rule stand unchanged.

In other action, the AMA established its first code of ethics relating to implantable radio frequency identification devices (RFIDs), or “chips.”

RFIDs bear an identifying number unique to the wearer that is revealed when scanned by a handheld scanner or “interrogator.” The ID links to a potentially huge amount of medical and personal information, including allergies, medical conditions, blood type, and history. Currently, the VeriChip manufactured by VeriMed (Delray Beach, FL) is the only RFID approved by the U.S. Food and Drug Administration for implanting in humans for the purpose of identification.

In the ethics council’s report, CEJA Chairman **Robert M. Sade**, MD, notes that RFIDs represent “another promising development in information technology,” but cautions that they “also raise important ethical, legal, and social issues.”

The CEJA report states that while use of RFID identification may improve patient safety, it also may pose physical risks and threats to privacy.

The AMA recommends that physicians who consider the implantable chips — which are inserted just below the skin, usually on the patient’s arm — disclose the medical uncertainties associated with the devices.

Doctors also should work to protect privacy by storing confidential information only on RFID devices that are as secure as electronic medical records. The AMA expressed concerns that the devices might migrate under the skin and be difficult to remove; VeriMed has stated that the method for insertion ensures they stay in place.

“Physicians cannot assure patients that the personal information contained on RFID tags will be appropriately protected,” the AMA cautions. The chips should not be implanted or removed without prior patient consent, the delegates said. ■

Chronic pain: Is it a human rights issue?

States, nations addressing research, access to care

Chronic pain has gathered increasing international attention as a human rights issue, and a bipartisan bill introduced in Congress in July seeks to mandate the right of chronic pain sufferers to education, treatment, and research into the

condition.

“Medicine is at an inflection point, at which a coherent international consensus is emerging: The unreasonable failure to treat pain is poor medicine, unethical practice, and is an abrogation of a fundamental right,” according to **Frank Brennan**, MBBS, DCH, a palliative care specialist in Sydney, Australia.¹ Brennan and colleagues write in the July issue of *Anesthesia & Analgesia* on the medical, legal, and ethical reasons for declaring access to pain management a global human right.

The National Pain Care Policy Act of 2007, introduced by U.S. Rep. Mike Rogers (R-MI) and Rep. Lois Capps (D-CA), addresses chronic pain issues on a national level by proposing research, grants for education and training, and public awareness.

“Pain is the leading cause of disability in the United States, and is straining our health care system,” says Capps, a registered nurse. “This legislation takes several important steps to improve the assessment, understanding, and treatment of pain. Hopefully, this will provide much needed relief for many people suffering from pain.”

The bill would authorize the Institute of Medicine to conduct a special conference on pain care; establish permanent authorization for a pain consortium at the National Institutes of Health; set up a grant program for pain care education and training; and direct the Department of Health and Human Services to develop and implement a pain management public awareness pain.

“For many cancer patients, fear of cancer pain is worse than fear of death itself,” according to **Daniel E. Smith**, president of the American Cancer Society Cancer Action Network. “The good news is that nearly all cancer pain can be relieved if treated adequately.”

Pain carries ‘massive costs’

Brennan and his colleagues assert that inadequate pain treatment is an entrenched problem around the world, related to cultural, societal, religious, and political factors — including the acceptance of torture. Poorly controlled pain has

CME answers

9. A; 10. C; 11. D; 12. B.

potentially serious adverse effects, both physical and psychological, as well as “massive social and economic costs to society.” Cancer pain, Brennan states, is a special concern, with up to 70% of cancer patients experiencing severe pain caused by their disease or its treatment.

Ignorance and fear — specifically, “opiophobia” and “opioignorance” — contribute to the inadequacy of pain management, Brennan writes, because physicians are untrained and uncertain when it comes to effective use of opioids. He suggests that lack of training in proper use of morphine and other opioids is compounded by the occasional, highly publicized prosecution of physicians for opioid prescribing.

Some nations and states — including Australia and California — have passed laws defining a right to adequate pain management, protecting medical practitioners who treat pain in terminally ill patients, or introducing requirements for pain management and education.

For the second year, the American Cancer Society, the Lance Armstrong Foundation, and Susan G. Komen for the Cure released a “report card” on states’ pain management policies. The report was issued in July and is available at www.painpolicy.wisc.edu/Achieving_Balance/RC2007.pdf.

The 2007 report card shows that California and Wisconsin had the greatest grade improvement. Other states whose grades improved from last year were Arizona, Colorado, Connecticut, Kansas, Massachusetts, and New Hampshire. Improvements were most often in removing legal restrictions that challenged pain management, or implementing state medical board pain management policy statements. Kansas, Wisconsin, Michigan, and Virginia are deemed to have the most balanced pain policies in the nation.

Reference

1. Brennan F, Carr DB, Cousins M. Pain management: A fundamental human right. *Anesth Analg* 2007; 105:205–221. ■

Pain doctor gets five years in prison for trafficking

A Virginia physician who specialized in pain management has been sentenced to nearly five years in prison for prescribed large amounts of opiates. The sentence imposed in federal court against William E. Hurwitz, MD, 61, comes for his conviction earlier in 2007 on 16 counts of drug trafficking. The sentencing judge said Hurwitz should have been able to tell that some

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. ■

COMING IN FUTURE MONTHS

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of his patients were drug dealers or drug abusers.

According to prosecutors, Hurwitz's 400 patients, who came from 39 states to his clinic in Northern Virginia, sought and received prescriptions for OxyContin and morphine. One patient received a prescription for 1,600 pills per day, prosecutors alleged. Hurwitz was charged as part of a lengthy multi-jurisdictional probe into OxyContin trafficking that eventually resulted in more than 130 convictions. ■

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CME Questions

9. According to ethicist Bryan Liang, which of the following triggers that might cause patient confidentiality to be breached could be considered a public welfare situation?
 - A. There is opportunity to prevent harm to an identifiable individual.
 - B. A court order is issued.
 - C. The patient files an injury lawsuit.
 - D. A patient's surviving family asks for information.

10. According to Chochinov's mnemonic for preserving patients dignity, A-B-C-D refers to:
 - A. Access, Behavior, Compassion, Drugs
 - B. Analgesics, Benevolence, Continuity of care, Directives
 - C. Attitude, Behavior, Compassion, Dialogue
 - D. Advance directive, Behavior, Caregiver, Dialogue

11. Which of the following are provisions of Massachusetts' new universal health insurance plan?
 - A. Free health insurance to residents with incomes slightly above or below the poverty level
 - B. Sliding-scale costs for low- and moderate-income residents who have no source of coverage
 - C. A state-run source for coverage with different choices of affordable health insurance plans for individuals and their families
 - D. All of the above

12. In White's, et al, review of deaths of intensive care patients, how many of the deaths during the study period were found to be in incapacitated patients who had no surrogates or advance directives?
 - A. >1%
 - B. 5%
 - C. 10%
 - D. 17%