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Task force suggests health care rationing in catastrophes

Care focus is on whole, not individual

"If a mass casualty critical care event were to occur tomorrow, many people with clinical conditions that are survivable under usual health care system conditions may have to forgo life-sustaining interventions owing to deficiencies in supply or staffing."¹

In a nation whose Founding Fathers emphasized the freedom and autonomy of the individual to form the basis for the United States as we know it today, those words could create alarm in some.

But in the "Summary of Suggestions From the Task Force for Mass Critical Care Summit, January 26-27, 2007," that group chose to weight its suggested protocols on mortality vs., for example, life years saved in the event of a mass casualty event.

The task force met in Chicago in January 2007 following extensive literature searches with MEDLINE, OVID and Google databases from January 1966 to November 2006, as well as other types of publication searches. The group later communicated electronically and in conference calls after forming writing committees when it initially convened to develop the manuscript.

The result almost a year later (the manuscript was submitted and accepted for publication in March 2008), in a 67-page document that offers specific suggestions in four documents titled, respectively: "Definitive Care for the Critically Ill During a Disaster: Current Capability and Limitations"; "Definitive Care for the Critically Ill During a Disaster: A Framework for Optimizing Critical Care Surge Capacity"; "Definitive Care for the Critically Ill During a Disaster: Medical Resources for Surge Capacity"; as well as "Definitive Care for the Critically Ill During a Disaster: A Framework for Allocation of Scarce Resources in Mass Critical Care."

"...No one had really taken the soup to nuts approach of what really are the likely events, what are the likely capabilities that are going to be brought to bear, and what are the situational contexts

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which will create certain limitations to be able to augment access," notes **Lewis Rubinson, MD, PhD**, of the Harborview Medical Center in Seattle, and one of four authors of the manuscript.

"How can we prepare ahead of time, so that this likelihood of having to decide between people never becomes a reality? Still, it would be irresponsible of us if we just bury our heads in the sand and don't take on a fair, just and objective means to allocate, knowing that we're trying to reduce the plausibility, but the plausibility will always exist," Rubinson tells *Medical Ethics Advisor*.

In addition to suggestions for rationing health care – albeit with a full consideration of the ethics associated with such decisions — is an "absolute

frank statement that everyone will get dignified care," in the scenario that the task force envisioned, according to Rubinson.

"You may not get a ventilator if there are orders of magnitude of people all needing it, and you are much more sick than someone else, because they're more likely to benefit," he says.

As the executive summary points out, the "vast majority" of mass casualty events "do not generate overwhelming numbers of critically ill victims."

The suggestions, as the title indicates, are just that — not policies or guidelines, he says. The task force suggestions are meant to help state and local level planning, and the groups that are involved in this planning, since most health care emergency procedures are developed at these levels.

While most of the mainstream media attention on the suggestions focused on the rationing of health care that is specifically suggested, Rubinson said the group's ethical considerations began long before this point.

Ethical construct framed

"So, even before allocation takes place, there is a potential ethical construct that has to be newly created that leads, again, from individual focus to population focus," he says. "And for those specifics, we hesitate to recommend to each community to do their own specifics, because then every community is going to be doing something differently. The only way to truly do things fairly and justly is to have people following similar things."

For example, by following these suggestions, it would prevent smaller hospitals with fewer resources from bearing the brunt of the care during a mass catastrophe, and therefore placing their patients at higher risk than perhaps at other facilities.

With the rationing of health care comes obvious obligations for what could be considered fair treatment, even when the goal is to save those who may benefit most from receiving therapies or treatments under the circumstances.

Rubinson says that the suggestions are careful to specify the "triggers" that would lead to rationing of health care. For example, Suggestion 4.3A states, among other things, that "critical care will be rationed only after all efforts at augmentation have been exceeded."

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Editorial Questions

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"The task force assumes that [emergency medical critical care (EMCC)] has become exhausted and a Tier 6+ level has been attained or exceeded," Suggestion 4.2 states.

One aspect of the rationing of health care is that decisions will be made by the medical professionals, i.e., "Rationing of critical care will occur uniformly, be transparent, and abide by objective medical criteria."

Another suggestion, 4.3D, states that "Rationing should apply equally to withholding and withdrawing life-sustaining treatments based on the principle that withholding and withdrawing care are ethically equivalent."

Palliative care is also an essential part of the suggestions for rationing health care in an EMCC.

"...[For] anyone who practices critical care, palliative care and end-of-life care [are] a huge part of what we do, so it was just logical to have that as part of this strategy," Rubinson says.

Related to the rationing of health care, the suggestions actually spell out that "providers should be legally protected for providing care during the allocation of scarce resources in mass critical care when following accepted protocols."

In providing for this in policy, it would have to be done at the state level, he says.

"We wanted to give [stakeholders] specifics, so that ultimately, when they do want to implement this, they have something to take to their legislature, because no legislature is going to give them carte blanche . . .," Rubinson says. "Clearly, that's not a wise strategy, either, because we want to make sure that the public is protected as well as possible."

The goal of any legislation would be to provide "either immunity or indemnification from civil and criminal liability," Rubinson says.

Creating surge capacity

"Every hospital with an ICU should plan and prepare to provide EMCC and should do so in coordination with regional hospital planning efforts."

The suggestions specifically say that hospitals should plan to provide EMCC for a "total critically ill patient census at least triple usual ICU capacity." And, hospitals should plan to deliver this level of care for 10 days "without sufficient external assistance."

One has only to think of the ravages of Hurricane Katrina, or more recently in Myanmar, to think of the number of days that can pass before some type of aid or assistance

outside the affected area may be available.

Hospitals also should plan to have EMCC include such things as IV fluid resuscitation, vasopressor administration, and antidote or antimicrobial administration for specific diseases.

In suggestion 3.3 in the document related to providing medical resources at surge capacity, one of the specifics is that rules should be developed "for medication restriction (eg, oseltamavir if in short supply during an influenza pandemic)," as well as guidelines for extending the shelf-life of medications.

The suggestions also address "staffing models" for operations during surge capacity, which include four specifics, including one that "systematic efforts to reduce care variability, procedure complications and errors of omission must be used when possible."

Conclusions reached

The task force hinged its efforts on EMCC to provide what it considers an "effective conceptual and operational framework" for responding in the best way possible to mass casualty events.

Focusing on the "good of the collective society," the task force decided that its goal was to provide a framework that may allow those responding in such events to "do the greatest good for the greatest number."

And finally, the task force again noted that the decisions that often are required during a natural or manmade catastrophe are "complex" and "fraught with ethical dilemmas that require thoughtful consideration well in advance of their use in an emergency."

In the event the public or other stakeholders object to rationing, regardless of the greater good of the task force's values, Rubinson said that providing the best health care to every person in certain catastrophes is "an impossible situation."

So, while the task force's goals are to reduce the likelihood of an individual needing health

care being deprived of that care, Rubinson said, "I don't really think it's fair to say that it will never happen." ■

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1. Deveraux, A. et. al. Summary of Suggestions From the Task Force for Mass Critical Care Summit, January 26-27, 2007. *Chest*. 2008; 133: 1S-7.

Discharge process is a balancing act

Weigh autonomy vs. patient safety

"Currently, there is no national policy governing discharge planning."

So noted **Barbara Chanko**, RN, a health care ethicist who was one of the speakers in a Veterans Health Administration national ethics teleconference in late May.

Using three scenarios based on real-life situations, ethicists from the National Center for Ethics in Health Care of the VHA sought to illustrate how ethics policies are often easy to develop in theory, but those theories "may sometimes be quite difficult to implement," according to Chanko.

"VHA is committed to ensuring that each patient is treated in the most appropriate care setting for his or her condition, and discharged to an environment that is safe," she said. "VHA is also committed to shared decision-making with patients."

What can make discharge planning so difficult is the fact that some patients prefer a plan for discharge that the healthcare team believes is unsafe. An unsafe environment, says Chanko, is "one that the team considers to lack the necessary medical and/or social support to meet the medical needs of the unique patient."

Such a living situation might be an unclean home where the patient is at risk of infection, or where neglect or abuse is demonstrated by caregivers or others in the home. In an attempt to evaluate a particular living situation, the health care team asks the patient to report, conducts and independent report and asks for a report from the patient's family, as well.

"The ethical values that come into play in discharge decisions include autonomy, independence, quality of life, safety, patient well-being

and the professional integrity of the health care team," Chanko says. "A patient who has decision-making capacity has the right to have his or her decisions respected where treatment choices or refusals are concerned."

Members of the health care team, however, have their own professional standards to uphold, and are "obligated to promote patient well-being and to protect patients from harm whenever possible," she says.

In the first scenario, a patient with severe mobility impairment wished to be discharged to live at home, although the health care team felt that he was not able to care for himself appropriately and should not be discharged to his home, as a consequence. However, while hospitalized, the patient had continued paying rent on his home, an apartment, for several months. Also, two psychiatric evaluations had found that the patient had decision-making capacity.

"The ethics committee reminded the health care team that safety was not the only important value in this cases — autonomy was also," Chanko says.

Ultimately, the ethics committee persuaded the health care team to release the patient to his own home by arguing that "absent strong justification to take away the patient's liberty rights," he should be released to an apartment with additional resources.

Offering a summary of the ethical analysis behind this recommendation by the ethics committee, Chanko noted, "First of all, a patient with capacity has to right to choose a particular quality of life that is consistent with his own values. As with other treatment choices that are accepted or refused, the quality of life chosen by the patient may or may not be one that members of the ethics committee and the health care team would choose for themselves, or for others that they care for. Or may not be the safest choice."

A second scenario hinged on a capacity assessment of an 84-year-old male who was determined not to have capacity to make a decision about the environment to which he would be discharged, and also did not understand the seriousness of his medical condition. However, his only relative, a niece, had twice placed him in a nursing home, and in each instance, the patient left the nursing home, saying he wanted to return home instead.

Susan Owen, PhD, also a health care ethicist

participating in the audioconference, defined a capacity assessment as “a clinical determination made by the clinician who is in charge of the patient’s care.” If mental illness is a factor, often there is also a consultation from a mental health practitioner.

“It is important to note that decision-making capacity is not an all-or-nothing phenomenon,” Owen says. “Ethical practice requires that clinical capacity be understood as decision-specific. Although mental or physical impairment may cause someone to lose all decision-making capacity, some people have the capacity to make one choice, but not another.”

According to Owen, “sound” decision-making requires four essential elements:

- the capacity to communicate choices;
- the capacity to understand relevant information;
- the capacity to appreciate the situation and its consequences;
- the capacity to manipulate information rationally.

Kenneth Berkowitz, MD, chief of ethics consultation at the VHA, noted that “assessing decision-making capacity is not always value-neutral,” i.e., health care practitioners sometimes make decisions subjectively.

Also as noted in a 1990 *New England Journal of Medicine* article, titled “When Competent Patients Make Irrational Choices,” Owen said, “It is difficult in both theory and practice to distinguish irrational preferences from those that simply express different values, attitudes and beliefs. The effort must nonetheless be made in order to safeguard the patient and his or her autonomy.”

A patient, or his or her surrogate, also have the capability to challenge the primary health care provider’s assessment regarding decision-making capacity, if either party disagrees with the results of the assessment. The patient or surrogate would do this by contacting the patient advocate or by requesting a consultation with the local ethics team, Owen says. Beyond that, if no resolution could be reached, the issue would be referred to the chief of service or chief of staff for resolution.

Within the health care team itself, the primary provider holds the ultimate authority in disagreements over a capacity determination or assessment. Even then, that provider’s decision can be challenged by contacting the chief of service or chief of staff.

SOURCES

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- **Barbara Chanko**, RN, MBA, health care ethicist, VHA.
- **Susan Owen**, PhD, health care ethicist, VHA.

For all stakeholders in a discharge planning decision, mutual goal-setting is the key, and Chanko offers several questions that should be considered toward this end, including:

- “Do I understand why my patient made this decision?
- What are the patient’s goals?
- Can I help my patient identify a different course of action that will enable him or her to honor the same goals and values?
- What are my goals in this situation?
- Are there intermediate goals on which I could focus?
- Are there medically acceptable alternatives, even if they’re less desirable, that my patient my accept? In other words, are there ways that I can meet my patient’s goals and provide good clinical care?”

As with much of health care, good communication seemed to be the key ingredient to resolving disagreements, and not just at the point where a discharge plan is being developed or implemented.

As Berkowitz noted, “. . . at the beginning of the admission and throughout the hospitalization, the patient, family and provider should be continually working toward a mutual understanding of goals of care and agreed upon solutions that promote these goals.” ■

Affective forecasting may impact medical ethics

Professor offers insight based on psychiatric lit

There’s no doubt that physicians are the lynchpin of the healthcare system. And when it comes to patient education and counsel regarding diagnoses, prognoses and possible death, they

also bear the leadership role.

In a paper published earlier this year in the *Cambridge Quarterly for Healthcare Ethics*, one of two authors, **Rosamond Rhodes**, PhD, professor, medical education and director, bioethics education at the Mount Sinai School of Medicine in New York, suggests that this paternalistic role played by doctors is both necessary and good.

The reasons behind the importance of objective physician education and counseling of patients, she suggests, is due to the fact that patients are subject to what is known generically as “affective forecasting,” or the fact that our judgments about what our mental state may be in the future are clouded with distortions.

Citing studies in psychology by T.D. Wilson and D.T. Gilbert, Rhodes notes that these studies found that when subjects were asked to predict their own emotional responses in the future to negative events, they were often “off target,” according to Rhodes and Strain, when those predictions were compared to how the subjects actually felt after the negative events occurred.

“Although these psychological studies include no medical examples and make no claims about their application to medicine, it strikes us that this work has very significant implications for medical ethics ...,” the authors write.

Some of the types of distorted thinking include what is known as focalism, or instances where an individual or patient may exaggerate a certain feature of a negative event, and anticipate their future reactions accordingly. Durability bias refers to patients assuming that their negative emotions in response to a negative event will be more intense and last longer than they often do.

The fact that people are often more resilient and optimistic than they think is evidenced by examples such as how individuals responded to such catastrophes as Hurricane Katrina. Although the city was devastated, people interviewed often responded with the thought that the hurricane gave them an opportunity to rebuild and correct some of the cities problems that existed prior to the storm.

“This phenomenon of ignoring out ability to cope and failing to take it into account in predicting our future affect is called ‘immune neglect,’” the authors write.

In the “medical environment,” the authors note that not only are patients affected by affective forecasting, but so are doctors and families of the

SOURCES

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patients. Furthermore, the authors suggest that policymakers in healthcare also are affected by this distorted thinking.

But how does this affect medical ethics and ethics policies? For the patient diagnosed with cancer, that patient may focus only on the negative possibilities that come with such a diagnosis, such as a scar from a mastectomy or loss of hair as a result of chemotherapy. For patients either in denial or who focus on hair loss rather than overall improvements in their condition, affective forecasting can have “serious consequences for the affected patient,” the authors write.

Affective forecasting might also prevent a patient from ever visiting a doctor in the first place, out of fear that they may hear bad news.

Families, often claiming they are protecting the patient from bad news, sometimes instruct physicians not to give their loved ones a negative diagnosis or prognosis. Family members often cite cultural reasons for not wanting to give the family member bad news, but the authors note that this is true regardless of whether the family is European, Asian, African or from Latin America.

Since physicians can be affected by this distorted thinking, one way to address is through awareness, first, and using cognitive behavioral therapy with patients, i.e., talking with them in such as a way as to have them think differently about their situation.

Rhodes told *Medical Ethics Advisor*, “There’s an important place for making physicians aware of the phenomenon. And the training they need in cognitive behavioral therapy is not so deep and significant that I think it’s more awareness – enough to give them confidence to raise questions and have a conversation about the judgments of patients or family members.”

Another way to counter distorted thinking in

patients, she said, is to “put the emphasis on the appointment of a proxy decision maker, an agent, rather than the [writing out] the details [of potential treatments].”

“I think the value of recognizing this distortion is recognizing that we can also . . . make adjustments. The greatest value is when you have someone you can speak to, so if the physician knows – if it becomes part of medical education to make doctors aware of this distortion – then it gives doctors a license to question a patient’s judgement, to encourage them to think about their decisions and accept them, and the same for family members and surrogates,” Rhodes said.

Knowledge, in this case, is meant to “empower” doctors to speak directly with the patient.

“It authorizes them, instead of leading them to think, ‘Well, if I tell the patient [something] again and again, I’ll be paternalistically interfering.’ Yes, you are paternalistically interfering, but it’s justified, because the patient’s judgment is likely to be distorted, and if you can get them over the distortion, they can make more reasonable decisions,” Rhodes told *Medical Ethics Advisor*.

The difficulty in mitigating the potential consequences of affective forecasting is with public policymakers, and that difficulty comes as result of not having “anyone in the role that a doctor could play,” Rhodes said. The paper gives three examples in the public policy arena where distorted thinking may be a factor: organ transplants, genetic testing in children and assisted suicide.

“It’s just a mass hysteria. You hear the people in the genetics counseling community talk about why we can’t test children. They all lock-step believe it, although if you look at other policies it is out of sync,” Rhodes said. “If you look at what happens when you tell children that they’re actually dying from some condition, none of the [negative things] happen.”

In their conclusion, the authors write that “well measured medical paternalism” is not the problem associated with distorted thinking in patients and caregivers. In fact, they see such paternalism as “good medical practice.” The “moral problem” they identify is when affective forecasting seems to appear as “medical beneficence.”

“There, a significant danger lies in clinicians and policymakers allowing their distorted fears to move them,” the authors write. “The actions

and policies that reflect unchecked affective forecasting result in the imposition of biased conclusions on others in the name of promoting great good.”

When such attitudes “usurp the decision of others,” Rhodes and Strain suggest there is cause for alarm, because as they indicate, “significant ethical boundaries are crossed.”

Reference

1. Rhodes, R., Strain, J. Affective Forecasting and Its Implications for Medical Ethics. *Camb Q Healthc Ethics*. 2008; 17(1): 54-65. ■

UK’s ‘right-to-die’ card stirs controversy

Card is available in public places

One individual in the UK, who happens to be on the Salford City Council in Great Britain, has introduced what is being called the “right-to-die card” in that country and has set off a controversy among those in the Christian pro-life movement and those who choose it as a way to make their wishes known in the event they are incapacitated due to sudden injury or illness.

According to a BBC magazine report, those against the card, which is available in many public places including pubs, banks and libraries, say it could lead to euthanasia. Those who support the card say it is a useful way to implement that country’s Mental Capacity Act, implemented in 2007, which allows adults to draw up advance directives, the report said.

The card is meant to be carried with the person, and is intended to direct caregivers to detailed instructions, typically with relatives, friends or their usual physician, regarding what to do if they are no longer able to make decisions about their health care in life-threatening situations, the BBC reported.

But before ethicists or the public anticipate this idea leaping across the pond, at least one bioethicist suggests that the procedures and processes already in place in the United States provide sufficient alternatives for patients in such situations.

"It's not so different," says **Art Derse**, MD, JD, director, Medical and Legal Affairs, Center for the Study of Bioethics, Medical College of Wisconsin, in Milwaukee.

Derse notes that patients in the United States have a similar approach in two categories: the pre-hospital Do Not Resuscitate (DNR) orders; and a document referred to as POLST (Physicians Orders Concerning Life-Sustaining Treatment).

DNR orders "are physicians' orders not to resuscitate that have been made by a physician that is information to paramedics or EMTs when they come to an emergency situation," Derse explains.

These two documents, as well as other legal documents available, can spell out what the patient's wishes are for the emergency medical system.

"Our advantage here in the United States is that they are physicians' orders that are arrived at with the patient in agreement," Derse says. "In Great Britain, it does not appear as if you must have a physician as someone who's actually agreeing with, or actually giving an order, so it does make it more difficult.

The difficulty, he said, exists because patients often don't know what's going to happen until resuscitation is attempted.

"When someone decides that a patient ought not to be resuscitated, it's really looking at prognosis, so you wouldn't want a healthy young person carrying this card in their back pocket, without any underlying medical problem, just because they think, 'Well, it's possible that I could end up in a state that I don't want to be [in], so I'm going to carry one of these cards around,'" Derse says. "On the other hand, a card like this might be extremely appropriate for someone who's got terminal cancer and does not want resuscitation."

Another danger with such a card is the possibility that the card could be separated from the person to whom it actually belongs, particularly in an emergency situation, leading to potentially withholding treatment for the wrong person, Derse says.

John Moskop, PhD, a professor of medical humanities at the Brody School of Medicine at East Carolina University, as well as director of the bioethics center at the University Health Systems of Eastern Carolina in Greenville, SC, said he would be against such cards being available in the United States.

"Although I am a strong advocate for advance care planning and advance directives, especially

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health care powers of attorney, I would not favor introduction of a card like the one described," Moskop says. "The main reason is that I don't believe that these cards would be a reliable way for people to convey their wishes regarding medical treatment."

He cites the disadvantages of the card's small size, thus allowing them to carry limited information about care, i.e., a "yes" or "no" request.

"In fact, very few people would choose either to accept or refuse *all* treatment," Moskop says. "Instead, most people want treatment under certain circumstances and not under other circumstances, but a small card would not be able to communicate these more complex wishes."

Another fact he cites is the fact that the card is apparently intended primarily for use in emergency situations, when "it is most difficult to determine whether treatment can be successful." ■

Stop-smoking counseling: more effective than thought

Study: Physician input makes a difference

While it might seem that physician lectures to patients about the dangers of smoking are falling on deaf ears, experts in the United States and England say doctors who take a few minutes to talk with patients about their smoking really do make a difference when it comes to helping them quit successfully.

"Assuming an unassisted quit rate of 2 to 3 percent, a brief advice intervention can increase

quitting by a further 1 to 3 percent," writes researcher **Lindsay Stead**, MA, MSc, of the University of Oxford in England, in *Cochrane Database of Systematic Reviews*.¹

A team of researchers looked at 41 studies of more than 31,000 smokers, and found that the impact of physician advice is perhaps more than expected.

"To a non-clinician, these results may seem underwhelming, but [they] are really quite significant when you consider how many people who smoke see a physician every year — about 80 percent — and how many more of them would quit if all doctors advised them to do so at every visit," comments **Abigail Halperin**, MD, a University of Washington physician and researcher who specializes in prevention and treatment of tobacco-related diseases. Halperin was not a participant in the published review.

The reviewers looked at studies conducted between 1972 and 2007. When they pooled data from 17 trials of brief advice compared to no advice, they found significant increases in quit rate among the group that got some kind of counsel from a physician.

Efforts did not have to be lengthy or complicated: The researchers found no statistical difference between intensive and minimal endeavors. However, the studies did not select study participants based on motivation to quit smoking, which might have affected the findings on intensive interventions.

"Cessation interventions are typically highly cost-effective, so even a very small improvement in effect from intensifying the intervention could well be cost-effective," says Stead.

Halperin points out that there are still some 45 million smokers in the United States, and about 70% of them say they want to quit.

"Of these, about half try to quit and less than 5% are successful. If we assume that half of these patients are advised by their [physician] to quit

smoking now — a generous estimate — and that 2% more would quit if they were all advised to, then we could see an additional 720,000 smokers become nonsmokers each year," Halperin suggests. "This would have a huge impact on public health, since tobacco-related diseases are by far the nation's largest contributor to disability and premature death — not to mention health care costs."

The majority of smokers require not one, but several quit attempts, to stop smoking for good. Stead says once a doctor identifies a patient as a smoker and discovers that he or she is willing to make a quit attempt, then follow-up and referral — in addition to a brief intervention — can help ensure success.

Persistence is important, Halperin stresses, because only a small percentage of people who quit remain nonsmokers beyond six months to one year without additional help.

"In the two programs where I work, we assist patients in developing a quit plan, provide practical counseling, and prescribe nicotine replacement therapy or other medication to ameliorate withdrawal symptoms, and are seeing 25- to 35-percent quit rates," she reports. "These steps can be accomplished by any physician or other health care provider, or by referring the patient to a telephone quit line or other program that provides this kind of evidence-based support."

Stead says a barrier to providing intensive intervention to all patients, even smokers who are initially resistant to the idea, may be that physicians don't believe it can be as effective as the review shows it to be.

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REPRINTS?

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Society forms policy on use of palliative care

Thoracic society says it is "obligation"

Palliative care is an obligation owed every patient with critical disease, and not just those for whom curative options have been exhausted, according to a national medical society.

The American Thoracic Society (ATS) has published an official clinical policy statement on palliative care to serve as a guideline for clinicians for incorporating palliative care given to patients with serious respiratory disorders and critical illnesses.

In the past 15 years, palliative care has emerged from the background to become a medical specialty, and the ATS policy "recognizes palliative care as an important part of what doctors, nurses, and other health care professionals should be doing," according to **Paul N. Lanken, MD**, professor of medicine and medical ethics at the Hospital of the University of Pennsylvania and co-chair of the ATS task force that wrote the statement.

Defining palliative care as an integral part of the treatment of seriously ill patients, the statement promotes:

Individualized care that is patient- and family-focused;

Integrated care that is offered when suffering begins and should continue even after the patient's death with the psychological, spiritual, and practical support of his or her surviving caretakers;

Comprehensive symptom management to control shortness of breath, pain, and other physical complications, as well as the psychological challenges related to illness or dying; and

Professional competence and development of specific skills for health care providers who are involved in palliative care, especially the ability to communicate compassionately and effectively to help patients and family members make decisions about care by determining treatment goals, developing appropriate strategies in line with those goals, and preparing advance directives.

The statement also provides practical information for clinicians, such as when to consider referral to hospice care and how to withdraw mechanical ventilation, and emphasizes the need

for training, education, and research.

(The ATS policy on palliative care is available online at <http://www.thoracic.org/sections/publications/statements/pages/respiratory-disease-adults/palliative-care.html>.)

African-Americans get less EOL discussion

Physicians less likely to discuss issues

A new study on ICU physicians conducted by an assistant professor at Case Western Reserve University in Cleveland found that physicians are less comfortable discussing end-of-life issues and do it less frequently with African-American patients and their families than with Caucasian patients and families.

J. Daryl Thornton, MD, also of the Center for Reducing Health Disparities at MetroHealth Medical Center in Cleveland, led the study and presented his findings at the American Thoracic Society's International Conference in Toronto in May.

One in five Americans will die in the ICU or shortly following a stay in the ICU. Often, these deaths follow a decision by the patient's family to withdraw life-sustaining treatment, according to the university.

"That is why it is so important that physicians are comfortable delivering difficult and sometimes complex diagnoses, potential outcomes and prognoses to patients and families in the ICU," said Thornton. "Our study suggests there may be some underlying biases and/or discomfort among physicians, which impacts their ability to have these difficult conversations with families."

The researchers examined data from the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT), which was conducted between 1989 and 1994 involving a group of 9,105 seriously ill hospitalized patients and

CME answers

1. A; 2. B; 3. A; 4. B

their 1,241 physicians at five major medical centers across the country.

After adjusting for a variety of factors such as severity of illness and insurance status, physicians reported having had prognostic conversations with 58% of their white patients but only 41% of their African-American patients.

The researchers acknowledged that the study data are “dated,” but suggested that the findings should be replicated as an “important area for health disparities research.” ■

Non-invasive ventilation helpful in lung cancer

NIV may ease breathing difficulty

A paper presented at the American Thoracic Society’s 2008 International Conference in Toronto in May suggests that patients with end-stage lung cancer may benefit from noninvasive ventilation (NIV).

The study suggests that NIV may be more effective at reducing breathing difficulty than standard oxygen therapy, and it has the advantage of reducing such patients’ reliance on morphine, enabling them to have a higher level of lucidity in their final days.

“With oxygen therapy, you might improve oxygenation of the whole body with a small cannula inserted into the nose,” said **Stefano Nava**, MD, chief of the respiratory critical care unit at Istituto Scientifico di Pavia in Italy, who led the research. “NIV implies the application of a face mask connected to [a] ventilator. The main advantage over oxygen is that NIV not only improves oxygenation, but also the work of breathing.”

The ATS said that this is the first research to compare the two therapies, and it is the first randomized controlled study to investigate the relief

of respiratory distress in end-stage cancer patients.

Nava and his colleagues enrolled 92 patients who met the criteria and agreed to be randomized to receive either oxygen therapy or NIV. Three-month mortality for the groups was 89% and 87% respectively, and was not significantly different between the two groups, according to the ATS. Roughly a third of each patient group was discharged alive after an average of two weeks. ■

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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. ■

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- discuss new information about hospital-based approaches to bioethical issues and developments in the regulatory arena that apply to the hospital ethics committee;
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- learn how bioethical issues specifically affect physicians, patients, and patients’ families. ■

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CME Questions

25. The majority of mass casualty events worldwide do not generate a large number of critically ill patients.
- A. True
B. False
26. The VHA does not support the value of patient autonomy in discharge decision-making?
- A. True
B. False
27. Affective forecasting refers to:
- A. The suggestion that our beliefs about what our future mental states are likely to be are distorted.
B. The belief that all our instincts are correct.
C. The belief that anything we think comes true.
D. The suggestion that thought has no impact on behavior.
28. The so-called right-to-die card is available in what country:
- A. United States
B. Great Britain
C. Australia
D. Israel

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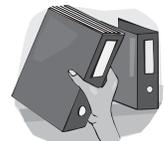
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