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IN THIS ISSUE

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The Joint Commission to hospitals: Monitor, correct disruptive behaviors

Bad behavior: Unethical or just inappropriate?

The Joint Commission in Oakbrook Terrace, IL, on July 9 issued a Sentinel Alert that would require hospitals to establish policies that address, manage and correct what it refers to as "intimidating and disruptive behaviors" by health care professionals in the facility setting.

The new requirement becomes effective Jan. 1, 2009.

According to the alert, such behaviors "include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities."

"Most health care workers do their jobs with care, compassion, and professionalism," says **Mark R. Chassin**, MD, MPP, MPH, president, The Joint Commission. "But sometimes professionalism breaks down and caregivers engage in behaviors that threaten patient safety. It is important for organizations to take a stand by clearly identifying such behaviors and refusing to tolerate them."

And the edict covers not only physicians, but also nurses, pharmacists, therapists, support staff, and administrators.

"Intimidating and disruptive behaviors in health care organizations are not rare," according to the *Sentinel Event Alert* Issue 40.

The alert notes that a survey conducted by the Institute for Safe Medication Practices (ISMP) found that 40% of "clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator."

"The presence of intimidating and disruptive behaviors in an organization, however, erodes professional behavior and creates an unhealthy or even hostile work environment — one that is readily recognized by patients and their families," the alert states.

It also cites studies that link patient complaints about disruptive behavior and malpractice risks.

"There is a history of tolerance and indifference to intimidating and disruptive behaviors in health care," the alert states.

"Organizations that fail to address unprofessional behavior stems from both individual and systemic factors."

Some of the reasons cited as possible factors contributing to unprofessional behavior are unique to the health care environment, and those include, according to the alert:

- increased productivity requirements;
- cost containment dictates;
- the hierarchal nature of the health care system;
- fear of or stress from litigation;
- changing personnel and/or roles of the health care team.

"I think the important question as to why this occurs in the workplace that's much more important than the psychological issues is this: bullying occurs in the workplace, disruptive behavior occurs . . . because it is allowed to occur in the workplace. That's the answer," says **John Banja**, PhD, clinical ethicist with the Center for Ethics and professor of rehabilitative medicine at Emory University in Atlanta.

Banja suggests that health care institutions need to understand how disruptive behavior can affect morale and how it affects that institution's delivery of health care to patients. And it is an ethical issue, he says, because people don't have the "moral right" to treat others in a disrespectful fashion.

For example, a nurse who has just been screamed at by a physician is not likely to be at his or her best when treating the next patient.

"Very, very often, people will leave the workplace — and these are good people — because they just can't stand to be around somebody with that kind of profoundly disrespectful behavior."

That results in bottom-line costs to the institution for recruiting new employees and training them.

"It's interesting that a lot of these people who [act out] these unprofessional behaviors actually don't think they're being unprofessional," Banja suggests.

Often, they believe that their behavior is "funny or amusing," especially when sexual innuendo is involved.

One reason that they aren't aware that their behavior creates problems for those around them is that, in many instances, no one has ever addressed the demeaning behavior and held them accountable for it.

One strategy that Banja suggests could be a simple intervention by someone of equal standing or higher in the organization to pull the offending health care professional aside and actually point out that they are being disrespectful, abusive or otherwise unprofessional.

"Often, just that sort of intervention alone, as a matter of fact, is enough to stop that behavior," Banja says. "It may not stop it forever. The person may need a tune-up from time to time. But it has been known to do good."

Suggestions to improve the situation

The Joint Commission has said that effective on the first day of 2009, it has a new Leadership

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standard for all of its accreditation programs in "two of its elements of performance" requiring both a code of conduct as well as a process for applying corrective measures for those who engage in disruptive behaviors.

The Joint Commission outlined 11 "suggested actions" in addition to the new Leadership standard. Those suggestions indicate that there should be "zero tolerance" for such behaviors, particularly the worst kind of behavior, such as assault or other criminal acts. The Joint Commission also suggests incorporating this policy "into medical staff bylaws and employment agreements as well as administrative policies."

Another suggestion is one to "develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior."

The Commission also suggests "tiered, nonconfrontational interventional strategies," beginning with what it calls "'cup of coffee' con versations." The commission also suggests "adequate resources to support individuals whose behavior is influenced by physical or mental health pathologies."

But there's no doubt that the overall message is: hospitals should not tolerate such behavior, or they do so at the risk of negatively impacting the institutional work environment, patient safety — and perhaps their bottom line. ■

Ethicists pen commentary on organ transplantation

Group calls for opt-in/opt-out

Ethicists primarily at the University of Pennsylvania in Philadelphia came together to pen a commentary appearing in June 26, 2008, issue of *The New England Journal of Medicine* calling for organ transplantation policies that would require potential organ recipients to opt-in or opt-out at the time they are listed for organs as to whether they would accept so-called "non-standard" organs.

Without such a policy, the ethicists say, and, for example, following a policy whereby the recipient gets to choose whether to accept an organ on a case-by-case basis after being informed of risks that may be associated with a particular organ, the organ donation process becomes vulnerable to personal biases that result in inequitable distribution and inefficiencies in the system.

As one of the commentary authors, **Scott D. Halpern**, MD, PhD, told *Medical Ethics Advisor*, the group decided to offer a public opinion of their thoughts on organ transplantation policy following a case that occurred in Chicago in late 2007.

In that case, four organ recipients of organs from one donor ultimately became infected with the HIV virus, as well as Hepatitis C, both of which infections were traced back to the donor.

That case alone prompted "a good bit of debate," Halpern said, and prompted the governing body for organ transplantation, UNOS (acronym stands for) in Richmond, VA, on the need to inform potential recipients of risks.

"This case, although incredibly unique…is [occurring] within a broader context of realizing that there are a variety of risks of organ transplantation, [that] often, recipients aren't informed of and many times they are not even risks that doctors could foresee," Halpern tells *MEA*.

In the *NEJM* article, the authors note that "Donors with behavioral risk factors are not barred from contributing to the organ supply, as they are from contributing to the blood supply, because scarcity is a much more salient feature of the organ supply. Indeed, approximately 10% of all patients on the waiting list for solid-organ transplantation die each year without receiving an organ."

The authors suggest that including donors with "behavioral risk factors" is one way to "narrow the growing gap between the supply of and demand for transplantable organs."

No organ transplantation is without risk, Halpern said.

"Because the risk could never be zero, there is a right among potential recipients to be

informed not only of all foreseeable risks, but also the fact that there may be some risks that could not be foreseeable," Halpern told *MEA*, although the overall risk of disease transmission is "exceedingly rare" in organ transplantation.

The Penn ethicists, after an evaluation including the local hospital and their region's organ procurement organization, realized that there was variability even within the various transplantation programs at that institution. They decided on a policy whereby potential recipients of organs would be notified of risks.

"In doing so, we realized that not only was there tremendous variability within our region regarding how informed consent for organ transplantation was being obtained, but there was tremendous variability within our own hospital," he said.

UNOS, he says, has certain policies designed to "guide transplant programs in relaying information about specific risks, but there is not general guideline and no sort of ethical framework for why a particular strategy is better than another," he says.

So, the group decided that if there is variability in programs at Penn and within their region, they felt that they could be "quite confident" that variability existed through the country.

The biggest problem with what Halpern sees as a lack of an ethical framework is that "variability has important consequences for recipients, not only because it means that recipients somewhere will be told of things they might want to know about, whereas recipients elsewhere won't, but it's also important because it — by giving people information and allowing them to make choices to accept or decline an organ based on that information.

"Those decisions have implications for how organs get allocated," Halpern said.

Halpern says organ transplantation recipients can be described as those who are "risk averse" and those who are "risk accepting." Most people who are at the point of being listed as donor recipients are very ill, and without an organ, "their time is short."

So, those who are risk averse might refuse an organ that was thought to have some risk associated with it, and then that organ would be offered to the next person on the list.

"Unfortunately, when allocating any scarce public good, of which transplantable organs are perhaps the most paradigmatic example, the choices of individuals have intricable consequences for society," Halpern says. "So, any choice that an individual makes to accept or decline an organ affects the availability in number and type of organs that would be available to others.

Therein lies what Halpern calls a "justice problem."

According to Halpern, UNOS has taken the positions that risks should be disclosed to potential organ recipients at the time that a specific organ becomes available. That question of when to inform a potential organ recipient of both foreseeable and unforeseeable risks is the crux of his group's argument, i.e., suggesting that potential organ recipients be informed of all possible knowable and unforeseen risks at the time they become listed.

Unforeseeable risks are important, because as Halpern points out, "it's an inevitable problem with the organ transplantation system, which is we can't always know everything we'd like to know about donors. They are often unable to communicate at a time when they become potential donors, and even the best available tests for infectious agents are not perfect."

UNOS, while not a federal agency, does have the power to enact federal policy, and make adherence to that policy a condition of being a member of its network.

"Unfortunately, in our view, [UNOS has] responded to the Chicago case by saying that people should be told about the risks associated with a specific organ at the time that it's offered, but…that's a problematic view for reasons of equity, efficiency and failure to actually help people make better decisions."

By allowing potential donor recipients to choose an organ on a case-by-case basis would

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perhaps allow social biases to enter into the selection process, Halpern suggests.

And the UNOS solution is problematic "because it raises tremendous potential for inequity in how organs get allocated, because it allows patients to cherry-pick those that best serve their own interest."

"It also creates the potential for patients to make judgments on accepting or declining an organ based on their own personal biases [such as] regarding whether homosexual men or an intravenous drug user or any other type of donor is someone that they wanted to be associated with," Halpern says. "It would be wrong to allow such biases to represent a means of allocating a public good, like transplantable organs are."

Risk inherent in organ transplantation

The current policy of UNOS, based in Richmond, VA, is such that patients who are organ donors who meet the criteria of being high risk for transmitting HIV as defined by the public health service's in 1994 in MMWR., recipients of those organs are made aware "that they are about to receive [such] an organ and they are provided with whatever questions and answers they may have related to the level of information that the transplant center has gotten from the donor."

So says **Michael G. Ison**, assistant professor, divisions of infectious diseases and organ transplantation at Northwestern University in Chicago and chair of the Disease Transmission Advisory Committee for UNOS.

The criteria are "generally behavioral based," he said.

Ison agreed with Halpern, who suggests that there is always the possibility of unforeseen risks associated with receiving a donated organ.

"The reality is . . .if people knew that there was an infection or a malignancy in a potential donor that could be transplanted to the recipient, we, in general, would not use those organs," Ison said.

Ison said that testing capability simply does not allow for screening for pathogens that is always reliable.

Unfortunately, he said, " . . .there's always going to be — even if we dichotomize [donor organs] — as was recommended in the opinion piece, there's still going to be a risk of acquiring an infection, a malignancy or having an adverse outcome that is unexpected."

Reference:

1. Halpern, Scott D., et al. Informing Candidates for Solid-Organ Transplantation about Donor Risk Factors. *N Engl J Med* 358;26, pp. 2832-2837. ■

AMA to study financial incentives for organ donors

Calls for modification of current law

The American Medical Association in Chicago at its annual meeting in June adopted policy calling for the modification of current law to allow pilot studies on financial incentives for organ donation from people who have died.

While the AMA has supported financial incentives for about 15 years, the new policy calls for a change in the National Organ Transplantation Act of 1984, which prohibits financial incentives for organ donation, AMA board member **Joseph Annis, MD**, tells *Medical Ethics Advisor*.

The 1984 act forbids what is termed "valuable consideration" for organ donors.

"Basically, the general feeling was that we should appeal to altruism as the motivation for people and their families donating organs from the cadavers," Annis says. "And we're speaking of organ donation from people that have died — not from living donors. That's a whole different ethical issue."

Annis cites research that indicates the percentage of people who donate organs after death hovers between 35% and 50%. And those numbers remain steady despite efforts to increase the number of donors through advertising and public education about the importance of organ donation.

While the number of donors remains in the same range, "the number of people who need donated organs continues to rise," Annis says.

"That being the case, we're seeing about 6,000 people a year, roughly 16 a day, die who are waiting for transplants," Annis says. "So, we're looking at ways of increasing the number of donors, and doing it in an ethical fashion."

There have been debates on both sides of the financial incentives issue, with some suggesting that people with less money would be exploited

in favor of people with more money if money was offered in return for organ donation, Annis says.

"It's an ambiguous area," he says. "It's an area that I think we'd like to study, because the only way you can really find out if something will work and what will work is to study it."

However, to take such a scientific approach ultimately to conduct pilot studies would require a change in the federal law.

Originally, the resolution that was set forth by the South Carolina delegation of the AMA for consideration was to call for legislation to change the law to allow financial incentives. After discussion by the AMA's House of Delegates, it was decided that they would call for a change in law to allow only for the issue to be studied.

Annis said any study of the issue without a change in the law to allow financial incentives would be "theoretical," and the AMA will likely reconsider the issue to call for a change in law in the future.

A variety of measures to compensate donors or their families could be considered, he says, such as a tax credit for the deceased's estate or money to go toward a funeral.

An ethicist's view of the proposal

Scott D. Halpern, MD, PhD, an ethicist at the University of Pennsylvania in Philadelphia, suggests that the AMA's proposal "is viewed by some as a lot less controversial than other proposals that have been highlighted by people in the community and by academics regarding incentives for people to donate one of their kidneys while they're alive.

Halpern, who is currently conducting research on financing incentives for living kidney donations, says is personal view is that paying a living person for a kidney donation might be not only "more beneficial from a social standpoint, but also less ethically concerning."

"The AMA policy refers to deceased organ donors. There are problems there. The first problem is: it would be wrong to think that there is a tremendous untapped supply of deceased donors that would reasonably be swayed by the offering of incentives," Halpern says.

Still, even if there is a "small minority" of people who would be encouraged to donate their organs if financial incentives were offered in return, then it would be worthwhile to study the issue.

Other strategies might offer even stronger incentive to increase the number of organ donors following death. He suggests a model in place in several European countries, which have policies that make everyone an organ donor at birth. If they choose not to be organ donors, they have to take action to opt-out of that status.

In the United States, the model is exactly the opposite, Halpern says, whereby people are required to "opt-in" to be organ donors.

"We know that organ donation rates in countries that have an opt-out policy are about twice as high as they are in countries that have an opt-in policy," Halpern says. "And you don't need to offer money to do that, you just need to change the default."

Offering money for organ donation, he says, "raises some concerns, justifiable or not, about

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the commodification of the body."

Some of those concerns are that any financial incentive would likely go to the deceased's family, as opposed to the donor, which he suggests could "impact either clinicians' judgment about pursuing organ donation or affect families' decisions about whether they allow the patient to become an organ donor."

"What we want to happen is that patients become organ donors because they have an interest in doing so," he says.

Finally, though, he says he doesn't oppose the AMA's call to study financial incentives for organ donors.

"What they're saying is we should explore the possibility, and we should do it in an evidence-based, research-oriented manner," he says. "That's very reasonable." ■

Mass customization discussed for EOL care

Article cites need for standards, cost-containment

Not long ago, people generally 'got sick and died,' — all in one sentence and all in a few days or weeks. The end of life had religious, cultural and contractual significance, while paid health care services played only a small part. Now, most Americans will grow old and accumulate diseases for a long time before dying."

Lynn, Joanne. "Living Long in Fragile Health: The New Demographics Shape End of Life Care," *Improving End of Life Care: Why Has It Been So Difficult? Hastings Center Report Special Report* 36, No. 6 (2005): S14-S18.

As the baby boomers age, medicine is allowing us to live longer, but perhaps sicker, managing chronic disease with medication and replacing parts that have broken down with a combination of medical devices and surgeries.

To **Joanne Lynn**, MD, that has long been cause for concern, i.e., the idea that many of us will be living longer in ill health. In May, Lynn addressed this topic at a briefing sponsored by The Hastings Center, based in Garrison, NY, with the address by Lynne occurring in Washington, DC. Her address was based on a 2005 article titled "Living Long in Fragile Health: The New Demographics Shape End of Life care."

Lynn, who spoke recently to *Medical Ethics Advisor* on this topic, suggested in the article that the outcomes of the SUPPORT project (or The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments), which enrolled 10,000 "seriously ill" patients from 1989 to 1994, told us a great deal of new information. (See box, p. 92, for findings.)

According to Lynn, such findings also provide hope for reforms that could benefit patients in decision-making and care chosen and provided at the end of life. Patients generally follow three trajectories toward death, which in shortened version involves: 1) long maintenance of good function; 2) slow decline in physical capacities punctuated by serious exacerbations; and 3) long-term dwindling of function, needing years of personal care. The problem lies in the expectation that more and more people will fall into the third category, and the question becomes how to pay for this more intensive, long-term care.

Lynn's solution to this increasingly common third trajectory is "mass customization," much the same way that an automaker might plan to meet the common preferences of the largest number of people in the vehicles they design and produce.

"[This approach] gives us a high-leverage way of organizing reform," Lynn told *Medical Ethics Advisor*. "You know, trying to make every single thing customized to every single patient would work, but it's a very expensive way to think about how to put together care.

"So, if instead we said, 'Patients of this sort tend to use hospitals in this way and nursing homes in that way and use this kind of home care, let's make sure that those things are readily available. And if the patient needs something different, then we'll go out of the boundaries and make that work."

Lynn predicts success of approach

Lynn also predicts the success of this approach based on a similar one used in obstetrics prior to reforms last century that led to expectant mothers to have more options for care, both during the birthing process, allowing for such preferences as home birthing, to breast feeding — things previously not allowed by many doctors up and for which many women

Findings from the SUPPORT Study

From 1989-1994 at VA facilities

Many patients suffer substantially in the time before dying.

The patients, their families, and their professional caregivers did not see adverse symptoms or aggressive treatment as serious shortcomings of care.

Statistical models could accurately predict the likelihood of survival for two or for six months, both for individual patients and for groups of patients.

Knowing reliable predictions concerning survival did not affect patients, family members, physicians or nurses: they continued to follow usual treatment patterns.

Prognoses remain ambiguous even very close to death. For example, the median person dying of heart failure today had a 50-50 chance yesterday to live another six months. Good care for the dying requires taking care of many who will live for a long time with their serious illnesses.

Counseling about the possible alternatives for care and encouraging decision-making that implemented patient preferences among available options had no effect upon patterns of care.

The course of care is much more strongly associated with the service supply and habit patterns of the local care system than with the particular preferences or prognoses of the individual patient.

Elements proposed for a reform agenda

Articulate thresholds of severity of illness that and settings and that are comprehensive across all care needs.

Insist on high standards of symptom prevention and relief, family support and planning ahead.

Pay sustainable salaries and decent benefits for such a system's employees, and discount the costly services that have much smaller expected benefits (often, the high-tech devices or costly drugs).

Develop supports for family caregivers, such as health and disability insurance, respite care, and evidence that the community honors and respects their work.

Develop adequate supply of all of the critical components of good care — hands-on services for personal care as well as hospital care and good nursing homes, as well as on-call nurses to handle crises in home care.

Monitor the effectiveness and efficiency of innovative approaches and deliberately replicate proven models, aiming to evolve a highly reliable, sustainable care system within a decade.

had to demand or advocate for themselves to be allowed to do. AT that point, public information campaigns addressing the issues kicked in and led to change. The "revolution" in this instance, Lynn says, is that "obstetricians learned to listen to their patients..."

"But another things is that if you showed up now and didn't say a word, you would get just about the right care, because they've customized [obstetrics] to just about what the public wanted," Lynn says. "And, so you no longer have to argue about whether you're going to have available some elements of natural childbirth, or support for breast feeding or any of those types of things. So, those are built-in. And then, the woman who doesn't want them can customize them out in her case."

Currently, there is a great deal of variability in the quality and types of care that patients who are facing the end of life receive. And that variability from center to center or hospital to hospital, is what needs to change, she says. While care is better than it was 25 years ago, the system still faces challenges.

So, how long might the revolution take before we have a standard-of-care in end-of-life care?

"It's always a matter of approximation…," she says. "So, you know, we've come a long way, but

we have a long way yet to go, especially on making care that's reliable and affordable. We have a lot more cases where things went well, but it's not reliable."

Reference

1. Lynn, Joanne . Living Long in Fragile Health: The New Demographics Shape End of Life Care," *Improving End of Life Care: Why Has It Been So Difficult? Hastings Center Report Special Report* 35, No. 6 (2005): S14-S18. ■

AMA issues apology on racial inequality

Shares current efforts to increase minority physicians

The American Medical Association (AMA) in Chicago in July issued a formal apology for its past history of racial inequality toward African-American physicians, and it highlighted its current efforts to increase the numbers of minority physicians and their participation in the physician membership organization.

The apology coincided with the publication of a commentary in the *Journal of the American Medical Association* (JAMA) by Ronald M. Davis, MD, immediate past president of the AMA, titled "Achieving Racial Harmony for the Benefit of Patients and Communities. [1]

A companion special communication published in *JAMA* published July 16, is titled "African American Physicians and Organized Medicine, 1846-1968." [2]

"The AMA is proud to support research about the history of the racial divide in organized medicine, because by confronting the past we can embrace the future," said Davis in a statement from the AMA. "The AMA is committed to improving its relationship with minority physicians and to increasing the ranks of minority physicians so that the workforce accurately represents the diversity of America's patients."

In his *JAMA* commentary, Davis wrote, "Physicians have long been members of a special moral community. They have sworn to uphold ethical principles that, in the case of the Hippocratic oath, date back to the fourth century BC."

The commentary noted that the AMA's first Code of Medical Ethics, adopted in 1847, "was introduced with a statement on equity." Davis also referenced the World Medical Association's Declaration of Geneva, which in its original form as adopted in 1948, states "I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient."

However, a "broader interpretation" of these two principles "would compel physicians to treat each other, as well as their patients, without prejudice.

But, Davis writes, "In this regard the AMA failed, across the span of a century, to live up to the high standards that define the noble profession of medicine."

The AMA said it created the Minority Affairs Consortium (MAC) to "address the specific needs of minority physicians and to stimulate and support efforts to train more minority physicians. The AMA's philanthropic arm, in collaboration with the MAC, awarded 12 students $10,000 scholarships under its AMA Foundation Minority Scholars Award program, for example.

"Five years ago, the AMA joined with the National Medical Association and the National Hispanic Medical Association to create the Commission to End Health Care Disparities," said Davis. "Our goal is to identify and study racial and ethnic health care disparities in order to eradicate them. We strongly support the "Doctors Back to School' program, which the AMA founded, to inspire minority students to become the next generation of minority physicians."

Davis also references the companion article by Robert B. Baker, PhD, and colleagues, which examines black-white relations over the history of U.S. medicine, outlining various instances in which equality was not upheld by the medical profession.

Among the harms he outlines from the article was the fact that the AMA listed African American physicians as "colored" in its physician directory in the early 20th century. Also, the AMA, he references, also was "silent" during the debates regarding the Civil Rights Act of 1964.

"These dishonorable acts of omission and commission reflected the social mores and racial segregation that existed during those times throughout much of the United States. But that context does not excuse them," Davis writes.

While noting the AMA's apology, Davis writes that the organization "recognizes that contrition cannot remove the stain left by a legacy of discrimination."

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1. Davis, Ronald M., "Achieving Racial Harmony for the Benefit of Patients and Communities: Contrition, Reconciliation, and Collaboration." JAMA, 300;3: pp. 323-325.

2. Baker, Robert B., et. al., "African American Physicians and Organized Medicine, 1846-1968: Origins of a Racial Divide." JAMA, 300; 3: pp. 306-313. ■

OPTN/UNOS to pilot paired donation program

The Organ Procurement and Transplantation Network (OPTN) and the United Network for Organ Sharing (UNOS) board of directors has approved what was termed elements of a pilot national system to facilitate kidney paired donations.

Kidney paired donation involves two or more living donor transplants where the initially intended donor/recipient pairs are medically incompatible; two or more donor/recipient pairs are then crossed to provide a compatible living donor for each recipient.

"The broader the base of people who can be matched, the more paired transplants can be done to help those in need," said Timothy L. Pruett, MD, president of the OPTN and UNOS and chair of the OPTN/UNOS board of directors.

The board's action followed the December 2007 passage of the Charlie W. Norwood Living Organ Donation Act, which the organizations said "clarified the legal basis for paired donation."

The initial pilot system will be voluntary, open to any living donor kidney transplant program meeting OPTN requirements and for any candidate on the OPTN waiting list.

Since 2000, about 350 paired donation transplants have been performed in the United States, according to UNOS. ▼

Survey shows support for physician-assisted suicide

According to a national survey of adults by ELDR magazine and ELDR.com on the issue of physician-assisted suicide, more than 80% of those responding said they believe that the choice to end one's life is a "personal decision."

Two-thirds of the adults said they want physician-assisted suicide made legal, as it is in the state of Oregon.

The publications said that its survey revealed that only half of adults over 60 years old have a living will or advance health care directive. ▼

AMA takes its message on the uninsured to Chicago

As part of its Voice for the Uninsured Campaign, the American Medical Association (AMA) in Chicago is taking its message to the public in that city. The AMA campaign is a three-year, multimillion-collar effort to encourage action to cover individuals who lack health insurance in the United States.

In June, 400 AMA medical students and residents were to attend a Chicago White sox game to talk to Chicago families about the crisis of the uninsured. They were also planning to encourage adults to vote in the November election with a mind toward influencing government efforts to provide insurance for uninsured patients.

CME answers

29. B; 30. A; 31. B; 32. A.

"With one one of the top five highest uninsured populations in the U.S., Illinois is not stranger to the tragedies faced daily by uninsured patients," said AMA board member and medical student Chris DeRienzo. "The nearly 2 million uninsured in Illinois, and the tens of millions more living across the U.S., live sicker and die younger, and they deserve better than the status quo."

The campaign features a Web site and will include television ads to air this fall on television stations throughout the country. ▼

Oncologists should think about cost of interventions

Such interventions may increase costs of care

A report appearing in the American Cancer Society's July/August issue of *CA: A Cancer Journal for Clinicians* suggests that cancer clinicians should understand and consider the economic impact of new interventions, which often have substantial costs.

The report in the peer-reviewed journal says health care budget constraints have made it necessary for clinicians to be mindful of the relative costs and benefits of new interventions used in cancer screening, diagnosis, treatment and support services for patients.

The ACS said the report highlights several examples of new interventions that may help specific populations but result in increased costs. They include magnetic resonance imaging (MRI) screening for breast cancer, which costs $1,000 per image, or 10 times the cost of screening mammography.

Positron emission tomography (PET) costs $1,800 for a scan for cancer staging. Or, consider the $48,000 per patient per year price tag for the use of intensity-modulated radiation therapy to treat prostate cancer.

According to the ACS, the authors write that "unless clinicians, other cancer health care providers, and cancer researchers are active participants in discussions regarding the relative costs and benefits of new interventions, others will make these cost-effectiveness conclusions. Having members of the oncology community exclude themselves from these discussions and from the process of determining costs and benefits of new cancer therapies is unlikely to be in the best interests of cancer patients."

The ACS said that the report reviews the

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

- Ethical issues in newborn screening
- Ethics and regulation
- Ethics in the surgical suite
- End-of-life care issues

CME Questions

29. In The Joint Commission's Sentinel Event Alert titled "Behaviors that undermine a culture of safety," the accrediting body is only referring to behavior by physicians.
A. True
B. False

30. In a commentary written by a group of ethicists for the *NEJM*, at what point did this group suggest that potential organ recipients choose to receive "non-standard" organs.
A. At the point they list to become organ recipients
B. At the point a specific organ becomes available
C. When they become aware that they may need an organ transplant
D. After a potential organ has been tested for infectious disease

31. The Joint Commission Sentinel Event Alert on "Behaviors that undermine a culture of safety" refers only to physician behaviors.
A. True
B. False

32. Joanne Lynn, MD, suggests implementation of "mass customization" to improve end-of-life care and cost containment.
A. True
B. False

methods used for economic analyses to help clinicians understand how economic evaluations of cancer interventions are performed so they better able to use — and critique — such evaluations.

The report says that clinicians should care about economic analyses for several reasons: patients are increasingly required to pay for a proportion of their medical care; expenditures need to be prioritized to determine the most reasonable use of limited health care funds; and it is important that recommended medical treatments be "good buys." ■