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IN THIS ISSUE

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Medical ethics at issue in North Carolina case involving executions

State statutes pit corrections department vs. medical board

Medical ethics is at the center of a case in the state of North Carolina, whereby the state Department of Corrections is at odds with the North Carolina Medical Board (NCMB) over physician participation in executions.

An executive protocol adopted by the DOC requires that a physician monitor the body functions of the condemned inmate and alert officials if he or she suspects suffering, according to an article in *Prognosis*, a publication of the North Carolina Bar Association and the N.C. Society of Healthcare Attorneys in May of this year. However, the NCMB position statement adopted prior to the executive protocol does not allow participation of attorneys, other than to certify death after the inmate has been declared dead by someone else.

Wallace C. "Chuck" Hollowell III, a partner with Nelson Mullins in Raleigh, NC, who wrote the article in *Prognosis*, suggests in his *amicus curiae* brief filed on behalf of the American Medical Association (AMA) in Chicago for the NCMB that the disagreement between the state DOC and the NCMB actually is a matter that should be decided by the North Carolina General Assembly rather than in a court of law.

Physicians stand firm that judicial executions are no place for physicians.

In the *amicus curiae* brief filed on behalf of the AMA, Hollowell references the North Carolina Medical Board's stance from its position statement on physician participation in executions by focusing on the physician-patient relationship as follows:

"The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship, founded on patient trust, is considered sacred, and when the elements crucial to that relationship and to that trust . . . are foremost in the hearts, minds and actions of the physicians licensed by the Board."[1]

The fact that many states have now transitioned to execution by lethal injection rather than other methods has initiated the need for

medical professionals to participate in executions.

"The inclusion of physicians in lethal injection medicalizes capital punishment by moving a process that has always been a function of the penal system into the domain of medicine," wrote **Lee Black**, JD, LLM, and **Robert M. Sade**, MD, in a 2007 article in the *Journal of the American Medical Association (JAMA)*. Sade is a former chair of the AMA's Council on Ethical and Judicial Affairs. His term ended in June 2007.

Each of the state agencies in North Carolina is acting in accordance with state statute, Hollowell says. If one of the agencies had violated a statute or the constitution, only then could it be determined that they had not performed their jobs according to law.

"From our perspective, that's certainly not the case; what it really boils down to is a policy issue," he says. "And our position would be that given the consistent and long-standing positions take by these medical organizations, in terms of medical ethics, then it's clear that this is a very core principle with medical ethics."

And the requirements of medical ethics and physicians in executions, Hollowell says, "should not be overridden lightly by either the courts or the General Assembly.

Given that oral arguments still must be delivered, Hollowell expects it will be six months to a year before a decision is rendered. And even then, there is likely to be no legal impact on a national basis, because what is being considered in the North Carolina case is state law.

"Perhaps the nationwide impact could potentially be a persuasive authority to the extent that this comes up in [other states] than North Carolina and [another state could] say, 'Here was a similar issue and here's how they handled it," Hollowell says.

Ethical implications of participation

Oddly enough, the mostly commonly used method of execution, lethal injection, was developed by a physician. Due to legal challenges to the method of lethal injection, physician participation in executions has been "publicly exposed," according to the *JAMA* article.[2]

Anesthesiologists, in particular, have been outspoken against physician participation in executions, Sade tells *Medical Ethics Advisor*, which is likely because they have been seen as those most likely to be needed in executions involving lethal injection.

"Anesthesiologists are the logical candidate for penal systems to seek to be the physicians who participate, because they are they ones who commonly manage those drugs, and presumably can use them more safely and more effectively than other physicians might," he says.

According to Sade, 38 states permit the death penalty, and 35 of those states discuss physician participation in executions; 17 of those require physician participation, and another 18 of those state permit physician participation, although they don't require it.

"Those that require it have trouble finding physicians to actually manage the IV or administer the drugs or measure out the drugs," Sade

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says. "There are various levels of participation — all of which the AMA considers to be unethical, so there are several states that have passed laws specifically to protect physicians."

Sade says in the North Carolina case, the DOC maintained to the court that while executions require medical knowledge and medical skills, an execution is not the practice of medicine. Therefore, the NCMB should have no authority to punish physicians who do participate in executions in that state.

"During the time that I was with the council, we took the position that physicians are required to act ethically, in the bounds of medical ethics, even when they [are] acting outside the practice of medicine," Sade tells *MEA*. "So that whether or not participation in lethal injection is considered medical practice, physicians still are ethically bound not to participate."

Some states also have passed law to protect not only physicians, but anyone else who participates in executions. Still, the names of three physicians who participated in executions in Georgia, North Carolina and in Missouri are known. The Missouri physician's name also was made public following an investigation by a journalist, according to Sade.

Following that incident, Missouri passed a law that would allow people who participate in executions to file civil suits if their names were made public, Sade says.

Chronology of the case

First, the NCMB issued a position statement on the matter in January 2007, according to the article in *Prognosis*, and it based that statement on the American Medical Association Code of Medical Ethics. That was followed by an Executive Protocol for executions issued by the DOC the following month, which required physicians to participate in lethal injections in that state – something strictly prohibited by the AMA's Code of Ethics and the NCMB's position statement.

Hollowell wrote that the DOC also in 2007 secured an injunction from the Superior Court which prohibited the NCMB from punishing physicians who participated in executions.

The DOC filed a petition to have the North Carolina Supreme Court consider the case, prior to it being heard by the North Carolina Court of Appeals, with the DOC suggesting that the case was likely to end up in the state Supreme Court ultimately, Hollowell tells *Medical Ethics Advisor*.

Most recently, in July, the NCMB filed a brief with the Supreme Court presenting its side of the argument, Hollowell says.

According to Hollowell, the next step that will occur is that the DOC will file its arguments in response to the NCMB brief in the Supreme Court. At some point after that brief is filed, the Supreme Court will hear oral arguments from both sides.

References

1. Hollowell, C. Physician participation in capital punishment in North Carolina. North Carolina Bar Association Health Law Section and the N.C. Society of Healthcare Attorneys. *Prognosis* 2008; 24(3): 3-6.

2. Black, L., Sade, RM, MD, "Lethal injection and physicians: State law vs. medical ethics." *JAMA* 2007; 298 (23): 2779-2781. ■

Some patients refuse to stop chemo at end of life

Physicians must guide patients

"Dr. O: 'I couldn't get him to stop thinking that he needed one more treatment. One more treatment was what he needed to spring him loose.'"[1]

The above quote from an article published in the *Journal of the American Medical Association (JAMA)* in June demonstrates the challenges that physicians can have with certain patients who, in everyday language, refuse to give up the fight to continue with their life, even if a prognosis suggests that is not possible.

In the case described in the *JAMA* article,

which is titled "The Role of Chemotherapy at the End of Life: 'When Is Enough, Enough?'" the patient underwent chemotherapy treatment a mere six days before his death. That begs the question of when should a patient seek hospice, and how can physicians aid in a patient's acceptance of a negative prognosis.

As baby boomers age and more people approach the end of life, there will likely be more people who choose the approach of fighting their disease past the point where they perhaps would have been better served to enter hospice — both for their own comfort and their families.

Part of the dilemma lies in the fact that chemotherapy is more available than in the past.

"As chemotherapy is increasingly available, and better tolerated, its use at life's end involves so-called sophisticated oncological assessment assessment, a focus on the patient's goals of care, and a balancing of perspectives of the patient and treating oncologist," the article states.

When considering treatment options —and potential outcomes — the article's authors, Sarah Elizabeth Harrington, MD, and Thomas J. Smith, MD, offer a series of questions for patients to ask. The authors are both of Virginia Commonwealth University.

They wrote that, "This can be provided to the patient in the waiting room for discussion with his or her physician."[1] **(See box right.)**

Still, as the article also notes, "It is critical to understand that people looking death in the eye have a different perspective."[1]

Struggle to deliver prognosis

According to **J. Vincent Guss Jr.**, MDiv., chaplain, Falcon's Landing Air Force Retired Officers Community in Potomac Falls, VA, "There are definitely [physicians] who have a difficult time . . theirs have a much easier time. On one level, it's never easy, because physicians are human and no one wants to communicate news that's perceived as bad."

Guss says that often, the reasons some physicians may have difficulty is that for them, a negative prognosis "represents a failure — a personal failure and a failure of science."

"They see death as the last illness to be cured, and it's incurable," he says.

Then, there are those physicians who either have some type of training relative to end-of-life care or "who are simply gifted within themselves" to be able to deliver bad news in a compassionate

Helpful Questions to Consider Asking About Palliative Chemotherapy

Treatment
- What is my chance of cure?
- What is the chance that this chemotherapy will make my cancer shrink? Stay stable? Grow?
- If I cannot be cured, will I live longer with chemotherapy? How much longer?
- What are the main side effects of the chemotherapy?
- Will I feel better or worse?
- Are there other options, such as hospice or palliative care?

- How do other people make these decisions?
- Are there clinical trials available?

— What are the benefits?
— Am I eligible?
— What is needed to enroll?

Prognosis
- What are the likely things that will happen to me?
- How long will I live? (Ask for a range, and the most likely scenario for the period ahead, and when death might be expected.)
- Are there other things I should be doing?

Will?
- Advance directives?
- Durable power of attorney for health care who can speak for me, if I am unable?
- Financial or family legal issues?
- Durable power of attorney for financial affairs?
- Trust?
- Family issues

— Will you help me talk with my children?

Spiritual and psychological issues
- Who is available to help me cope with this situation?
- Legacy and life review

— What do I want to pass on to my family to tell them about my life?

- Other concerns?

Source: Harrington SE, Smith TJ. The role of chemotherapy at the end of life: When is enough, enough?' *JAMA* 2008; 299(22): 2,667-2,678.

SOURCES

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and sensitive manner — even when there is no chance of a cure or recovery.

However, with more and more medical schools focusing on the humanities and the "spiritual dimensions" of health care in their programs, physicians are getting better at being the bearers of news that's hard for most patients to receive.

Many more now understand, too, as a result of such training, that "death is sometimes to be embraced and how to communicate that . . . when there is no other alternative than palliative or comfort care," says Guss.

Physicians, he said, need to be trained not only medically but also in such areas as psychology.

"It's a holistic approach," he says.

Advice for physicians

According to the article by Harrington and Smith, in their experience, "many families who choose . . . to enroll in hospice with they had done so sooner." And Guss's experience confirms that, he says.

Therein lies the challenge for certain physicians.

Guss recommends a team approach to end-of-life care, involving the patient, family, physicians, nurses, social workers, and any clergy offering comfort.

While, as chaplain, his primary obligation is to the patient, he also takes a team approach. He advises against giving "mixed messages," but to take an approach "that's clear, but very sensitive."

One of the primary concerns —and goals of the team approach —is to let the patient know that he or she is not alone.

Hospice a benefit

One way to introduce compassionate care is to introduce hospice, which some patients resist. He suggests not introducing hospice as a way of "giving up," but rather, "'This is the care that is indicated.'"

"And it's medical treatment, but a treatment to bring dignity and care in the real meaning of care for the patient and family."

Reference

Harrington SE, Smith TJ. The role of chemotherapy at the end of life: When is enough, enough? *JAMA* 2008; 299(22): 2,667-2,678. ■

Sedated patients require dignity and respect

All behavior is public

Occasionally, reports of physician misconduct while a patient is sedated make headlines — sometimes locally, sometimes nationally, and sometimes internationally.

But regardless of the details of any particular case, what are the standards of thought, approach, and behavior to which physicians and surgeons should adhere when treating a patient who is sedated?

Medical Ethics Advisor interviewed bioethicist **Laurie Zoloth**, PhD, professor of medical humanities and bioethics, and director of the Center for Bioethics, Science and Society at Northwestern University's Feinberg School of Medicine in Evanston, IL, in mid-August on this issue.

"Well, a patient, when they're sedated, does not lose their status and their dignity, as a human being whose body cannot be touched without permission," she says.

Zoloth describes the relationship between patients and physicians/surgeons as a "contractual" one, whereby the patient seeks help, and the surgeon then agrees to help and advises the patient of "certain risks and benefits and burdens."

"Anything outside of that, any other touch of the body that's not needed for the medical procedure is clearly in violation of that contract," she says. "Your relationship when you [sign on for care] has to be one of complete and utter trust that your body will always be regarded with care an dignity during any kind of surgery. And it should be that no one would touch you when you are unconscious [in] any way that they wouldn't touch you if you were awake or consenting."

Zoloth says there "clearly is a long history of bad behavior." As possible explanation for why

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"mischief" can occur with a sedated patient, she attributes some of it to the "unrelieved tension" that is often present in health care settings.

Temptation is there

John Banja, PhD, a clinical ethicist at Emory University in Atlanta, says, "The point is that professionals must never succumb to the temptation to be frivolous or disrespect someone."

But "temptation" does exist, often with an attempt toward humor, perhaps to alleviate the stress of this particular type of workplace.

Another component of the temptation occurs "when the person's face is not able to engage with you," and with the patient unable to communicate or respond, it can lead to an attitude of "objectivication of the body."

"An operating room isn't a locker room," Zoloth says, "and patients have the right to understand that their bodies won't become figures of fun. And that their suffering . . . isn't just a subject for amusement or joking around."

For example, in a surgical suite, the patient's life "hangs in [the surgical team's] hands."

Zoloth's professional research focuses on "getting people to tell the truth — and never to lie."

The type of behavior whereby a patient's body might be disrespected ". . . would be a violation of the promises made to patients . . .," Zoloth says.

"Any violation of that promise would be a lie, in essence, to be assuring patient's of one thing and then . . . doing something else," Zoloth says.

Professional life is public

One of the truths of all professions is that people "sometimes act differently [in private] than they would ever act in public," says Zoloth, citing as one example the recent case whereby former presidential candidate John Edwards admitted to an extramarital affair after denying it for several months.

And anyone acting in a professional role is always acting "in public."

"Your work is always public. It's always observed. It's always witnessed. It's always done in the name of a larger goal . . .," Zoloth says."So, even if you think there is no one watching you and there's just your buddies in the operating room, people are watching at all times," Zoloth says. "And if you're a person of faith, you could say that all of this behavior is witnessed by a higher moral force in the universe."

Trend is toward culture of respect

While the temptation may exist in the health care setting to behave inappropriately toward a patient, that culture of "bad behavior, a history of jocularity," the arrival of bioethics standards from the '60s onward is changing what many have viewed as a "paternalistic system" in health care, Zoloth says.

One concept that has entered the curricula of medical schools in teaching bioethics, has been the "autonomy and dignity of the patient."

The requirement in health care to have respect for a patient's autonomy "not only extends beyond the patient's ability to make a choice, but the ability of the patient's body to be regarded always as an actual, individual, important person in the world . . . "

"We're not a television show. It's not 'House' . . . and I think most physicians understand that and adhere to that standard," Zoloth says. ■

Bad behavior by physicians to be confronted

Fear of retaliation stops some from reporting it

Editor's note: In the August 2008 issue, Medical Ethics Advisor *reported on a new requirement by The Joint Commission to become effective January 2009 that hospitals monitor and correct so-called "disruptive behaviors" by health care professionals at their institutions. This month,* MEA *spoke with Laurie Zoloth at Northwestern University's Center for Bioethics, Science and Society. To discuss how physicians should address*

either incompetent or other bad behavior by other physicians.

Whether it's disruptive behavior or bad treatment of a patient due to incompetence, physicians and their colleagues can's simply choose to look the other way, according to ethicist **Laurie Zoloth**, PhD, professor of medical humanities and bioethics at Northwestern University's Feinberg School of Medicine. She also is director of the Center for Bioethics, Science and Society at Northwestern's Feinberg School.

But rather than scurrying off to file an anonymous or other type of complaint against a colleague behaving badly for whatever reason, the best approach is the direct approach.

"I think they're legally bound to confront their colleague, and I think that's true in every setting," Zoloth tells *Medical Ethics Advisor*. "It's extremely difficult in societies like ours that value collegiality and being nice . . . ."

The issue of bad behavior – again, whether it fits the definition of The Joint Commission's "disruptive behavior" or the prescribing of the wrong medication or wrong treatment for a patient – can become very personal when colleagues are forced to look at themselves, and decide their own reaction.

For example, Zoloth says, this is a type of situation that occurs often, and it is up to that individual to decide whether to "intervene to stop it and reclaim it from the insanity in the universe."

As with the illustration of surgeons/physicians and dealing with patients under sedation, in this situation, as well, Zoloth maintains that "all behavior is witnessed behavior."

"I think in every single area, you have to tell someone when they're doing something wrong," Zoloth says. "And I think that sometimes . . . the only excuse for not doing it is if you think they're going to hurt you."

Even if a colleague's response doesn't reach the level of outright aggression or violence, there are ways that they can retaliate professionally.

Confronting bad behavior, she says, is a "terribly important lesson."

"When you hear people say, 'I couldn't say anything, I was afraid he would retaliate, then you know something is broken far more than the individual person — you know, there's a brokenness in the system that doesn't allow people to confront wrongdoing," she says.

Fear of retaliation in reporting wrongdoing can certainly be a fear in medical students, interns, or residents.

She suggests that for those at this level of the health care profession, a "mechanism needs to be found for those complaints and those observations to be made without the individual person's career being devastated. And that's a very fine line."

Another component to such a situation is the "right of the accused to confront [his/her] accuser," she says, which opens up an entirely different level of "complexities."

"If you can have it as a practice that if you do bad behavior, then it's not going to be tolerated because your peers are going to stop it, that's the ideal before you get into hierarchical relationships and action and reporting." ■

Points for organizing an ethics committee

Determining structure is first step

Editor's note: Medical Ethics Advisor *is beginning an occasional series with articles designed to help provide useful information in the organizing and administration of ethics committees.*

When it comes to forming an ethics committee, whether a hospital is large or small, long-term thinking and planning generally is the key to success, it would seem. And while refinements can always be made, two challenges — training and recruiting — always seem to be present, according to **Felicia Cohn**, PhD, director of Medical Ethics at the University of California-Irvine School of Medicine.

"The first step is choosing the infrastructure and reporting functions you want your committee to have, and who will be responsible and accountable for the committee's work," Cohn says. "And that's going to vary depending on the kind of institution you have."

Three options noted

First things first. Among the three options noted by Cohn are the following informally designated models: medical staff; administrative committee; and independent, with the latter probably being the rarest example utilized, she says.

SOURCE

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"If you go and make it a medical staff committee, it's going to serve at the pleasure of the medical staff, so the medical staff president is going to have the ultimate authority over appointments and functions, and it's going to primarily address issues that the medical staff deals with," Cohn says. "So, it's going to be very clinically focused and deal mostly with bedside issues."

Other structure options

An ethics committee that is "constituted by the executive group" likely will have a "broader charge and may include not just clinical ethics but also organizational ethics," Cohn says.

The third option, which she describes as somewhat "free-floating," might be selected as the organizational model for the ethics committee if, for example, one hospital fits into a larger, overall health care system. It also is the organizational model likely to have the greatest level of independence from outside influences.

"So, for an institution that's concerned about biases from their executive level, or if there are issues external to the institution that need to be addressed, and they want to avoid interference from the institution, [this model] might be the way to go," Cohn says.

Recruiting is a challenge

One of the greatest challenges in organizing a committee is recruiting for it. In Cohn's experience, many people within a hospital or healthcare system may have interest in serving on the ethics committee. Unfortunately, some of those who express interest will not have the necessary training to serve, despite their "good intentions."

"Ideally, there would be at least one person with an academic background in bioethics and experience doing clinical ethics consultation, who can, if not chair the committee, administer the committee," says Cohn, who serves on the ethics committee of the University of California, Irvine, in addition to teaching ethics to medical students and residents.

If a medical staff model is selected, then it should be a goal of the organizing committee to recruit from all the clinical specialties – from primary care physicians to surgeons to rehab. But the list of specialty areas that should have representation does not end there; it should include other specialty areas such as nurses, social workers and respiratory therapists.

Risk managers are also helpful to have on such committees, but they may be constrained by too many other responsibilities demanding their time. One thing Cohn stresses is the enormous commitment that serving on an ethics committee requires of its members.

An ethics committee should also have one or more attorneys serving as members, but she says, "you need to find the right kind of attorney" — for example, one who is not just concerned with the letter of the law, but also is "more open to ethics analysis."

That could be the hospital's legal counsel, or it could be a member of the community.

Training not just knowledge-based

In addition to recruiting, training of ethics committee members is one of the fundamental challenges, according to Cohn.

"The hardest part about the training is it's not just . . . knowledge," she says. "It's skills and attitudes, and those are much harder to teach than knowledge. So, it's like medical education in a sense — it needs to be as much an apprenticeship as a class. [Members] need to observe consultations, learn to work with families and clinicians who are struggling with ethical issues and questions."

With healthcare professionals always being pushed for time, it's difficult to get them together for events such as weekend seminars. But such options are available, as are professionals who train ethics committee members who will come to a particular institution to conduct the training.

Another option is training with members of established ethics committees at other institutions.

"So far, I haven't found any resistance to sharing consultation strategies and background informational education," Cohn says.

Next month, Medical Ethics Advisor *will feature an article focusing on the different methods available for recruiting for ethics committees.* ■

Pharma industry revises ethics provisions

Code affects interactions with physicians

"In interacting with the medical community, we are committed to following the highest ethical standards, as well as all legal requirements. We are also concerned that our interactions with health care professionals not be perceived as inappropriate by patients or the public at large. This Code is to reinforce our intention that our interactions with health care professionals are professional exchanges designed to benefit patients and to enhance the practice of medicine."

— PhRMA's Code on Interactions with Healthcare Professionals.

The Pharmaceutical Research and Manufacturers of America (PhRMA) board in early July adopted a revised version of its Code on Interactions with Healthcare Professionals – revisions that will end distribution of the ubiquitous pens, mugs, and notepads and stop sales reps from providing restaurant meals to physicians and staff.

The revised code becomes effective in January 2009. The code was last revised in 2002.

A news release from the organization also said that the revised code "also affirms and strengthens previous statements that companies should not provide any entertainment or recreational benefits to health care professionals."

Included in the revised code are provisions that require companies to ensure their sales reps are trained in all applicable laws and regulations, as well as the provisions of the updated PhRMA Code on Interactions with Healthcare Professionals.

New code requires executive certification

The new code requires company CEOs and compliance officers to certify each year that they have a process in place to comply with the code. These officers also are "encouraged to get external verification periodically" that they have such processes in place.

"The problem that we have is [the] perception that a lot of the public [sees] the gifts and some of the things that are done [for physicians] in a negative light, and because of that, the academy wants to make sure that our members are looked upon as doing the right thing," says **Jim King**, MD, president of the American Academy of Family Practitioners (AAFP) in Leawood, KS.

King says he expects both members of his organization and the pharmaceutical and biotechnology companies that make up the PhRMA to abide by the revised code provisions.

SOURCE

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Additional revisions made

Other additions to the code include more detailed standards regarding the independence of continuing medical education; principles on the responsible use of nonpatient identified prescriber data; and additional guidance for speaking and consulting arrangements with healthcare professionals, including disclosure requirements for health care providers who are members of committees that set formularies or develop clinical practice guidelines and who also serve as speakers or consultants for a pharmaceutical company.

For example, in its guidelines on consultants, the PhRMA suggests that "token consulting or advisory arrangements should not be used to justify compensating health care professionals for their time or their travel, lodging, and other out-of-pocket expenses."

"Companies should continue to ensure that consultant arrangements are neither inducements nor rewards for prescribing or recommending a particular medicine or course of treatment," the code states. ■

ACS, NMA join to reduce cancer disparities

Initiatives to focus on alumni of black schools

The American Cancer Society in Atlanta and the National Medical Association in Washington, DC, have joined the strengths of their respective

organizations targeted to end disparities in cancer treatment and diagnosis among ethnic minority and underserved population groups.

The focus is on reducing inequalities in access to information and screening services, quality care and treatment, and end-of-life support.

Minorities often face obstacles

In a joint news release, the organizations said that racial and ethnic minorities can often face numerous obstacles to receiving equal access to quality cancer prevention, early detection and treatment services.

According to the organizations, many of these groups lack health insurance, live in rural or inner-city communities, have low incomes, and experience language barriers, racial bias and stereotyping.

Initial goals for the collaboration include developing and distributing culturally relevant consumer and professional materials that focus on prevention, early detection, and treatment of breast, prostate and colorectal cancer, as well as proper nutrition and physical activities.

Among other initiatives, the effort will target faculty and alumni of historically black colleges and universities. ■

Incorporating end-of-life issues into education

Introduce hospice as a resource for the terminally ill

End-of-life issues should be discussed while people are in good health. Just as people prepare for birth, it is important to prepare for death. The topic needs to be part of the health care discussion, says **Christin (Coco) Regas**, MSW, the consumer programs and services director for the National Hospice and Palliative Care Organization in Alexandria, VA.

There are many details to consider. Advance directives help take the guesswork out of medical decisions by providing such information as whether or not a person wants to be dependent on breathing machines or tube feeding. It would address whether or not a person wanted to be cared for at home — if possible when seriously ill — or move in with a family member.

Planning should cover all end-of-life issues from financial considerations to burial arrangements, says Regas. It is important to educate people about planning for end-of-life care because

most have not addressed it or articulated their wishes.

"Most people don't like to talk about it until they need to, but it can save a lot of heartache for everyone involved from the health care professionals to loved ones if people make their wishes known," says Regas.

The uncertainty can be avoided — even if people recognize they don't want to deal with end-of-life issues — and giving power of attorney for health care decisions to a family member or friend, she adds.

Preparing for the end of life also should include familiarity with the services available in the community in which a person lives. For example, people should know what type of home health care is available, whether or not a meal delivery service in their area provides hot lunches, and what type of long-term care facilities are available.

Hospices are a good source for such information, says Regas. These organizations often have a lot of information about the local resources, and they can offer guidance on the best way to select services. For example, they might suggest questions to ask when evaluating long-term care facilities.

Hospice should be one of the resources people are informed about before they need to use it to help care for a terminally ill family member, says Regas. The criteria for admission are usually a life-limiting diagnosis with a prognosis of six months or less.

Yet often education about hospice services takes place when care is required. Before families sign the informed consent paperwork to start services, an interview team meets with family members to go over the services provided. In the first meeting, many of the end-of-life issues are discussed or at least touched upon unless the team doesn't think the family is ready for such a discussion.

"If it is a new diagnosis and a new referral to hospice and the family is in somewhat of a state of shock or upset, the evaluation team may not go in depth about end-of-life issues," says Regas.

In such cases, the discussion on how hospice can assist the patient and family in determining their wishes for the end-of-life experience would be postponed until a later date.

Families should know that hospice provides extra support for terminally ill patients and caregivers. A medical team helps manage the patient's pain and symptoms, volunteers provide respite for caregivers, and social workers and chaplains provide emotional support. "Hospice is a holistic model of care that can provide extra support at a time when patients and their families need it most," says Regas.

Families can have as much or as little help as they want when they become involved with hospice. They may not want a lot of unfamiliar faces in their home at the end stage of life, but knowing there is someone to answer questions 24-

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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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- Barriers to hospice care in the United States
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CME Questions

33. In a North Carolina case involving physician participation in executions, the two state agencies in opposition to each other are the North Carolina Department of Corrections and the North Carolina Medical Board.
A. True
B. False

34. What are the reasons J. Vincent Guss Jr., MDiv, gives for certain physicians finding it difficult to deliver a negative prognosis?
A. Feelings of personal failure.
B. Thinking that there is a failure of science.
C. Physicians have emotions as most humans do.
D. All of the above

35. Felicia Cohn, PhD, suggests that training and recruitment are the two biggest challenges in forming and maintaining an ethics committee?
A. True
B. False

36. The revised Code of Interactions with Healthcare Professionals will become effective:
A. January 2009.
B. January 2010.
C. immediately.
D. when the board approves it.

Answers: 33. A; 34. D; 35. A; 35. A.

hours a day — or assist if needed — provides a sense of relief and comfort, says Regas.

Hospice also offers bereavement or grief counselors. Often, patients and families go through the grieving process before death actually happens, and trained counselors help them sort out their feelings and emotions about their circumstances.

While hospice services are often solicited for terminally ill patients, many now offer palliative care programs for people who have a serious illness but will not necessarily die in the next six months.

The subject of end-of-life services can be difficult for people; therefore, it is best to bring up such matters well in advance of the need. "We encourage physicians and health care professionals to start talking about end-of-life care long before it is needed. They should introduce the concept and talk about it little by little, visit by visit, so it is not such a shock if it is needed in the future," explains Regas. ■

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