

Virtual Mentor

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Virtual Mentor

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CASE AND COMMENTARY

Financial Incentives in Managed Care

Commentary by Kayhan Parsi, JD, PhD

Case

Mr. Nelson presents to Dr. Porter's office complaining of bitemporal headaches for a couple of weeks. A medical history reveals that Mr. Nelson has been experiencing difficulties and stress in his marriage, and a complete neurological physical exam is nonfocal. Based on his evaluation, Dr. Porter believes that the headaches are stress-related and can be managed by NSAID pain relievers and stress management. Mr. Nelson, however, believes that his headaches may have a more serious etiology and would like a CAT scan to rule out anything of greater concern. Mr. Nelson has read in the news that some health plans use financial incentives that reward physicians who save the plan money by ordering fewer expensive tests. Mr. Nelson asks Dr. Porter: "Are you not ordering the CAT scan because it is too expensive to get?"

Questions for Discussion

1. Some have advocated that disclosure of financial incentives be considered a part of the informed consent process. Should physicians be legally required to disclose this information. See *Neade v. Portes*.
2. Beyond the legal judgment on the matter, does Dr. Porter have an ethical obligation to disclose any financial incentives to Mr. Nelson?

See what the AMA *Code of Medical Ethics* says about this topic in Opinion 8.054 Financial incentives and the practice of medicine. American Medical Association. *Code of Medical Ethics* 1998-1999 Edition. Chicago, IL: American Medical Association; 1998.

Kayhan Parsi, JD, PhD is a fellow in the AMA Ethics Standards Group.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

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STATE OF THE ART AND SCIENCE

Should Genetic Information Be Treated Separately?

Faith Lagay, PhD

Incomplete patient charts? "Shadow" files? Though such practices sound as fishy as 2 sets of account books, federal and state legislative initiatives regarding genetic information could lead physicians to start keeping these sorts of double or shadow files. The belief that genetic information should be filed separately from other medical information and handled with special attention to confidentiality was termed "genetic exceptionalism" by the Task Force on Genetic Information and Insurance, an NIH-DOE joint working group of the Human Genome Project [1].

Ethicist Thomas Murray explains the main arguments in support of genetic exceptionalism [2]. The first points to the prophetic nature of genetic information. Whereas medical records detail the illnesses we have had and chronic conditions we now have, genetic testing can predict what we are likely to get in the future. Someone who is perfectly healthy and passes a pre-employment or health insurance physical with flying colors may be discovered, after genetic testing, to be predisposed to develop high cholesterol, breast or colon cancer, Huntington's or Alzheimer's disease. On this view, our genomes are, in the words of Murray's title, "future diaries." Genetic exceptionalism proponents claim that this prophecy should not be part of an individual's medical records. Insurance companies, on the other hand, argue that it's not fair for prospective policyholders to have information about their health that the prospective insurer doesn't have. That, they say, is like cheating at cards or signing up for home-owner's insurance when the fire truck's on the way to your house.

Our Genes "Inform On" Others

A second aspect of genetic test results that sets them apart from a simple history of our illnesses, past and present, is that such results can reveal information about family members' information that they themselves may not have, may not want to have, or may not want others to have. In the case of an autosomal dominant mutation, such as that associated with Huntington's disease, presence of the mutant allele in a young adult, call him Alex, means that one of his parents likewise has the dominant allele. If one of Alex's maternal grandparents had Huntington's, then his mother has the allele and transmitted it to Alex. (If a paternal grandparent had the disease, then Alex's father transmitted the allele.) Alex's mother may have avoided testing and wishes not to know whether or not she has the mutation. Alex's positive test result, however, will confirm that she does. Not all implications for kin are this dramatic; test results can designate others as carriers, for example. Test results can

also uncover an adoption or "false paternity," a misleading term that really means "false paternity claim"--the person calling himself the father is not the biological father.

Genetic Information Has Been Abused

Finally, genetic exceptionalists argue that past abuses of genetic information warrant special vigilance and preventive action. They refer not only to the infamous and heinous abuses of Nazi Germany, but to marriage restriction, sterilization, and even immigration policies in the US from the second decade of this century well past mid-century. Results of genetic information might now be used, some fear, to discriminate not only against those who exhibit symptoms of physical and mental conditions such as Huntington's or Alzheimer's disease, alcohol dependency, and psychosis but also against those with a genetic predisposition or "gene for" such conditions.

Genes Are Not the Sole Predictors

Murray disagrees with the genetic exceptionalism position, reasoning that, for one thing, it relies on what he calls the "2-bucket theory of disease" [3]. This theory would divide all diseases and disorders into 2 categories: genetically transmitted illness and non-genetic illness. Such is not the case, Murray asserts. Genetic influences on, to take one example, the fortitude of one's immune system, affect how frequently one contracts common colds and the severity of those colds. Yet, no one would refer to the cold or to flu as a genetic disease. Very little about our health has no genetic component, and, at the same time, very little about our health is determined only by our genome, much less by one gene.

The attempt to separate genetic information from non-genetic information is doomed, Murray thinks. Much of a patient's family history and personal health history is genetic information, but is not labeled as such because it is not the result of genetic testing. Must physicians stop a patient in the middle of a history and switch to a different, more secure set of records when the patient begins to list the illnesses and causes of death of his parents, grandparents, and other family members?

The impossibility of disentangling genetic from non-genetic information renders most state regulations on the privacy of genetic information ineffectual because most state regulations to date require special protections for results of genetic testing only. An employer or insurance company can reject a prospect or classify him as high risk for future heart disease, cancer, diabetes, Alzheimer's or Huntington disease on the basis of family and health history that would be released to them under most current legislation. For this reason, legislation and regulations that cover all patient records (such as President Clinton's executive medical records privacy order in late December 2000) will offer a more effective approach to protection against genetic discrimination.

"Genetic Exceptionalism" is Ethically Unjust

There is also a compelling ethical reason for not acceding to the plea for genetic exceptionalism: to do so would give preferential protection to someone who contracts a disease from so-called genetic causes. There is "no good moral justification for treating genetic information, genetic disease, or genetic risk factors as categorically different from other medical information, diseases, or risk factors" [4]. If genetic exceptionalism safeguards were in place, an insurance company could not deny coverage to a woman who has a BRCA gene on the basis of that test result. Yet a woman who had not been tested or who had tested negatively could be denied coverage on the basis of family history. When someone needs medical care, Murray argues, he or she needs medical care. To say that the care will be reimbursed only if the cause is genetic, in the most simplistic definition of that term, is unjust.

For these reasons, Murray and the Task Force on Genetic Information and Insurance ultimately concluded that genetic information should not be given special protection. Rather, society must decide which third parties--employers, insurers, schools, and so on--have the right to our medical records, including family histories, and under what circumstances they may have them. Then we must enact the proper rules and regulations to see that those conditions are met and penalize violators.

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HISTORY OF MEDICINE

Revising the Declaration of Helsinki: Accord or Discord?

Karen Geraghty

The Declaration of Helsinki emerged in the aftermath of World War II as one of the guidelines of biomedical ethical conduct. The Nuremberg Code had been formulated as a response to the judicial condemnation of the acts of Nazi physicians, and did not specifically address human subject research in the context of the patient-physician relationship. In 1964, the World Medical Association adopted the Helsinki Declaration as a response to concerns regarding research on patient populations. The primary purpose of the accord was to assert the interests of the individual patient before those of society.

In October 2000, at the 52nd World Medical Association General Assembly in Edinburgh, Scotland, the Declaration of Helsinki underwent a controversial revision, unleashing a firestorm of criticism from many researchers, drug companies, and bioethicists who claim that the new recommendations unnecessarily restrict and impede biomedical research on human subjects. Proponents of the changes claim that it protects patients by eliminating unethical research where the populations, such as those in developing nations, are most vulnerable.

At the heart of the controversy is paragraph 29 of the [Helsinki Declaration](#), which states that "the benefits, risks, burdens, and effectiveness of a new method should be tested against those of the best current prophylactic, diagnostic, and therapeutic methods. This does not exclude the use of placebo, or no treatment, in studies where no proven prophylactic, diagnostic or therapeutic method exists." In essence, the paragraph forbids the use of placebos as a control treatment in research studies unless no other proven treatment exists.

This language was adopted in order to curtail research trials in developing nations where the best care available to the local populations may fall far short of that in the industrialized world. Paragraph 29 is an attempt to set a universal standard of care for all patients, regardless of their geographic, political, or economic circumstances. Critics of this standard argue however, that it is necessary to recognize that developing countries cannot afford the same level of health care available in industrialized countries. Therefore, research trials, even those conducted with placebos in place of established therapies, are ethically permissible because they leave the patient population no worse off than before the research began. Advocates of the standard however, state that the reasoning of "better something than nothing"

basically puts the interests of society before the interest of the individual research subject, a fundamental breach in the purpose of the Helsinki Declaration.

This most recent revision in the Declaration (the document was previously revised in 1975, 1983, 1989, and 1996) is aimed at making the document relevant to today's field of medical research. As medicine becomes ever more global in its reach, the controversy regarding local or universal standards of care will continue to challenge both the interests of society and the interests of the individual patients [1-6].

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ART OF MEDICINE

Building a Memorial in the Face of Tragedy: AIDS and Quilt-making

Sara Taub, MA

With its upward of 44,000 individual panels and 83,000 names that span more than 720,000 square feet, the Names Project AIDS Memorial Quilt, of which this month's image constitutes a segment, is the largest community art work initiative in the world.

The project was conceived of in 1987, by a small group of strangers in San Francisco, to document for posterity the stories of friends and loved ones, whom AIDS had claimed. They provided the first quilted panels -- pieces the size of an average human grave, 3 feet by 6 feet - to celebrate the lives of persons dear to them, before inviting others around the country and the world to contribute to the work. The age-old tradition of quilt-making offered a creative means to bring grieving people together to tell stories and share company, in an effort to remember and heal. A quilt is, after all, a symbol and source of comfort and warmth.

What started off as an effort to remember the stories of people who had fought a battle with AIDS developed into a novel form of memorial, one that extends beyond its physical size, as the most recognizable symbol of the AIDS epidemic. Today the quilt plays an important role, in addition to its memorial function, as an educational tool and a unique work of art.

"Not all battles are fought with a sword," reads the slogan of the quilt, which highlights its efforts to help bring an end to AIDS through set goals. As the largest collection of information ever assembled about the effect of a disease, the quilt, which travels across the world, has helped to increase public awareness about the AIDS epidemic and its enormity. It has assisted with prevention of HIV through education and served to raise funds for AIDS service organizations within various communities.

As a work of art, the Quilt Project uses an array of materials (legos, keys, wedding rings, cremation ashes are just a few) and mediums (panels often come accompanied by documents which are cataloged) to narrate the popular culture of the past several decades and of the present. Individual panels of the quilt may be searched by name or by block number. Tragically, indeed, the story is still being written, as reflected by the continued growth of the quilt.

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PERSONAL NARRATIVE

"Hey Daktari, the Mzungu No Look Good!"

Robert Davidson, MD, MPH

This static-filled telephone call from a park ranger started an incredible chain of events. The mzungu, (roughly translated as European), turned out to be a 27-year-old Peace Corps volunteer who was working in a national park in Malawi. We immediately started planning how to transport him to the medical unit in Lilongwe. The first leg of the trip was in a park ranger truck that met the Peace Corps Land Rover on the highway. When he finally got to the medical unit, his blood pressure was 80/40, his pulse, rapid, and his temperature, 40.1 C. Following re-hydration, he perked up a bit and we awaited lab studies, suspecting malaria. When the results came in we were stunned. Trypanosomiasis, probably *Trypanosoma brucei rhodesiense*, was the diagnosis. Following a rapid review of Trypanosomiasis in my tropical medicine book, we quickly decided that we could not handle this in Malawi. We arranged for an air ambulance flight to South Africa where he was admitted to the ICU and started on suramin. His lumbar puncture was negative for CNS involvement that would have indicated adding arsenic, as suramin does not cross the blood brain barrier in adequate amounts. I have never treated anyone with arsenic, but it does not sound like something fun to do. As I write this, the volunteer is out of the hospital and doing well.

Avoiding an Epidemic

The next step in this saga was a phone call to the ministry of health who informed us that Malawi does not have Trypanosomiasis anymore because they had undertaken an eradication program two years ago. Well the bugs won again; five more cases were diagnosed in the same park area, all in Malawians. There are known tsetse flies in a number of areas in Malawi and neighboring Tanzania. There is no immunization against the protozoan parasites they carry. So we were faced with what to do with the other volunteers in the area. Thanks to modern communication, we were able to call for advice from the Peace Corps Headquarters and set up a plan for selected removal of some volunteers in known tsetse fly areas. So far, no additional cases in volunteers have occurred. However, we receive daily calls from volunteers who have been bitten by something and are worried they have African Sleeping Sickness.

Reflecting on the Incident

As I look back on this case, several things stand out. First is the issue of emergency transportation. There is no 911 system. It is rare to even find an ambulance outside the major cities. We recently went to see a reported new ambulance in Madagascar

that turned out to be a mini-bus with a litter. There was a driver and an attendant with no training. "But daktari, he is real strong." Earlier, I sat with a volunteer with acute appendicitis driving over rutted dirt roads in a vehicle with shocks that had long ago given up. I felt each jolt and knew he was suffering. I had no idea if this jostling was more likely to produce a perforation but sure hoped not. With the financial resources we have as a US agency, we can access air ambulances that are quite good. These are a godsend, as the in-country medical care resources in a place like Malawi are fairly primitive. There are some great doctors, but they just do not have the medicines, facilities or support necessary to care for really sick patients. I do feel a little guilty that we can fly the volunteer to an ICU in Pretoria when this is far beyond the finances of most Africans. However, I also realize that if the finances were available, they would be better spent on basic health supplies and initiatives, not air ambulances and ICUs.

Remembering the Basics

The second reflection was on tropical diseases. I flashed back to my parasitology course at the Indiana University School of Medicine. I remember saying to myself that I just had to memorize this stuff for the exam, since I would never see these bugs in patients. Like so many other things I knew as a medical student, I was wrong. However, I have found that it is not as hard as it sounds to take care of cases like this. The basic principles are the same. You need to deal with things like shock and dehydration. Once the patient is stabilized, you have time to look up these different diseases and read how to treat them. With access to the Internet and telephones, knowledge about tropical illnesses is readily accessible. Whose Lifestyle Is Unhealthy?

The third reflection concerns my admiration for the Peace Corps volunteers. Most volunteers complete their service with nothing more than an occasional bout of diarrhea. However, they live in remote villages often without electricity. They use pit latrines and rig up outdoor sun heated showers. They boil and filter the water they carry in buckets to their houses. They buy their produce at the village market and soak it in a chlorine bleach solution before cooking, as night soil [human feces] is the standard method of fertilization. They are constantly exposed to all kinds of parasites and viruses. They self-treat as much as possible with a medical kit supplied to them and a copy of "Where There is No Doctor." Yes, they do get diarrhea, URIs, various skin infections, both bacterial and fungal, and lots of anxiety symptoms. However, overall they do remarkably well and almost always return home healthier than when they came. Maybe the real message is the unhealthy lifestyles too many of us fall into in the United States.

Well, enough for this month. Daktari Bob signing off.

Robert Davidson, MD, MPH is professor in the Department of Family and Community Medicine at University of California, Davis, where his interests include both rural health and the organization and financing of health care systems. In the

past few years, he has served as both the Director of Rural Health and earlier as the Medical Director of Managed Care for the UC Davis Health System. *Out of Africa* is an on-line journal of his odyssey in the U.S. Peace Corps as the area Medical Officer in Eastern Africa.

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PERSONAL NARRATIVE

Through the Patient's Eyes: Not About Army

FR Burdett

Two short, plump, almost identical, fifty-ish nurses--one on each side--fuss over me, inserting IV's in both arms, making asides to each other about "these new needles," which they seem not to have used before.

The lines finally in place, there is a collective sigh from all three of us before they gather up the wrappers, cotton balls, and pieces of tape and prepare to exit. But first one asks, "Have you met Army yet?" anxious to find out before leaving my room.

"Not yet."

"He should be here soon," from the other as they titter out of the room.

When the door closes I take a deep breath; I hear myself exhale. There was not the first innuendo concerning Army. I already know "Army *always* watches ESPN." I reach for the TV control being careful not to dislodge the lines. Then I start flipping through the channels just to be watching something besides ESPN when Army gets there.

After fifty-six hospital channels I give up, turn off the TV, and lay back and close my eyes, reconsidering my decision to volunteer for this six month study of the "Effects of Testosterone on Elderly Men over Sixty"--a title I find both redundant and unflattering. This is the first of three hospitalizations when I will contribute samples of thigh muscle to science in exchange for a total of \$150 and whatever effects bi-weekly injections of testosterone--or placebo--might have.

Army will infuse me, cut me, remove little pieces of me, draw any number of tubes of my blood. In short, I will entrust my life to this man on three different occasions--or quit the study.

I'm not going to like Army; I already don't. I've surmised he represents everything I dislike-- General Patton, John Wayne, the military industrial complex, the Christian right, jocks--just about all of it.

He enters. Military flat top. Introduces himself. Shaggy military flattop. Do I mind watching ESPN? About forty. Pops open a Diet Coke. He doesn't need the caffeine.

Hums the ESPN theme. Slender but very large biceps and shoulders. Examines my legs before selecting one. Probably used steroids.

It may not have been like that. I don't really know what happened first when Army walked in. There probably wasn't a truly definable "first." Army happened all at once and I try to reconstruct. In fact, he isn't alone. A colleague and technician have accompanied him, been introduced, and are also preparing for the procedure but I've only seen Army.

We watch ESPN. I don't say, "I'm not a jock. I don't follow sports." Army critiques the clips from the previous night's games, recognizes and relives clips from prior games and prior seasons with the excitement of a professional commentator. He keeps humming the theme.

"You're not allergic to lidocaine, are you?" he interrupts himself.

"Is that novocaine?"

"Exactly."

"Never have been."

Army continues: "You're going to feel a little stick. Tell me if I hurt you. There's no reason for you to hurt. Lidocaine's cheap."

The consent form explained that amino acids, fatty acids and glucose will be infused through the catheters in the arm. Two one-hour infusions of Indocyanine green through a vein in the leg will measure blood flow. Two incisions will be made in the thigh during the course of the day from which three pea-sized samples of muscle will be taken using a biopsy needle.

"How's the book?" he refers to a paperback from *The New York Times Advice, How-To and Miscellaneous* list laying on the stand by the bed.

The book is trite. I'm embarrassed that he thinks I'm reading it. "Well it's okay for something like this--you don't have to concentrate."

"That's about what I thought."

That's about what I thought he'd think.

I lied. I'm not prepared for him. Being prepared for Army is not as simple as just disliking him. I'm intimidated. I care about what he thinks.

On ESPN a basketball player in what Army calls "a three thousand dollar suit" doesn't pay child support for several children from as many relationships. Army is

offended. I venture, "Fifteen and sixteen year old fathers that I work with want kids because they want to have somebody."

"That's kind of sad." Not quite the response I would have expected from Army.

"How lucky we are to have had the kind of upbringing we had." He doesn't know about my upbringing but I don't challenge him. Then, "Are you warm enough without a shirt?"

I am lying spread-eagle on the bed, naked except for a sheet pulled like a loincloth between my legs. I look at the tangle of plastic tubes, bags, and machines attached to each of my limbs. "No, I'd like to put one on right now," I say using my best sarcasm.

"We can do that."

"Just kidding, Army. I'm okay." But I wonder how he would have done it.

I tell Army how I've willed my skin to the burn center where he works; take them whatever money I find during my walks; how the receptionist is thrilled when I walk in with a Ziploc bag of beat up coins to make my anonymous contribution. I go on to say that I've considered volunteering there, but am not sure I could handle seeing kids who've been burned so badly. Army replies that they get most of their skin from cadavers and that most of the kids seem to accept their lot in life; he doesn't encourage me.

I become absorbed watching him. He's good at what he does, has high standards, and is a demanding taskmaster. It shows in the relationship with Missy, his junior colleague. I notice she uses sarcasm to deal with him too. She tells me, "I was the only girl in the family with four older brothers. They hired me because they thought I could hold my own with Army."

Army is clearly bored whenever there is a lull in activity. Even ESPN doesn't hold his interest. Some of the stories are being repeated. "This is the third time for some of this stuff--did you notice that, Army?" Missy encourages me with a chuckle.

Army cedes control of the remote. Other channels are covering the Seinfeld finale scheduled for that night. "Seinfeld's whiny. They're all losers," says Army. "Kramer's the only funny one."

"Kramer? He'd only slide into my apartment one time." I hadn't thought of Seinfeld as a loser. Or Elaine. Now I wonder what Army sees that I don't.

When the team breaks for lunch, Missy leaves a banana on the stand by my book. My lunch drips slowly into the tubes in my arms. But I forget about the banana as I concentrate on urinating into a plastic bottle without turning over and pulling out

the lines. I hang the bottle back on the rail on the side of the bed, turn out the light and pull up the sheet the best I can. The room has cooled since the other three left.

I'm embarrassed now that I've needled Arny all morning about everything I could come up with from being type "A" to a few barely noticeable gray hairs. I even asked him how everything is *tomorrow* when his mind seemed to be racing somewhere way ahead of the rest of us. I don't have much time for remorse; they come back early. Missy tells me, "I carpool with Arny. If I'm not at least five minutes early that's late to him."

Arny isn't as big as he seemed when he came in this morning. Thin--except for his arms and shoulders--not very tall. Has dimples--multiple.

"Your feet feel cold."

"I'm fine, Arny."

The afternoon's procedures aren't much different from the morning's--more blood samples, more lidocaine, more biopsies. I learn more about Arny--helicopter pilot, colonel, Harley rider, jock--but not John Wayne. Still impressive to watch, very bright, caring. You have to admire him. Damn. I have to admire him.

"How dare you?" My blood has clotted in the arterial line. Arny is uncharacteristically quiet until he gets it flowing again and gets his final sample. Then, "In just a minute, you can see my work of art."

Closing up, he tells me "You've got tough skin. I can get the needle in but I can't get it out the other side."

"I've worked hard on my tough skin, Arny," I say under my breath.

The banana is still sitting on the stand beside the bed--too speckled for Missy since it's sat out all day. Arny peels it part way then holds it out for me. I break off half. Kind of a communion.

"Arny, I've enjoyed it." A funny way to say what I'm feeling. He laughs it off.

They leave. I eat. I go home in an hour. The stitches come out in a week. The scars fade but not the experience. I like Arny.

FR Burdett walks the seawall and writes in Galveston, an island off Texas, in the Gulf of Mexico.

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PERSONAL NARRATIVE

Through the Student's (or Physician's) Eyes: "Five Miles From Tomorrow"

Audiey Kao, MD, PhD

"More people have attempted to climb Mount Everest than have visited here longer than 72 hours-- allowing a unique hybrid of Siberian and Inuit tradition to flourish under the radar of the Western world. The resulting population is genetically and culturally distinct from any other in the world."

Shah S. Five miles from tomorrow. *JAMA*. [A Piece of My Mind] 2000;284:1897-1898.

When Virtual Mentor linked to this essay in January 2001, we believed it to be a factual account. However, the essay's authenticity has since been challenged by the author's clinical prefect, Dr. Michael D. Swenson. For more information about the disputed case, see Dr. Swenson's August 2001 letter to *JAMA*:

Swenson, Michael D.; Shah, Shetal I. A Story About Suicide in the Arctic [Letters]. *JAMA*. Aug 2001;286:919.

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VIEWPOINT

Physician-Assisted Suicide: What's Legal and What's Professional?

Faith Lagay, PhD

Physician-assisted suicide claimed front-page status again as the year 2000 drew to a close. In late November, the Dutch Parliament approved a bill legalizing euthanasia and physician-assisted suicide, making the Netherlands the first country to do so formally. Earlier that month, US voters in Maine considered legalizing physician-assisted suicide in their state. Question One on their referendum ballot asked succinctly and in plain English: "Should a terminally ill adult who is of sound mind be allowed to ask for and receive a doctor's help to die?" Maine voters said "no" (meekly) by a vote of 51.5 percent to 48.5 percent.

Supporters on both sides of the question campaigned heavily in Maine. Those opposing the practice advanced 2 chief arguments: (1) legalizing physician-assisted suicide will cause pressure on terminal patients who fear their illness is burdensome--physically, emotionally, or financially--to their families or caretakers and, (2) as Maine Medical Society's executive VP Gordon Smith put it, "physician-assisted suicide goes against 2,000 years of medical ethics" [1]. Smith has a point. The current version of the AMA's 150-year old Code of Medical Ethics prohibits physician-assisted suicide in the same strong language it uses in prohibiting physician involvement in euthanasia. In opinion E-2.211, "physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."

That a state can legalize physician-assisted suicide, as Oregon has in fact done, highlights the difference between what's legal and what's ethical; what the state *allows* residents to do and what members of a given profession, in this case medicine, believe they *ought* to do. Though a state may legalize physician-assisted suicide--or abortion, or capital punishment, for that matter--it cannot force doctors who oppose the practice on grounds of professional ethics or from personal beliefs to participate. In Oregon, the legal right to seek a physician's help in ending one's life went into effect in 1997. An assessment of how the legal right was exercised during 1998 found that, of the 15 patients who committed suicide with the help of physicians, 6 had been refused initially and had consulted doctors until finding one who would agree to help [2].

Why Some Physicians Help

Most terminally ill patients who wish to commit suicide want to do so by medical means, nonviolently, out of respect for themselves and others. Yet medical suicide

is not easy to accomplish; dosage and timing of drug administration matter critically, especially if the drug is taken orally, and failed attempts can cause greater trauma than death itself for the patient and caregivers. Patients may beg caregivers to complete their failed attempt at dying. These circumstances and possible consequences convince some physicians that helping a patient who is determined to end his or her life prevents a greater harm than it causes. Moreover, some believe that ending, at a patient's request, the physical pain and mental anguish from which that patient will not recover does not violate the spirit or goals of medical ethics.

What Ethical Choices Does a Physician Have?

If a state does legalize physician-assisted suicide, what choices do physicians in that state face? Must they opt either to (1) refuse aid to patients determined upon killing themselves, thus driving those patients to seek help from other, possibly unknown, physicians or inexperienced caregivers or (2) violate their profession's principal code of ethics?

There are many services physicians can provide a patient who asks for assistance in dying without violating professional ethics or personal beliefs. First, they must confront the task of presenting the most accurate possible prognosis. This is a difficult but critical task that only the physicians can perform. It demands skill, experience, and courage. In his recent book on the importance (and underuse) of prognosis, Nicholas Christakis emphasizes that the lack of a prognosis, or an inaccurate one, can lead patients to make bad choices near the end of their lives [3]. Next, physicians must carefully describe all possible treatment and palliative care options with the patient and discuss what he or she can expect as consequences of each of those care options, as well as the consequences of accepting no treatment or care. Physicians can also play a role in referring terminally ill patients to others--psychiatrists, hospice workers, clergy--who can evaluate their mental status and help them consider end-of-life decisions. And physicians can agree to maintain their relationship with the patient, no matter what course the patient finally chooses, without directly participating in suicide activity if that is the patient's ultimate choice.

In 1997, the University of Pennsylvania's Center for Bioethics commenced a project called Finding Common Ground to explore, among other topics, how physicians should respond to requests for assistance in dying [4]. One report from the project examined whether physicians were the only professionals, or even the best professionals, to aid in helping terminally ill patients end their lives [5]. The report concluded that doctors played a necessary but not a sufficient role. Physicians are best equipped among health care professionals to determine the patient's diagnosis, prognosis, and full range of treatment options. These activities in themselves, of course, do not violate the AMA Code of Ethics that prohibits physician assistance with suicide: they are professional services rendered to all patients. The remaining activities that, according to the report, patient suicide should entail are: preparing the person for dying, providing the means, providing support during administration of the medications and while the patient is dying, managing complications,

reporting the assisted suicide, and coordinating the overall process. These need not be carried out by physicians. Even prescribing of the drug could fall within the professional purview of nurse practitioners and physician assistants. In addition to health care professionals, clergy, social workers, and other counselors could participate. In this case, each of these health care professions would face the ethics question that physicians now confront and on which the AMA has taken a stand.

The Role of Physicians in Effecting Laws Compatible with Ethics

Some bioethicists believe that, when law and professional ethics come into conflict, physicians have obligations beyond their one-on-one covenant with patients. Alex Capron and Eliot Friedson, for example, have written that physicians have a social and political duty to create an environment that encourages the ethical practice of medicine [6]. On this view, physicians should support and campaign for regulations that ensure humane care for the terminally ill and reimbursement for the costs of proper end-of-life care. Such provisions will reduce patients' concerns that their end-of-life care is overwhelmingly burdensome to others.

Physicians should also consider how best to care for and respond to those competent, terminally ill individuals in intractable pain who wish to die without spending days or weeks paralyzed from pain-killing medication or comatose and who desire help from medical professionals in doing so. The number of individuals in this category should remain few, but there will always be some. It is desirable to have guidelines and practices in place that allow health care professionals to respond legally *and ethically*. The absence of such guidelines, promotes unethical behavior among those who are genuinely trying to do what they deem best for their patients.

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VIEWPOINT

Politics, Policy, and Medicine

Audiey Kao, MD, PhD

- As a result of the recent federal elections, 13 women including First Lady Hillary Rodham Clinton will be serving as Senators in the United States Congress, the highwater mark for women in Senate history. Both Senators in the states of California, Washington, and Maine will be women. In the House of Representatives, 56 of the 425 members will be women.
- The AMA's House of Delegates is the legislative and primary policy-making body of the Association, and thus, it is often referred to as the Congress of the AMA. The House comprises 535 delegates selected by state medical societies, medical specialty organizations, special sections, military and other government service entities, and other organizations granted seats by the House. According to a recent AMA report, the House of Delegates is 88 percent male whereas the overall physician and medical student population is 75 percent male.
- The House of Delegates convenes twice a year in June and December to deliberate and vote to establish official AMA policy. In the recently concluded December 2000 meeting, several actions were taken, including support for making emergency contraception pills more readily available. In addition, the House of Delegates voted to revise the [Principles of Medical Ethics](#) in response to changes in medicine and the health care system. The revisions included two new principles stating that "a physician shall, while caring for a patient, regard responsibility to the patient as paramount" and "a physician shall support access to medical care for all people." According to the AMA's Constitution and Bylaws, the House of Delegates can vote on approving these revisions to the Principles in their next meeting, which will be in June 2001 in Chicago.
- AMA's Code of Medical Ethics Opinion E-9.012 states that "physicians enjoy the rights and privileges of free political speech shared by all Americans. It is laudable for physicians to run for political office, to lobby for political positions, parties or candidates, and in every other way to exercise the full scope of their political rights as citizens." It is natural that in fulfilling these political responsibilities, physicians will express their views to patients or their families. However, communications by telephone or other modalities with patients and their families about political matters must be conducted with the utmost sensitivity to patients' vulnerability and desire for privacy. Conversations about political matters are not appropriate

at times when patients or families are emotionally pressured by significant medical circumstances.

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VIEWPOINT

Classical? Celtic Harp? Big Band? Show Tunes? What Turns You on in the OR?

Faith Lagay, PhD and Sara Taub, MA

Classical? Celtic harp? big band? show tunes? What turns you on in the O.R.? Or are you one of those who thinks that, aside from the "sponge" and "hemostat" orders and a bit of running narrative explanation, silence is golden during surgery?

Musical preferences differ greatly among surgeons who like to work with background tunes, but they agree on the benefits. Music, they say, improves both their ability to cope with stress and fatigue and the speed and accuracy of their performance. As Eric L. Lazar, a surgery resident puts it simply: "I seem to think better with it on."

At present, there are no data to support these claims, but one study looked at the effect of music during experiments that mimic the stress of surgery. In this study, surgeons performed the same tasks with musical selections of their own, experimenter-selected control music, and no music. When working with their own selections as background, participants were less influenced by external distractions and thus better able to concentrate on the task and perform it correctly. Moreover, their cardiovascular responses remained significantly lower and they exhibited only small changes in blood pressure over baseline, even when under stress.

Surgeons who prefer to work in a silent environment offer various reasons for their choice. Since musical preference is so highly individual, some consider it just too complicated and bothersome to find selections that would appeal to the entire team. Other surgeons rank it as an interference, and some strongly denounce music's effect on their team's and their own concentration and mood. Furthermore, they think it detracts from the professional image of the team and the gravity of their task; this is of special concern when the patient remains awake during surgery.

It's worth noting as part of this discussion that some researchers believe that music has a therapeutic impact on patients. Pieces that are selected by patients, according to these researchers, can help anaesthetize them before surgery, calm their heart rate and respiration during, awaken them after, and reduce their experience of pain.

Should music be played in the operating room during surgery? There's no intrinsically "right" answer. It seems, though, that since the surgeon is not alone in

the room or in the work being done there, the decision about whether and what to play should be a collective one.

To read the views of several surgeons around the country on listening to music in the OR, as well as the musical preferences of those who engage in the practice, please refer to Kristen Watson's piece, 'A new spin on medical "records": Music in the OR,' in the *Journal of the College of Physicians and Surgeons at Columbia University*.

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VIEWPOINT

Edmund Pellegrino, MD, Exemplary Role Model

Audiey Kao, MD, PhD

Dr. Edmund Pellegrino, John Carroll Professor of Medicine and Medical Ethics at Georgetown University, is a physician who has been a role model and mentor to countless physicians. Over his long career, Dr. Pellegrino has worked to promote and strengthen the sacred relationship between individuals who are ill and thus vulnerable and their physicians who have "the power to do enormous good and enormous harm." A man of deep faith and conviction, he has tirelessly extolled the importance of physicians' virtues such as intellectual honesty and fidelity to patient as the ethical basis of the clinical encounter. According to Dr. Pellegrino, one teaches virtue by acting virtuously. This conviction has served as a guiding principle in his professional life, and partly explains his infectious appeal and influence in the field of medical ethics and professionalism.

As the author of more than 500 published works, Dr. Pellegrino has written on subjects ranging from the history and philosophy of medicine to professional ethics and the patient-physician relationship. He has received numerous honorary degrees and awards including the Benjamin Rush Award for Citizenship and Community Service from the American Medical Association and the Abraham Flexner Award for Distinguished Service to Medical Education from the Association of American Medical Colleges. His energy and passion for his life's work was palpable during a recent interview that I had with him. This passion and enduring enthusiasm are reflected by the fact that he always leaps and does not walk on to the stage when giving a lecture or presentation—not bad for a 40-year old, let alone an 80-year old.

For being a shining example of a physician who strives to live a virtuous and robust life, we are proud to present Dr. Edmund Pellegrino with the *Virtual Mentor* Award for being an exemplary role model in medicine.

Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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