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Do No Harm: End-of-Life Care

Upcoming Issues of *Virtual Mentor*

February: Emergency Medicine
March: Medical Residency
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FROM THE EDITOR

Form Follows Function: Virtual Mentor's New Format

Audiey Kao, MD, PhD

Chicago is home to many of the world's most recognizable buildings, as well as some of its most renowned architects. One of these architects was Louis Sullivan. His designs were based on the principle that the functional use of a building should dictate the shape and layout of its physical spaces. In other words, Sullivan espoused the importance of form following function.

Chicago is also home to one of the world's leading professional institutions, the American Medical Association (AMA). The AMA was founded more than 150 years ago, in large part to establish a code of ethics for medicine – the first such national codification of professional ethics in history.[1] Since its inception more than 3 years ago, *Virtual Mentor (VM)* has been guided by these historical roots in establishing an online forum for exploring and addressing ethical issues in medicine. While *VM's* mission has not changed, this month's issue reflects significant changes in editorial content. It is our expectation that *Virtual Mentor's* new form will better serve its longstanding function – strengthening the ethics and professionalism of tomorrow's physicians.

Our readers will notice *Virtual Mentor's* shift to a more thematic focus. Every month, a topic of ethical relevance to the practice of good medicine will be explored and addressed. By examining a single topic from many perspectives, we hope our audience will not only gain a greater understanding of the ethical issues in medicine, and thus, how better to address these challenges, but also of the complex relationship between the ethical dimension of care and the clinical and legal considerations.

In addition to a more thematic focus, a core portion of *VM* content will be presented in a form that can be printed and readily used by medical educators in formal teaching settings. In each *VM* issue, the core set of teaching tools may include:

- PowerPoint® presentations with explicit learning objectives that can be used in medical school courses or hospital grand rounds;
- Cases in clinical ethics and/or health law with expert commentary;
- Journal article reviews with questions for discussion in easily printed formats for distribution to students and residents;
- Glossary of relevant terms and concepts;

- Evaluation instruments that test students' knowledge and understanding of issues and topics covered by a theme issue.

It seems fitting to me that the initial issue of the new and improved *Virtual Mentor* is on the guiding ethic that has served as the foundation for sound medical practice - first do no harm. With the increasing advances in medical technology, physicians have the potential to do great good for patients, but also to inflict great harm. In this issue, we explore and address the challenges that physicians confront when they decide that further treatment would be harmful to their patients. As always, I encourage and welcome your suggestions and thoughts about how we can improve *Virtual Mentor's* content and form to better fulfill our function and mission.

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CASE AND COMMENTARY
Balancing Parental Wishes with Medical Judgment
Commentary by Joal Hill, JD, MPH

Case
Jonathan Roland, an 18-month-old boy diagnosed with a rare form of pediatric cancer 4 months ago, is critically ill. Initial chest surgery and chemotherapy went well, but complications developed 3 months into treatment. His parents agreed to emergency surgery, even though Jonathan was at high risk for hemorrhaging because of the medications used for his cancer treatment. This complication did occur, and Jonathan went into shock. He was placed on extra corporeal membrane oxygenation (ECMO), but has not done well. Because of swelling and infection, his surgical wound is open, and he remains at risk for bleeding, which greatly complicates routine care.

The medical staff disagrees about the propriety of placing Jonathan on ECMO, given his diagnosis of a cancer for which survival rates are very low and the risks imposed by chemotherapy drugs. One of the primary physicians asked to be removed from the case, explaining that Jonathan's care has been driven more by his father's unwavering insistence that "everything be done," than by sound medical decision making and consideration of Jonathan's best interests. Some staff share this view, and several have expressed concern that, for Jonathan, the cure is worse than the disease.

Other staff members believe that medical judgment has been responsibly exercised. A consulting oncology specialist notes that few established standards exist for treating Jonathan's rare form of cancer. Therefore, while he agrees that the prognosis looks grim, he does not believe that the decision to continue ECMO is unsupportable, particularly if the parents understand the situation and wish to proceed.

At issue today is the parents' refusal of a DNR order. A family and staff conference is called, to which the physician-chair of the pediatric ethics committee is invited. One of the physicians tells her, "We want you to convince the family to withdraw treatment, or at least agree to the DNR order."

Before the parents join the conference, members of the team—social worker, chaplains, nurses, and physicians—summarize their perspectives of the case. While everyone exercises self-control, it is evident that tensions run high, and that the morale of the entire unit is affected by the case. Disagreement continues about how

Jonathan's care should have been handled when complications first arose, but there is consensus that: (1) Jonathan's parents love their son; (2) Jonathan's prognosis is very poor; (3) His parents appear to understand the condition and outlook for their son. The team is divided about whether treatment should be withdrawn or continued, and also about whether or not Jonathan's parents should have the final say about that question.

When they join the conference, Jonathan's parents describe their son's condition accurately. They know he is likely to die, but believe it is their duty to give him every possible chance. "Even if the odds are only 1 in 10,000 or less," his father says, "We must make sure he has every opportunity. He has survived to this point. Only God knows whether he will live or die. Whether in this life or in the next life, I do not want my son to ask me, 'Daddy, why didn't you fight for me?' We cannot agree to stopping any treatment that gives him a chance of survival." One of the physicians asks, "If we exercised authority to withdraw treatment against your wishes, how would you respond?" Jonathan's father replies, "If you do everything for my son and he dies, that is the will of God. But if you do not do everything, then I would blame you for his death."

In the face of this impasse, what should the pediatric ethics committee chairman recommend? Should Jonathan's parents decide whether his treatment continues with full code status, or should the medical opinion of the physician directing Jonathan's care override their preferences?

Commentary

Decisions regarding care of critically ill babies are among the most difficult deliberations in patient care. It is impossible to know what these patients would want if they could speak for themselves, and, as this case illustrates, the emotional investment of parents and medical staff is considerable. Death may be harder to accept since it cannot be seen as a "natural" end to a long life.

For Jonathan's father "doing everything" seems compatible with the sacrificial nature of parental love. On the other hand, it is Jonathan who bears the burdens of treatment, which, in view of his prognosis, members of the medical team view as disproportionate to the benefits.

Compelling reasons exist for allowing Jonathan's parents to determine his treatment, provided they have decisional capacity and are adequately informed based on sound medical judgment. It is they who are primarily responsible for their child, and who, regardless of the outcome, will live with the result for the rest of their lives. However, the considerable deference we give to parental decision making is not absolute. Certainly we would question parental decisions for this patient if they seemed primarily motivated by personal convenience, potential financial reward from his survival or death, or other factors not directly related to Jonathan's well-being.

The medical team will also live with the results of this case in the future. This includes the possibility of being blamed by family members for a patient's death. The emotional burden of such cases can be difficult for those whose life's work is giving care. Although there is no ethical distinction between appropriately withholding or withdrawing treatment, real but often unspoken feelings of defeat and abandonment often make the latter more emotionally difficult for families and physicians. The purpose of medicine is to provide treatments that are beneficial to Jonathon, not merely those that make an impact physiologically. When there is genuine uncertainty about the efficacy of a particular course of treatment, error should be on the side of preserving life. However, the fact that treatments are initiated does not mean that they can never be withdrawn.

Several factors complicate this very difficult case. The number of physicians involved in Jonathan's care make it possible that his parents received mixed signals about the purpose and efficacy of various treatments. The continued lack of consensus about how Jonathan's complications should have been treated may also indicate lack of continuity in which physician has been the primary coordinator of care and communicator with Jonathan's parents.

Certainly there is some confusion about the ethics committee chairman's role. The fact that she is a physician does not mean that she is there to help other physicians "convince the family." Rather, she should ask questions and help the team determine the range of options available to them.

Assuming that initiation of ECMO was an appropriate recommendation for this patient, it should have been made as a treatment trial to be reassessed at appropriate intervals. Recommendations should then have been made to continue or discontinue treatment with other appropriate changes in the patient's care plan. In some cases this entails transition from potentially curative treatments to those that are palliative. Judgments about the burdens and benefits of treatment are not entirely medical, since they involve perceptions and preferences around quality of life issues. However, the physician's role requires making recommendations (and providing the rationale) for particular courses of treatment, not merely presenting all "doable" options as a menu from which patients are to pick and choose. This case offers an opportunity for the care team to evaluate how it coordinates complex care in terms of which physician remains in charge of Jonathan's case and how medical recommendations are communicated to families over time. These issues are not always straightforward, particularly in teaching hospitals where staff rotation may interrupt continuity of care.

Deliberation about how to better manage such cases in the future, however, does not solve the problem of how to proceed in this case. The question to be answered is not merely whether or not to continue this therapy, but for how long and with what criteria for justifying withdrawal. If that point is reached and the parents continue to refuse, it may be necessary to initiate appointment of a guardian to represent Jonathan's interests. This would no doubt make the current impasse even

more adversarial. However, while assessment of the burdens and benefits of treatment cannot be made without regard to parental preferences, the medical team should not abdicate its role by agreeing to continue ECMO indefinitely or until the parents agree to stop.

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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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CASE AND COMMENTARY
Ventilator Withdrawal of Patients with "Zero Capability" for Respiratory Function
Commentary by Michael Harlos, MD

LR had been ventilator dependent since his diagnosis of amyotrophic lateral sclerosis approximately 1 year earlier; his initial presentation and deterioration were so rapid that he was actually placed on a ventilator before his diagnosis of ALS was confirmed.

Throughout his illness, LR was clear and consistent about the circumstances that would prompt him to request that he be withdrawn from ventilator support. His quality of life in recent weeks had crossed the threshold of tolerable existence for him.

His physical deterioration was such that he could no longer fully blink his eyelids. Apart from being able to move his eyes laterally, he had no other motor activity. His respiratory nurse had noted that during endotracheal tube changes, during which he was briefly removed from his ventilator, he had absolutely no respiratory capability.

I was called to assist in the ventilation withdrawal of LR in his home. In my preparation for this event (with which I have had little prior experience), I reviewed the literature on ventilator withdrawal. I found no published documents that took an aggressive stance toward preemptively medicating those who have "zero capability" for respiratory function. The general approach seems to be one of preemptive opioid and sedative administration followed by either rapid or slow weaning from the ventilator, with "reactive-dosing" of opioids and sedatives in doses proportionate to distress.[1-14]

I could find no specific mention of the unique challenge posed by my patient or by those with other illnesses (such as "locked-in syndrome" following a stroke) that result in:

1. Complete respiratory insufficiency due to neuromuscular disease, but with the central respiratory drive intact, so the sensation of air hunger is preserved.
2. Absence of simple and reliable indicators of distress, ie, the patient cannot grimace or otherwise indicate distress. Monitoring pulse would not be

reliable due to the tachycardic response to both hypoxia and the premedication with scopolamine that was given to minimize secretions.

Even if there were reliable measures by which to monitor distress (perhaps bispectral index monitoring), one would always be "one step behind" the suffering. The onset of the effects of morphine following an intravenous push is 6-8 minutes,[15, 16] during which time the patient will feel as though he is suffocating.

There are several certainties about this situation:

1. Complete withdrawal from ventilation will be followed by death after several minutes. The time depends on the frailty of the patient and the degree of oxygenation prior to withdrawal.
2. Opioids and benzodiazepines (the most common medications used in symptom control during ventilator withdrawal, whose most serious immediate adverse effect is respiratory depression) cannot compromise the respiratory capabilities of the patient further than the disease itself already has. That is, with these medications, one cannot hasten the death of an individual who has preexisting complete and absolute respiratory insufficiency.
3. Without adequate medication, the patient will feel air hunger.
4. When medication is administered in response to distress there will be patient suffering. ("Reactive dosing" is, by definition, in response to suffering.)

Thus, within the spectrum of circumstances in which ventilator support is withdrawn, there are those as described above who have zero respiratory capability, for whom death will occur within minutes of complete ventilator withdrawal, and whose respiratory function cannot be further compromised by opioids and benzodiazepines.

I propose that for this group of patients there is a moral obligation to assure that air hunger is absent throughout the entire withdrawal of ventilation. With the informed consent of the patient, opioid and benzodiazepine administration must be preemptive and definitive, obviating the need for reactive dosing and precluding the possibility of air hunger. To achieve this result, doses of opioids and benzodiazepines should be several times those currently recommended.

I also feel that morphine (the "gold standard" opioid for symptom control during weaning from ventilators[1, 3, 4, 6-9, 13, 14, 17, 18]) is inadequate for "reactive dosing" during terminal weaning. Its time to onset of action after intravenous bolus is 6 - 8 minutes. This is unacceptable, particularly when newer opioids (of the anilinopiperidine class, such as fentanyl, sufentanil and alfentanil) have a much more rapid onset (1 - 2 minutes).[15, 16, 19]

When discussing my thoughts about appropriate dosing for this patient to colleagues who work in ICU, there was agreement that one could not further

compromise respiratory function with opioids or benzodiazepines, and I was advised that on this basis such an aggressive approach could be "defended." I found the choice of the word "defend" both intriguing and disturbing, as it indicated that the proposed approach was outside the usual standard of practice, and implied vulnerability to criticism if not medico-legal repercussions. My stance is that the real "defending" should be by those who choose a conservative preemptive dose and who pretend to be able to react to the suffocating sensation of air hunger with drugs (morphine) that take 6-8 minutes for simply the onset of effect, when the patient will die within 10-15 minutes after ventilator support is discontinued.

I believe that the published literature needs to tease out the specific circumstance of absolute respiratory incapability from circumstances where varying degrees of capability for independent ventilation exist, and must promulgate appropriate guidelines for the former. It is imperative for the team involved in the care to have a clear evaluation of the patient's respiratory status, and to be confident in their assessment of complete respiratory incapability. Additionally, as in the case I presented, the patient must have clearly requested aggressive management of distress or potential distress, such that he or she would sleep through the weaning process.

Failing to take these considerations and requests into account compromises patient comfort to the point where, in my opinion, the ethical principals of beneficence and nonmaleficence are threatened.

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IN THE LITERATURE

Influence of Physician Bias on End-of-Life Care

Michelle Lim

The debate over end-of-life care issues has long centered on the correct balance between patient autonomy and physician judgment. Despite the common notions of shared decision making and societal emphasis on patient choice, studies have shown apparent discrepancies between the patients' preferences and physicians' decisions regarding the management and care of patients with terminal prognoses. More often than not, these studies support the argument that physician biases are more influential in end-of-life care decisions than patient values.[1-4] Other studies argue further that patient "choice" is more of an illusion than a reality.[5-6] A 1997 study in *Clinical Nephrology* by physician George W. Rutecki, et al. entitled "Nephrologists' Subjective Attitudes Towards End-of-Life Issues and the Conduct of Terminal Care",[7] adds a new perspective to the debate of physician bias by examining how physicians' attitudes towards death and dying affect the type of end-of-life care they give. The authors found that nephrologists' discomfort with dying patients greatly influences their decisions regarding life-sustaining treatments and their willingness to hasten the death of terminal patients.[7]

Rutekci, et al. anonymously surveyed 125 nephrologists to assess their attitudes towards death and their care of terminal patients. Part of the survey measured the physicians' anxiety towards death and their discomfort with dying patients. Another part of the survey asked physicians how often they: (1) omit life-saving treatments (with or without patient knowledge); (2) have been asked by the patient or the patient's family to hasten death; and (3) would, in the event that it became legal, hasten death of certain patients. Physicians were also asked what factors, such as dementia, depression, or the presence of cancer, they considered prior to recommending the discontinuation of dialysis treatment. Other factors, such as the physician's age, their formal ethics training, the number of years spent caring for dialysis patients, and the percentage of time spent teaching versus private practice were also included in the survey.[7]

The authors focused their analysis on the nephrologists' self-reported discomfort with dying patients and their fear of death as these correlated to their attitudes towards the hastening of death and the omission of life-sustaining treatments. They found that the more uncomfortable physicians were with dying patients the more likely they were to initiate or continue life-prolonging treatments. These physicians were also less likely to say they might assist in death-hastening measures, even if this option were legalized. In fact, 43 percent of the respondents stated they would

"never" assist in hastening death if such measures were legalized. And 25 percent reported "difficulty honoring advance directives" if these went against what the physician believed was best for the patient. No significant association was found between the fear of death scale and omission of treatments or death-hastening responses.[8]

Based on these results, Rutecki, et al. suggest that decisions regarding terminal patient care may be altered by a nephrologist's point of view and subjective attitudes toward dying patients. The authors believe that this study adds another dimension to the possible physician influences that affect decision making in end-of-life care. After reviewing studies that asked physicians in other specialties about their attitudes towards end-of-life care, the authors found results consistent with their own findings.[7]

Rutecki, et al. present suggestions to remedy the disturbing trend, based on recommendations made by Dr. David Orentlicher and the American Medical Association's Ethics and Health Policy Counsel.[5] The authors suggest that physicians carefully examine their practices to ensure they are not imposing their subjective attitudes onto patient decision making and that they are involving patients in the decision-making process by encouraging them to express their values and preferences. They further propose intensifying ethics education, especially for physicians routinely involved in end-of-life care. Rutecki, et al. refer to a study which suggests that educational interventions result in greater expression of patient preferences and patient-physician discussion of treatment choices during the decision-making process.[9] Based on this study, they advise that such educational initiatives focus physician attention on how their subjective attitudes influence end-of-life care. Then, presumably, physicians will become more sensitive to their patients' desired treatment.

Questions for Discussion

1. As a clinician, how would you balance your professional medical judgment with your patient's treatment preferences for end-of-life care if they differ?
2. Rutecki, et al suggest educational interventions directed at physicians' subjective influences on end-of-life care decision making. What do you think that educational intervention (curriculum) should include?
3. The authors believe that nephrologists' personal attitudes influence treatment decisions for their patients with terminal illnesses. How might attitudes of other physicians influence their treatment decisions for patients with acute or chronic illnesses?

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HEALTH LAW

Oregon v. Ashcroft: Physician-Assisted Suicide with Federally Controlled Substances

Amber Orr, JD, MPH and Linda MacDonald Green, LLM

Upon being diagnosed with colon cancer Dr. Barber closed her medical practice in Portland, OR and is going to move home to Houston for treatment and the support of her family. She is referring her patients to other clinicians and asks her friend and co-worker, Dr. Xavier, to accept a particular patient, EH. EH, is a 46-year-old woman with liver cancer who has enjoyed a long, trusting relationship with Dr. Barber. Dr. Barber has been a strong advocate for EH and hand-picks Dr. Xavier to take over EH's care because of her confidence in his professional skills and wisdom. Dr. Barber also asks Dr. Xavier to complete an important task that she was unable to complete before her illness and hasty retirement. She tells Dr. Xavier that the completion of the task will allow her to focus on her family and provide comfortable closure to her medical career.

She asks Dr. Xavier to write a prescription for secobarbitol for EH so that EH can make a decision about her own death. Three physicians have certified in writing that EH is within 6 months of death. A psychiatrist has found EH to be mentally competent. In her medical file is a long, compelling letter EH wrote detailing why she wants access to barbiturates to end her life, how she has researched her options, and how she willingly asked Dr. Barber for a prescription.

After careful consideration Dr. Xavier determines that EH meets all the eligibility criteria for assistance under the Oregon Death with Dignity Act. Dr. Xavier is aware that he will be required to record his prescription of the lethal dosage of barbiturates (a federally regulated substance) with the Oregon Department of Health. Dr. Barber reminds Dr. Xavier that Oregon voters approved the physician-assisted suicide law by a 60 percent majority. Dr. Xavier consults other friends and colleagues who also insist that EH has the right to make difficult choices about her death, and they suggest that any alternative could be equated with abandonment of EH in her time of need. Dr. Xavier also knows that the US Attorney General John Ashcroft issued a directive encouraging the Drug Enforcement Agency (DEA) to take action against any physician who assists in a suicide, and that the directive has been challenged in federal court.

In his own mind, Dr. Xavier believes that terminally ill adults have a right to death with dignity, yet he knows that the ethical code of his profession does not allow physician participation. There is also the possibility that, with the US Attorney

General's office's initiative, he might lose his license to prescribe federally regulated substances. Dr. Xavier considers the harm that such a loss would to cause his professional career if he could no longer prescribe.

Questions for Discussion

1. Is physician-assisted suicide fundamentally incompatible with physicians' role as healers? See AMA Principles III and IV and see what the AMA *Code of Medical Ethics* says about this topic in Opinion 2.211.Physician-Assisted Suicide. American Medical Association. *Code of Medical Ethics 1998-1999 Editio*n. Chicago, IL: American Medical Association; 1998.
2. EH's needs for powerful pain medication will increase as her illness progresses. Should Dr. Xavier be concerned about prescribing adequate pain medication that could result in EH's unintentional death even where medically appropriate? See DEA press release.
3. Proponents of Ashcroft's position claim that DEA agents will easily be able to determine the differences between intentionally causing a death and prescribing enough medication to provide adequate pain relief. Do you agree?
4. If Dr. Xavier wants to abide by the ethics of his profession, what should he tell Dr. Barber and EH?

Subsequent Legal Proceedings

The legal question of authority over Oregon physicians hinges on federal versus state's rights. In 1997 the US Supreme Court ruled that the Constitution does not guarantee citizens a positive right to demand the aid of a physician in committing suicide. But it left the question of legality of physician-assisted suicide to state legislatures to decide. A 2001 US Supreme Court decision about the medical use of marijuana prompted Ashcroft's insistence that federal law regulating controlled substances be uniform throughout the United States and not be superseded by state law. However, at a hearing on November 8, 2001, federal District Judge Robert E. Jones issued a Temporary Restraining Order (TRO), enjoining the defendants from enforcing, applying, or otherwise giving any legal effect to the attorney general's directive. Judge Jones reasoned that there would be "irreparable harm" to citizens of the state of Oregon who were relying upon the Death with Dignity Act if the new federal directive were to go into effect before the case was heard fully on the merits. That temporary restraining order was extended until Judge Jones issued his decision.

On April 17, 2002 Judge Jones issued his decision, Oregon and Rasmussen v. Ashcroft, 192 F. Supp. 2d 1077 (April 17, 2002). The judge opined that through his directive, Ashcroft evidently sought to stifle an ongoing "earnest and profound debate" in the various states concerning physician-assisted suicide. The judge went on to rule in favor of the state of Oregon and entered a permanent injunction enjoining the defendants from enforcing, applying, or otherwise giving any legal effect to the Ashcroft directive. The judge's ruling rested on the finding that Congress never intended, through the Controlled Substances Act or through any

other current federal law, to grant blanket authority to the Attorney General or the DEA to define, as a matter of federal policy, what constitutes the legitimate practice of medicine. Upholding the long standing principle that control and regulation of medical practice is a state prerogative, the court found that the Attorney General exceeded his authority in attempting to override the state's definition of "legitimate medical practice."

On May 24, 2002 the federal government announced it would appeal Judge Jones's decision in the Ninth Circuit Court of Appeals. Briefs have been filed, and a hearing date is expected to be set in late January 2003.

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STATE OF THE ART AND SCIENCE

How to Change Routes of Administration of Opioids

Audiey Kao, MD, PhD

Pain management is a critical competency in medicine especially when palliation, and not treating the underlying disease, is the physician's focus. Oftentimes physicians need to change the route of administration of opioid analgesics. For example, a patient may be unable to take oral medication, and may require pain medication parenterally. When changing routes of administration an equianalgesic table is a useful guide for dose selection.

Equianalgesic Doses of Opioid Analgesics		
Oral/Rectal Dose (mg)	Analgesic	Parenteral Dose (mg)
100	Codeine	60
-	Fentanyl	0.1
15	Hydrocodone	-
4	Hydromorphine	1.5
2	Levorphanol	1
150	Meperidine	50
10	Methadone	5
15	Morphine	5
10	Oxycodone	-

- To switch between routes of opioid administration use the equianalgesic information on the horizontal axis. For example, 150 mg meperidine orally per day is equivalent to receiving 50 mg of meperidine intravenously.

- To switch between opioids, use the information on the vertical axis. For example, 10mg of oxycodone orally is equivlent to 50mg of meperidine intravenously.
- Long term opiate use can lead to tolerance which requires increasing the dose of medication to achieve pain control. When switching between opioids, there is the possibility of cross tolerance, which is usually incomplete. A patient may have some tolerance to a new opiate as a result of being on a previous opiate. Therefore, experts suggest that you begin the new opiate between 50 and 75 percent of the equianalgesic dose.

Quick Case
Mrs. A is receiving adequate pain control on 10mg of oxycodone PO q4h, but is now unable to take medication by mouth. You decide to switch her to meperidine intramuscularly. What dose of meperidine would you prescribe so that she has approximately equal daily amount of analgesia?

Calculating the Answer:
1. Figure out total daily dose of oxycodone:
10mg X 6 = 60mg/d PO oxycodone

2. Use equianalgesic table to determine conversion ratio:
10 mg PO oxycodone = 50 mg IM meperidine
60 mg/d PO oxycodone = x mg/d M meperidine

3. Solve for X
X = 300mg/d of IM meperidine

4. Correct for cross tolerance of 70%
0.70 X 300mg/d of IM meperidine = 210mg/d of IM meperidine

5. Decide on schedule
35mg IM q4h of meperidine

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POLICY FORUM

Physician-Assisted Suicide: The Law and Professional Ethics

Faith Lagay, PhD

The 1997 US Supreme Court ruling regarding physician-assisted suicide is often misrepresented or misunderstood. The question before the court was specific: Are state laws that criminalize physician-assisted suicide unconstitutional? The high court ruled that such laws were not unconstitutional. That ruling, however, did not make physician-assisted suicide a crime throughout the land. It declared, rather, that legalizing or criminalizing physician-assisted suicide (P-AS) was a matter of states' rights; that is, a matter for each state to decide for itself.

Three years prior to the high court's decision, Oregon voters had approved a referendum legalizing P-AS by a slim margin of 51 percent. Following the Supreme Court ruling, Oregon offered the question to voters again, in November 1997, this time receiving a 60 percent majority in favor of legalizing the practice.

Four states besides Oregon—Michigan, Washington, California, and Maine—have asked voters about P-AS, and voters in all 4 have turned it down. On the Maine referendum ballot in 2002, the question 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.

Forty-six states stand opposed to Oregon, formally criminalizing P-AS. Forty of them (most recently Ohio in November 2002) have passed statutes that prohibit the practice, and 6 prohibit it by common law. Three states—North Carolina, Utah, and Wyoming have neither criminalized nor legalized physician-assisted suicide.

Those who oppose the practice advance 2 main 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 155-year old *Code of Medical Ethics* prohibits physician-assisted suicide in the same strong language it uses in prohibiting physician involvement in euthanasia: "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."[2]

In an attempt to override Oregon's Death with Dignity Act, the statute that regulates the legal use of P-AS, US Attorney General John Ashcroft issued a directive in November 2001 entitled "Dispensing of Controlled Substances to Assist Suicide." The directive asserts that assisted suicide is not "a legitimate medical purpose" for potentially lethal drugs classified under the Controlled Substances Act. Under the directive, doctors who use these drugs to assist suicide are subject to having their federal narcotics licenses suspended or revoked. The directive caused much consternation, even among physicians who do not support and would not participate in P-AS, because it puts at risk all doctors who prescribe narcotics for management of intractable, end-of-life pain. A large part of the medical community expressed the fear that the directive would undo years of work spent in overcoming fears of addiction and securing adequate pain relief for patients. In April of 2002, US District Judge Robert Jones put a permanent restraining order on the Ashcroft Directive, explaining that Ashcroft had "overstepped the authority of the federal Controlled Substances Act when he declared that physician-assisted suicide was not a 'legitimate medical purpose'."[3] The US Attorney General's Office has said it will appeal Judge Jones's ruling.

Law versus Professional Ethics

That a state can legalize physician-assisted suicide, as Oregon has done, highlights the difference between what is legal and what is 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 personal beliefs to participate. There is a difference between what voters want and what constitutes sound medical practice, according to Gregory Hamilton, MD, co-founder and past president of Physicians for Compassionate Care, a group that opposes P-AS. "It's up to the medical profession—not Judge Jones or the voters of Oregon—to decide what's a legitimate medical practice," Hamilton said.[3]

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 prognosis. This is a difficult but critical task that only the physician can perform. It demands skill, experience, and courage. In *Death Foretold*, physician Nicholas Christakis emphasizes that the lack of a prognosis, or an inaccurate one, can lead patients to make bad choices near the end of life.[4] Next, physicians must carefully describe all possible treatment and palliative care optionsto 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. Meanwhile, however, physicians should maintain their relationship with the patient, no matter what course the patient finally chooses, short of participating in suicide, if that is the patient's ultimate choice. Withdrawing and withholding treatment, including ventilator treatment, CPR, and even nutrition and hydration, at the express request of the patient or patient's surrogate are all within the bounds of professional practice, according the *Code of Medical Ethics*.[5]

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.[6] 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.[7] 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 Medical 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 Advocacy Role of Physicians

Many 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.[8] 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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POLICY FORUM

Policy Proposal: Do Not Resuscitate Orders, A Call for Reform

David Weissman, MD

I recently conducted my monthly teaching session with the oncology ward team; I asked what they wanted to talk about within the broad realm of *palliative care*. The unanimous answer: "DNR orders". I asked why, knowing full well their answer. They said, "we know it's required under hospital policy to ask patients their preference about resuscitation, but these cancer patients . . . well . . . you know . . . they're dying . . . it doesn't make sense." Designed to ensure patient autonomy while at the same time identifying patients in whom resuscitation is not indicated, DNR orders have become an example of how a well-meaning application of modern medical ethics has led to untold patient/family suffering and, less appreciated but quite significant to the issue of improving end-of-life care, health professional distress.

Cardio-pulmonary resuscitation (CPR) is a medical procedure designed to restore heart and lung function, originally intended for patients suffering an acute catastrophic event. As an emergency life-saving procedure it is a medical treatment that does not require patient consent. In fact, in most health care facilities, patient or surrogate consent is needed to *withhold* a resuscitation attempt. Common sense would dictate that CPR is not indicated, at some point in the illness trajectory, in patients dying an expected death from cancer, heart disease, dementia, and other chronic medical conditions.[1] Research on CPR effectiveness has confirmed that patients with advanced cancer, patients in renal failure, or patients with pneumonia or multi-organ failure requiring an intensive care unit have a near zero chance of ever leaving the hospital.[2] While the research findings are comforting, it is just plain common sense that CPR is a dumb idea for these patients, as they are dying from organ failure unrelated to sudden cardio-pulmonary arrest. Of course the survival figures for these patients are not all zero, the rare patient will survive to leave the hospital, presenting the problem of invoking medical futility as a basis for denying CPR for an individual patient.[3]

My hospital has a typical DNR policy: (1) *Prior to writing a DNR order, it is hospital policy that a discussion should be held between the attending physician and patient or surrogate decision maker;* (2) *a non-decisional patient with a valid advance-planning document indicating a desire for no resuscitation, is indication for a DNR order. Three years ago the hospital added a futility clause: A DNR order may be written whether or not the patient/surrogate agrees, if 2 physicians deem that a resuscitation attempt is futile, that is, it will not restore cardio-pulmonary*

function or achieve the expressed goals of a decisional patient; the patient or surrogate must be informed of this decision, along with the hospital administration. Note that, regarding the discussion in point (1), the actual policy uses the word "should" not "is required" (as is true in many hospitals), but physicians and nurses have come to understand the policy as an absolute mandate, fearing legal consequences if they fail to discuss DNR with all patients, including those dying the expected death. Thus, by written sanction and customary practice clinicians feel obligated to discuss CPR as a therapeutic option. The results of this policy are all too familiar—countless hours devoted to family meetings dealing solely with patient-family-staff discord over CPR decisions, rather than focusing on how the hospital can best support a patient and family through the dying process. These conflicts generally revolve around some combination of misperception about the expected benefits/burdens of CPR and/or psychological denial of expected death and/or unresolved psychologic issues between the dying and their family/surrogates. The unnecessary anxiety and tension that develops over DNR orders deflects attention and energy from the more pressing issues of symptom control, resolution of patient-family conflicts, and a focus on anticipatory grief.

Why DNR Orders Are Problematic

Institutional DNR policies were developed prior to any sustained effort at health professional education concerning the communication skills necessary to implement such policies. This failure to provide appropriate education has in part been responsible for fueling the problem. Commonly heard questions such as, "Would you like us to do everything if your heart stops?" or "What would you like us to do if you stop breathing?" or "You don't want us to break your ribs, do you?" should be permanently banned from the health professional lexicon. Jim Tulsky, MD has done some of the most elegant research on DNR and advanced directive communication skills; his findings are not pretty.[4-6] In 1 study of DNR orders, he found that in discussions between 31 medical residents and patients, only 4 physicians discussed the likelihood of survival and only 5 mentioned the risks of resuscitation.[5]

Although increasing attention has focused on education, the question remains whether or not education itself, as an instrument of practice change, is the most appropriate avenue to improve the DNR problem.[7] What type of education is required in order to fix the DNR problem? A cursory review of the educational domains needed for mastery of the skill of DNR discussions in the setting of a terminal illness, includes demonstration of basic and advanced medical interviewing skills; demonstration of ability to give unwanted news and discuss treatment limitation; understanding prognostic factors for chronic diseases; understanding the risks, benefits, appropriate indications and contra-indications for the medical procedure of cardio-pulmonary resuscitation; and, finally and perhaps most importantly, the ability of the clinician to self-reflect on the personal meaning of treatment limitation and the finality of caring for a dying patient. The reason for so many diverse educational domains is that *DNR discussions should always take place within a larger framework of an advanced care planning discussion, a discussion that includes disease prognosis and mutually agreed upon goals of care*.

And yet, despite this daunting list of necessary skills, who is most likely to be entrusted, or rather, assigned, to discuss DNR orders in teaching hospitals?—The lowest person in the medical hierarchy—the intern, if not the junior or senior medical student. Why? Because, the discussion of DNR represents an unsolvable contradiction for the physician, resulting in a level of distress that makes avoidance of the task a desired goal. Senior physicians routinely pass the responsibility down the line to those who are least able to refuse. When is the last time you saw senior residents lining up for the chance to "go get the DNR order"?

No matter where I go and teach about end-of-life care, the same theme emerges—a sense among physicians and nurses of being forced by institutional policy, reinforced by the fear of medical malpractice, to discuss DNR issues in the face of imminent death from "natural causes." Forget for a moment that doctors often have poor communication skills and that they fail to appropriately contextualize DNR orders within the larger goals of care for the dying—it is the very nature of being forced to do something that feels wrong, that is such burden to the clinician. Why should we expect clinicians to feel good about caring for the dying when they feel pressured, by the real or perceived threat of malpractice or institutional sanctions, to offer a medical procedure they know is not only useless, but downright harmful? Should we continue efforts to teach communication skills around advanced care planning? Absolutely. But, I have now come to believe that the inherent tension of the current paradigm, whereby clinicians feel an obligation for mandatory DNR discussions in all patients, cannot be resolved solely by education. We must seek DNR policy reform that brings the reality of CPR as a medical intervention in line with the professional responsibility of caring for the dying.

Proposed Policy Reform

What would DNR policy reform look like? First and foremost it would acknowledge that physicians are not required to discuss the procedure of CPR, in all its gory details, in the setting of expected death. Writing a DNR order in this setting, without a complete discussion of the risks/benefits and purpose of CPR, is well within the capacity of an attending physician. Whether or not any discussion of CPR is needed in this setting is still considered highly contentious, although some hospitals have adopted so-called "unilateral DNR orders," sometimes requiring 2 physicians to agree, or an ethics committee consultation, or notification of the decision to the patient/surrogate and/or hospital administration.[7-9] A middle ground approach is to talk to patients/surrogates about the goals of care and mention "breathing machines" or "life support" as a euphemism for CPR. Language that I often teach to resident physicians when discussing end-of-life goals and treatment options is: "I will provide you with maximal treatments for your pain or any other symptoms you may experience; I do not recommend the use of breathing machines or other artificial means to prolong your life." Note, this language contains an explicit physician recommendation, and demonstrates appropriate professional leadership, rather than abrogating such leadership in favor of unrestrained patient autonomy (as in, "What would you like us to do if your heart stops?") Whatever the exact phrasing used, I strongly support the notion that CPR does not have to be

explicitly discussed when death is expected. Furthermore, I do not believe such a decision requires a mandatory ethics committee decision or notification of the patient/surrogate or hospital administration. Rather than external control to ensure that the order is appropriate, I favor a hospital policy that links recognition of impending death to an institutional commitment to end-of-life care---a formal family support/bereavement program that begins at the time death is anticipated and/or a mandatory visit by a palliative care nurse/team member to assess for adequacy of symptom control and discussion of care setting options.

But what about patient autonomy—doesn't this approach take an important decision away from the patient where it rightfully belongs? Tomlinson and Brody, discussing the authority of physicians to make decisions about futile treatments say, "physician authority over the use of futile treatment is the protection of patient autonomy...it is inherently misleading to offer a futile treatment, and so it is corrosive of autonomous choices to do so."[3] But what about paternalism—won't this type of policy be dangerous by giving too much power to the clinician? Again, Tomlinson and Brody clearly articulate that the balance between patient autonomy and clinician paternalism is not "a zero-sum game: whenever the patient gains power, the physician loses it, and vice versa, but rather can be one of "shared power."[3]

I could imagine a new DNR policy, added to an existing policy that discusses the important role of clinicians in setting the tone for routine advanced care planning, including DNR discussions, as something like this:

The attending physician may write a DNR order after a decision has been established between the physician and a decisional patient or surrogate, that the goal of future medical care is to provide a level of care that does not interfere with the natural illness progression toward death. The application of this policy is appropriate in the following situations:

1. *When a life-prolonging medical treatment is withdrawn and the expected outcome is death (eg, withdrawal of mechanical ventilation, or artificial hydration).*
2. *When patients exhibit signs and symptoms of the syndrome of 'imminent death' (aka actively dying), in the setting of a terminal illness.*
3. *When patients with chronic illness, or acute illness in the setting of a severe chronic illness, have declining functional ability so that death is expected within days-weeks*.

This type of policy would rightfully restore a measure of physician authority over a medical procedure and eliminate the paradox of offering a useless procedure in those situations where resuscitation and unrestrained patient autonomy has no role. However, this policy is by no means perfect. At issue is when and how it is decided that death will likely occur within days-weeks and whether or not physicians would abuse their responsibility by ignoring the central point of the policy---that a mutual

decision to forgo life-prolonging medical treatment is established as the goal of care, *prior to writing the DNR order*. Several options for dealing with this include establishment of a quality improvement system for DNR orders that would track usage and appropriateness, mandatory clinician education that includes appropriate demonstration of an end-of-life goal setting discussion (mandatory demonstration of the skill of actually performing CPR is already required, why not add the skill of discussing CPR!), and distribution of education material for patients/surrogates that explains the institutions' DNR policies.

I am eager to give such a policy a try as I see the current policy causing far more harm---patient/surrogate/staff conflicts, loss of professional authority over a medical decision, lack of attention to important end-of-life tasks, psychological harm to clinicians and families, patient indignity, cost---than good--respect for patient autonomy. There have been hundreds of thousands, if not millions of words written about DNR orders. I don't expect mine will be the last. I welcome your comments on both the need for DNR policy reform and suggestions for new policy initiatives. I would like to see palliative care practitioners take a leading role in working to define new DNR policies that better reflect the realities of care at the end of life. g those who are genuinely trying to do what they deem best for their patients.

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