Abstracts

For Ethics, Professionalism, and End of Life Care

Given space limitations and varying reprint permission policies, not all of the influential publications the editors considered reprinting in this issue could be included. This section contains abstracts from additional articles the editors deemed well worth reviewing.

Physician-Assisted Suicide: Legal and Ethical Considerations
Darr K
Journal of Health Law Winter 2007; 40(1):29–63

As medicine's technical limits have become increasingly clear, Americans seem more willing to address end-of-life decision making. A major development during the 1990s was physician assistance in dying: physician-assisted suicide in Michigan, Oregon's Death with Dignity Act, and developments in Europe, most notably The Netherlands. This evolution toward recognizing the appropriateness of assistance in dying raises legal and ethical issues for physicians and healthcare institutions such as nursing facilities and acute care hospitals. These issues include the effects on providers' values systems, the trust between patient and provider, and the "slippery slope" that voluntary, active assistance in dying will become involuntary, active assistance. This Article addresses the policy issues that institutions must confront in a changing environment.

Physician-Industry Relations. Part 1: Individual Physicians
www.annals.org/cgi/reprint/136/5/396.PDF
Coyle SL
Annals of Internal Medicine March 20 2007; 146(6):469

This is part 1 of a 2-part paper on ethics and physician-industry relationships. Part 1 offers advice to individual physicians; part 2 gives recommendations to medical education providers and medical professional societies. Physicians and industry have a shared interest in advancing medical knowledge. Nonetheless, the primary ethic of the physician is to promote the patient's best interests, while the primary ethic of industry is to promote profitability. Although partnerships between physicians and industry can result in impressive medical advances, they also create opportunities for bias and can result in unfavorable public perceptions. Many physicians and physicians-in-training think they are impervious to commercial influence. However, recent studies show that accepting industry hospitality and gifts, even drug samples, can compromise judgment about medical information and subsequent decisions about patient care. It is up to the physician to judge whether a gift is acceptable. A very general guideline is that it is ethical to accept modest gifts that advance medical practice. It is clearly unethical to accept gifts or services that obligate the physician to reciprocate. Conflicts of interest can arise from other financial ties between physicians and industry, whether to outside companies or self-owned businesses. Such ties include honorariums for speaking or writing about a company's product, payment for participating in clinic-based research, and referrals to medical resources. All of these relationships have the potential to influence a physician's attitudes and practices. This paper explores the ethical quandaries involved and offers guidelines for ethical business relationships.

Boundaries, Blackmail, and Double Binds: A Pattern Observed in Malpractice Consultation
Gutheil TG
The Journal of the American Academy of Psychiatry and the Law 2005; 33(4):482–3

A scenario common to several boundary violation/sexual misconduct cases is reviewed and discussed. Common features include an articulate patient whose high functionality concealed more primitive dynamics that arose in the therapy; boundary problems, often on an "attempted rescue" basis; and eventual litigation in some form. The patient's high functioning appeared to cause the therapists to underestimate the severity of the patients' disturbances. Drawing on forensic experience, the author analyses the cases and suggests risk management approaches.

Psychiatry and Terminal Illness
http://wwl.cpa.apc.org:8080/Publications/Archives/CJP/2000/Mar/Mar2000.asp
Chochinov HM
Canadian Journal of Psychiatry March 2000; 45(2):131

Objective: To provide an overview of the palliative care literature salient to the psychiatric aspect of end-of-life care. **Method:** A literature review was conducted, targeting primarily empirical studies that addressed the following topics: 1) psychological issues pertaining to life-threatening conditions; 2) family issues in the context of palliative care; 3) psychological issues and challenges faced by end-of-life health care providers; and 4) psychiatric disorders, including depression, anxiety, and organic mental disorders, in people with terminal illness. **Results:** There is a small but emerging literature that can guide psychiatrists in their role of providing care to dying patients. **Conclusions:** While psychiatry has made tremendous inroads toward providing care to patients throughout the life cycle, its presence is only just beginning to be felt in end-of-life care. Within the domain of palliative care, psychiatry has an expanded and important role to play.

Physicians and the Pharmaceutical Industry: Is A Gift Ever Just A Gift?
http:jama.ama-assn.org/cgi/content/full/283/3/373
Wazana A
JAMA January 19 2000; 283(3):373–80

Context: Controversy exists over the fact that physicians have regular contact with the pharmaceutical industry and its sales representatives, who spend a large sum of money each year promoting to them by way of gifts, free meals, travel subsidies, sponsored teachings, and symposia. **Objective:** To identify the extent of and attitudes toward the relationship between physicians and the pharmaceutical industry and its representatives and its impact on the knowledge, attitudes, and behavior of physicians. **Data Sources:** A MEDLINE search was conducted for English-language articles published from 1994 to present, with review of reference lists from retrieved articles; in addition, an Internet database was searched and 5 key informants were interviewed. **Study Selection:** A total of 538 studies that provided data on any of the study questions were targeted for retrieval, 29 of which were included in the analysis. **Data Extraction:** Data were extracted by 1 author. Articles using an analytic design were considered to be of higher methodological quality. **Data Synthesis:** Physician interactions with pharmaceutical representatives were generally endorsed, began in medical school, and continued at a rate of about 4 times per month. Meetings with pharmaceutical representatives were associated with requests by physicians for adding the drugs to the hospital formulary and changes in prescribing practice. Drug company-sponsored continuing medical education (CME) preferentially highlighted the sponsor's drug(s) compared with other CME programs. Attending sponsored CME events and accepting funding for travel or lodging for educational symposia were associated with increased prescription rates of the sponsor's medication. Attending presentations given by pharmaceutical representative speakers was also associated with nonrational prescribing. **Conclusion:** The present extent of physician-industry interactions appears to affect prescribing and professional behavior and should be further addressed at the level of policy and education.

The Illusion of Futility in Clinical Practice
Lantos JD, Singer PA, Walker RM, Gramelspacher GP, Shapiro GR, Sanchez-Gonzalez MA, Stocking CB, Miles SH, Siegler M
The American Journal of Medicine July 1989; 87(1):81–4

The claim that a treatment is futile is often used to justify a shift in the physician's ethical obligations to patients. In clinical situations in which non-futile treatments are available, the physician has an obligation to discuss therapeutic alternatives with the patient. By contrast, a physician is under no obligation to offer, or even to discuss, futile therapies. This shift is supported by moral reasoning in ancient and modern medical ethics, by public policy, and by case law. Given this shift in ethical obligations, one might expect that physicians would have unambiguous criteria for determining when a therapy is futile. This is not the case. Rather than being a discrete and definable entity, futile therapy is merely the end of the spectrum of therapies with very low efficacy. Ambiguity in determining futility, arising from linguistic errors, from statistical misinterpretations, and from disagreements about the goals of therapy, undermines the force of futility claims. Decisions to withhold therapy that is deemed futile, like all treatment choices, must follow both clinical judgments about the chance of success of a therapy and an explicit consideration of the patient's goals for therapy. Futility claims rarely should be used to justify a radical shift in ethical obligations.

NOTES

Errata

Fall 2007

Levine BH, Albucher RC: Patient Management Exercise: Substance abuse: diagnosis and treatment. Spring 2007. A production error caused a mixup in charts for "Decision Point E: Match the following variety of specific strategies for patient education and counseling with their corresponding definitions." The chart on page 177 shows the strategies correctly matched. The chart on page 177 should have appeared on page 182, as the answer to Decision Point E. The chart on page 182 should be disregarded.