NETWORK NEWS

The newsletter of the Florida Bioethics Network

a Health Service Group of the Florida Hospital Association - P.O. Box 531107 - Orlando, Florida 32853-1107 - 407-841-6230

August 1998 **98-4**

President's Message

Energizing Ethics Education

Kenneth W. Goodman, Ph.D.
University of Miami Forum for Bioethics and Philosophy

One of the greatest challenges for ethics committees is education: How do you come up with high-quality activities that are interesting, educationally sound, and—dare we say it? — fun?

Like it or not, ethics education must overcome obstacles that are unfamiliar in other areas of institutional practice. Unlike infection control, say, ethics is seen by some as having little effect. Unlike record keeping, ethics is thought by some to be of no practical use. Unlike rigorous outcomes tracking, ethics is often thought of as touchy-feely or, worse, loosey-goosey.

While such beliefs are false, colleagues disdainful of ethics education are not fully to blame. The problem is that ethics as presented at some (perhaps many) institutions is just plain boring.

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8th Annual Florida Bioethics Network Conference

Current Challenges in Healthcare Ethics

Have you made your reservation? October 21-23, 1998 Orlando Airport Marriott

This year's conference promises to be one of the best ever. Whether you are brand new to the field of bioethics or if you have been chairperson of your committee for many years, you will find programs of interest. A wide range of experts from around the state will be offering thought provoking presentations on "Current Issues in Healthcare Ethics" so make your reservation today! Call 407-841-6230 for more information.

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Upcoming Conferences

Ethics Committees: Developing, Participating In and Leading a Successful Hospital Ethics Committee, Sept. 14-16, 1998, University of Florida, 352-846-1097. Co-sponsored by FBN.

Ethics and The Aging, September 18, 1998, Gulf Coast Community College, Panama City, FL, 850-747-7133.

End of Life Care in the 21st Century: Incorporating Palliative Care into Mainstream Medicine, November 20, 1998, Hyatt Regency Tampa, 813-974-4296.

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Network News welcomes letters, comments and articles for inclusion. Please send any correspondence to dmphotos@gte.net or Cathy Emmett, Hospice of Southwest Florida, 5955 Rand Blvd., Sarasota, FL 34238, Fax: 941-921-5813.

Energizing Ethics Education

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It shouldn't be.

Yet how many of us have sat through lectures that seemed to last longer than an independent counsel investigation? Endured presentations by well-meaning folk with only a tenuous grasp of the material? Been intimidated by self-proclaimed "experts" who mistake professional standing or Power Point foo-foo for insight or pedagogical competence?

There is no need for this. There are a number of ways to craft engaging, even exciting, ethics education programs for hospitals, nursing homes, hospices, managed care organizations, and other institutions. What is needed is creativity, institutional backing, and the belief that ethics is a source of practical guidance for health care professionals—and not merely one of the domains in which to get the Joint Commission ticket punched.

Following are a number of ideas for energizing an ethics education program.

- Make someone responsible for it. That is, identify someone who cares and is knowledgeable about bioethics. Then let him or her run with it. Some institutions have created "ethics education subcommittees" to do this.
- Identify useful and engaging resources. Find journal articles, position statements, news reports and the like, evaluate them for quality and interest, and distribute them. Make sure in looking at journals to avoid turgid prose and intellectual arm waving, and make sure to include items from a variety of professional literatures: medicine and nursing and bioethics and social work and health law and pastoral care and health administration .... Then make sure to keep these readings on file for new members, future reference, etc.
- Find colleagues with good platform skills and who know what they're talking about. Most institutions have human resources they don't recognize — health professionals, administrators and others whose personal interests, education or employment can make them a fine source of presentations, in-services and the like.
- Be creative about format and media. People like debates, and there is no shortage of issues on which reasonable people disagree. Staffers like to pitch in—to participate—and some institutions have had great success with moderated forums or group discussions. Explore institutional newsletters and Web sites as opportunities for "ethics corners." Show a video.
- Think of novel topics and do not be afraid of controversy. While death and dying are the meat and potatoes of much ethics education and debate, many other issues are too often overlooked: nurses and

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(vs.?) physicians as primary care providers; home care; case management; institutional public relations; computers and health care; disciplinary procedures for health professionals; managed care contracts; access to health care—or abortion or organ transplants or Viagra ...

- Find community partners. Look outside the institution for participants in your ethics education program. Legislators, community and professional society leaders, and even colleagues from "competing" institutions can be outstanding additions to the curriculum.
- Play with the cards you're dealt. If the program is at noon (don't they all seem to be?), serve lunch. If you want help, get it. If you need an expert, find one.

These are exciting times in bioethics. The issues are important, the challenges are difficult and the stakes are high. Those responsible for ethics education enjoy an opportunity to teach colleagues, better their institutions, help society and improve patient care. In an environment shaped by awful stresses, that is very good news indeed.

Panel For the Study of End-of-Life Care

Submitted by Cathy Emmett, RN, MSN, CS
Hospice of Southwest Florida

An amendment to the Alzheimer's Disease Initiative bill during the 1998 Florida legislative session created a Panel for the Study of End-of-Life Care. The panel convened for it's first meeting on July 28th in Tallahassee. I was honored to be chosen as the representative from the Florida Nurses Association. Twenty-one other individuals have been chosen to represent groups such as Hospice organizations, the long-term care industry, hospitals, and the Department of Elder Affairs. The July meeting was mainly organizational. Representative Robert Brooks, MD, (who sponsored the original legislation) was chosen as chair of the panel. Bentley Lipscomb, Secretary for the Department of Elder Affairs, was selected as vice chair. The group agreed to meet monthly and to hold meetings around the state. The next meeting was scheduled for August 17, 1998 in Tallahassee, with future meeting dates and locations to be determined. A series of at least three public hearings will be held before the end of the year.

At the July meeting, the group also decided to form three work groups to further study and make recommendations on: 1) Pain and Palliative Care; 2) Advance Directives; and 3) Regulatory and Financial Issues. I look forward to working on this panel and will keep you informed of its progress.

Managed Care Initiative

Kathryn A. Koch, MD, FACP, FCCP, FCCM
FBN Northern Regional Representative

At the 1998 Annual Meeting of the Florida Medical Association, held at Marriott's Orlando World Center May 13-15, the Florida Bioethics Network took another step in its Managed Care Initiative.

Kathryn A. Koch, MD, FACP, FCCP, FCCM, the FBN Northern Regional Representative, organized a Managed Care Symposium presented on May 14 for CME. Speakers included:

Kathryn Koch, MD: Ethics in Managed Care
Richard O. Jacobs, JD, health care and corporate attorney with Holland & Knight in Tampa: Physician Liability in Managed Care
Bob Casey, MD, Florida State Representative: Politics of Managed Care
Arthur Palamara, MD, President, Broward County Medical Association: Problems and Issues in Managed Care
Richard Romeis, MD, President & CEO, The Romeis Group, Inc in St. Petersburg: An Insider's View of Managed Care: Resetting the Vision

A general framework for application of ethical behavior in the managed care setting was presented. The audience was referred to the article published in the November 1997 special issue of the FMA Journal on Bioethics for a review of the rights and responsibilities of all parties in that setting (Koch, KA, Griffin, ER. The New Health Care Triangle: The Ethics of Managed Care. The Journal of the Florida Medical Association Inc. 1997:84:488493).

Other issues also included: opportunities presented by a managed care environment to improve the health of populations; failures of the managed health care system to manage health or quality; physician, MCO and community issues in state laws and regulations; mechanisms to ensure continuity and minimize risk; the State's interest in the health of the population and in health care spending; political solutions to problems in delivery of health care in the managed care setting; alternative options in health care delivery; and a "Vision for the Future."

A summary of the Vision for the Future is that all parties in the health care triangle—the physician, the patient, and the MCO—must be accountable and responsible. Health care personnel in general, and physicians in particular, must take a leadership role in health care regardless of the payor mechanism but in particular with this payor mechanism, in order to ensure fair and equitable distribution of health care resources.

The panel approach to this seminar was very well received: every panel member addressed different perspectives on the ethical issues and conflicts of interest occurring in the managed care setting. Dr. Koch has been invited by the Florida Chapter of the American College of Physicians to do another presentation at their Annual Chapter Meeting in Boca Raton in September.

New Project to Improve Physicians' Care for Dying Patients: AMA Will Reach Every Practicing MD

Through a $1.54 million grant from the Robert Wood Johnson Foundation, the American Medical Association is sounding a "wake-up call" to every physician in the United States to improve the way they care for patients at the end of life. The initiative, called the Education for Physicians on End-of-Life Care (EPEC) is a national grass roots, train-the-trainer program. The project will focus on two areas: (1) helping physicians work with patients in advance care planning; and (2) providing opportunities for physicians to increase their skills in palliative medicine—also called "comfort care."

The EPEC curriculum will address:

- How to deliver the news of a life-threatening diagnosis;
- How to conduct a basic patient assessment in end-of-life care;
- How to manage imminent dying and bereavement;
- How to handle prognostic uncertainty;
- How to approach futility situations; and
- How to respond to requests for physician-assisted suicide.

The EPEC curriculum will be disseminated through a series of four regional conferences to be held in Chicago, Boston, Phoenix and Atlanta throughout the fall of 1998 and the spring of 1999. Attendees for these focused educational conferences will be selected through a special application process.

To obtain more information on the EPEC Project, write or call: EPEC, Institute for Ethics, AMA, 515 North State Street, Chicago, IL 60610 ~ (312)-464-4979

Facts about the Florida Bioethics Network

FBN Membership has grown over the past several years. Forty-three percent of our members reside in the West region (which includes the Tampa/St. Pete area), 23% are in the South, 16% in the North, 6% in the Panhandle and 1 member is out of state. Our membership has doubled since 1995. If you know someone who would like to join, contact any FBN Board member for membership brochures or call Diane Bennett at 407-841-6230.

Case Report: The Code as Ritual

Submitted by Kathryn A. Koch, MD, FACP, FCCP, FCCM

Mr. P. is a 46 year old veteran and born-again Christian. He has carried a diagnosis of esophageal carcinoma for over a year, which has metastasized despite chemotherapy (including steroids). The tumor, originating at the gastro-esophageal junction, has extended up his mediastinum to his left neck, and into the left pleural cavity. Unable to eat, he has a jejunal feeding tube. Despite this, he has been semi-ambulatory as recently as 48 hours prior to admission to the ICU.

He is admitted to the ICU with acute respiratory failure due to pseudomonas pneumonia, with septic shock. His wife is adamant that he receive all possible treatments, including cardiopulmonary resuscitation, per his prior wishes. After an initial 72 hours of severe instability, he awakens on mechanical ventilation and himself confirms these wishes.

He proves unable to wean from the ventilator. After completing a two-week course of antibiotics for his pneumonia, he again becomes febrile and his respiratory failure worsens. He is proved to have persistent pseudomonas pneumonia, now partially resistant to antibiotics.

Now every day he experiences a critical event: critical oxygen desaturation, bradyarrythmias, tachyarrythmias, and hypotension. But he remains conscious, and persists in his request for ongoing aggressive ICU care as well as resuscitation should he arrest.

His wife explains in his presence that in their belief, the cancer is the "enemy." If they have a strong enough faith, God as healer will listen to their faith and cure him. If they have enough faith, they will experience a miracle. In their faith, the human physician is merely a mechanic. She clearly states that should he change his mind, she would honor those wishes as well.

Every effort is made to explain to them in clear terms that continuing aggressive treatment will only prolong his death and his suffering. Using the mechanic analogy, it is explained that sometimes an automobile is so wrecked it cannot be repaired. Using the healer analogy, it is the physician's responsibility to admit the limits of his or her ability to change the course of illness. It was explained that the physician's skill is itself a God-given talent and it is the physician's responsibility to respond to the signs given by God. It is a measure of the physician's skill to responsibly acknowledge the limits of that skill.

Mrs. P. responds by saying that asking her to accept a Do Not Resuscitate decision is equivalent to asking her to murder her husband. The medical staff disagree with this position, but the attending and Mrs. P. agree to disagree. The chaplain is asked to visit with her

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Case Report: The Code as Ritual

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and her husband in order to attempt to air this issue. This is unsuccessful. An Ethics Committee consultation is requested. The Ethics Committee consultants indicate that we should follow the patient's wishes.

At four weeks into his ICU course he is on 100% oxygen and has required heavy sedation and paralysis. He becomes more hypotensive and as pressures are increased, the paralytics and then the sedation is weaned. All sedation is withdrawn and he fails to awaken. Twenty-four hours later he develops renal failure. Pressures are escalated to a physician-determined maximum, and then not further increased. Dialysis is not offered. He becomes more hypotensive.

His wife is notified that she should be on 24-hour, around-the-clock watch: there is absolutely nothing else that can be done. Later that night he has the first of seven codes. For the first six, she remains unobtrusively in the back of the room, and then steps forward to lay on hands after a heart-beat and pulse are re-established. Each code is run a little or less aggressively. After the sixth code, she acknowledges that she needs to let go. The seventh code is run even less aggressively. When she is told that it was unsuccessful, she steps forward from the back of the room and says goodbye.

Some Discussion:

Although exceptionally difficult for medical staff, it is not unreasonable to have family present in the room during cardiopulmonary resuscitation. There are several reasons why this may be helpful in the final decision-making process, particularly in medical futility cases:

it allows the family to witness the good-faith attempts of staff to honor the patient's request for full code

it allows the family to witness the brutality of cardiopulmonary resuscitation, reinforcing the medical reasons given by the staff for not administering CPR in terminal cases

it allows the family to see firsthand the limits of medical technology

it allows them the final ritual of resuscitation which may be necessary for them to accept death (1,2).

In a principles-based analysis of how this case was handled, it can be said that the patient's autonomy was clearly honored, and that the ongoing treatment including resuscitation was beneficial and NOT harmful because of his beliefs. Justice was done for the patient and his wife within their belief system. Justice was however not done for the care-givers, who were forced to manage this patient against their better judgment. Justice was also not done for the rest of the ICU patients, as this patient consumed incredible resources in equipment and personnel long after it was clear that he had no medical chance for response to treatment. The only way justice for the rest of the ICU population could be met given this situation was if the interns learned how to run a code from the practical experience Mr. P. would offer them when he did arrest.

In a virtues-based analysis of how this case was handled, it can be said that both the medical staff AND Mrs. P. acted in good faith, with veracity, and with mutual trust despite disagreement. The implementation of the virtues of respect for autonomy and of fairness are subject to the same criticisms above.

On the topic of miracles, "the belief in and hope for a miracle is at the heart of many family decisions that result in the provision of nonbeneficial treatment" (3). The medical staff in this instance formally and openly discussed the differences in belief systems on teaching attending rounds, with the family and chaplain present.

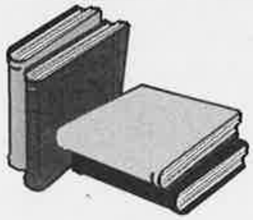
The attending physician supported the medical staff in facing Mr. and Mrs. P's request for futile resuscitation, by acknowledging that even if CPR had no value from a medical point of view, it did have value as a ritual. It was therefore therapeutic from that standpoint.

1. Lantos JD: Bethann's death. Hastings Cent Rep 1995;25:22-3.

2. Koch, KA, Dehaven MJ, Kellogg-Robinson M. Futility: It's Magic. Submitted for publication, Clinical Pulmonary Medicine.

3. Wagner, JT and Higdon, TL. Spiritual issues and bioethics in the intensive care unit: The role of the chaplain. Critical Care Clinics 1996;12:15-27.

Book Update



Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine, by Albert Jonsen, Mark Siegler, and William J. Winslade, 4th Edition, McGraw-Hill, 1998.

This book recently received an enthusiastic review in JAMA. The authors represent an ethicist, clinician and legal scholar point of view. Words used to describe this book included "complementary style," and "a fluid and consistent work."

Response to the Case of "The Code as Ritual"

Submitted by Jim Wagner, Ph.D., M.Div., Shands Hospital @ the University of Florida and Program in Medical Ethics, Law, and the Humanities, University of Florida College of Medicine

As presented, this case is of a patient who insisted on receiving non-beneficial and futile treatment that prolonged the dying process, consumed phenomenal resources, and emotionally battered staff. It finally ended with the surrogate accepting the patient's death. The patient's apologetic for making such demands revolved around his hope for a miracle. He believed that miracles might occur if he persevered with a "strong enough faith" to compel "God as healer" to intervene and eliminate the "enemy" of illness. The patient viewed the medical providers as "mechanics." They must provide treatments that violate their integrity as an extension of the patient's faith.

In my opinion, the overall response of Dr. Koch and her staff was thoughtful. Most of us would probably agree that this case might have been handled in a comparable fashion in our own hospitals. I also suspect that Dr. Koch and her staff came on the scene at the most challenging time in this patient's illness history. Several of my comments on "Ritual" reflect this assumption. Primarily, I want to focus on the issue of how providers might have placed appropriate limits on patient autonomy in this case.

First, Dr. Koch provided little information about the previous year of cancer treatment prior to the ICU admission. Could the previous attending physicians have been contacted? Did anything occur during that year which might have benefited the ICU staff? Undoubtedly, the opportunity had existed for discussions between the patient and the providers about an advance directive, values, faith concerns, and the role of the physician. Earlier conversations could have alerted providers to what probably lay ahead when treatments became ineffective.

If the pre-Koch physician had clarified any issues, it might have been possible to take several actions in anticipation of the challenges in this case. For example, both the ethics process and the chaplain could have been used much earlier. Also, since the value system of the patient in this case is unique, perhaps transfer to a provider with similar values could have been arranged. If not, the ethics consult team might have suggested an approach that would have helped the physician set limits. As a part of this plan, the chaplain might have been asked to cultivate a relationship with the patient's pastor. He might have educated the pastor about end-stage illness and perhaps have enlisted him in encouraging a more mature faith response from the patient. All of this could have occurred without the patient having to give up the hope of a miracle.

Second, I agree with Dr. Koch that it can be beneficial to have willing family members present during cardiopulmonary resuscitation. Preparing the family for what they will witness is essential. Careful attention to staff motivation is also important. For example, I have seen several cases like "Ritual" when staff was angry with the family for having to do CPR. The intent of including family was to "punish" them, as staff felt punished, by having them see the violence done to their loved one. The possibility of this intent existing, understandable as it is, ought to be discussed among staff and resolved prior to an invitation being made to the family.

Third, I want to comment on Dr. Koch's conclusion that "even if CPR had no value from a medical point of view, it did have value as a ritual." This statement is a reminder to me of our human need to search for a meaning that softens a bewildering experience. Dr. Koch must have been relieved that CPR was not completely meaningless as it resulted in the wife "letting go." In my opinion, however, the wife's resolution serves us inadequately if we do not revise the conclusion. In "Ritual," administering CPR multiple times is a symbol of inappropriate care at end-of-life. Seven resuscitative efforts cannot become ritual!

The major issue in "Ritual" is whether staff could have limited patient autonomy. General efforts have focused on establishing futility policies.[1] An existing policy would have provided a formal mechanism, which would have outlined a process for setting limits.[2] Arguments supporting this approach are based on the theory of justice and the principle of physician autonomy. Also using the theory of justice, Crandell[3] has recommended that insurers include a policy rider, which can be selected to assure that non-beneficial treatment will be provided. The costs, however, would be the responsibility of the patient and not subsidized by society.

Is "Ritual"a case where limits could legitimately be placed on patient autonomy? If so, when is it appropriate to have limits and how might limits be justified? A potential ethical approach to answering these questions may lie within the process of informed consent. We could argue as to whether there is informed consent in this case. We might more readily agree, however, that the informed consent process was not satisfactory.

From the provider's perspective, informed consent requires that a physician give information specifically tailored to a particular patient's need of knowing and understanding. This disclosure should include the nature of the physician's recommended intervention, its risks and benefits, alternative treatments with their risks and benefits, and the risks of no treatment. The physician should conduct this process without the use of coercion or manipulation.[4] The protection in

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Response the the Case of "The Code as Ritual"

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this process for the physician is that s/he will not be guilty of battery.

Most discussions of informed consent have focused on the provider role. But what is the patient's responsibility in fulfilling informed consent? Generally, the patient in light of his/her values and goals should consider relevant medical recommendations. From this mix, the patient makes a voluntary decision. The patient is then protected from the confusion of being offered irrelevant treatment alternatives. Nothing guarantees that both the patient and the physician will be in complete agreement about the patient's choice even when the process is thoughtfully completed. In fact, there may be cases when no agreement exists. This is especially true when a patient refuses life-saving treatment.

When treatments are offered and chosen, a reasonable test for a successful informed consent process would be that both the patient and the physician find common ground on which to stand with integrity. When value conflicts are pronounced between patient and physician, passing this test is a bigger challenge. An example of finding this "common ground" in a situation as difficult as "Ritual" might be the case of a "vitalist" patient approaching end-of-life. Such a patient would demand that biological life be maintained as long as possible. In most situations it is likely that the physician would not share this value. The physician, however, can provide treatments that do precisely what the patient asks. In that sense, the treatments are not futile. Although there is not complete agreement between the patient and the physician, there is common ground.

In the "Ritual" case, however, I believe that there was no common ground identified on which both patient and physician could stand. This problem pre-existed Dr. Koch, but surfaced when treatments became ineffective. A better informed consent process could have helped both patient and provider to identify and resolve this conflict at the outset. In this case, two issues needed resolution. First, Dr. Koch attempted to address with the patient their philosophical difference on the role of the physician. Second, this discussion needs to extend to and clarify what alternative treatments would be offered to the patient. The common ground between the patient and the physician might have been an agreement that if a miracle occurred, it would come from God and not through the physician's mechanical provision of inappropriate treatments.[5]

There was a functional example in "Ritual" of this common ground even though it had not been clarified. I am referring to the physician's not offering renal dialysis, although it fir the definition of the patient's request for "aggressive ICU care." I suspect dialysis was not offered because it was viewed as irrelevant.

The issue of the refusal to offer irrelevant treatment alternatives is stickier when CPR is the treatment. In this type of case, a positive step forward would be to officially remove the requirement that CPR be administered unless a DNR order is written. Practically, it might be adequate for the family to be informed that CPR will not be provided, or that only one attempt would be made. It would require courage on the physician's part to communicate that CPR would be limited. This posture would relieve family from the feeling that they are killing their loved one by deciding not to resuscitate. When the patient is a vitalist, or in quality-of-life cases, a patient choice of CPR should be retained.

WEB Connections

In the last issue of Network News we supplied information on several web sites and invited our membership to share any other favorite sites. Jane Hendricks submitted the following information: www.ampainsoc.org

This is the Internet address for the American Pain Society. One of the offerings on this web site is a position statement from the APS on Treatment of Pain at the End of Life: The position statement was prepared by the society's Task Force on Pain, Symptoms and End of Life Care. The statement calls for education of physicians, nurses, patients and families regarding pain treatment, that pain be made "visible" and routinely charted as a "fifth vital sign," among other recommendations. For the complete position statement, visit this web site on your next surfing expedition. Thanks to Jane for sharing this information!

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[1] Medical Futility Guidelines, 1998, Health Council of South Florida, Inc., Miami, FL. Contact: Laura Atkins at 305-263-9020.

[2] Halevy, A. & Brody, B., "A Multi-Institutional Collaborative Policy on Medical Futility," JAMA, August 21, 1996, Vol. 276, pp 571-574.

[3] Crandell, L., "Health Care Reform and Payment for 'Non-Beneficial' Medical Interventions at the End of Life: Is There a Policy Solution?" In Health Care Crisis? The Search for Answers. Edited by Misbin, R., Jennings, B., et al. Frederick, Maryland: University Publishing Group... 1995, pp 123-134.

[4] Jonsen, A., Siegler, M., & Winslade, W., Clinical Ethics. Fourth Edition. New York: McGraw-Hill, 1998, pp55-56.

[5] Wagner, J. & Higdon, T., "Spiritual Issues and Bioethics in the Intensive Care Unit." In Critical Care Clinics. Edited by Kathryn Koch, 12:1, January, 1996, pp 15-27.

Response to the Case of Mrs. H

Submitted by Jane E. Hendricks, Esq., Miami, Florida

There are perhaps 5 exceptions to the requirement of obtaining informed consent from the patient herself.

1) Emergency—the presumption is that the patient would want care unless previously indicated and documented otherwise. Usually 2 physicians document emergency (life or limb-threatening or permanent disablement or disfigurement would result; See also FS 395.002(8)) and proceed to treat.
2) Therapeutic privilege—this doctrine allows the physician some discretion as to what to divulge to patients. While the physician has a duty to be truthful, it is not absolute. Incomplete truthfulness may be justified at times if the truth-telling conflicts with other duties of the physician such as the Hippocratic Oath's admonition to "do no harm"-to protect the patient. This is the essence of the therapeutic privilege. If complete truthfulness will alarm the patient—will generate anxiety—this may be counterproductive to the healing process or the patient's wellbeing. The therapeutic privilege is interpreted narrowly by the courts, meaning that it should be used with caution and the record adequately documented justifying the reason for lack of candor with the patient.
3) Patient asks not to be informed—Physicians are often faced with patients who ask that details of a given treatment not be divulged to them. They agree to the care suggested by the doctor and accept the risks involved. The suggested approach is that the physician make an effort to inform the patient indicating that, for record-keeping purposes, a consent needs to be signed and the patient informed prior to the signature. If the patient is adamant about deferring to the judgment of the physician or someone else and not wanting to be informed, then a detailed notation in the patient's record should be made to this effect.
4) Compulsory treatment situations—In some instances treatments will be rendered to patients without their informed consent if the treatment is necessitated by mental illness or communicable diseases for which treatment or testing is ordered pursuant to state law. A physical history should be obtained from the patient whenever possible so as to avoid administering drugs or treatment, which could cause an adverse reaction in the patient.
5) Repetitive or continuous forms of care—Dialysis, chemotherapy, radiation treatment or physiotherapy are common forms of repetitive treatment for which an informed consent at the beginning of the treatment sequence is sufficient and therefore it is not necessary to obtain an informed consent at the beginning of each subsequent treatment. If the treatment plan remains unchanged, then repeat consents for each visit are unnecessary.

Florida's constitutional right of privacy (Article I, section 23) states in so many words "every natural person has the right to be let alone and free from governmental intrusion into his private life..." It is this right of privacy which justifies a designation of a health care surrogate and the surrogate making decisions, even if the patient is still competent.

I would argue that Mrs. H has declined being informed herself and indicated her daughters be advised of the test results. She should be asked to sign a health care surrogate designation to be activated immediately based upon her right of privacy.

It could also be argued that she should not be informed of her condition based upon "therapeutic privilege." The anxiety generated by the information would have a deleterious effect on her health and well being. The chart should be well documented to this effect.

Input from social service and pastoral care is helpful, as well as a third party who could confirm the values of a Vietnamese woman of Mrs. H's age group.

Save the Date

The University of Miami's seventh annual "Clinical Ethics: Debates, Decisions, Solutions" conference has been scheduled for March 26, 1999, in Fort Lauderdale. To be offered in conjunction with the Miami Area Geriatric Education Center, the conference will emphasize end-of-life issues, including advance directives. For more information or to receive a brochure when available, please contact:

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