

Bioethics *in brief*



Fall 2004

UNIVERSITY HOSPITAL OF SUNY UPSTATE MEDICAL UNIVERSITY

SYRACUSE, NEW YORK

CASE OF THE MONTH

Problematic DNR Orders

Editor's Note: See separate article in this newsletter for a synopsis of University Hospital's DNR Policy.

by Joel Potash, MD

CASE ONE

Charles Jones, 87, is readmitted from a nursing home one day after hospital discharge where he had been treated for persistent loss of appetite and abdominal pain. His death was anticipated in weeks to months. Upon being readmitted to the hospital, Mr. Jones is dehydrated and moaning as if he is in severe pain. Mr. Jones also has coronary artery disease, atrial fibrillation, and recurrent pleural effusions. He is barely conscious, requires a transfusion of four units of blood, and is not expected to live to discharge.

Mr. Jones has a valid Health Care Proxy (HCP) dated 1992 and updated in 2003 at a routine visit to his internist. The document lists his son Andrew as his proxy, and his other son James as alternate. Mr. Jones does not have a nursing home Do Not Resuscitate

(DNR) order, but does have a Living Will (1992) that states: "If I have an irreversible physical condition without reasonable expectation of recovery, I do not want tube feedings, a ventilator, antibiotics or cardio-pulmonary resuscitation, but I do want as much pain medicine as is needed to keep me comfortable."

Dr. Smith, the attending surgeon, recommends a DNR order based on "futility," with morphine to control pain. Both sons refuse a DNR order and request full cardio-pulmonary resuscitation (CPR). They say that their dad is a fighter and values life. The sons feel that Mr. Jones' moaning is due to anxiety, and they are concerned that morphine could "kill him" in his deteriorated condition.

CASE TWO

Mary Brown, 60, has end-stage liver disease. She was intubated by an Emergency Medical Technician en route to the Emergency Department because she was "unresponsive" and in respiratory distress. She is now in the ICU on a ventilator. Mrs. Brown's husband Thomas, her health care proxy, met her at the hospital. Mrs. Brown has a non-hospital DNR order completed in her internist's office three months ago when Mrs. Jones learned that she had end-stage liver disease with a life-expectancy of six months to a year. Dr. Green, the ICU attending, informed Mr. Brown

that she would write a continuing DNR order, but Mr. Brown refused to consent to a DNR for his wife. Mr. Brown said, "That's not what my wife meant. We talked about this. She would like a shot at CPR, and if she doesn't do well in a couple of days, then we can stop." The ICU nurses are concerned about whether it is appropriate for a terminally ill patient with an out-of-hospital DNR order to be intubated and on a ventilator. Meanwhile, Mrs. Brown is waking up.

continued, next page

Bioethics *in brief*

ETHICS COMMITTEE

Bioethics in Brief is a newsletter of the Center for Bioethics and Humanities, in cooperation with University Hospital's Ethics Committee. Opinions expressed in *Bioethics in Brief* are those of the authors and should not be taken to represent the position of University Hospital or the Center for Bioethics and Humanities. Information about sources used in the newsletter can be obtained by calling the Center for Bioethics and Humanities, 464-5404.

Questions, suggestions, or comments?

Would you like to be added to our mailing list? E-mail us at ethics@upstate.edu

Have a question about an ethical issue?

We are always happy to talk in confidence about ethical concerns; you may reach us at the Center for Bioethics and Humanities at 464-5404. Ethics consultations are available by calling the hospital operator (464-5540) and asking for the ethics consultant on call, or by contacting any of the ethics consultants at the center (Robert Daly MD; James Dwyer PhD; Kathy Faber-Langendoen MD; Robert S. Olick JD, PhD; and Joel Potash MD).

Editorial Board

Editor-in-chief: Deirdre Neilen PhD

Managing Editor: Robert S. Olick JD, PhD

Editorial Consultant: Kathy Faber-Langendoen MD

Writers: N. Barry Berg PhD; Barbara Fero RN, NP; Melissa S. Freeman MA; Joel Potash MD; Melanie Rich; Michelle Waite

Design and production: Marketing and University Communications, Melanie Rich, Director

The Center for Bioethics and Humanities at SUNY Upstate Medical University, established through the generous support of the Medical Alumni Association, is committed to promoting clinical health care and health policy which is patient-centered, compassionate, and just. We accomplish this through educational initiatives in bioethics and the medical humanities, clinical ethics consultation, and multidisciplinary research and scholarly writing.

© 2004 Center for Bioethics and Humanities. Permission is granted to make up to 20 copies for institutional use.



—continued from page 1

Who can have a DNR order?

Every patient admitted to a hospital in New York State is presumed to consent to CPR in the case of cardiac or respiratory arrest. But any adult patient with capacity for making medical decisions may request that a DNR order be written in his chart, even if he is not terminally ill. If the patient lacks capacity, a health care proxy can make the same decisions about a DNR order as the patient, but should base them on the patient's wishes, if they are known. If there is no HCP, a guardian, family member, or a close friend may request or agree to a DNR order, only if the patient: (1) is terminally ill (has less than a year to live), or (2) is permanently unconscious; or (3) CPR is considered medically futile, or (4) is extraordinarily burdensome.

A physician may write a DNR order without consent of the patient or authorized decision maker with concurrence of a second physician, only if CPR would be futile *and* there is no appointed agent, guardian, family member or friend to be found. Mr. Jones, if he had decisional capacity, could request or consent to a DNR order. Mrs. Brown, if she had decisional capacity, could continue or revoke her DNR. Mr. Jones' son, Andrew, could make the same decisions about a DNR as his father could, as could Mr. Brown for his wife, since they are both legally appointed proxies. In fact, even if they were not, they could request or consent to a DNR because their family members are terminally ill. Mr. Jones' statement in his Living Will should guide his son's decision, unless the circumstances in the Living Will do not reflect his current situation. Mr. Brown has raised a reasonable doubt about his wife's intentions about a DNR order; since Mrs. Brown is now waking up, it may be wise not to write a DNR order until she awakens and confirms or revokes her existing non-hospital DNR order. Calling Mrs. Brown's primary physician might clarify the intent of the patient at the time of writing the DNR order. In fact, when Mrs. Brown awoke, she did agree with her husband's assessment and revoked her DNR in writing.

How should DNR discussions be documented?

Physicians should write a note in the body of the chart explaining the circumstances under which the DNR order was completed.

When should a DNR order be discussed with a patient?

If neither Mr. Jones nor Mrs. Brown had a DNR order prior to admission, it would be prudent for the doctors to discuss DNR with Mr. Jones' son and Mrs. Brown's husband because of the low rate of success of CPR and the possible complications, such as anoxic brain damage, in their situations. Because of Mr. Jones' poor condition, there should have been a discussion about DNR/CPR with him or his son Andrew before his last discharge from the hospital. When patients become terminally ill, when they have a chronic, progressive disease with a significant downhill course, or if they have previously had a cardiac or pulmonary arrest, it is wise to discuss CPR and DNR with them. The reason this is not done more often is that some health care providers find it difficult to discuss problems in dying, due to concerns about worrying their patients, or because of their own emotional responses. If a patient's condition takes an unexpected turn for the better, the DNR order should be re-discussed.

How successful is CPR?

On average, about 15 percent of hospitalized patients whose hearts or lungs stop functioning are successfully resuscitated and leave the hospital alive. In the case of terminally ill patients, like Mr. Jones and Mrs. Brown, only 3 percent who have CPR leave the hospital alive. CPR is most successful in the operating room and in the cardiac catheterization lab. The use of automated external defibrillators may improve the success rate of CPR outside of the hospital.

What happens with a nursing home or non-hospital DNR on admission to a hospital?

When Mrs. Brown arrived with a nursing home DNR, it remained effective in the hospital until the attending physician wrote a continuing DNR order, which she must do within 24 hours of admission. To write a continuing DNR order, the attending need not discuss DNR/CPR again with the patient, although, as Dr. Green did, it is considerate to do so.

What if there are disagreements between the patient/family and the physician, or among family members, about DNR/CPR?

Every effort should be made to reach consensus. For example, when Mr. Brown objected to Dr. Green's proposal to write a continuing DNR for his wife, Dr.

Green should have had an extended discussion with Mr. Brown about his wife's wishes. If the dispute cannot be resolved, one or more parties should seek an ethics consultation or dispute-mediation in a timely fashion. In such a situation, a DNR order should not be written, and an existing DNR order should be revoked until the dispute is resolved or 72 hours have elapsed (by state regulation). The ethics consultant should be contacted to meet with the family and physician.

When Mr. Jones' sons met with the ethics consultant and it became clear to them that Mr. Jones was dying and that CPR was unlikely to work, Andrew consented to a DNR order. Andrew also consented to pain medication when he was shown that his father's groaning was occasioned by turning or changing position, and when he was reassured that a small dose of morphine would not cause his father to stop breathing, but would relieve the apparent pain.

Are DNR orders automatically suspended in the Operating Room?

New York State regulations and University Hospital Policy (D-08) do not allow suspension of a DNR in the OR without a patient's/authorized decision maker's informed consent. All professional organizations of anesthesiologists, surgeons, and OR nurses recommend "required reconsideration" with the patient/ authorized decision maker of a standing DNR order before surgery, but all support the rights of patients to undergo surgery even with a DNR order.

Is it ever appropriate for a patient with a DNR order to have a tracheal intubation or be placed on a ventilator?

A DNR order only applies to CPR in the case of cardiac or respiratory arrest. All other treatments are allowable. For example, a patient may go to the ICU, receive antibiotics, or have a feeding tube placed. If the patient has respiratory distress, one way of relieving this is to intubate the patient; this is not ruled out because the patient has a DNR. When the patient is dying, palliative care of respiratory distress may be accomplished with the use of morphine, rather than by intubation. It would be helpful to discuss situations like this in advance with dying patients/authorized decision makers to learn what their expectations are of treatments other than CPR. Some will want them and others will not. It is possible to negotiate a Do Not Intubate (DNI) order with a patient/ authorized decision maker.



University Hospital's DNR Policy

by *Melanie Rich*

Editor's Note: This is a summary of University Hospital's DNR policy. For complete details, refer to the University Hospital Administrative Policy D-08.

Withholding cardiopulmonary resuscitation (CPR), which is at the crux of any DNR order, must be done in accordance with the provisions of Article 29-B of the Public Health Law. At University Hospital, CPR is defined as restoring cardiac function or

supporting ventilation (breathing) in the event of a heart attack or respiratory arrest. These measures include, but aren't limited to, chest compression, mouth-to-mouth breathing, intubation, intravenous medications, electrical defibrillation, and open chest cardiac massage.

Who decides about DNR?

It is presumed that, absent a conversation to the contrary, every patient would consent to CPR in the event of cardiac or respiratory arrest. Further, every adult patient is presumed to be able to make a thoughtful and appropriate decision regarding resuscitation. Any determination that an adult patient lacks this capacity is to be made by the attending physician. The attending should notify the patient of this determination, assuming he or she is capable of understanding it, as well as the patient's health care agent or surrogate, if any, and the facility director if the patient was transferred from a mental health facility. Otherwise, the attending physician and staff will honor a DNR order appropriately executed by a capable adult.

The patient who is incapable but who has a health care agent relinquishes responsibility to the health care agent. If no agent has been named, a surrogate may be a guardian, spouse, adult child, parent, adult sibling or close friend.

Waiving patient consent for a DNR order

If the attending physician, with the written concurrence of another New York State-licensed physician, determines that the patient would suffer immediate and severe harm from a discussion of CPR, he or she may instead obtain the consent of the health care agent or surrogate.

When the patient is a minor

The attending physician, in consultation with the minor's parent or legal guardian, must first determine if the minor has the capacity to make a decision regarding resuscitation. If the minor does, the consent of both the minor and the parent or guardian must be obtained prior to issuing a DNR order. In these cases, the attending must attempt to inform both parents of the decision prior to issuing the order. If one parent opposes the decision and the matter cannot be resolved, the matter must be submitted to the Dispute Mediation Board.



When DNR orders must be renewed

A DNR order must be renewed after seven days for acute care inpatients and at least every 60 days for “alternate level of care” (ALC) patients. Continuation orders must be written within 24 hours of patient arrival from another facility. When an order requires a concurring physician, he or she must personally examine the patient. An expired DNR order, however, should still be honored if the patient’s circumstances have not changed significantly.

Revoking a DNR order

A DNR order can be revoked by:

a capable patient, health care agent, surrogate, parent or legal guardian as long as the revocation is signed and dated, or requested orally in the presence of an adult witness;

the attending physician who has determined that the patient no longer suffers from the underlying medical condition that prompted the DNR order.

Disagreements about CPR/DNR

An ethics consult may be helpful in resolving disagreements. Unresolved disputes must be submitted to the Dispute Mediation Board which is comprised of a representative from Hospital Administration, the Ethics Consultation Service, Patient Relations and the Medical Staff. During the determination procedure, no DNR order can be issued until the dispute has been resolved, the Board has concluded its efforts toward resolution, or 72 hours have elapsed. Note that the Dispute Mediation Board cannot issue a DNR order.

When a staff member objects to a DNR order

If a caregiver objects to providing care in accordance with a DNR order, the hospital will take reasonable steps, such as adjustments in staffing, to accommodate the staff member's objection. (Refer to Bioethics in Brief Spring 2004 for further information on staff rights.)

Twelfth Annual

PRESIDENT'S

Ethics Symposium

October 20, 2004

The 12th Annual President's Ethics Symposium, **Questioning Authority: Individual and Institutional Conscience in Health Care**, will examine the moral responsibilities of individual clinicians and of administrators, hospitals and other health care institutions, when faced with laws or regulations that engender ethical conflict. Guest speakers and interactive panels will address issues ranging from HIPAA to end-of-life care. The event, sponsored by President Eastwood's office and under the direction of the Center for Bioethics and Humanities, is scheduled for October 20 from 3 to 6 pm in Weiskotten Hall's Medical Alumni Auditorium. More information is available by calling 315-464-8464 or on the web at www.upstate.edu/cbh/

Ethics Consults at University Hospital

by K. Faber-Langendoen, MD

When can an ethics consult be useful?

Ethics consults help those who must make an ethical decision think through their options and the possible consequences of their choices. For example, we've been asked:

- What should be done when a spouse, appointed as health care proxy, is not making decisions in the patient's best interests?
- What should clinic staff do if they find out that a patient (who is also a physician) has health issues that may impair the patient's ability to function as a physician?
 - Should the doctors write a DNR order if a prisoner has no family, is now irreversibly dying, and previously refused all medical treatment (but was never asked about DNR)?
 - Do nurses have to take care of a verbally abusive patient?

Does the ethics consult tell me what I have to do?

We generally do not "rule" on what should be done; the ethical decision remains that of those involved in the case. Our job is to make clear to people where there is ethical consensus, what the relevant literature, policy, and law might be, and help them think through possible choices and their consequences.

I'm not the attending physician. Can I call an ethics consult?

Anyone directly involved in the particular issue may call a consult. This includes nurses, attendings, consultants, housestaff, medical students, social workers, etc.

Does the attending physician need to approve the request for a consult?

We generally encourage the person requesting the consult to first speak with the attending, when appropriate, rather than calling a consult without the attending's knowledge. However, the attending's permission is not necessary for a consult. If a consult is done, the attending will be notified.

I don't think the right thing is being decided for a patient, but I don't know if an ethics consult will help. What should I do?

Call us and we'll talk through whether a consult would be useful. If we don't think an ethics consult will help, we might recommend a Palliative Care consult, discussion with the Hospital Attorney, or further conversation with other members of the health care team, as appropriate.

How do I request a consult?

The hospital operator (464.5540) has the call schedule and pager numbers; this information is also posted on the patient care units.

When are consultants available?

8 a.m. to 5 p.m., 7 days a week. Consultants respond to consults on the day they are requested. For formal, inpatient consults, a preliminary note is expected within 24 hours; on weekends, assessment may wait until Monday if the Consultant determines that the issue can safely be deferred and if the person requesting the consult agrees.

What if I have an emergent ethical problem after 5p.m.?

After hours, call the hospital operator and ask for the hospital nursing supervisor or hospital administrator on call.

What does a formal ethics consult involve?

The consultant will assess the situation within 24 hours (sooner, if necessary), reviewing the medical record and speaking directly with those involved in the issue.

continued

A physical meeting or conference call between all the relevant parties is often required to elicit and address varying points of view. The consultant will write a note for the medical record of an inpatient or send a letter to the requesting health care professional, as appropriate.

Is the consult confidential?

A formal ethics consult usually is not strictly confidential, because we will need to talk with other involved people, and because we generally place a note in the medical record. We usually inform the person requesting the consult who else we will need to speak with in order to provide advice. We provide "curbside consults" in some circumstances, which are kept confidential; they may be of limited help because they are generally only based on information from the caller, without independent evaluation by the consultant. If you have an ethical problem but want to discuss it confidentially, call us and we'll let you know how we can help.

Who provides ethics consults?

Senior ethics consultants with expertise and training in bioethics provide the consults. Our disciplines include medicine, law, and philosophy. Although one of us fields calls for the month, we frequently confer with one another. We also get input from other members of the Ethics Committee with other kinds of expertise. When the case has a legal component, we often consult with the hospital's attorneys. Senior consultants are Robert Daly, MD; James Dwyer, PhD; Kathy Faber-Langendoen, MD (also the Consult Service Director); Robert Olick, JD, PhD; and Joel Potash, MD.

Malpractice Frustration

by Michelle Waite

Doctors across the country are feeling the effects of medical malpractice lawsuits. Malpractice insurance premiums are rapidly increasing, to the point where doctors who cannot afford the insurance are retiring early, moving to states with lower premiums, or ceasing to perform risky procedures. According to the American Medical Association (AMA), 20 states are in a medical liability crisis.

This situation has caused many doctors to question their duty to provide treatment. The AMA Code of Ethics states that a physician has the right to choose which patients to treat, except in emergency situations. The Code of Ethics also states that a physician cannot refuse treatment on the basis of race, gender, or HIV status.

But can a physician refuse to treat someone based on his/her occupation? J. Chris Hawk, III, MD, a surgeon from South Carolina, believes that refusing to treat malpractice attorneys will discourage lawyers from accepting frivolous lawsuits and lower insurance premiums. Dr. Hawk, a delegate to the AMA, presented his ideas during the AMA's 2004 annual meeting on June 15.

In Resolution 202, Dr. Hawk writes, "If trial attorneys were given the opportunity to experience the access problems caused by the professional liability crisis, then perhaps they would be willing to help change the system." He concludes, "except in emergencies, it is not unethical to refuse care to plaintiffs' attorneys and their spouses." Dr. Hawk reasons that the conflict of interest between these patients and himself renders him unable to provide the best medical care.

Local malpractice lawyers are not the only ones being singled out. According to a recent USA Today article, Clinton "Rick" Miller, MD, a neurosurgeon in Portsmouth, NH, stated that he would not treat the President of the New Hampshire Trial Lawyers Association because he lobbied against limiting malpractice awards. The Associated Press reports that Michael G. Kanosky, Jr, MD, a plastic surgeon in Mississippi, refused to treat the daughter of a state legislator, Rep. Earle Banks, because her father opposes tort reform.

The medical community has been searching for a solution to the malpractice insurance crisis to no avail. Many physicians understand the frustration of those who support denying care to attorneys, but most do not feel this is an ethical solution. The Associated Press reported that during Dr. Hawk's proposal to the AMA, many members voiced their strong objections even after he asked to formally withdraw the resolution. Though the AMA did not accept Resolution 202, the frustration and anger underlying it remain.





Upstate's Anatomical Gift Program

by N. Barry Berg, PhD

Editor's Note: In our last issue, we reported on the controversy surrounding UCLA's Willed Body Program. Here, Dr. N. Barry Berg, Director of Upstate Medical University's Anatomical Gift Program, explains how our willed body program functions.

SUNY Upstate Medical University's Anatomical Gift Program was established in accordance with the provisions of the Uniform Anatomical Gift Act. This program is licensed by the New York State Department of Health as a Non-Transplant Anatomical Bank whose responsibilities include receiving, preparing, storing, and utilizing human cadavers donated to Upstate Medical University for the education of health professionals and medical research.

The program reports directly to the chair of the Department of Cell and Developmental Biology and consists of a director, who is a faculty member in the department, and a laboratory director, who is a licensed funeral director, an administrative assistant, and two half-time support technicians. Both the director and laboratory director are active members of the

Associated Medical Schools of New York Anatomical Committee and are involved in the development and promulgation of the rules and regulations governing the transportation and use of human cadavers in New York State as well as ensuring an adequate supply of human cadavers to fulfill the teaching needs of member institutions. Program personnel are also involved with disseminating information concerning the program and for coordinating the annual Cadaver Memorial Service.

The program began over 40 years ago and is an integral component of Upstate Medical University. We usually receive between 170-190 donated bodies per year. There are two ways a person can have their body donated to our program upon their death. He/she may pledge his body prior to death by filling out the appropriate form. Alternatively, family members can request to donate the body of a recently deceased family member.

All donated cadavers must be transported to our facility by a licensed funeral director. The direc-



tor also brings a copy of the Death Certificate, a Burial Transit Permit, and a signed Permission Form that states the next-of-kin consents to the donation. The latter document is essential, as the next-of-kin must agree to carry out the wishes of the deceased. Even if the deceased is a pledged donor, we will not accept the body without the next-of-kin's permission.

Once the body is received, a sample of blood is taken and sent for testing for communicable diseases, including HIV. If the tests are negative, then the body is accepted and either embalmed or stored frozen. The process of embalming takes about six months to complete; family members are informed that we will keep the

donation for a maximum of two years. After that time, the remains are cremated and returned to the next-of-kin. About 80 percent of donated cadavers are used for teaching anatomy to medical students, physical therapy students, residents and faculty. The remainder are used by various clinical departments in our hospital such as Orthopedics, ENT, Emergency Medicine, and Anesthesiology.

The Uniform Anatomical Gift Act states that an anatomical gift is an unrestricted one. That is, once a cadaver is donated to an entity, that entity has the right to use that body as it sees fit as long as no laws are broken (unless the donor has specifically restricted the cadaver's use). Unfortunately, the laws governing usage are vague. The problems in the UCLA Willed Body Program remind us that actions and choices can be legal but may not be ethical. To the best of my knowledge, the only law that was broken at UCLA was that the program director personally received money for the sale of body parts. Had the money gone to the program, no laws would have been broken.

We have a moral obligation to the donor and to the public. The public trusts us to use the donated body in a responsible manner. Thus, for our program, donated bodies are used for teaching or for research. Only faculty at Upstate Medical University are allowed to use cadavers donated to our program for research. Faculty must submit a copy of the research proposal to us prior to beginning a study. We stipulate that they must perform the research in an environment that is not accessible to the public and that has been deemed suitable for the safe use and storage of cadavers, preferably at Upstate.

Dan Jaeger, our laboratory director, and I are members of the Associated Medical Schools of New York Anatomical Committee. The membership in this committee consists of gross anatomy course directors and body donor program directors from all of the medical schools in New York State. One major goal of this committee is to promulgate guidelines for the use of human cadavers. The committee is working to amend Section 52-11 of the New York State Public Health Law to improve the rules and regulations governing the use of whole body donations. We have also agreed as a group to do the following:

1. Develop contracts between Anatomical Gift Programs and schools wanting to use human cadavers stating the terms and conditions under which a human cadaver may be used;
2. Provide cadavers only to institutions licensed by



Photos on pages 8 and 9: Upstate Medical University students working with Dr. Berg in the new Anatomy lab in Weiskotten Hall.

the State Health Department as Non-Transplant Anatomical Banks;

3. Not to provide or transport unembalmed human cadavers;
4. Utilize and provide to member institutions whole cadavers, not parts;
5. Use only reputable Licensed Funeral Directors for transportation of human cadavers;
6. Develop accounting programs to track and maintain accurate records concerning cadaver usage.

In conclusion, all of us at Upstate's Anatomical Gift Program recognize the primary importance of these donations in educating health care professionals. We work hard to ensure that every cadaver is used respectfully for that purpose and that purpose alone. We will continue our efforts to maintain the highest standards and integrity of our program and for all programs in New York State.

Abuse of Nurses

by Barbara Fero, RN, NP

Even though most patients and their families praise the nursing staff who care for them during hospitalization, many nurses can recall instances of verbal abuse either from patients or families. Verbal abuse can include insults, name-calling, yelling, swearing, and belittling the efforts made by the nurse. Patients or families may ignore or be condescending to the nurse. Occasionally, verbal abuse escalates into threats of or actual physical violence.

Illnesses and injuries can cause extreme stress for patients, families, and for health care workers themselves. The potentially life-threatening factors that result in hospitalization may aggravate situations that can escalate into abuse. Abuse is a situation in which one person, through actions, words, tone, manner or other non-verbal cues maltreats or harms another. Abuse can take many forms: verbal, emotional, and physical.

In addition to abuse by patients or families, abusive behavior can come from supervisors, co-workers or physicians. Verbal or emotional abuse from a fellow health care professional often stems from interpersonal conflict in situations of unequal power. Reactions of nurses to verbal and emotional abuse include feelings of frustration, humiliation, and returned anger. The impact of verbal and emotional abuse should not be minimized, since the effects can be similar to actual physical assault.

Examples of physical abuse include grabbing, pushing, striking,

slapping, as well as menacing or threatening actions. Physical injury can affect the professional career of the injured nurse as well as his or her personal life. Especially vulnerable are nurses in high-risk areas such as the emergency department and psychiatric settings. Mental illness, substance abuse, and extreme stress are factors that create risk, as well as situations in which nurses are caring for patients with a history of violent behavior.

Nurses are also vulnerable to another form of abuse: sexual harassment. Because the intimate nature of nursing often requires close physical contact with patients, inappropriate touching or suggestive remarks are sometimes encountered. There can also be inappropriate behavior of a sexual nature from supervisors or co-workers.

Nurses who have suffered any of the various types of abuse can have many adverse reactions. Actual physical injury or disorders such as headaches or GI disturbances can result in lost work time as well as costly treatments. In addition to physical injury, the less obvious effects of abuse may include embarrassment, humiliation, anxiety and/or depression, decreased morale, low self-esteem, and insecurity about one's professional competence. Anger, guilt, and a loss of job satisfaction can result.

Under the ANA Code of Ethics for Nurses (2001), the duty of a nurse is to provide care for every patient with compassion and respect. Nurses are expected to demonstrate respect for all patients

and their families, to be non-judgmental, and to exhibit fairness to all. As professional caregivers, nurses are expected to cope with difficult patients and families and to be understanding and caring at all times. Compassion is the hallmark of nursing care. In the past, nurses have often passively accepted abusive behavior as just another burden of the nursing role. This passive acceptance has led to underreporting of nurse abuse, even as recent studies tell us that abuse in the workplace is a continuing concern for nurses.

Prevention of abusive situations must become a greater priority in the acute care setting. The personal safety of nurses and other patients and families in the area must be considered. Training sessions for caregiver staff focusing on principles of safety can emphasize strategies for defusing situations with a potential for abuse. Institutional protocols and procedures to deal with these situations proactively can minimize problems when they do occur. Increased security measures and systems to alert supervisory and security personnel as quickly as possible when there is a potentially violent situation would also reduce instances of abuse.

In addition, assertiveness skills to educate others that abusive actions will not be tolerated must become a priority of the nursing profession. Nurses and other health care providers have a right to be respected and valued by colleagues, patients, and families alike.

There Ought to be a Law!

Current Controversies in Assisted Reproduction

by Robert S. Olick, JD, PhD

The growing list of genetic testing options available to infertile individuals seeking assisted reproductive technology (ART) services gives new meaning to the words family planning. Carrier and prenatal testing have been used for some time to avoid the birth of children with disabilities such as Tay-Sachs, cystic fibrosis, Down syndrome and other conditions. The new face of ART is pre-implantation genetic diagnosis (PGD), a technique that allows testing of embryos created by in vitro fertilization (IVF) for a number of “disease or disability genes,” and the opportunity to select unaffected embryos for implantation.

Because this technique allows early detection of affected embryos prior to implantation, it offers an alternative to the burdensome decision whether to abort an affected fetus following prenatal diagnosis. PGD can also be used to screen for late-onset conditions, such as Alzheimer's disease, and for gender selection. A number of couples recently used PGD to have children who would be compatible stem cell donors for older siblings with leukemia or Fanconi's anemia. Future advances may well add to the PGD menu testing for non-medical, non-therapeutic purposes to select “positive” traits of future offspring.

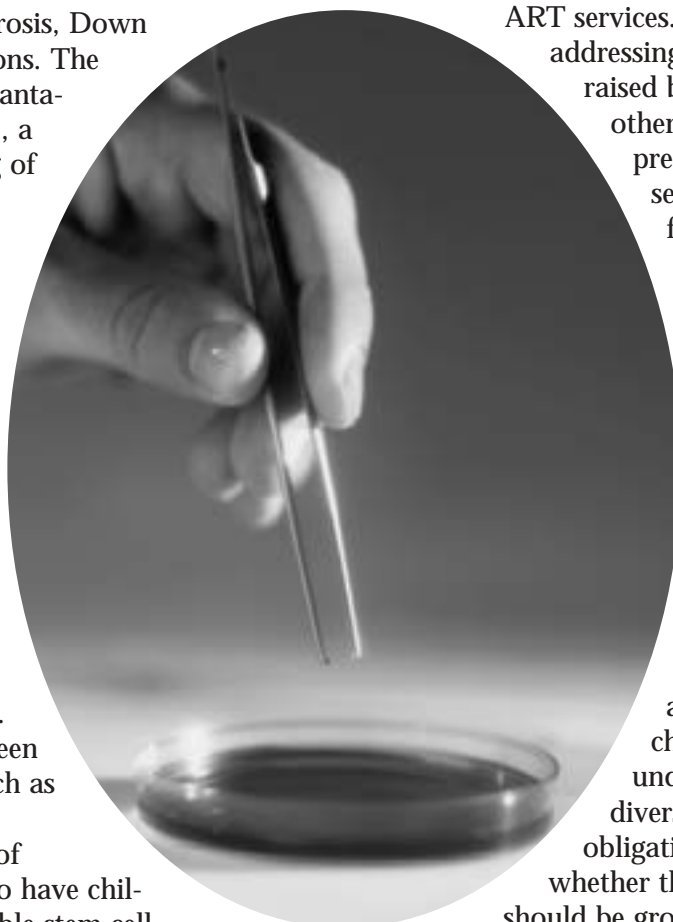
At present, IVF and related fertility services are provided by a largely unregulated industry. Practitioners and intending parents enjoy substantial freedom to pursue the benefits, and assume the risks, of ART. A 1992 federal law aims at consumer protec-

tion, requiring reporting of data regarding the efficacy of ART to the Society for Assisted Reproductive Technology under the auspices of the Centers for Disease Control. Much of the data is publicly available. State laws typically address matters of facility regulation and insurance coverage for ART services. Only a few states have laws addressing even some of the ethical issues raised by prenatal testing, PGD or other ART services. The field relies predominantly on professional self-regulation, and prescribes few enforceable, uniform boundaries for itself.

Standing at the intersection of genetics and procreation, the promise and prospects of ART are intertwined with profound ethical, social and policy questions. Among them are the nature and limits of procreative freedom; the meaning of parenthood; the benefits, risks and harms associated with creating children through ART; our understanding of disability, diversity and difference; our obligations to future generations; and whether the future of ARTs can and should be grounded in a common morality.

Our answers to these and other questions will shape the role of government and law in structuring, limiting, facilitating or prohibiting the use of ARTs.

Take a set of difficult and morally contentious, even divisive issues; an open consumer-oriented market; advances in medical science and technology; subject private, sometimes agonizing and controversial choices to public scrutiny under the glare of increasing media attention, and you have a familiar bioethical recipe for public policy and law reform.



The Plight of the Uninsured

by Melissa S. Freeman, MA

According to a June 2004 report by the private foundation, Families USA, 81.8 million people under the age of 65 became uninsured at some point during 2002-2003. Many of these individuals had health insurance for part of the year. Still, it is disquieting that this figure almost doubles the 43.6 million uninsured for the entire year first published by the U.S. Census Bureau in September 2003. More than four in five individuals who went without health insurance during 2002-2003 were connected to the workforce, a far different outlook on the composite make-up of the uninsured. Families USA reported that the age group with the highest number of uninsured individuals was among the 18-to-24 year olds (50.3 percent).

Recently, the number of individuals without health insurance has captured the attention of the U.S. Committee on Energy and Commerce because of the substantially higher costs of health care each uninsured person may face compared to those who do have health insurance. Different reports have suggested that a person without health insurance may be billed 60-

500 percent more for the same health care experience in comparison to a person with health insurance. Why the significant difference in billing practices for hospitals? Government and other third-party payers negotiate discounts and set fees with hospitals and other health care providers. However, there is no one negotiating on behalf of the person who is uninsured; therefore, hospitals can charge the "full price," which is often far more than the average person can pay out-of-pocket.

With one in three non-elderly Americans currently without health insurance, there is a very good chance that your college-aged son or daughter, cousin, hairstylist, local grocer, or private businessman does not have health insurance. All of them are at risk of paying these higher prices for health care. High-interest loans, bankruptcy, harassment, and even jail can be the consequences of not being able to afford or purchase insurance. The plight of the uninsured goes beyond limited access to health care. It now includes a higher cost for the health care they do receive.

81.8 million Americans under 65 were uninsured sometime during 2002-2003.



Center for Bioethics and Humanities
750 East Adams Street
Syracuse, New York 13210