

FROM THE FIELD...

Early in the HIV/AIDS epidemic, medical concerns overshadowed ethical issues. But professionals soon learned that caring for AIDS patients required them to be moral as well as clinical leaders.

The Early Years of HIV/AIDS at the New York Campus, VA NYHHS

Michael S. Simberkoff, MD

In the beginning, we called it gay-related immunodeficiency syndrome (GRID). The first patient with GRID appeared on the wards of the New York VA Medical Center (NYVAMC, now the New York campus, VA NYHHS) in 1979. He was a young man with Kaposi's sarcoma (KS) that was widely disseminated on his skin, mucous membranes, and in his lung. He died despite efforts to control the disease with chemotherapy. He was followed by a stream of others, some with unexplained fever, lymphadenopathy and weight loss; some with malignancies (e.g., KS or non-Hodgkins lymphoma); some with opportunistic infections . . .

Continues at www.va.gov/vhaethics/2003-2/field8.html



IN THE LITERATURE...

Masur H, Emanuel E, Lane HC. Severe acute respiratory syndrome: Providing care in the face of uncertainty [editorial]. *JAMA* 2003;289:10-12.

Bernstein M, Hawryluck L. Challenging beliefs and ethical concepts: The collateral damage of SARS [commentary]. *Critical Care* 2003;7(4):269-71.

Maunder R, Hunter J, Vincent L, et al. The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital. *Canadian Medical Association Journal* 2003; 168(10): 1245-51.

McStay R. Terminal sedation: Palliative care for intractable pain, post Glucksberg and Quill. *American Journal of Law, Medicine & Ethics* 2003; 29(1): 45-76.

Continues at www.va.gov/vhaethics/2003-2/literature8.html



ON OUR WEB SITE...

New Report from the NEC

Should clinicians ever accept gifts from their patients? see them socially? engage in business undertakings with them? The latest report from the National Ethics Committee, *Ethical Boundaries in the Clinician-Patient Relationship*, addresses questions of how to define the limits of ethically appropriate behavior by health care professionals in their interactions with patients. It examines the concept of professionalism in health care, clarifies the concepts of "boundaries" and "boundary violations," and analyzes examples of potentially problematic actions to help clinicians identify and avoid professionally inappropriate conduct.

Download a PDF copy from www.va.gov/vhaethics/download/boundaries.pdf



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2003/2

spotlightevents

Ethics Is a Critical Focus Area for Systemwide Training

The results of the 2003 EES National Training Critical Focus Areas survey are in and ethics was identified as a national training priority for FY2004. In fact, ethics moved up from No. 20 in last year's rankings to No. 8 for the coming year.

As the primary office in VHA for addressing complex issues in health care ethics, the National Center for Ethics in Health Care collaborates with the Employee Education System to bring outstanding programs like monthly National Ethics Teleconferences to leaders and practitioners throughout VHA. New programs now in development include the *Integrated Ethics Program (IEP) Initiative*, designed to apply quality improvement principles to health care ethics.

Upcoming National Ethics Teleconferences

October 28, 2003 — Ethics Center education chief William Nelson, PhD, looks back on 20 years of health care ethics in VHA. Noon-1:00pm Eastern.

November 19, 2003 — Marybeth Foglia, MN, MA, examines ethical issues in practicing procedures on the newly dead. 1:00-2:00pm Eastern.

Call-in: 1-800-767-1750
Access code: 28410#

bestpractices

A Duty to Treat

Lawrence Deyton, MSPH, MD
Chief Consultant, VHA Public Health Strategic Health Care Group

The outbreak of severe acute respiratory syndrome (SARS) is over, for the moment. That gives us an opportunity to reflect on the lessons this and other infectious diseases have taught us about the ethical aspects of health care and public health, as well as the extent and limits of the "duty to treat." And it gives us an opportunity to think about how those lessons should guide us in our, inevitable, next encounter.

Many lessons have been clinical. Tuberculosis, for example, pushed us to develop new isolation methodologies; HIV made "universal precautions" routine in good clinical practice; hepatitis B brought prophylactic vaccination to protect health care workers, while flu prompted vaccination of caregivers to protect themselves and high-risk patients. The threat of bioterrorism has led us to ask to what we can expect health care professionals, absent specific contraindications, to accept the significant risks of smallpox vaccination in the cause of being "first responders."

We've learned that we must think about infection control beyond the individual level if we are to protect our patients, our colleagues and employees, and our health care system.

Risk & Responsibility Infectious Disease, Public Health & Professionalism

Other lessons have been ethical. We've learned that our efforts to prevent, control, and treat infectious diseases raise important moral concerns. For example, today we recognize that we must balance obligations to protect the health of third parties with obligations to respect the rights and civil liberties of individuals who are infected/have been exposed to disease. And how compulsory directly observed therapy runs up against the right to refuse treatment that patients enjoy in

other contexts. We've come to understand how mandatory reporting poses challenges for privacy and confidentiality and how, in the presence of social stigma, it can create a perverse incentive for individuals not to disclose or seek care, hampering efforts to improve prevention and treatment.

If we have been taken completely by surprise by AIDS ... why should we think we will be spared the visitation of other unanticipated plagues that will also prove refractory to modern medicine? If and when such future epidemics strike ... what kind of medical profession will the public want then?

John D. Arras
"The Fragile Web of Responsibility: AIDS and the Duty to Treat"
(1988)

Among the significant ethical issues posed by infectious disease have been what AIDS physician Abby Zuger called "physician-oriented issues." . . .

Continues at www.va.gov/vhaethics/2003-2/best8.html



inthisissue

BestPractices: A Duty to Treat

PolicyPerspectives: The Administrator's Dilemma

EthicsRounds: Taking Risks to Protect Patients

about the center

Founded in 1991, the National Center for Ethics in Health Care is VHA's primary office for addressing the complex ethical issues that arise in patient care, health care management, and research. The Ethics Center is headquartered in Washington, DC, and has satellite offices in New York and Seattle.

our mission

The mission of the National Center for Ethics in Health Care is to clarify and promote ethical health care practices within VHA and nationwide.

Send us your

feedback

Please send any questions, comments, or address changes to the address above, or e-mail us at vhaethics@hq.med.va.gov.



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ASBH Annual Meeting

The American Society for Bioethics and Humanities will hold their annual meeting jointly with the Canadian Bioethics Society October 23-26 in Montreal, Quebec. The theme for this year's meeting is Bioethics Across Borders, and will focus on interdisciplinary approaches in bioethics. Session topics range from reproductive ethics, to research oversight, to ethics consultation, to health care reform, to health care and research in multicultural settings, and more. For more information, visit: www.asbh.org/annual_meeting/index.htm.

PRIM&R Annual IRB Conference

Public Responsibility in Medicine and Research (PRIM&R) is holding its annual IRB conference and related programs December 4-7 in Washington, DC. This year's theme is Reclaiming the Belmont Principles for Human Research Protections: Looking Back to Move Forward. CME credit is available. For more information visit: www.primr.org.

President's Council on Bioethics

The next President's Council on Bioethics' meeting will take place October 16-17 in Washington, DC. At the last meeting members of the President's Council discussed stem cell research and public policy implications. More information and reports from the President's Council on Bioethics are available at: www.bioethics.gov



Ellen Fox, MD
Director
National Center for Ethics in Health Care

a word from

Infectious diseases bring into the spotlight ethical tensions inherent in the work of health care professionals. In the context of infectious disease, the duty to preserve and protect the well-being of individual patients often pulls against the duty to serve the public welfare, for both individual clinicians and health care systems.

Recognizing what the professional duty to treat does and does not require of clinicians, what can reasonably be asked of them in the interests of protecting patients and others, and how best to distribute resources calls for ethical reflection and judgment. The ability to use such ethical skills as well as clinical expertise can be stretched thin when health care professionals confront the uncertainty and urgency of

a new, life-threatening disease, as clinicians and health care administrators did in Asia and Canada in the outbreak of SARS early this year.

The task of balancing multiple obligations isn't unique to the context of infectious disease. But dealing with an outbreak can sharpen our focus on the values at stake in health care. Each new threat can promote refinements not only in clinical skills and techniques but in the skills of ethical discernment and judgment as well. The lessons of past encounters with infectious disease, reflected on, can help us become better prepared to meet the next set of challenges.

polycy perspectives

The Administrator's Dilemma

Matthew K. Wynia, MD
The Institute for Ethics, AMA
and
Bette-Jane Crigger, PhD
National Center for Ethics in Health Care

Health care administrators responding to infectious disease face not only clinical but ethical challenges. They must balance sometimes competing responsibilities to patients, the public, and staff.

Consider the recent SARS outbreak. The Centers for Disease Control and Prevention (CDC) has established clinical guidelines for managing potential SARS exposures in health care settings. The CDC generally recommends that institutions take steps to prevent unprotected exposure of staff, establish mechanisms for surveillance of health care workers who have

contact with SARS patients, monitor employee absenteeism for signs of emerging infection, and isolate staff who have had unprotected, high risk exposure (<http://www.cdc.gov/ncidod/sars/exposureguidance.htm>). As the probability of actual exposure increases, the stringency of specific CDC recommendations also increases, because of the increasing risk to patients, the public, and fellow health care workers. But measures such as isolation and quarantine not only pose significant logistic challenges and can take a heavy toll on material and human resources, there are important ethical considerations at stake as well. Organizational leaders must balance duties to protect the public welfare, provide appropriate care for all patients, and respect the well-being, rights, and dignity of health care workers. . . .

Continues at www.va.gov/vhaethics/2003-2/briefs8.html



looking forward

Ethics Self-Assessment Toolkit

Ethical health care practices are essential to health care quality—but how do you measure ethics quality? Through its **Ethics Self-Assessment Toolkit (ESAT)** initiative, the National Center for Ethics in Health Care is developing tools to make that possible.

As part of **ESAT**, a *Staff Survey on Clinical and Organizational Ethics* is currently in its final phase of pilot testing. The survey is designed to help facilities evaluate their ethics programs and practices by eliciting staff perspectives on current ethics-related practices, ethical practice standards,

and organizational factors that affect ethical health care practices.

Questions cover practices relating to shared decision making, end-of-life care, privacy and confidentiality, professionalism, resource allocation, and the ethical environment and culture. For example, questions might ask staff whether patients are provided with understandable information about their prognoses, whether clinicians emphasize relief of suffering for patients who are dying, or whether leaders communicate the reasoning behind resource allocation decisions.

The survey was pre-tested at 4 VHA facilities earlier this year to refine questions and test the validity and reliability of responses. The instrument will be available to all facilities in 2004.

A complementary *Facility Workbook*, which will help facilities critically examine how they currently promote ethical health care practices and guide them in designing strategies to improve the quality of their health care ethics, is in development.



ethics rounds

Taking Risks to Protect Patients

Leland Saunders, MA
National Center for Ethics in Health Care

In December 2002 the CDC recommended that all health care providers and first-responders—roughly 450,000 people—be vaccinated against smallpox. By the end of March 2003 the number of people vaccinated within this group nationwide was less than 1%. In VA that number was slightly higher, reaching 7% of health care providers by the end of May 2003.

There are several reasons why so many people declined to be vaccinated, but the one that looms largest is the negative health risks associated with the vaccine. The vaccine commonly causes toxic and/or hypersensitivity rashes, can lead to secondary bacterial, fungal, and parasitic infections and/or permanent disability, and the surface virus can easily spread to close contacts. Indeed, the smallpox vaccine is so dangerous, and the contraindications so extensive, that few people even qualify to receive it—another reason the number of vaccinated individuals is so low. For example, in one hospital, of

550 volunteers for the vaccine only 38 qualified to receive it.

If smallpox is at one end of the vaccine spectrum, what about the other end? Consider the following scenario:

Dr. M is a cardiologist specializing in the care of geriatric patients. She is well regarded as a skilled and compassionate physician by both colleagues and patients.

The hospital where Dr. M works recently offered the influenza vaccine to all health care providers, but she declined to be vaccinated. It is now flu season, and several of the patients Dr. M recently treated are suffering from the illness.

Mr. R, a frail and immunosuppressed elderly gentleman in his 80's is typical of Dr. M's patients. Given the vulnerability of her patient population, is Dr. M ethically obligated to be vaccinated against the flu (even though vaccination is not required by policy)?

To analyze this case, we first have to back up a little bit and ask why some vaccines are recommended for health care providers. There are really two reasons: to protect health care providers from being infected by patients (thereby assuring that providers remain healthy and available to treat more patients), and to protect patients from being infected by health care providers. These, in turn, are based on two ethical duties practitioners have to patients—to provide care regardless of personal risk, and to minimize harm, in this case by protecting them from infectious agents during the course of treatment. . . .

Continues at www.va.gov/vhaethics/2003-2/ethicsrounds8.html

