NCMS ETHICAL AND JUDICIAL AFFAIRS COMMITTEE MEETING
Friday, July 25, 2014, 11:30am-1:30pm
North Carolina Medical Society, Raleigh, NC

AGENDA

Mental Health and Background Checks for Gun Ownership

Referred Resolutions

Policy from American Psychiatric Association

Policy from NC Psychiatric Association

RESOLUTIONS 1 & 5 from 2013 HOUSE OF DELEGATES – REFERRED TO THE ETHICAL AND JUDICIAL AFFAIRS COMMITTEE

RESOLUTION 1 - Mental Health and Background Checks for Gun Ownership

RESOLVED, That the North Carolina Medical Society supports mental health background checks prior to weapon purchase and further, if a patient owns a gun and becomes mentally unstable, local authorities should be contacted to research, conduct background checks and ensure that the mentally unstable and ill patient is not in possession of or have easy access to a weapon. Further, the Medical Society acknowledges that this will not stop all gun violence, but it may remove weapons from mentally unstable patients and that isn't a bad thing. ***(policy)***

RESOLUTION 5 – Handgun Laws

RESOLVED, That the North Carolina Medical Society calls upon the North Carolina General Assembly to:

1. Create a registration process for handguns and automatic weapons which includes mental health background checks.
2. Purchasers of these weapons would be banned from ownership if they have a history of hospitalization for mental illness.
3. Owners of handguns would have their license revoked and the weapon removed from their possession if after purchase they become mentally ill with hospitalization.
4. That physicians who treat the mentally ill have a process created to contact authorities to inquire if a handgun is owned by a patient applying for a concealed weapon permit.
5. That permit for the handgun be attached to the gun and each subsequent sale requires a full background check to include mental health and is transferred with the sale of that weapon. ***(action)***

Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services

Debra A. Pinals, M.D.,* with assistance from
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NOTE: Assembly Action Papers submitted by John De Figueiredo, M.D., Gail Robinson, M.D., Carolyn Drazinic, M.D., Ph.D., and the Connecticut Psychiatric Society are reflected in this document.

* Representative of the American Academy of Psychiatry and Law

Approved by the Board of Trustees, July 2013
Approved by the Assembly, May 2013

"Policy documents are approved by the APA Assembly and Board of Trustees...These are...position statements that define APA official policy on specific subjects..." – *APA Operations Manual.*

The American Psychiatric Association recognizes the critical public health need for action to promote safe communities and reduce mortality due to firearm-related violence. As such, the APA supports the following actions:

1. Many deaths and injuries from gun violence can be prevented through national and state legislative and regulatory action. These actions should include:
   a. Limiting access to guns by persons who are identified as dangerous, whether or not they have been diagnosed with a mental disorder;
   b. Requiring more extensive background checks and waiting periods on all gun sales or transactions;
   c. Requiring safe storage of all firearms in the home, office or other places of daily assembly; and
   d. Limiting access to semi-automatic firearms, high capacity magazines and high velocity ammunition to reduce risk of critical injuries and death from firearms;

2. Research and training on the causes of violence and its effective control should be a national priority.
   a. Given the difficulty in accurately identifying those persons likely to commit acts of violence, federal resources should be directed toward the development and testing of methods that assist in the identification of high-risk individuals.
   b. Funding for such research should be supported broadly, drawing on a range of resources such as the Centers for Disease Control, the National Institutes of Health, the National Science Foundation, academic institutions, and community foundations. Administrative, regulatory or legislative barriers to federal support for violence research, including research on firearms violence, should be removed.
   c. Psychiatrists, as well as other physicians and health professionals, must continue to be trained to assess and respond to those individuals who may be at heightened risk for violence or suicide. Such training should include education about speaking with patients about firearm access and safety. Appropriate federal and state resources should be allocated for training of these professsionals. (see APA Position Statement on Firearms Access: Inquiries in Clinical Settings)
   d. Resources should be increased for safety education programs related to responsible use and storage of firearms.

3. Recent attention to the mental health system has highlighted the need for improved services and access to care.
   a. Early identification and treatment of mental disorders, including school-based screening, should be prioritized in a national and local agenda to augment prevention strategies, reduce the stigma of treatment, and diminish the consequences of untreated mental disorders.
   b. For those people with mental illness who ultimately pose an increased risk of harm to themselves or other people, barriers to accessing appropriate treatment should be removed. Access to care and associated resources to enhance community follow up should be maximized to ensure that patients obtain treatment and are not lost to care.
   c. Because privacy in mental health treatment is essential to encourage persons in need of treatment to seek care, laws mandating psychiatrists and other mental health professionals to report to law enforcement officials everyone who appears to be a danger to themselves or others are likely to be counterproductive and should not be adopted.
   d. The President of the United States should consolidate and coordinate current interests in improving mental health care in this country by appointing a Presidential Commission to develop a vision for an integrated system of mental health care for the 21st century.

Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services

North Carolina Psychiatric Association

Approved by the Executive Committee, March 5, 2014

The North Carolina Psychiatric Association acknowledges the lawful and appropriate use of firearms by the citizens of North Carolina including members of the Association. Nevertheless the North Carolina Psychiatric Association must recognize the critical public health need for action to promote safe communities and reduce mortality due to firearm-related violence. The North Carolina Psychiatric Association supports the position adopted by the American Psychiatric Association in this regard. As such, the North Carolina Psychiatric Association supports the following actions:

1. **Many deaths and injuries from gun violence can be prevented through legislative and regulatory action on the national and statewide levels.**

   These actions should include:
   a. Limiting access to guns by persons who are identified as dangerous, whether or not they have been diagnosed with a mental disorder;
   b. Requiring more extensive background checks and waiting periods on all gun sales or transactions;
   c. Requiring safe storage of all firearms in the home, office or other places of daily assembly; and
   d. Limiting access to semi-automatic firearms, high capacity magazines and high velocity ammunition to reduce risk of critical injuries and death from firearms;

2. **Research and training on the causes of violence and its effective control should be a national and statewide priority.**

   a. Given the difficulty in accurately identifying those persons likely to commit acts of violence, federal and state resources should be directed toward the development and testing of methods that assist in the identification of high-risk individuals.
   b. Funding for such research should be supported broadly, drawing on a range of resources such as the Centers for Disease Control, the National Institutes of Health, the National Science Foundation, the North Carolina Department of Health and Human Services, the North Carolina Department of Public Safety, the North Carolina Department of Justice, our eminent institutions of higher learning, and community foundations. Administrative, regulatory or legislative barriers to federal and statewide support for violence research, including research on firearms violence, should be removed.
   c. Psychiatrists, as well as other physicians and health professionals, must continue to be trained to assess and respond to those individuals who may be at heightened risk for violence or suicide. Such training should include education about speaking with patients about firearm access and safety. Appropriate federal and state resources should be allocated for training these professionals.
   d. Resources should be increased for safety education programs related to responsible use and storage of firearms.

3. **Recent attention to the mental health system has highlighted the need for improved services and access to care.**
   a. Early identification and treatment of mental disorders, including school-based screening, should be prioritized in a state-wide agenda to augment prevention strategies, reduce the stigma of treatment, and diminish the consequences of untreated mental disorders.

b. Barriers to accessing appropriate evaluation and treatment services for those people with mental illness who ultimately pose an increased risk of harm to themselves or other people should be removed. Likewise the North Carolina Psychiatric Association urges the removal of barriers to accessing services for those individuals suffering from substance abuse. Access to care and associated resources to enhance community follow up should be maximized to ensure that patients obtain treatment and are not lost to care.

c. Because privacy in mental health treatment is essential to encourage persons in need of treatment to seek care, laws mandating psychiatrists and other mental health professionals to report all individuals who appear to be dangerous to themselves or others to law enforcement officials are likely to be counterproductive and should not be adopted.

d. The Governor of North Carolina should consolidate and coordinate current interests in improving mental health care in this state by appointing a Mental Health Advisory Commission to develop a vision for an integrated system of mental health care which corrects prior reforms that have been responsible for the degradation of the quality of mental health care provided to the citizens of North Carolina..

Date of draft: 5 December 2013

Professional Use of Social Media

North Carolina Medical Society

NCMS Policy on Physicians' Use of Social Media

October 19, 2012 at 2:08 pm

Continuing the NCMS' initiative to inform and educate the medical community about social media and the importance of maintaining professionalism and the physician-patient relationship, here are a few standards that medical practices should actively follow while using

social networks:

- Medical practices should be aware of patient privacy and confidentiality that must be maintained in all online environments.
- Medical practices should safeguard private information on social networking sites.
- Medical practices must maintain appropriate boundaries in accordance with professional ethical guidelines in order to preserve the physician-patient relationship.
- To avoid negatively impacting the physician-patient relationship, medical practice staff should consider separating professional and personal content published online.
- If unprofessional content is posted online, a medical practice should bring this information to the attention of the individual so that he or she may remove it or take other appropriate action.
- It is important to realize that information posted online can negatively affect the reputation of a medical practice. Because of this, it is vital that medical practices take the necessary precautions while using social media.

By following these recommendations and creating a social media policy addressing these matters, medical practices will be able to effectively have an online presence, foster collegiality within the profession via social media, and provide opportunities to publicize public health issues through a new communication medium. This summary is based on a policy adopted by the NCMS House of Delegates in 2011. For more information regarding the policy, view the NCMS Policy Manual (Password Protected).

More Posts in Bulletins

- **NC House Budget is Encouraging on Medicaid Reform**

  June 11, 2014

- **e-Billing for Workers' Comp Claims Takes Effect July 1**

  June 11, 2014

- **Accountable Care Toolkits Now Available for Cardiologists, Oncologists and Emergency Physicians**

Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice

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Report of the Special Committee on Ethics and Professionalism

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Introduction and Charge

In recent years the medical profession has become aware of the opportunities and challenges that social media and social networking websites present for physicians. As technology has advanced, many hospitals and health care organizations have found it necessary to create their own policies in order to protect physicians and patients alike. In 2011, FSMB Chair Janelle A. Rhyne, M.D., MACP, asked the members of the Special Committee on Ethics and Professionalism to develop guidelines for state medical and osteopathic boards to consider for their use in educating their licensees on the proper use of social media and social networking websites.

The Special Committee on Ethics and Professionalism was charged with providing ethical and professional guidance to the FSMB membership with regard to the use of electronic and digital media by physicians (and physician assistants, where appropriate) that may be used to facilitate patient care and nonprofessional interactions. Such electronic and digital media include, but are not limited to, e-mail, texting, blogs and social networks. The Committee's proposed model guidelines contained in this report also focus on ways that physicians can protect the privacy and confidentiality of their patients as well as maintain a standard of professionalism in all social media and social networking interactions.

The FSMB is grateful for the efforts of the members of the Special Committee on Ethics and Professionalism who provided input and direction for this project.

Model Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice

Section One
Preamble

The use of social media has become increasingly important across all industries – including health care. *QuantiaMD* surveyed more than 4,000 physicians and reported in September 2011 that 87 percent use a social media website for personal use and 67 percent use social media for professional purposes.[1] In addition, there is evidence that physicians connect with patients through social media websites. Research indicates that 35 percent of practicing physicians have received friend requests from a patient or a member of their family, and 16 percent of practicing physicians have visited an online profile of a patient or patient's family member.[2]

Social media use presents several challenging questions for administrators and physicians, such as where the boundary of professionalism lies, and whether work experiences can be shared without violating the privacy and confidentiality of patients. One meta-analysis of physician blogs found that nearly 17 percent included enough information about patients for them to be identified.[3]

Medical schools and their students often use online social networking websites,[4,5] and students have been disciplined for posting unprofessional online content.[6] In addition, most physician licensing authorities in the United States have reported incidents of physicians engaging in online professionalism violations, many of which have resulted in serious disciplinary actions. In a 2010 survey of Executive Directors at state medical boards in the United States, 92 percent indicated that violations of online professionalism were reported in their jurisdiction. These violations included Internet use for inappropriate contact with patients (69 percent), inappropriate prescribing (63 percent), and misrepresentation of credentials or clinical outcomes (60 percent). In response to these violations, 71 percent of boards held formal disciplinary proceedings and 40 percent issued informal warnings. Outcomes from the disciplinary proceedings included serious actions such as license limitation (44 percent), suspension (29 percent), or revocation (21 percent) of licensure.[7]

These growing concerns about physician use of social media underscore the need for social media policies. Many hospitals and health care organizations, such as the American Medical Association, American College of Physicians, Cleveland Clinic, and Mayo Clinic, have developed social media policies.[8,9,10,11]

Social media has enormous potential for both physicians and their patients. It can be used to disseminate information and forge meaningful professional relationships. However, these benefits must occur within the proper framework of professional ethics, and physicians need information on the importance of maintaining the same professional and ethical standards in their online activity or communications using other forms of electronic media.

The FSMB has developed this policy to encourage physicians who use social media and social networking to protect themselves from unintended consequences of such practices and to maintain the public trust by:

- Protecting the privacy and confidentiality of their patients
- Avoiding requests for online medical advice
- Acting with professionalism
- Being forthcoming about their employment, credentials and conflicts of interest
- Being aware that information they post online may be available to anyone, and could be misconstrued

The FSMB acknowledges that there may be instances in which a physician's professionalism or care is questionable and not addressed in this policy or other FSMB policy. Any time a physician enters into a relationship with a patient, whether it is electronically or in person, the physician should abide by the same rules or statutes established by the state medical board.

Section Two
An Appropriate Physician-Patient Relationship

The health and well-being of a patient depend upon a collaborative effort between the physician and patient. The physician-patient relationship is fundamental to the provision of acceptable medical care, and physicians are expected to recognize the obligations, responsibilities and patient rights associated with establishing and maintaining an appropriate physician-patient relationship. The relationship between a physician and patient begins when an individual seeks assistance from a physician for a health-related matter, and the physician agrees to undertake diagnosis and treatment of the patient.[12] The physician-patient relationship can begin without a personal encounter, which allows for online interactions to constitute the beginning of the relationship. Physicians should remember that when using electronic communications they may be unable to verify that the person on the other end of the electronic medium is truly the patient; likewise, the patient may not be able to verify that a physician is on the other end of the communication. For that reason, the standards of medical care do not change by virtue of the medium in which physicians and their patients choose to interact.

The following narratives demonstrate examples where unintended consequences of physicians' use of social media and social networking may undermine a proper physician-patient relationship and the public trust.

1. A urologist who is an astute clinician and well respected by his colleagues recently began posting his comments, views and observations on Twitter. The same day that the United States Preventive Services Task Force came out with a recommendation, in October 2011, against routine Prostate-Specific Antigen (PSA) screening in healthy men for prostate cancer, he posted a tweet with writing that used disrespectful language to disagree with the recommendation. The tweet has now gone viral and has been read by many of his patients, colleagues, fellow researchers, family and friends.

2. A patient noted disrespectful language on a physician's blog when the physician expressed frustration towards another patient who had to visit the emergency department multiple times for failing to monitor her sugar levels. The physician referred to the patient as "lazy" and "ignorant" on their blog.

3. Approximately two years after a physician left his private practice, a former patient asked to "friend" him on Facebook. The physician had set up a Facebook account to participate in a review course for Maintenance of Certification (MOC), but remained on Facebook to stay in touch with family. The physician felt conflicted about the request because he was no longer the patient's physician, and had no intention of returning to private practice. The patient was also very emotionally fragile, and cried at most office visits. The physician wrestled with whether or not to accept the request, but eventually did so for fear that rejecting the request would damage the former patient's self-esteem. The former patient never posted anything inappropriate, and only contacted the physician to wish him him a happy birthday. The physician

still feels uncomfortable maintaining this online "friendship," and has considered closing his Facebook account.

4. A psychiatrist in her 30s used Facebook to befriend a former female patient of similar age who she took care of when she was a psychiatry resident in another state. They had "hit it off" because they had similar tastes in music and art and developed a level of trust that the patient said she had not had with anyone else. They now periodically exchange pleasantries on Facebook, but lately the patient's affect online appears different, worrying the psychiatrist. The psychiatrist is planning to spend the holidays with her family in the same state as her former patient, and is considering getting together with her former patient to "catch up," but is unsure how to properly initiate contact with her former patient. Should the psychiatrist just meet her for coffee? Is it appropriate for them to meet at all? She knows she probably shouldn't use Facebook because it may not be private, but she also doesn't want to give the patient her personal e-mail address.

5. A concerned patient notes that her physician frequently describes "partying" on his Facebook page, which is accompanied by images of himself intoxicated. The patient begins to question whether her physician is sober and prepared to treat her when she has early morning doctor's appointments.

6. A physician comes across the profile of one of his patients on an online dating website and invites her to go on a date with him. The patient feels pressured to accept the invitation because her next appointment with her physician would be awkward if she refuses.

7. A first-year resident films another doctor inserting a chest tube into a patient. The patient's face is clearly visible. The resident posts the film on YouTube for other first-year residents to see how to properly do the procedure.

These examples highlight the importance of proper boundaries within the physician-patient relationship. Even seemingly innocuous online interactions with patients and former patients may violate the boundaries of a proper physician-patient relationship.

Physicians should not use their professional position, whether online or in person, to develop personal relationships with patients. The appearance of unprofessionalism may lead patients to question a physician's competency. Physicians should refrain from portraying any unprofessional depictions of themselves on social media and social networking websites.

Section Three
Parity of Professional and Ethical Standards

To ensure a proper physician-patient relationship, there should be parity of ethical and professional standards applied to all aspects of a physician's practice, including online interactions through social media and social networking sites. Referencing the FSMB House of Delegate's *Model Guidelines for the Appropriate Use of the Internet in Medical Practice,* adopted in 2002, physicians using social media and social networking sites are expected to observe the following ethical standards:

Candor

Physicians have an obligation to disclose clearly any information (e.g., financial, professional or personal) that could influence patients' understanding or use of the information, products or services offered on any website offering health care services or information.

Privacy

Physicians have an obligation to prevent unauthorized access to, or use of, patient and personal data and to assure that "de-identified" data cannot be linked back to the user or patient.

Integrity

Information contained on websites should be truthful and not misleading or deceptive. It should be accurate and concise, up-to-date, and easy for patients to understand. Physicians using medical websites should strive to ensure that information provided is, whenever possible, supported by current medical peer-reviewed literature, emanates from a recognized body of scientific and clinical knowledge and conforms to minimal standards of care. It should clearly indicate whether it is based upon scientific studies, expert consensus, professional experience or personal opinion.

How these ethical standards relate to the proper use of social media by physicians is explored further in the next section.

Section Four
Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice

The following guidelines are recommended for physicians who use social media and social networking in their personal and professional lives.

Interacting with Patients

Physicians are discouraged from interacting with current or past patients on personal social networking sites such as Facebook. Physicians should only have online interaction with patients when discussing the patient's medical treatment within the physician-patient relationship, and these interactions should never occur on personal social networking or social media websites. In addition, physicians need to be mindful that while advanced technologies may facilitate the physician-patient relationship, they can also be a distracter which may lessen the quality of the interactions they have with patients. Such distractions should be minimized whenever possible.

Discussion of Medicine Online

Social networking websites may be useful places for physicians to gather and share their experiences, as well as to discuss areas of medicine and particular treatments. These types of professional interactions with other physicians represent an ancillary and convenient means for peer-to-peer education and dialogue. One current example is Doximity, a professional network with more than 567,000 U.S. physician members in 87 specialties. Using Doximity, physicians are said to be able to exchange HIPAA-compliant messages and images by text or fax and discuss the latest treatment guidelines and medical news in their specialty.[13] While such networks may be useful, it is the responsibility of the physician to ensure, to the best of his or her ability, that professional networks for physicians are secure and that only verified and registered users have access to the information. These websites should be password protected so that non-physicians do not gain access and view discussions as implying medical advice, which may be counter to the physicians' intent in such discussions. Physicians should also confirm that any medical information from an online discussion that they plan to incorporate into their medical practice is corroborated and supported by current medical research.

Privacy/Confidentiality

Just as in the hospital or ambulatory setting, patient privacy and confidentiality must be protected at all times, especially on social media and social networking websites. These sites have the potential to be viewed by many people and any breaches in confidentiality could be harmful to the patient and in violation of federal privacy laws, such as HIPAA. While physicians may discuss their experiences in non-clinical settings, they should never provide any information that could be used to identify patients. Physicians should never mention patients' room numbers, refer to them by code names, or post their picture. If pictures of patients were to be viewed by others, such an occurrence may constitute a serious HIPAA violation.

Disclosure

At times, physicians may be asked or may choose to write online about their experiences as a health professional, or they may post comments on a website as a physician. When doing so, physicians must reveal any existing conflicts of interest and they should be honest about their credentials as a physician.

Posting Content

Physicians should be aware that any information they post on a social networking site may be disseminated (whether intended or not) to a larger audience, and that what they say may be taken out of context or remain publicly available online in perpetuity. When posting content online, they should always remember that they are representing the medical community. Physicians should always act professionally and take caution not to post information that is ambiguous or that could be misconstrued or taken out of context. Physician employees of health care institutions should be aware that employers may reserve the right to edit, modify, delete, or review Internet communications. Physician writers assume all risks related to the security, privacy and confidentiality of their posts. When moderating any website, physicians should delete inaccurate information or other's posts that violate the privacy and confidentiality of patients or that are of an unprofessional nature.

Professionalism

To use social media and social networking sites professionally, physicians should also strive to adhere to the following general suggestions:

- Use separate personal and professional social networking sites. For example, use a personal rather than professional e-mail address for logging on to social networking websites for personal use. Others who view a professional e-mail attached to an online profile may misinterpret the physician's actions as representing the medical profession or a particular institution.
- Report any unprofessional behavior that is witnessed to supervisory and/or regulatory authorities.
- Always adhere to the same principles of professionalism online as they would offline.
- Cyber-bullying by a physician towards any individual is inappropriate and unprofessional.
- Refer, as appropriate, to an employer's social media or social networking policy for direction on the proper use of social media and social networking in relation to their employment.

Medical Board Sanctions and Disciplinary Findings

State medical boards have the authority to discipline physicians for unprofessional behavior relating to the inappropriate use of social networking media, such as:

- Inappropriate communication with patients online
- Use of the Internet for unprofessional behavior
- Online misrepresentation of credentials

- Online violations of patient confidentiality
- Failure to reveal conflicts of interest online
- Online derogatory remarks regarding a patient
- Online depiction of intoxication
- Discriminatory language or practices online

State medical boards have the option to discipline physicians for inappropriate or unprofessional conduct while using social media or social networking websites with actions that range from a letter of reprimand to the revocation of a license.

Future Changes

The Federation of State Medical Boards recognizes that emerging technology and societal trends will continue to change the landscape of social media and social networking, and how these websites are used by patients and physicians will evolve overtime. These guidelines are meant to be a starting point for the discussion of how physicians should properly communicate with their patients using social media. These guidelines will need to be modified and adapted in future years as technology advances, best practices emerge, and opportunities for additional policy guidance are identified.

Section Five
Key Definitions and Glossary

Blog - Blog is a word that was created from two words: "web log". Blogs are usually maintained by an individual with regular entries of commentary, descriptions of events, or other material such as graphics or video. Entries are commonly displayed in reverse-chronological order. "Blog" can also be used as a verb, meaning to maintain or add content to a blog.

Bridging – Bridging can refer to the function patient networking sites serve for people living with chronic disease. Social networking for the chronically ill bridges the gap between the restrictive conditions in which they live and access to support groups and other resources that are important for coping and recovery.

Chat - Chat can refer to any kind of communication over the Internet, but traditionally refers to one-to-one communication through a text-based chat application commonly referred to as instant messaging applications.

Comment - A comment is a response that is often provided as an answer of reaction to a blog post or message on a social network. Comments are a primary form of two-way communication on the social web.

E-mail - Electronic mail, commonly called e-mail or email, is a method of exchanging digital messages from an author to one or more recipients. Modern e-mail operates across the Internet or other computer networks.

Facebook - Facebook is a social utility that connects people with friends and others who work, study and live around them. Facebook is the largest social network in the world with more than 800 million users.

Forums - Also known as a message board, a forum is an online discussion site. It originated as the modern equivalent of a traditional bulletin board, and a technological evolution of the dialup bulletin board system.

Hashtag - A hashtag is a tag used on the social network Twitter as a way to annotate a message. A hashtag is a word or phrase preceded by a "#". Example: #yourhashtag. Hashtags are commonly used to show that a tweet, a Twitter message, is related to an event or conference.

Instant Messaging - Instant messaging (IM) is a form of real-time direct text-based communication between two or more people. More advanced instant messaging software clients also allow enhanced modes of communication, such as live voice or video calling.

LinkedIn - LinkedIn is a business-oriented social networking site. Founded in December 2002 and launched in May 2003, it is mainly used for professional networking. As of June 2010, LinkedIn had more than 70 million registered users, spanning more than 200 countries and territories worldwide

New Media - New Media is a generic term for the many different forms of electronic communications that are made possible through the use of computer technology. The term is in relation to "old" media forms such as print newspapers and magazines that are static representations of text and graphics.

Skype - Skype is a free program that allows for text, audio and video chats between users. Additionally, users can purchase plans to receive phone calls through their Skype account.

Social Media - electronic communication through which users create online communities to share information, ideas, personal messages, and other content.

Social Networking - networking using an online service, platform, or site that focuses on building social relations among people who share interests and/or activities.

Texting - Text messaging, or texting, refers to the exchange of brief written text messages between fixed-line phone or mobile phone and fixed or portable devices over a network.

Tweet - A message or update that one posts on Twitter.

Twitter - Twitter is a platform that allows users to share 140-character-long messages publicly. User can "follow" each other as a way of subscribing to each others' messages. Additionally, users can use the @username command to direct a message towards another Twitter user.

Webinar - A webinar is used to conduct live meetings, training, or presentations via the Internet.

Wiki - A wiki is a website that allows the easy creation and editing of any number of interlinked web pages via a web browser, allowing for collaboration between users.

Wikipedia - Wikipedia is a free, web-based, collaborative, multilingual encyclopedia project supported by the non-profit Wikimedia Foundation.

Yelp - Yelp is a social network and local search website that provides users with a platform to review, rate and discuss local businesses and services.

YouTube - YouTube is a video-sharing website on which users can upload, share, and view videos.

For a more detailed glossary of social media terms, see the link below.

http://blog.hubspot.com/blog/tabid/6307/bid/6126/The-Ultimate-Glossary-101-Social-Media-Marketing-Terms-Explained.aspx

Section Six. References

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Further Reading

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Professional use of social media

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The Board recognizes that social media has increasing relevance to professionals and supports its responsible use. However, health care practitioners are held to a higher standard than others with respect to social media because health care professionals, unlike members of the lay public, are bound by ethical and professional obligations that extend beyond the exam room.

The informality of social media sites may obscure the serious implications and long term consequences of certain types of postings. The Board encourages its licensees to consider the implications of their online activities including, but not limited to, the following:

- Licensees must understand that the code of conduct that governs their face to face encounters with patients also extends to online activity. As such, licensees interacting with patients online must maintain appropriate boundaries in accordance with professional ethical guidelines, just as they would in any other context.
- Licensees have an absolute obligation to maintain patient privacy and must refrain from posting identifiable patient information online.
- A licensee's publicly available online content directly reflects on his or her professionalism. It is advisable that licensees separate their professional and personal identities online (maintain separate email accounts for personal and professional use; establish a social media presence for professional purposes and one for personal use, etc.).
- Because privacy is never absolute, considerations of professionalism should also extend to a licensee's personal accounts. Posting of material that demonstrates, or appears to demonstrate, behavior that might be considered unprofessional, inappropriate or unethical should be avoided.
- The online use of profanity, disparaging or discriminatory remarks about individual patients or types of patients is unacceptable.
- Licensees should routinely monitor their own online presence to ensure that the personal and professional information on their own sites is accurate and appropriate.

The Board also endorses the Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice adopted by the Federation of State Medical Boards which can be accessed at http://www.fsmb.org/pdf/pub-social-media-guidelines.pdf Furt.her discussion of this issue by the Board's Medical Director can be found at http://www.ncmedboard.org/articles/detail/practicing_medicine_in_the_facebook_age_maintaining_professionalism_online

Futility of Care

American Medical Association Code of Ethics

Principles of Medical Ethics Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Adopted June 1957; revised June 1980; revised June 2001.

Opinion 2.035 - Futile Care

Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care, as defined in Opinion 2.03, "Allocation of Limited Medical Resources," and Opinion 2.095, "The Provision of Adequate Health Care," not on the concept of "futility," which cannot be meaningfully defined. (I, IV)

Issued June 1994.

Opinion 2.037 - Medical Futility in End-of-Life Care

When further intervention to prolong the life of a patient becomes futile, physicians have an obligation to shift the intent of care toward comfort and closure. However, there are necessary value judgments involved in coming to the assessment of futility. These judgments must give consideration to patient or proxy assessments of worthwhile outcome. They should also take into account the physician or other provider's perception of intent in treatment, which should not be to prolong the dying process without benefit to the patient or to others with legitimate interests. They may also take into account community and institutional standards, which in turn may have used physiological or functional outcome measures. Nevertheless, conflicts between the parties may persist in determining what is futility in the particular instance. This may interrupt satisfactory decision-making and adversely affect patient care, family satisfaction, and physician-clinical team functioning. To assist in fair and satisfactory decision-making about what constitutes futile intervention: (1) All health care institutions, whether large or small, should adopt a policy on medical futility; and (2) Policies on medical futility should follow a due process approach. The following seven steps should be included in such a due process approach to declaring futility in specific cases. (a) Earnest attempts should be made in advance to deliberate over and negotiate prior understandings between patient, proxy, and physician on what constitutes futile care for the patient, and what falls within acceptable limits for the physician, family, and possibly also the institution. (b) Joint decision-making should occur between patient or proxy and physician to the maximum extent possible. (c) Attempts should be made to negotiate disagreements if they arise, and to reach resolution within all parties' acceptable limits, with the assistance of consultants as appropriate. (d) Involvement of an institutional committee such as the ethics committee should be requested if disagreements are irresolvable. (e) If the institutional review supports the patient's position and the physician remains unpersuaded, transfer of care to another physician within the institution may be arranged. (f) If the process supports the physician's position and the patient/proxy remains unpersuaded, transfer to another institution may be sought and, if done, should be supported by the transferring and receiving institution. (g) If transfer is not possible, the intervention need not be offered. (I, V)

Issued June 1997 based on the report "Medical Futility in End-of-Life Care," adopted December 1996 (JAMA. 1999; 281: 937-41).

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Institutional Futility Policies are Inherently Unfair

Philip M. Rosoff

Abstract For many years a debate has raged over what constitutes futile medical care, if patients have a right to demand what doctors label as futile, and whether physicians should be obliged to provide treatments that they think are inappropriate. More recently, the argument has shifted away from the difficult project of definitions, to outlining institutional policies and procedures that take a measured and patient-by-patient approach to deciding if an existing or desired intervention is futile. The prototype is the Texas Advance Directives Act, but similar procedures have been widely implemented both with and without the protection of the law. While this method has much to recommend it, there are inherent moral flaws that have not received as much discussion as warranted. Because these strategies adopt a semblance of procedural justice, it is assumed that the outcomes of such proceedings will be both correct and fair. In this paper, I argue that there are three main irremediable defects in the policy approach: there is the potential for arbitrary decision-making about futility in specific cases; there are structural, pre-ordained consequences for ethnic minorities who would be disproportionately affected by the use of these procedures; and the use of rationing justifications to support the use of these policies. These flaws detract so much from any benefit that could be derived that they make such strategies more harmful than helpful.

Keywords Futility · Procedural justice · Medical decision-making

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Introduction

For more than 20 years, physicians, bioethicists, lawyers and others have debated the issue of futile treatment for patients. Despite a declaration several years ago that there was really nothing more to discuss, in essence pronouncing any further discussion or dialogue about futility to be futile, the conversation and controversy continues (Helft et al. 2000). Notwithstanding this prolonged and intense argument, a consensus has yet to be reached on what types of care should count as futile medical treatment, other than perhaps those that might qualify as so-called "physiological futility" (Bernat 2005; Schneiderman et al. 1990). This latter form of intervention describes the rare requests for treatments that have no rational basis for efficacy, such as antimicrobial antibiotics for viral infections, cardiopulmonary resuscitation on a dead patient, and the like. While uncommon, demands for these types of therapies are denied in a straightforward and uncontroversial manner, since there is little debate on what would be certified as futile under this heading. However, it is the vast other space occupied by interventions that are thought to be inappropriate and/or reasonably ineffective that has provoked the most dissension and argument.

Disagreements about what should be valid goals of medical care for specific patients, and the world of potential or possible interventions that could be employed to reach those goals underlie most, if not all, arguments about futile therapies. On the one side, doctors, nurses and other healthcare professionals have opinions about the worthiness of treatment—whether it is capable of attaining a reasonable objective within the clinical and social context occupied by the patient—while on the other, family members (and less commonly, patients themselves) possess different views about the same therapy and its value. Other than the recognition amongst physicians (and many patients, at least in the abstract) that there is such a thing as treatments that will not help a particular patient and thus can be pronounced as futile, there is little else agreed upon. Most importantly, it may be impossible to disentangle evaluations of objective (quantitative) and subjective (qualitative) estimations of futile care. Similarly, who should have the final say on pronouncing a treatment as futile—patients, doctors, courts or some combination—remains unsettled. Some hold that it would be an abridgement of personal autonomy to deny patients what they desire so as to try and achieve their ends, irrespective of its plausibility or chances of success (Gampel 2006).[1] Conversely, it has also been suggested that these decisions rightly belong to doctors: to have it otherwise would violate a principle of professional integrity (Halevy 2008). Finally, there are those who do not distinguish between endless demands for hoped-for curative interventions and ever-escalating costs in the context of a financially stressed health care system (Callahan 1998).

In the absence of some agreement on a definition of what futile medical treatment is, many authors have advocated utilizing a standardized, institutional procedure that dilutes and distributes responsibility for assessing futility or lack of therapeutic benefit on a case-by-case basis, dispersing it to a specially designated committee using a uniform and consistent methodology (Heilig et al. 1999; Halevy and Brody

[1] For a view from someone who is not a physician, see Katz (2011).

1996). The assumption is that an application of a form of procedural justice should bestow the benefits of a fair adjudication process and hence a just outcome.[2] This has the presumed advantage of not requiring an affirmation of a single, all-embracing definition of futile care, but does introduce a dependence on local healthcare provider preferences in decision-making for these assessments. The attraction of this approach is that one does not need to define what futility *is* for everyone, only that the proposed intervention that is a matter of dispute has been declared to be so by local experts who are supposed to be best situated to make such a clinical judgment. The state of Texas has enacted legislation that embodies this approach (Fine 2001; 2000), and a number of authors have endorsed this strategy (Moratti 2009; Fine 2009; Fine and Mayo 2003; Stewart 2011; Truog 2009a, b).[3] The Ethical and Judicial Affairs Committee of the American Medical Association has also approved of this methodology.[4] Even so, there are components of the Texas-like procedural approach that have drawn criticism, especially the use of hospital Ethics Committees as a critical element in the process.[5]

Even acknowledging the difficulties involved in providing an encompassing, unitary definition of clinical futility, it is certainly reasonable to accept that doctors (and others) believe that many medical interventions may be viewed as situationally inappropriate and hence incapable of achieving the stated goals of physicians and patients. However, I believe that the organizational, professional and moral reliance on institutionalized procedures to assess medical appropriateness is in error. While it is true that these approaches can establish consistent rules to be followed in addressing difficult clinical situations and seem to have eliminated many of the structural problems associated with more paternalistic and idiosyncratic methods, there remain fundamental ethical issues that may be immune to any kind of practical solutions. They reveal both substantive and procedural matters at stake. They are based upon a mistaken conclusion that if the process itself is fair and provided with

[2] For a discussion of procedural justice, in both its impure and pure forms with its challenges, see Daniels and Sabin (2008, pp. 79–81) and Rawls (1999, pp. 74–78). The point that Rawls makes in his descriptions of perfect and imperfect pure procedural justice are extremely relevant to my criticism in this essay. It is assumed that a carefully considered and crafted procedure, such as TADA, will—if followed studiously—result in a just outcome, irrespective of the specificity of local circumstances of each case. The error in this assumption is that illustrated by Rawls in his example of a trial, in which the result that is hoped for (the truth) is not guaranteed even if all the rules are obeyed in punctilious fashion. One could qualify this wish by stating that so long as we get the truth (the right answer) almost all the time, then that is good enough (of course, this begs the question as where the cutoff should be between an acceptable and unacceptable level of mistakes).

[3] These references give an excellent overview of both the development and some of the challenges in the Texas law [especially Dr. Fine's (2001) paper on the history of the statute]. See also Heitman and Gremillion (2001) and Fine and Mayo (2003).

[4] This is concisely expressed in "Opinion 2.037—Medical Futility in End-of-Life Care", available at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2037.page. Importantly, the last part opines that when all other efforts at dispute resolution have failed (including attempting to transfer the care for the patient to another physician or facility), "the intervention need not be offered".

[5] The main distinction is that the institution may go to court to attempt to have surrogate decision-makers removed on the grounds of making medically inappropriate decisions on behalf of the patient (Truog 2009a, b; Truog and Mitchell 2006; Brett 2005). For a discussion of some of the unresolved legal issues, see (Bissel 2010; O'Callaghan 2008).

sufficient safeguards to protect the interests of both patients and healthcare providers, then the outcomes must *ipso facto* be fair. While it is possible that this may be true, it is in turn dependent upon a premise that the facts about a specific clinical case are themselves true and that the procedure is initiated upon reliable clinical evaluations in an unbiased manner. It is this aspect of hospital futility policies that I wish to discuss in this paper. My concern lies not with a concept of futility per se; rather, it is with how the formal procedural methodology is applied in the healthcare setting.

Inherent Flaws in Futility Policies

To be scrupulously fair, a process must treat patients similarly who are similarly situated, ignoring morally immaterial facts about them such as ethnicity, sexual orientation and the like, unless a good case could be made for how these facts could be medically relevant. Examples of other commonly occurring irrelevant features about a person include skin color, country of origin, and gender. With a procedure that is so often invoked in clinical situations in which patients are *in extremis* or near the end of life, and in which treatment decisions can have consequences that are irrevocable (such as death), one must be vigilant that it is both intrinsically just and is applied impartially. Truog has voiced some concerns about this, but he (and others) have failed to see the most grave deficiencies (Burns and Truog 2007; Truog 2009a, b). I am not worried about the process so much as I am about what I think are irremediable elements that are integral to even the most meticulously crafted and conscientious procedures. In some ways, my disquiet is consequentialist in nature, in that there may not be anything fundamentally objectionable to the concept of withholding futile or non-beneficial medical interventions from patients, even over objections they (or their families) may have after careful education and consideration. Rather, the worry is about how implementing such institutional processes can play out in "real life" and the effects they could have on a variety of patients, especially historically and currently vulnerable populations.

I see at least three flaws in a procedural process for defining and acting on determinations of futile medical interventions, the first two of which have not previously been mentioned in the many years of discussions of this topic. The third has been examined in the past, but I will analyze it in a more substantial way. These flaws are independent of any specific criticisms that can be leveled at any particular process. They apply to both statutorily supported policies (like TADA and those in states—such as Maryland—which have enacted versions of the Healthcare Decisions Act, even those that are purposefully patient-centered or oriented) and those that are institution-specific (Galambos 1998). Maryland H.G. § 5-611 pertains to non-emergency situations and states "a patient's attending physician may withhold or withdraw as medically ineffective a treatment that under generally accepted medical practices is life-sustaining in nature only if the patient's attending physician and a second physician certify in writing that the treatment is medically ineffective and the attending physician informs the patient or the patient's agent or

surrogate of the physician's decision." However, the statutory language also points out "nothing in this subtitle may be construed to condone, authorize, or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying." While this law does not offer the sweeping legal protections from civil and criminal liability afforded physicians and healthcare institutions as does TADA, it does endorse the general consensus that physicians should not be compelled to provide care which they—in their best clinical judgment—is non-beneficial or "futile". Whether physicians and hospitals actually take advantage of this law in practice is an open question, although at least one institution does refer to this statute in its policy on "Futile or Medically Ineffective Treatment".[6]

My claims do not rest on having a uniform, all-encompassing definition of futile medical care. It is enough to agree that there is such a thing as inappropriate or ineffective treatment and that doctors individually or somewhat collectively feel capable of making such a "diagnosis" when it presents itself. Indeed, beyond some minimal level of clinical characteristics that can be held to be commonly associated with critically ill patients in the intensive care unit (for example), the interpretation of futile care upon which one relies may differ radically. It does not matter so much that there is such as thing as futile care (and I believe that there is); rather, the salient point is that there is much disagreement at the bedside as to when it is appropriate to invoke such a declaration. The fact that consensus does not exist (unlike that for whole brain death, for example) only serves to strengthen my argument that the initiation of a futile care assessment can be dependent on a variety of things (see below) which can lead to an arbitrary application with potentially injurious consequences for all concerned.

Finally, any discussion of futility and policy approaches to cope with the problem must locate the areas of greatest concern. Few would quarrel about disagreements about care that do not involve the potential of death as a result of who "wins" the argument. Practical experience with TADA would suggest that this is indeed the case.[7] So the clinical focus of my critique is (generally) the ICU bedside in which demands or requests by family members for therapeutic interventions such as hemodialysis, initiation or continuation of mechanical ventilation, or cardiopulmonary resuscitation are viewed by the medical team as unwarranted, ill-advised and/or without benefit (i.e., "futile"). The inability to reach agreement on the value—or lack thereof—of these and other potentially (biologically) life-preserving treatments is the endpoint at which declarations of an irresolvable impasse are made and futility policies invoked. Attempts to reach clinical and psychological unanimity are abandoned and a process is initiated which is purportedly fair to all parties concerned. It is the fairness of the process that I wish to examine.

[6] The Johns Hopkins Hospital, Baltimore, MD.

[7] See Smith et al. (2007). In this review of 5 years' worth of experience with TADA, the overwhelming majority of cases appeared to involve end-of-life decision-making. Also see (Fine and Mayo 2003) for other details of this process.

Arbitrary Initiation of Futility Determinations

While it is common that physicians often concur on what the expected results will be of a particular patient's disease, doctors can (and do) disagree with each other and nurses disagree with each other and doctors about many clinical issues. This is particularly true with patients who are critically ill or near the end of life. Such is the nature of the intrinsic uncertainty of medical prognosis and clinical outcomes. Unanimity of opinion is not required to proceed with difficult cases. Nonetheless, in situations in which fundamental differences arise, either between members of the healthcare team or with families, decisions must be made: one person's views must prevail at some point, and therein lies a problem. In all policies publicized to date, the initial determination about whether an existing or proposed intervention is non-beneficial is left up to the discretion of the Attending physician, and the proposed process is only initiated after she decides to do so. Thus, the procedure is activated when a patient's doctor thinks that an existing or proposed possible treatment is futile. Conversely, any patient whose doctor, for whatever reason, does not believe that the intervention is inappropriate, can proceed with that treatment without review, and irrespective of whether the patient's clinical information would or would not support an opinion of futility if subjected to external and independent examination. Hence, two patients similarly medically situated could have radically different interpretations of the appropriateness of their care solely depending upon the views of their doctor(s). Futility determinations are, therefore, susceptible to arbitrary application (although not necessarily with malicious intent). It should be pointed out that these policies (as in Texas, for example) do allow for doctors to resist family demands to both withdraw life support (when the family has made a determination of futility and the doctor disagrees) as well as sustain it. However, the controversy (and the vast majority of cases) does not surround keeping patients alive, but moving to terminate (or not initiate) measures that would continue to maintain life. This does not mean to say that physicians in these clinical situations act solely at their own discretion as others on the health care team (nurses, housestaff when present, allied health personnel, social workers, even administrators) all can weigh in on the appropriateness of the goals of care and the trajectory of treatment, including specific requested or proposed interventions. However, the attending doctor has disproportionate power to activate the process and guide the direction of declarations of futility. Indeed, it is the very fact that judgments of (non-physiological) futility can be contingent upon the intuitive and subjective (and potentially arbitrary) evaluations that reveals a problem with the procedural approach.

Prior discussions with the patient and family can certainly help anticipate potential conflicts before they arise and have been shown to decrease their frequency and potency (Alpers and Lo 1999; Jacobs 2009; Morrison and Meier 2004; Silveira et al. 2010). While it is true that advance directives may guide physicians in their recommendations, these documents are also open to interpretation by patients, families and doctors (Larochelle et al. 2009). They thus may serve to endorse or prevent inappropriate treatment, depending upon their content and its construal by those involved in the case. The important point is that

physicians act as evaluators, guides and situational translators of directives and the clinical scenario: different doctors may view the same set of circumstances differently, leading to an inherent variability in the assessment of futility. While the effects of this may be muted after the initial assessment (by requiring agreement in the judgment by one or more other attending physicians), that is not true for the primary diagnosis.

It is conceivable that this obstacle could be overcome, perhaps by some form of periodic review of all patients in the hospital who meet certain specified medical criteria (e.g., permanent unconsciousness or multisystem organ failure), but that seems potentially overly intrusive and demanding and unlikely to be granular enough to be inclusive. And even here there are often gradations of dysfunction, especially in such states as progressive dementia (for example) that may lead to interpretative confusion and overly subjective assumptions and prognoses. Of course, this panel could simply be charged with ensuring that the doctors who are taking care of the patients who meet these criteria are notified that they may wish to consider them eligible for considerations of futility. Even so, the practicality of such an approach seems dubious at best.

The reliability of this (or the traditional) approach is dependent upon physicians' prognostic skills and their ability to intuit that a proposed or existing treatment will be (or is) ineffective. Irrespective of other factors that may influence an arbitrary assignment of futility, the well-known inaccuracy of physicians' prognostic predictions is a major confounding factor. For instance, there are a number of elements that contribute to prognostic uncertainty and the unpredictability of clinical forecasting that include both patient factors and those unique to doctors (Poses et al. 1989, 1991; Vig et al. 2007; Zier et al. 2008; Wilkinson 2009; White et al. 2010). Are doctors' capability in this area so reliable and consistent, both between physicians evaluating the same patient and in the same doctor analyzing similar situations, that we can have confidence in the process? Unfortunately, the data are mixed at best, and mostly discouraging (White et al. 2010; Zier et al. 2008; Truog 2008; Allen et al. 2008; Hakim et al. 1996; Poses et al. 1991, 1989). While it is true that some categories of prognoses for clinical circumstances are better than others, there is still a significant amount of observer judgment, and thus bias, that is involved (Tversky and Kahneman 1974; Wilkinson 2009; Fox 1957; Montgomery 2006). The role of variability and uncertainty in prognosis and, therefore, the directly derivative appraisals of putative futile treatment, injects a further concern about the potential for inconsistent and irregular application of such policies.

Of course, the judgment that a particular treatment is futile is contingent upon how one defines the word in clinical application, in itself a source of potential variability in implementation. One of the most oft-cited references giving a definition of futility is that of Schneiderman and his colleagues (Schneiderman et al. 1990, 1996). While seemingly offering the clarity of a conclusive numerical definition of futile care, there is more than a hint of arbitrariness inherent in their initial proposal to rely on both published data and the physician's personal experience of the previous 100 cases to determine a notion of futility in the 101st case to present itself. It seems reasonable to assume that each doctor will have had different experiences with the last 100 patients who were in reasonably similar

medical and social circumstances compared with the index patient who is the focus of a possible determination of futile care. Moreover, some young attending physicians may not have the depth of experience called for in this formulation, in which case their evaluations may be even more suspect. In this vein, Gabbay has recently called into question the reliability of this method for concluding that a treatment may be futile (Gabbay et al. 2010). While one could admire the current system because of the respect it shows for individual physician judgment, and the fact that invocation of futility needs to be confirmed by a second attending physician, it is the very nature of that judgment and its potential for unequal application that leaves it open to potential abuse. Alternatively, the attending physician could incorporate the views of Lantos (and others) who stress the importance of embracing the goals of care of the family (and patient, if known) to judge whether an existing or proposed approach is futile (and without benefit) (Lantos et al. 1989; Helft et al. 2000; Lantos 2006). While this approach may appear to be more inclusive, fair and less one-sided, it could augur an inability to reach any decision other than to accede to the demands of the family if some form of compromise cannot be reached, thus not really solving the problem.

One could counter this claim by stating that many decisions made by doctors suffer from arbitrariness. Indeed, it could even be asserted that this is a beneficial aspect of medical practice, if it is also bound to the idea of individualized patient care. However, in this context I am designating the term in a less congenial conception, implying lack of uniformity and intimating a degree of capriciousness in its application. But since medicine is rife with these kinds of decisions, what can distinguish those made under the guise of futility, and any others? The main difference is that the former almost always involves end-of-life decisions and are thus irreversible and irrevocable. While it is true that taking out a child's tonsils is also irreversible, the consequences for the patient are not as severe. And that might be true of most other types of decisions that are left to individual physician interpretation. Indeed, the attempts to have uniform, fixed and redundant methods for determining (whole) brain death, speaks to the seriousness with which we approach these kinds of decisions. At the same time, many of the controversies about organ donation after cardiac death reside in the potential flexibility of deciding when someone has met the criteria for death (this has been especially problematic for young children). This is not to say that many doctors are guilty of inconsistent or arbitrary clinical assessments of the utility of therapeutic interventions in any given case. It is enough to say that there is both a necessary degree of uncertainty and unreliability in doctors' predictions of outcomes and their views of the value of individual treatments for specific gravely ill patients in the particular circumstances of an individual patient and family. This introduces sufficient indeterminacy that raises concern when the result of an assessment of futile treatment may be irrevocable.

It has been suggested that one of the virtues of the procedural method is its use of multiple layers of analysis, most importantly requiring the evaluation and assent of an ethics or medical review committee which is distanced from the case and the personalities involved (such as physicians, nurses and family members) (Fine 2009; Smith 2008; Heitman and Gremillion 2001). But while seemingly unassailable upon

superficial analysis, closer scrutiny reveals similar flaws in this component of the process as well, notably that institutional reviews of cases usually engage committees whose members have either poor training in this area (such as Ethics Committees) or have inherent conflicts of interest due to their being composed of hospital employees. This problem may be partially mitigated by the presence of outside independent members, such as community representatives and the like. But the fact of the matter is that the majority of people whose duty would be to pass judgment on the appropriateness of a particular medical intervention are, to a greater or lesser extent, colleagues of the individuals who made the initial determination of futility and, therefore, subject to at least the appearance of a conflict of interest. Moreover, the majority of hospitals confronting questions of medical futility may not have such formally constituted (and trained) committees, leading to further challenges for independence and dispassionate evaluation.

Another situation introducing potential variability in application of these policies is the fact that hospitals take care of patients from numerous different backgrounds, and some people are simply treated as "more important" (or less important) than others. For instance, it would not be difficult to imagine a prominent or wealthy patient with terminal, metastatic cancer, who does not have an advance directive, and whose family is demanding the continuation of mechanical ventilation or dialysis. Would this patient's doctor(s) push that hard to stop these interventions? Even if he did so as a matter of conscience, one can readily envision how the hospital administrators would view this form of refusal to satisfy the wishes of a VIP. Or consider the family of a patient demanding a specific treatment, who threatens to go to the news media if it is not provided? What reasonable chief medical officer, risk manager or attending physician would wish to suffer the adverse publicity that could possibly result? Either situation could produce an uneven and inequitable application of the policy to patients in similar medical situations, divided solely by non-clinically relevant characteristics. Even though one of the advantages of the procedural approach can be its backing by the institution or by statute, I expect that there may be certain patients who may have greater pull than others (Truog 2000; Truog and Mitchell 2006). In addition, I suspect that an independent review committee, be it an Ethics Committee or some impartial medical evaluation group, could have great difficulty maintaining their autonomy if they were considering removing life support from a prominent patient whose family opposed such a move. They would be just as susceptible to subtle (or not-so-subtle) pressures as anyone else in the institution. This is not simple speculation as "special" treatment of VIPs has been well documented (Diekema 1996; Guzman et al. 2011; Smally et al. 2011).[8] One could counter this argument by stating that VIPs forced to remain on life support and receiving futile treatment continue to suffer, thus undergoing what many would interpret as less-than-special care. But the fact that VIPs might get different treatment from others limits the fairness of the system, from which both they and others might arguably suffer the consequences.

[8] Ironically, by virtue of their "special" treatment, VIPS may be subjected to substandard care in the misguided idea to provide them with the "very best" bedside management (i.e., the Chief of Medicine instead of the senior resident providing everyday care).

Moreover, it should be noted that assessments of futility (by attending physicians) do not occur in a vacuum. Certainly, there are the views of the family that must be taken into account. But there are many other members of the "health care team", including nurses, junior doctors, social workers, etc., all of whom may have opinions that may differ from those of the doctor(s) in charge, and can serve as a counter to her assertions. However, one cannot count on these positions being persuasive (in either direction) or even being present, thus leading again to the potential capriciousness of the system and differential outcomes for similarly situated patients.

Finally, many hospitals may have their own, somewhat unique, versions of these procedural approaches. Furthermore, different physicians will have different feelings about what is appropriate therapy and what is non-beneficial or futile, and this could be locally "cultural" in the sense that institutions may have distinctive ways of thinking about these things. There is certainly evidence that physicians with different backgrounds, and especially certain religious beliefs, hold views that might intrude upon a purely dispassionate, procedural approach to futile care (Curlin 2007a, 2007b; Cohen et al. 2008).

Ethnic Disparities

Given the well-known differences in desire for, and utilization of, aggressive care at the end of life by African-Americans (and possibly Hispanics), even in situations that many doctors would label as futile, it is likely that a disproportionate share of patients who would be affected by these policies would be members of these minority groups, even if it is applied fairly and equitably (Wojtasiewicz 2006; Blackhall et al. 1999; Boulware et al. 2003; Degenholtz et al. 2003; Kagawa-Singer and Blackhall 2001; Moseley et al. 2004; Waters 2001; Hanchate et al. 2009; Johnson et al. 2010). While a recent paper has suggested that these differences are more associated with socioeconomic class than ethnicity per se (Volandes et al. 2008), the end result may be the same (and a more rigorously controlled study disputes this finding) (Muni et al. 2011). Irrespective of the reasons causing this imbalance, there could be an over-representation of the poor in the futility group, independent of whether this designation was valid or not. Indeed, in some of the initial reports of the experience with TADA, the majority of patients were members of racial minorities (Okhuysen-Cawley et al. 2007). While on its face, these observations do not lead to a diagnosis of prejudice and discriminatory application, it is impossible to know with certainty if such is the case with some individual patients. However, it is possible that this does have the potential for such dire public consequences that it could rob these policies of any potential good they might have: even the appearance of gross inequities could have devastating results on public confidence and trust in doctors and hospitals.

While the data support the conclusion that African-Americans utilize more intensive care at the end of life than others, these patients have to gain access to that care in the first place, and studies have repeatedly demonstrated the inequities in access to treatment, especially expensive, high-tech treatment (Cruz-Flores et al. 2011; Gregory et al. 2006). Furthermore, since racial and ethnic minorities are more

represented in lower socioeconomic groups and less frequently members of those classes who might be called privileged in the eyes of attending physicians and hospital administrators, the chances of their requests not even being considered for exclusion, as mentioned in the discussion above of the first flaw, would be low.

It has been suggested that the differential demands for extensive (and potentially non-beneficial) end of life treatments by ethnic minorities, stem from a history of poor treatment by the medical system, thus generating pervasive mistrust, and the fear that suggestions to electively terminate life support in the very ill may represent a form of racial prejudice in which there is a lack of desire to expend expensive resources on this ethnic group. The effect of this legacy of distrust permeates all aspects of the modern medical system in the US (Rajakumar et al. 2009; Johnson et al. 2008; Gust et al. 2008). If a careful analysis of those patients for whom futility has been invoked and institutional policies activated demonstrates that a disproportionate percentage of them are African-American (to date, data on a large cohort—such as for Texas—has not been published), such a finding could only enhance a sense of suspicion and lack of faith in the healthcare system and doctors and nurses.[9] Further, since futility policies, especially those modeled after the Texas law, can force unyielding patients and families to forgo or withdraw treatments found to be futile, this can only strengthen beliefs in the inherent unfairness and bias of the system. Hence, the paradoxical effects may be to increase the number of patients demanding that "everything" be done or increase inequities by leading to patients abandoning the quest for certain types of care which they think may be denied them.

These policies seemingly appeal to mediation and reflective discussion, but are actually designed to be coercive if all else fails. The threat of being transferred to another doctor or even another hospital can be intimidating or compelling by itself, but the fact that the policies make it publicly known that the hospital can unilaterally take the action it deems best, can certainly be interpreted as coercive (this is true of TADA and is permitted by some hospital policies in states which do not have the kind of statutory authority as Texas).[10] When employed with populations who may not be accustomed to fighting back, or whose resources for doing so are limited, the final outcomes are predictable, and certain to reinforce pre-existing fears and suspicions.

I am not claiming that these policies are applied inequitably, only that they sum up that way, because of the disproportionate use of intensive care at the end of life. Even if we could guarantee that every futility determination was fair and equitable (between patients) and applied correctly, we would be left with their *apparent*

[9] There has not been a detailed analysis of either the ethnicities of patients for whom TADA has been invoked or the possible effects of this law and its implementation on healthcare system trust in minority communities in Texas, mainly because the data does not exist. Interestingly, Dr. Fine, one of the original architects of TADA, has stated that there was concern about collecting demographic data mainly for these reasons, even though such results would not in and of itself be proof of discriminatory application of the law (R. Fine, personal communication).

[10] For instance, this is the case at individual hospitals in North Carolina, Massachusetts and Maryland. I am grateful to Prof. Lance Stell and Drs. R. Truog and M. DeCamp for providing me with their hospital's policies in this area.

inequitable application, simply because of the differences in demands (along ethnic lines) for certain types of life-sustaining care. Even the appearance of these inequities could be enough to damn the entire system in the eyes of the vulnerable public and thus lead to at least a form of illegitimacy. Appearances do count—perhaps unfortunately—but they do.

Bedside or Local Rationing

Another potential problem with futility policies is that there could very well be a temptation to justify bedside decisions of the uselessness or inappropriateness of a treatment by appealing to its excessive cost, the scarcity of ICU beds, the lack of patient insurance, etc. Is there any way to make an institutional futility policy not have all of the problems associated with "bedside" rationing? A number of years ago, Jecker and Schneiderman recognized the problem of conflating the two (Jecker and Schneiderman 1992). They noted that "futility has no explicit distributive meaning but refers instead to a specific cause-and-effect relationship. Rationing, by contrast, always indicates a distributive choice, rather than a cause-and-effect logic. Thus, although rationing based on quality or probability of medical outcome partially overlaps with futility, a difference remains. Whereas rationing indicates a priority between scarce resources, futility implies that a particular medical intervention produces a low likelihood or quality of effect". Can, or will, doctors and hospitals appeal to runaway healthcare costs or the scarcity of certain resources as a rationale to justify determinations of futility for some patients? Or, perhaps more worrisome is that because of the explosion of uninsured patients, there may be increasing pressure to terminate care that seems to serve no purpose in these and other patients who have minimal-to-no resources. If so, is this reasonable? As hospitals continue to look for ways to cut costs to improve their bottom line, increasing pressure may be brought to bear on physicians to question whether they can justify certain types of interventions that may have only marginal-to-no real benefit for patients, in much the same way that the urgency to discharge patients as quickly as possible and to use generic medications is repeatedly stressed. In and of itself, there is nothing inherently wrong in using less expensive means to achieve the same objective; indeed, there is much to be said in favor of this approach. But when such thinking encroaches on judging the value of individual treatment options for specific patients, the opportunity for physician decision-making to be unduly influenced by financial considerations becomes quite real, especially when the compensation of doctors is affected by the bottom line (Shafrin 2010; Melichar 2009).

Varying opinions—both pro and con—have been offered on this subject (Zimrin and Hess 2007; Hurst et al. 2008; Ubel and Goold 1997; Baily 2011). Ubel has defined rationing as the limitation of possibly beneficial healthcare services (Ubel 2001, chap. 3). Presumably, any intervention other than the truly physiologically futile could qualify as potentially being to a patient's benefit. Bedside rationing takes other factors into account to restrict access to, or remove, certain beneficial treatments, and these could include cost. However, the experience with allocation of

a truly scarce resource, livers for transplantation, demonstrates the potential pitfalls in leaving wide discretion for eligibility for treatment to healthcare providers; a similar fix for futility policies may be lacking (Moylan et al. 2008).

While rationing and futile care have little in common except the denial of a specific intervention which *could* be provided (could in the sense that it exists and there are not technical or feasibility limitations that proscribe its use), the concept of the latter may be used to justify the former if appeals to other, more truthful explanations are less palatable. For example, it may be easier for a physician to deny a patient certain treatments or interventions that also happen to be relatively expensive, by appealing to the nation's rapidly expanding healthcare budget (and the contribution of potentially inappropriate or marginally effective therapies to it), rather than a patient-specific rationale of medical and therapeutic inappropriateness. The danger of this approach should be obvious. It suffers from the moral risk of any type of allocation scheme that confuses two distinctly separate concepts, as well as the distinct hazard of having decisions made by individuals about other individuals without prior review. Of course, if a certain resource is scarce, either by choice or chance, and the powers that be decide—appropriately—to maximize the amount of benefit per patient (or perhaps for society) as a basis for making allocation decisions, a judgment of futility necessarily eliminates a patient and treatment from further consideration.

For instance, the widespread use of drugs, devices, surgeries, etc. for which little-to-no evidence of efficacy exists other than anecdotal or poorly performed studies of case series and the like, is well-known (Rosoff and Coleman 2011). This type of futile or non-beneficial "treatment" is ubiquitous in the practice of medicine in the United States. Interestingly, in these situations, doctors readily accede to patients' wishes and often initiate such inappropriate treatments themselves, with only professional societies and academic medical educators complaining about the necessity for evidence-based medical practice.[11] Admittedly, there is certainly an emotional and quantitative difference between futile therapeutics in ambulatory care and when unsupported, ineffective or non-beneficial interventions are used in the ICU for patients with life-threatening conditions, but they are qualitatively the same. Thus, it is difficult to base the individual and singular denial of a requested intervention (that may indeed be futile) on the basis of its cost, unless this is done pervasively and systematically to all who are medically similar, and the results of such denials also serve to ground them. I realize that the procedural safeguards will potentially prevent individual physicians from exercising their own judgment about what is or is not beneficial care, but different hospitals quite near each other may have very different ways of doing things. It thus strikes me that this could simply be bedside rationing writ large (on an institutional scale).

Conclusion

Is there any way to overcome the obstacles to the procedural approach I have described? At a minimum, such policies should be as accurate, consistent,

[11] See Callahan (2009). He calls this phenomenon "patient self-definition".

reproducible and immune from individual bias and capricious decision-making as possible. But, while they make a valiant effort to be such, and have many virtuous aims, they fail in at least three substantive ways as I have suggested. No reasonable person would suggest that futile treatments are a worthwhile goal in themselves. What one—or perhaps many—doctor(s) thinks is futile on its face, may serve to satisfy an objective which a patient or his family believes to be valuable, thus negating any unified or uniform claim of futility. In the absence of either individual or societal consensus about reasonable expectations of what medicine can provide and the goals of care in critically ill patients, it is unlikely that these disagreements will be resolved any time soon. Many families will continue to insist on receiving treatments that physicians and nurses judge to be of little value or worthless. Patients and families will justify their demands using any number of different reasons, including appeals to religion and redress for prior exclusion from the healthcare system because of ethnic bias. Hospital futility policies are an attempt to address this conundrum. But unless they are freely persuaded to accept the pronouncement of "futile care", we will only delegitimize a category of patient desires for certain types of care in certain clinical situations by unilaterally declaring them as unacceptable.

I should emphasize that I do not take issue with a concept of futility as variously defined. Pellegrino reminds us that the concept of futile care in medicine is neither new nor novel (Pellegrino 2005). He writes that it is an important part of practice: when to know what one is doing or is proposing may not achieve the ends of the dyad of patient and physician. But he—not uniquely—brings up some important points that have been overlooked by most, if not all, writers in this area. He, along with everyone else, seems to locate futile care exclusively in the arena of conditions at the end of life: in the ICU, the cancer ward, etc. But a far greater application of futile or non-beneficial interventions exists in everyday medical practice. For instance, Prendergast raised such a point in his description of physicians acceding to, or rejecting, patient requests for antibiotics to treat a viral upper respiratory tract infection; but his goal was to illustrate his argument about futile care (Prendergast 1995). While the stakes of situations in which these interventions are employed may not be as dramatic and suffused with emotion as most end of life scenarios, they nonetheless are the most common form of futile care and we should not lose sight of the implications of this state of affairs. Prendergast believes that what makes futility calculations so burdensome and laden with passion, and thus different from the lack of benefit calculus of antibiotic use in the common cold, is the disproportion that exists between care for the very sick and care for those who will most likely get well irrespective of what is done for (or to) them.

While Pellegrino carefully endorses a procedural approach for implementing a standardized method for dealing with these complex situations, as *one* possibility, I think that this is where the problem lies. I believe that the entire discussion of futile medical treatments or care boils down to a single issue: can the profession of medicine unilaterally declare some wishes and desires of patients or families to be illegitimate and thus not to be respected and obeyed? If this is true, then the futility argument wins and there should be little disagreement about withholding or withdrawing certain treatments in certain situations without the consent or assent of

the patient or surrogate as long as these decisions are applied fairly and consistently, and the situations in which they are germane, are themselves justifiable with good reasons. There is precedent for this. In 1968, when the Harvard *Ad Hoc* Committee published its report on "brain death", it was a novel idea that a new category of death (or actually, death equivalence) was created. This proposal was generated in response to a new generation of medical technology that kept patients biologically alive who would most certainly have died previously (Anonymous 1968). Over the next 12 years or so, a consensus emerged that this idea both was reasonable and justifiable, eventually leading to the adoption of state laws that recognized this clinical state as another form of death (Bernat 2009; Wijdicks 2001; Bioethics 2008). While there appears to be a societal agreement with this idea, there are dissenters, but they are a distinctly minority view (Truog 2007). No one would argue that brain dead people are not biologically alive, in any real or even philosophical sense. The moral justification for whole brain death lies in making it a state that is as good as dead. For futility arguments to hold, especially the controversial ones in end of life situations, a similar justification must be made: new treatments or existing treatments are not appropriate because the patient is as good as dead.

Of course, this delegitimizes the views of patients or families who would hold otherwise. This position also entails that perspectives that discount patient suffering or depend on miraculous cures (which is different from hoping for such an event to occur), or see value and meaning in bare biological existence (even if the patient does not meet whole brain death criteria) will not be honored. It should also be noted that consistency demands that this delegitimization should not distinguish between the desires of individuals expressed for themselves either directly or via an advance directive, or those of surrogates making decisions for others. In addition, this view necessitates holding that there are some clinical situations that are in the best interests of no one, and hence cannot be supported. That being said, such an approach would require a societal consensus about what kinds of medical care demands we can legitimately respect and under what circumstances, and those that are so out of bounds that we can declare them futile. We have done this with whole brain death; perhaps the time may be coming when we can do the same with other devastating, irreversible kinds of damage.

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NAME: Policy and Procedure for Resolution of Disputes Over Withholding or Withdrawing Non-Beneficial Treatment

EFFECTIVE DATE: 11/1/2014

INTRODUCTION:
Due to recent advances in technology and medical care, there is increased ability to prolong the life of the terminally ill patient. Despite the ability to sustain biologic function of the terminally ill, the decision to do so may be contrary to generally accepted health care standards of the physician, the institution and the community.

Traditionally, the medical community has relied on patients either having written Advance Directives that can guide care after patients lose decision-making capacity, or family members who can faithfully interpret and execute the patient's wishes about end-of-life care. Consistent with this, North Carolina law recognizes as a matter of public policy that an individual's rights include the right to a peaceful and natural death and that a patient or the patient's representative has the fundamental right to control the decisions relating to the rendering of the patient's own medical care, including the decision to have life-prolonging measures withheld or withdrawn in instances of a terminal condition. North Carolina statutes outline certain accepted procedures to exercise these rights, but such procedures are "nonexclusive." (N.C.G.S. § 90-320). N.C.G.S. § 90-320 further provides "Nothing in this Article shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-prolonging measures in any lawful manner."

Ideally, decisions made for terminally ill patients should be based upon definite and attainable goals, including cure or palliation, stated prior to embarking upon a course of treatment, and should result from a careful discussion between the patient (if able), surrogate, family, and the medical team. Nevertheless, there are situations that are not adequately addressed or resolved by an Advance Directive or by the wishes of the surrogate/family. These situations most often arise when in the view of the medical providers, the medical care or interventions that are being administered or proposed are believed to be medically "futile," "ineffective," "non-beneficial," or "inappropriate" because (1) the treatment being given or requested cannot achieve or no longer achieves the goals of care, (2) the treatment fails to hold a reasonable likelihood of bringing about the patient's recovery and serves only to postpone the moment of death by sustaining, supplanting or restoring a vital function, or (3) the goals themselves are unrealistic. While the application of the concepts of medically "futile," "ineffective," "non-beneficial," or "inappropriate" treatments (used interchangeably throughout this Policy and Procedure) must be determined and applied on a case-by-case basis, in general, these terms denote interventions that cannot cure the terminal illness and cannot change the ultimate course of the terminal illness or terminal condition. The following **PROCEDURE** represents Duke University Hospital's approach to addressing disagreements regarding the application of and response to these concepts in clinical practice.

PROCEDURE:

1. The Procedure is applicable both to treatments that have yet to be initiated and those that are ongoing.

2. This Procedure is applicable to all patients at Duke University Hospital, including children, inpatients and outpatients.

3. Prior to initiating steps 4-8, and after first informing the patient/authorized surrogate[1] of his/her position on the treatment at issue, the Attending Physician should obtain a Palliative Care consult (or Ethics consult if appropriate) as this may result in resolution with regard to goals of care without resorting to further measures. If such a consult does not resolve the issues, then the Attending Physician may proceed to the next step.

4. If after diligent attempts have been made to resolve the disagreement via the involvement of consultation by Palliative Care and/or Clinical Ethics, the Attending Physician believes that an existing or desired treatment is ineffective/non-beneficial/futile and the patient/surrogate(s) believes that the proposed or existing treatment will be/is appropriate, the Attending Physician should seek a consultation with another Physician who is not directly involved with the care of the patient (either presently or in the past).

    a) If the consulting physician disagrees with the Attending Physician:
        1) Both physicians should enter their opinions in the patient's chart including their respective reasons for concluding that the existing or proposed treatment is or is not appropriate.
        2) Then, the treatment in question shall be given or continued.
        3) Under such circumstances, the transfer of attending physicians may be appropriate.

    b) If the consulting physician agrees with the Attending Physician:
        1) Both physicians should enter their opinions in the patient's chart including their respective reasons for concluding that the existing or proposed treatment is not or would not be appropriate.
        2) The Attending Physician should promptly provide the patient/surrogate with notice of the opinions of the two physicians. The patient/surrogate shall then have 3 business days to reconsider his/her position regarding the treatment. The Attending Physician shall advise the patient/surrogate of the option of the possibility of transfer to another facility if he/she does not provide consent to withhold or withdraw the applicable treatment. During this 3-day period, all ongoing treatments will continue.
        3) If the patient/surrogate does not agree to withhold or withdraw the applicable treatment and a transfer is not pursued within 3 days, the matter should be referred to the *Patient Care Review Committee* ("Committee") for final resolution.

[1] The Attending Physician should document in the chart the names and relationships of any authorized surrogate decision-makers who are participants in this discussion.

5. For any case referred to the Committee, both Risk Management and University Counsel should be informed that this process has been initiated; however, they will not be participants in any part of the decision-making process.

6. The Committee process is as follows:
    a. The Committee will have 9 members. If it wishes, the Committee can appoint a subgroup of its members to review the chart and interview the relevant physicians, nurses, other health care providers and patient/family, who can then present the case to the entire Committee.
    b. The Committee's members should include:
        - 1 member from Hospital Pastoral Care who will serve as the Chair.
        - 1 social worker who is not clinically involved.
        - 2 members of the Hospital Medical Staff who are not clinically involved with the case.
        - 2 members of the Hospital Nursing Staff who are not clinically involved with the case.
        - 1 member from the Hospital Ethics Committee who was not part of any prior Ethics Consult in the case.
        - 2 members from the Hospital Patient Advisory Council or community.
    c. The Committee shall gather the relevant facts as follows:
        i. The Committee (or subgroup) should engage in an intensive review of the chart and have discussions with the Attending Physician of record, the consulting physician, any other persons involved with the care of the patient, the patient/surrogate (and any family members or others if the patient/surrogate wishes).
        ii. In the event that the patient/surrogate declines to participate, the Committee shall consult with any applicable Hospital staff who are able to provide information on the patient's perspective. The decision by the patient/surrogate not to participate shall not invalidate the Committee's decision, nor shall it prejudice their view of the case.
        iii. The Committee shall have the authority to seek input on the case from other physicians, as it deems necessary to reach a decision. If any such consulted physician is not a Duke physician and if such input cannot be obtained without disclosing Protected Health Information, as defined by HIPAA, the Chair of the Committee will work with University Counsel to obtain a HIPAA-compliant business associate agreement from the consulted physician.

7. At the end of the fact-gathering and consultation process (which should be performed thoroughly, but expeditiously), the Committee will meet in closed session (without the Attending Physician of record or patient/surrogate) to discuss the case and vote on a recommendation.
    a. The Committee will keep detailed notes of its deliberations. Its written recommendation will be part of the medical record; it will include a summary of the discussion and the reasons supporting its recommendation or conclusion. The Chair of the Committee will sign the report.

b. If the Committee does not reach unanimous agreement regarding the appropriateness of the treatment, it will be continued or initiated, as applicable. The Attending Physician may at this point attempt to transfer care of the patient to another Duke physician, or offer to transfer care of the patient to another institution, if an accepting Duke physician or outside institution agrees to the transfer.
c. If the Committee reaches a unanimous opinion that the treatment is inappropriate, the Attending Physician and the Chair of the Committee will inform the patient/surrogate in person and give him/her/them a copy of the report and answer any questions about the report.

8. If the patient/surrogate continues to request the treatment after receiving the Committee's report, he/she will again be offered the possibility of transfer to another institution, if feasible.[2] The patient/surrogate should be informed that he/she (or the applicable insurer) might have to pay for the transfer. Hospital personnel will make all reasonable efforts to assist in completing a transfer within 7 business days. The patient/surrogate should also be informed of the right to seek a court order to mandate the continuation or initiation of the desired treatment. If a court order is not sought nor transfer arranged with 7 business days, ongoing applicable therapies will be withdrawn or not offered as soon as practical and any applicable additional therapies will not be initiated.

9. The Chief Medical Officer shall be notified if the failure to provide or the withdrawal of the non-beneficial treatment is likely to lead to the death of the patient. She/he will be responsible for notifying Decedent Care and coordinating with the DUH representative to Carolina Donor Services.

10. Most of the patients who will be affected by this policy will be terminally ill and the desired intervention that is judged to be non-beneficial by the Attending Physician, (hemodialysis or mechanical ventilation for example), may itself be life preserving and need to be implemented urgently to perform that function. Even if this policy and procedure is executed as efficiently and rapidly as possible, these therapies may have to be initiated on a potentially temporary basis until a resolution is reached. If the decision were made that the therapy is indeed non-beneficial, then it would be withdrawn.

11. All decisions reached by the Committee, using the procedure above, shall be considered institutional decisions, and all Duke University Hospital physicians, nurses, and other clinical staff, as WELL as patient or community members of the Committee shall receive support from hospital Administration, Risk Management and University Counsel in implementing the decision.

REFERENCES:

1. N.C.G.S. § 90-320
2. N.C.G.S. § 90-322
3. AMA Ethics Opinion 2.037 "Medical Futility in End-of-Life Care"

[2] It may not be possible to safely transfer the patient to another hospital for extremely ill patients in the intensive care unit, where many of these situations arise.

4. CEJA Report 2 – I-96, Medical Futility in End-of-Life Care (JAMA, 1999; 281: 937-941)

DEVELOPED BY: Duke Hospital Ethics Committee

POLICY PRIMARY: Chair, Duke Hospital Ethics Committee
Chief Medical Officer, Duke Hospital

SCHEDULED REVIEW DATE: XXXXXX

Apology Law

Apology in North Carolina Medical Malpractice Proceedings

Apology statutes have gained in popularity across the country to encourage disclosure of medical error to patients and families. However, the majority of these laws are not as all-encompassing as one might think. For an excellent comparative analysis of all such statutes, see: William M. McDonnell and Elisabeth Guenther, "Narrative Review: Do State Laws Make it Easier to Say 'I'm Sorry?'" *Annals of Internal Medicine* 149, no. 11 (December 2, 2008): 811-816. Only eight states offer broad protection for admissions of error. North Carolina is not one of the eight.

Our statute reads as follows:

> **NC Gen Stat §8C-1, Article 4, Rule 413. Medical actions; statements to ameliorate or mitigate adverse outcome.**
>
> Statements by a health care provider apologizing for an adverse outcome in medical treatment, offers to undertake corrective or remedial treatment or actions, and gratuitous acts to assist affected persons shall not be admissible to prove negligence or culpable conduct by the health care provider in an action brought under Article 1B of Chapter 90 of the General Statutes. (2004-149, s. 3.1.)

Careful interpretation of this language reveals that the provider is protected only for apologies regarding the outcome – not for commission of an error. Thus the following statement by a provider would be inadmissible in a claim against that provider: "I'm sorry your surgery did not go as well as you had hoped; I recommend that we perform a corrective procedure for which you will not be charged." However, if the clinician were to openly admit having made a mistake, his statement would be admissible.

Contrast the North Carolina language with the more broadly worded statutes of our neighbors to the south:

> **SC Code Ann. §19-1-190**
>
> (D) In any claim or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, any and all statements, affirmations, gestures, activities, or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of benevolence which are made by a health care provider, an employee or agent of a health care provider, or by a health care institution to the patient, a relative of the patient, or a representative of the patient and which are made during a designated meeting to discuss the unanticipated outcome shall be inadmissible as evidence and shall not constitute an admission of liability or an admission against interest.

> **GA Code Ann. §24-3-37.1**

> (c) In any claim or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, any and all statements, affirmations, gestures, activities, or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of benevolence which are made by a health care provider or an employee or agent of a health care provider to the patient, a relative of the patient, or a representative of the patient and which relate to the unanticipated outcome shall be inadmissible as evidence and shall not constitute an admission of liability or an admission against interest.

South Carolina and Georgia are two of the eight states offering broad protection for statements admitting error. By comparison the North Carolina statute seems inadequate.

This is an excellent example of divergence between law and ethics. Clinicians seeking statutory protection for error disclosure may find themselves unable to fulfill what they consider to be their moral duty. Aaron Lazare, MD in his book *On Apology* (Oxford University Press 2004) describes the essential elements of a full apology – one that would be perceived as such by the recipient. These elements are:

- An acknowledgement of the offense, including details and validation that the behavior was unacceptable.
- An expression of remorse, shame, forbearance (meaning a promise to refrain from similar actions in the future), and/or humility that conveys acceptance of responsibility.
- Some form of reparation.

Lazare asserts that mere expressions of regret (as in "I'm sorry this happened to you") are inadequate, often perceived as empty by patients and families. Yet this is exactly what the NC statute permits, and little else.

The National Quality Foundation (NQF) has issued guidelines for disclosure following an adverse outcome. NQF recommends that an expression of regret be made immediately, with an apology to follow only if investigation reveals that the adverse outcome is attributable to an unambiguous error. Also noteworthy, NQF asserts that emotional support be offered to providers as well as to patients/families.

The AMA Council on Ethical and Judicial Affairs has also commented on error disclosure. CEJA Report 2-A-03 (2003) states in relevant part:

> The medical profession's stewardship of patient well-being is thus the ethical foundation of the profession's commitment to the prevention of patient harm through error reduction. Additionally, the physician's duty to deal honestly with patients extends the ethical responsibility beyond error reduction to a duty to relate the openness to patients who may have experienced harm.
>
> Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or

judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred.

In summary, while there is ample support for error disclosure and apology in ethics and from the patient safety community, the NC apology statute does not afford significant protections for clinicians who wish to be open and forthcoming.

For those who would like a comprehensive guide to error disclosure, I would also recommend: Robert D. Truog, et al., *Talking with Patients and Families about Medical Error,* Johns Hopkins Univ. Press: Baltimore, MD (2011).

Reviews | 2 December 2008

Narrative Review: Do State Laws Make It Easier to Say "I'm Sorry?"

William M. McDonnell, MD, JD; and Elisabeth Guenther, MD, MPH

[+] Article and Author Information

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Article | Figures | Tables | References | Comments (0)

Abstract

Abstract | The Case for Disclosure and Apology | Encouraging Disclosure and Apology | Current State Apology Laws | The Effects of Apology Laws | Advice for State Legislatures | Implications for Physicians | References

Initiatives intended to reduce the frequency and impact of medical errors generally rely on recognition and disclosure of medical errors. However, fear of malpractice liability is a barrier to physician disclosure. Some U.S. state legislatures have attempted to encourage physicians to disclose medical errors by enacting â€œapology laws.â€ The authors reviewed the codified statutes of each of the 50 states and the District of Columbia to determine the prevalence and characteristics of such apology laws. They found that many states have recently adopted apology laws and that there is variability in these laws. The authors review some of the important differences in these laws and explore the potential impact of apology laws.

The medical literature and lay press have increasingly reported on the incidence and impact of medical error. Among the most influential is the Institute of Medicine report "To Err is Human: Building a Safer Health System" (1). The report estimated that more than one half of the adverse medical events occurring each year are due to preventable medical errors. These medical events cause 44 000 to 98 000 deaths annually in the United States (1). The annual costs associated with these errors in lost income, disability, and health care expenditures may be as much as $29 billion (1). The potential for severe consequences

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The Case for Disclosure and Apology

Abstract | The Case for Disclosure and Apology | Encouraging Disclosure and Apology | Current State Apology Laws | The Effects of Apology Laws | Advice for State Legislatures | Implications for Physicians | References

The errors in any system must be identified before they can be corrected. Therefore, initiatives intended to reduce the frequency and impact of medical error generally rely on recognition and disclosure of medical errors (1). Protected, voluntary incident-reporting systems have reduced errors in other industries (2). A similar approach to disclosure may be crucial in identifying and reducing systematic medical errors (1). Physician disclosure with apology is also a widely supported way to address the adverse effects of medical error, and ethicists and physicians concur that disclosure and apology are ethically indicated (3–4). In addition, evidence suggests that affected patients and their families benefit substantially when physicians disclose medical errors, express sympathy, and apologize (3, 5). These communications enable patients to understand what has occurred and, in some cases, to obtain appropriate compensation (3). Moreover, full disclosure increases patient satisfaction, trust, and the likelihood of a positive emotional experience and reduces the likelihood of disrupting the physician–patient relationship (6). Improved physician communication may actually mitigate the harm from some errors, as well as reduce the incidence of future errors.

Despite the well-recognized benefits of disclosure and apology, however, most physicians simply do not communicate their errors to their patients (6–7). Fear that such statements might result in malpractice liability is a substantial barrier to physician disclosure (8–9). Physicians are often reluctant to express feelings of sympathy and condolence to patients who experience adverse outcomes and are even more reluctant to acknowledge medical errors.

These liability concerns on the part of physicians are historically well founded. The legal term *hearsay* relates to evidence based on past statements. The general hearsay rule usually precludes quoting previous statements to prove the truth of those statements at trial (10). However, a well-established exception to this general rule poses a clear risk to defendant physicians. The "admission by party opponent" exception to the hearsay rule specifically allows past statements made by a defendant physician to be used against him at trial (10). For example, in the Colorado malpractice case *Fognani v. Young*, in which a family member asserted that the defendant physician had stated that he was "sorry about your father's situation" and that "things might have turned out better had I been more up to date on current treatment options," the Colorado Supreme Court noted that these statements could be introduced at trial and that they "could subject [the physician] to liability" (11). Because of this "admission by party opponent" exception, physician disclosures and apologies pose a substantial risk in subsequent malpractice cases. As a result, lawyers routinely advise their physician clients to "keep quiet" about medical errors (12–13).

Encouraging Disclosure and Apology

Abstract | The Case for Disclosure and Apology | Encouraging Disclosure and Apology | Current State Apology Laws | The Effects of Apology Laws | Advice for State Legislatures | Implications for Physicians | References

Some lawmakers have attempted to encourage physician disclosure and apology by legislatively overruling the "admission by party opponent" exception. In 2005, Senators Hillary Rodham Clinton (D, New York) and Barack Obama (D, Illinois) proposed the National Medical Error Disclosure and Compensation (MEDIC) Act (14). This bill emphasized open disclosure of medical errors to patients, apology and early compensation, and a comprehensive analysis of the events on a nationwide basis (14).

Although the U.S. Congress did not pass the MEDiC Act, some state legislatures have made similar attempts to encourage physician disclosure by enacting apology laws. Unfortunately, the medical literature lacks a complete and accurate resource to inform physicians of the current status of apology laws and to compare these laws among the states. As a result, physicians are unfamiliar with the apology laws in their respective states (Huffman-Dracht HB, McDonnell WM, Guenther E. Resident education in medical errors: a survey. In preparation.). Unless the scope, availability, and potential benefits of existing apology laws are presented to physicians in a clear, succinct manner, such laws are unlikely to affect physician disclosure and apology. Therefore, we sought to identify and analyze all apology laws in the United States and to describe the specific legal protections that they provide.

Current State Apology Laws

Abstract | The Case for Disclosure and Apology | Encouraging Disclosure and Apology |

James M. Lai, MD, ScM

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On 20 November 2007, we used the electronic legal database Westlaw (Thomson Reuters/West, New York, New York) to conduct a comprehensive review of the codified statutes of each of the 50 U.S. states and the District of Columbia. We repeated the search and updated the database on 31 March 2008. We used the "50 State Surveys" resource of Westlaw to search state statutes under the headings "Tort Reform," "Medical Malpractice," and "Patient Safety and Medical Errors Reforms." In addition, we conducted Boolean searches of the Westlaw database of all state statutes by using various combinations of the following search terms: *physician, doctor, healthcareprovider, apology, remorse, regret, sympathy, disclose, medicalerror,* and *outcomesofmedicalcare.* Furthermore, we reviewed the indices of all state statutes to locate any apology statutes not identified by the preceding searches.

Of the 50 states and the District of Columbia, 36 (71%) have enacted apology laws protecting voluntary disclosures (15–50) (Table). In 28 of these states, apology laws prevent the use of expressions of sympathy, regret, and concolence against the physician in subsequent litigation (16, 19–21, 23–40, 42–45, 47, 49) (Figure). For example, using the facts from *Fognani v. Young,* the physician's statement that he was "sorry about your father's situation" could not be used at trial (51). However, the statement "things might have turned out better had I been more up to date on current treatment options" is arguably an admission of fault and could be used against the physician. In the other 8 states, apology laws protect admissions of fault as well as expressions of sympathy (15, 17–18, 22, 41, 46, 48, 50) (Figure). In these states, both of the statements in the *Fognani v. Young* case, and even one as explicit as "I made a mistake," would be excluded by the apology law.

Table. Types of Apology Laws

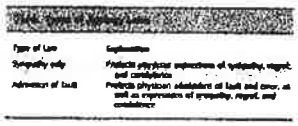

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Figure.

Types of apology laws, by state.

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The most important distinction among these apology laws is whether admissions of fault are protected. However, we noted many additional variations between states. For example, 1 state (Vermont) only protects oral, but not written, statements (46). Moreover, 4 states (Florida, New Jersey, Nevada, and Pennsylvania) have moved beyond the concept of voluntary disclosure and have enacted laws mandating that hospitals or their physicians notify patients of medical errors leading to adverse outcomes (52–55). Each mandatory notification law protects the required disclosure from being used as evidence of fault in any malpractice action.

The Effects of Apology Laws

Abstract | The Case for Disclosure and Apology | Encouraging Disclosure and Apology | Current State Apology Laws | The Effects of Apology Laws | Advice for State Legislatures | Implications for Physicians | References

The impact of apology laws on physician disclosures and on quality of care remains unclear. Thirty-four apology laws (94%) became effective on or after 1 January 2000, and 24 of these only became effective on or after 1 January 2005. Because they are so recent, and because physicians remain unfamiliar with them,

there is little evidence yet whether apology laws improve communication and whether they reduce medical error. As physician familiarity with these laws increases, studies addressing these questions will be important (5, 56).

Litigation activity related to medical errors might serve as one measure of the frequency and effectiveness of physician disclosure. Patients who feel that they have been deprived of full disclosure and appropriate apology may be more likely to pursue malpractice litigation (57). Conversely, some experiential evidence suggests that full disclosure, apology, and fair compensation may result in lower litigation costs arising from medical error. The University of Michigan reports that since it adopted a policy of full physician disclosure of medical error in 2001, a marked reduction in malpractice claims and decrease in legal expenses have occurred (58).

A similar experience has been reported by the Lexington Veterans Affairs (VA) Medical Center in Lexington, Kentucky. After the Lexington VA Medical Center adopted a full-disclosure and fair-settlement approach, the hospital had more settled claims, fewer plaintiffs' verdicts, and reduced payments per claim (59). The VA was so impressed with this experience that it adopted a full-disclosure policy across all hospitals in the VA system (60).

Disclosure as a way to reduce litigation costs, however, remains controversial (61–62). Studdert and colleagues (63) argue that with physician disclosure of medical error, "an increase in litigation volume and costs is highly likely." They note that the vast majority of patients who suffer from medical errors are unaware of those errors and, consequently, never file malpractice claims (63). However, widespread disclosure and apology may "flag" such errors and prompt more claims than are dissuaded by the apologies (63).

Whether a reduction in litigation costs, absent a change in the underlying quality of care, is a useful outcome is also controversial. Some argue that any change to the medical malpractice system that reduces litigation costs leaves more health care system resources available for delivery of care (57, 64). In contrast, some patient advocates have suggested that these reduced litigation costs simply reflect injured patients being deprived of appropriate compensation for their injuries (65–66).

Regardless of whether reduced litigation costs are a net value, the evidence that patients and their families receive tangible benefits from the act of disclosure and apology itself may be sufficient justification for apology laws. Even if increased disclosure and apology are unsuccessful in reducing systemic errors and improving quality of care, an increase in such physician communication might nonetheless be a beneficial product of apology laws.

Advice for State Legislatures

Abstract | The Case for Disclosure and Apology | Encouraging Disclosure and Apology | Current State Apology Laws | The Effects of Apology Laws | Advice for State Legislatures | Implications for Physicians | References

Many state legislatures have tried to increase apology and disclosure through apology laws. Such laws offer discrete legal protections. Nevertheless, physicians have generally declined to disclose errors due to liability concerns, and these concerns can only be eased if physicians are informed about their legal protections. We encourage states to explore ways to better inform physicians about existing apology laws.

For states still contemplating apology laws, evidence is currently insufficient to know what effect such laws will have on physicians' communications, on malpractice litigation activity, or on the incidence of medical error. Moreover, additional research is needed to assess the implications of "sympathy only" versus "admissions of fault" laws. At this time, we cannot make an evidence-based recommendation on whether to adopt an apology law and, if so, which type. Nonetheless, if further experience shows that disclosures and apologies can be fostered with apology laws, then improved physician–patient relationships, better patient understanding of their adverse outcomes, increased patient satisfaction, and medical error reduction might all be realized.

Implications for Physicians

Abstract | The Case for Disclosure and Apology | Encouraging Disclosure and Apology | Current State Apology Laws | The Effects of Apology Laws | Advice for State Legislatures | Implications for Physicians | References

Issues regarding medical error and potential malpractice liability understandably make physicians uncomfortable. Nonetheless, apology laws may present new opportunities to discuss difficult topics with patients. Our article might be viewed as a first step in educating physicians about these new opportunities. In states in which no apology laws have yet been enacted, physicians have the opportunity to work with

ETHICS/CONCEPTS

Emergency Physicians and Disclosure of Medical Errors

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Error in medicine is a subject of continuing interest among physicians, patients, policymakers, and the general public. This article examines the issue of disclosure of medical errors in the context of emergency medicine. It reviews the concept of medical error; proposes the professional duty of truthfulness as a justification for error disclosure; examines barriers to error disclosure posed by health care systems, patients, physicians, and the law; suggests system changes to address the issue of medical error; offers practical guidelines to promote the practice of error disclosure; and discusses the issue of disclosure of errors made by another physician. [Ann Emerg Med. 2006;48:523-531.]

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INTRODUCTION

With the publication of the Institute of Medicine report *To Err is Human* in 2000, error in medicine became a high-profile national issue.[1] As a result, physicians, patients, and the general public are more aware than ever of the incidence of medical error. Responding to this increased awareness, scholars and policymakers have offered a variety of proposals for addressing the problem of medical error.[2-11]

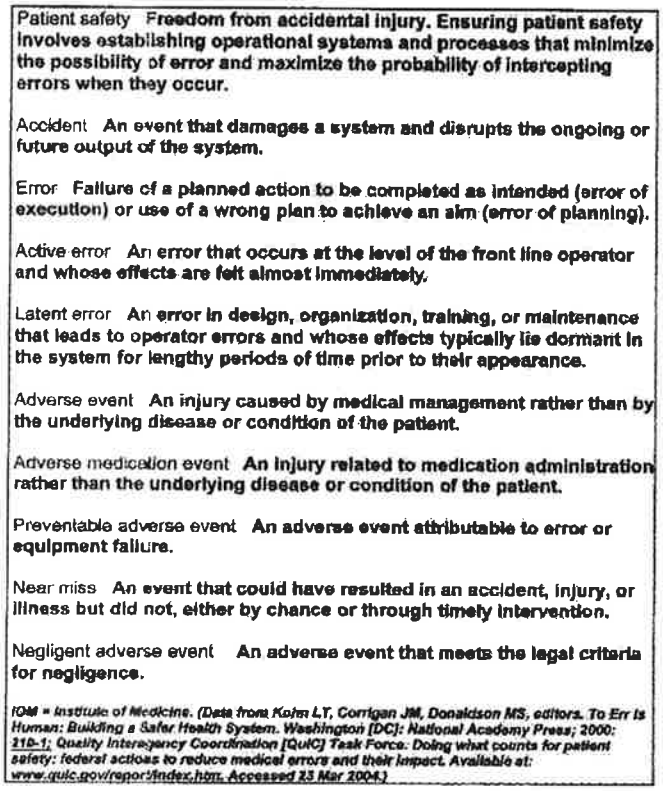
Emergency physicians are no strangers to medical error. One recent study in a busy academic emergency department (ED) identified 18 errors per 100 ED patients.[12] In September 2003, the American College of Emergency Physicians approved a new policy statement, titled Disclosure of Medical Errors, that directs emergency physicians who discover an error to inform the patient promptly about the error and its consequences.[13] The policy recognizes that substantial obstacles, such as unrealistic expectations of physician infallibility, lack of training in communication techniques, and fear of liability, hinder the free disclosure to patients of medical errors. The policy therefore recommends several initiatives to encourage error disclosure, including the development of institutional policies on this subject, continuing education programs on error disclosure, and appropriate tort reforms and system-based changes.

This article will examine the issue of disclosure of medical errors in the context of emergency medicine. It will review the concept of a medical error, propose the professional duty of truthfulness as a justification for error disclosure, examine barriers to error disclosure, suggest system changes to address the issue of medical error, offer practical guidelines to promote the practice of error disclosure, and discuss the issue of disclosure of errors made by another physician.

DEFINING MEDICAL ERROR

Greater attention to patient safety has resulted in a significant increase in academic discourse about what constitutes a medical error. The Institute of Medicine defines medical error as the "failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim."[1] In some cases, the application of this definition is unambiguous. In symmetry errors, for example, a procedure is performed on the wrong side[14]; in medication errors, a dosing protocol or route is incorrectly administered.[15] Other actions, particularly those involving diagnostic processes and other cognitive processes, may be much more difficult to characterize as error, particularly given the information available to the provider at the time.[16,17] See the Figure for Institute of Medicine definitions of other terms commonly used in discussion of medical errors.

Medical errors often result in harm to patients, and this explains our increased efforts to identify and minimize such errors. It is important to recognize, however, that there is no *necessary* connection between medical error and patient harm. Some errors may not harm the patient. For example, an obvious error may occur in a patient's treatment, such as administration of a medication prescribed for a different patient, but the patient may experience no ill effects from that medication. In contrast, treatments can cause serious harm to patients in the absence of any error. For example, a patient may experience severe complications from a medication even though the



Patient safety **Freedom from accidental injury. Ensuring patient safety involves establishing operational systems and processes that minimize the possibility of error and maximize the probability of intercepting errors when they occur.**

Accident **An event that damages a system and disrupts the ongoing or future output of the system.**

Error **Failure of a planned action to be completed as intended (error of execution) or use of a wrong plan to achieve an aim (error of planning).**

Active error **An error that occurs at the level of the front line operator and whose effects are felt almost immediately.**

Latent error **An error in design, organization, training, or maintenance that leads to operator errors and whose effects typically lie dormant in the system for lengthy periods of time prior to their appearance.**

Adverse event **An injury caused by medical management rather than by the underlying disease or condition of the patient.**

Adverse medication event **An injury related to medication administration rather than the underlying disease or condition of the patient.**

Preventable adverse event **An adverse event attributable to error or equipment failure.**

Near miss **An event that could have resulted in an accident, injury, or illness but did not, either by chance or through timely intervention.**

Negligent adverse event **An adverse event that meets the legal criteria for negligence.**

IOM = Institute of Medicine. (Data from Kohn LT, Corrigan JM, Donaldson MS, editors. To Err Is Human: Building a Safer Health System. Washington [DC]: National Academy Press; 2000: 218-1; Quality Interagency Coordination [QuIC] Task Force. Doing what counts for patient safety: federal actions to reduce medical errors and their impact. Available at: www.quic.gov/report/index.htm. Accessed 23 Mar 2004.)

Figure. IOM nomenclature for patient safety.

medication is a standard treatment for the patient's condition and was administered correctly.

MEDICAL ERROR AND THE DUTY OF TRUTHFULNESS

Truthfulness is widely recognized as a central professional responsibility of physicians. The American Medical Association's "Principles of Medical Ethics" include the principle that "a physician shall . . . be honest in all professional interactions . . ."[18] Similarly, the American College of Emergency Physicians' "Principles of Ethics for Emergency Physicians" direct that "Emergency physicians shall communicate truthfully with patients . . ."[19] In pledging to be truthful with their patients, physicians acknowledge that patients are moral agents who deserve to be treated with dignity and respect.

To make important health care choices, patients expect and are entitled to accurate information about their medical condition and treatment alternatives. In addition to enabling patients to make informed treatment choices, open and honest communication between physicians and patients fosters the trust and cooperation essential for a successful therapeutic relationship.

Although there is strong consensus that physicians owe a duty of truthfulness to their patients, the scope and limits of that duty are less well established. Some limits of the duty of truthfulness are, however, reasonably clear. Because the physician-patient relationship is a professional (and not a personal) relationship, the duty applies only to information about the patient's medical condition and its treatment.[20] Moreover, the duty does not require disclosure of all medical information. Physicians need not, for example, provide purely technical or insignificant information to their patients, because total disclosure is neither practical for physicians nor desired by (or advantageous for) patients.[21]

How, then, can physicians determine what information is and is not owed to their patients? A potential source of guidance about disclosure of information to patients can be found in the legal doctrine of informed consent. As that doctrine evolved in law and ethics during the past half-century, standards have been adopted about the amount of information that should be disclosed to patients to enable them to give an appropriately informed consent. One widely accepted legal standard appeals to the concept of the reasonable person, asserting that the physician should disclose what a reasonable person in the patient's position would want to know to make an intelligent and informed treatment decision.[21] This standard could be extended beyond the consent process to direct physicians to share with their patients the information a reasonable person in the patient's position would want to know about his or her medical condition, including the diagnosis, prognosis, course and outcomes of treatment, complications, and errors in their care.

How might this standard of disclosure be applied when medical errors occur? If disclosure is based on what the reasonable person would want to know, it clearly cannot be a "fair-weather" phenomenon, required only when the information is benign and the patient's outcome is excellent. Rather, physicians should also share bad news with their patients, including the news that an adverse event was the result of an error made in their care. Only in this way can physicians demonstrate that they remain committed to the patient's well-being and are willing to work to correct the problem and improve the patient's condition. The alternative, attempting to hide or cover up the error and hoping that the patient will not discover his or her misfortune, potentially transforms physicians from patient advocates into patient adversaries. At the very least, nondisclosing physicians are placing their own interests ahead of the interests of their patients.

If we assume that patients would want to know about medical errors that significantly affect their medical condition and its treatment, are there also errors about which they may not want to know? If an error is minor or is quickly corrected and therefore has only a minimal or no effect on the patient's condition or ongoing treatment, there may be no strict duty to disclose it to the patient. Physicians may, nevertheless, choose to inform their patients about these inconsequential errors and reassure them that the error has been corrected and has not had any adverse effects.

Patients' expectations for error disclosure continue to be explored, and most of the available evidence suggests that patients want to be told about all errors that occur in their medical care.[22-24] For example, 91% of members of a New England health maintenance organization who responded to a survey on medical errors agreed with the statement "Patients should always be told if an error is made—even if the patient is not injured or harmed."[22] In a survey of ED patients, 88% stated they wanted to "know everything" about errors that occurred in their health care, whereas 12% wanted to be informed of a mistake only if it affected their health.[23] In a prominent study using focus groups, patients unanimously agreed that they should be informed about any error that caused them harm.[25] These focus group patients, however, expressed mixed opinions about whether patients should be told about near misses, and the study authors recommend limiting such disclosures.

In rare circumstances, it may be appropriate for emergency physicians to limit disclosure of information to their patients on the basis of "therapeutic privilege." Like the reasonable person standard of information disclosure, the doctrine of therapeutic privilege has its origins in the law of informed consent. According to this doctrine, if a physician judges that the disclosure of certain information will in itself be highly detrimental to the patient, as, for example, disclosing the occurrence of a serious error to a medically unstable or emotionally fragile patient, the physician may refrain from providing that information.[26] Commentators caution that such situations "should be rare and based on well-delineated reasons that outweigh and therefore supersede the presumption to disclose and apologize."[26]

BARRIERS TO ERROR DISCLOSURE

For a variety of reasons, many physicians have sought to avoid the difficult topic of medical error.[27] Recent studies of the frequency of medical errors, however, have forced institutions and individual professionals to confront this problem directly. One obvious way to respond to medical errors is to identify them when they occur, to disclose them promptly to interested parties, and to seek out and correct the causes of errors. There are, however, a number of barriers to implementing a practice of error identification, disclosure, and investigation. This section will examine, in turn, significant barriers to error disclosure posed by health care systems, patients, physicians, and the law.

System Barriers

Despite recent calls for improved error surveillance and disclosure, health systems in the United States are generally not designed to reward, compensate, or otherwise encourage the processes of error recognition, disclosure, investigation, and remediation. Although legal histories, malpractice awards, and letters from the National Practitioner Data Bank are basic components of hospital credentialing, hospitals rarely require members of their medical staff to engage in error disclosure activities.

In academic medical centers, institutional practices may often inhibit error disclosure. Teaching sessions, such as ward rounds or mortality and morbidity conferences, may indeed identify and discuss medical errors.[28,29] When they do focus on medical errors, however, these sessions may be used to embarrass "guilty" physicians or to examine the sequelae of errors rather than to teach about the importance of identifying key errors and developing constructive ways to prevent or respond to them.

Health care systems, like individual professionals, have a strong interest in avoiding malpractice liability, and they may view medical errors as a major liability risk. Systems may, therefore, assign to risk managers rather than physicians the task of responding to reports of medical error. If risk managers respond by trying to deny, minimize, or cover up the error, physicians may draw the conclusion that the system has no interest in acknowledging or disclosing medical errors.

The distinctive environment of the hospital ED may create its own specific barriers to addressing medical errors. High patient volume, high acuity, and the largely episodic nature of care in the ED may increase the risk of errors and inhibit their identification and disclosure. Errors may occur more frequently in the ED than in other treatment settings because physicians must often act quickly and with only limited information about the patient's condition and medical history.[30] The ED is also characterized by multiple transitions in care, from one attending physician to another, one resident to another, one nurse to another, an emergency physician to a consulting specialist, and so on. These frequent transitions can increase the risk of medical error as a result of incomplete, inaccurate, delayed, or poorly organized transfer of information and failure to reevaluate a previous physician's assessment or treatment plan.[31]

ED patients are eventually either admitted to the hospital or discharged, and emergency physicians typically do not provide ongoing or follow-up care. Thus, unless a medical error manifests itself rapidly, the emergency physician will not have an opportunity to identify, disclose, or investigate it. Because emergency physicians generally do not have a long-term relationship of trust with their patients, they may fear that injured patients will have few qualms about taking legal action against them and so may be reluctant to disclose an error in their care.

Care in the ED is typically provided by multidisciplinary teams of health care professionals. The Institute of Medicine has identified a team approach to health care as a key strategy for improving patient safety, through increased communication and cooperation among the team members and better coordination of care.[32] To achieve this outcome, team members must embrace the goal of improving patient safety and be willing to work together to achieve it. Based on a survey of emergency physicians, nurses, and emergency medical technicians in one ED, however, Hobgood et al[33] conclude that "providers have limited insight into their own error pattern, rarely assist others with error identification, and when errors are identified, often

do not inform others, including the patient, of these events." Improving patient safety and care systems in the ED setting will therefore require specific education on teamwork skills, coordination of care, and communication.

Patient Barriers

Physician efforts to disclose medical errors may also be frustrated by an inability to contact patients once they leave the ED. Many ED patients are unable or unwilling to provide contact information because they are undocumented immigrants, fugitives from the police, travelers, or visiting foreigners who lack a telephone, a stable or verifiable address, or, in some cases, a legitimate identity. Other patients grow tired of long waits in the ED and may leave before physicians have an opportunity to discuss a medical error with them or obtain their contact information.

Emergency physicians are unable to disclose medical errors to many ED patients because of the patient's condition. Even if an error is quickly identified, the patient may already be dead or may be unable to receive the information because he or she is unconscious, demented, intoxicated, or otherwise mentally impaired. As immigration and travel increase, language and cultural differences between patients and physicians are becoming more common barriers to engaging in sensitive, nuanced discussion of medical errors.

Physician Barriers

Widely held beliefs and attitudes of physicians also create strong barriers to the disclosure of medical errors. Physicians are taught the foundational principle *primum non nocere* (first, do no harm) early in their medical careers. This basic tenet has become both a professional and a societal expectation of physicians. When an error occurs, physicians, as leaders of the health care team, often feel a profound sense of failure. In the aftermath of medical errors that have caused serious harm to patients, physicians acknowledge feeling shame, a sense of professional inadequacy, and grave doubt about their competence.[23,34-36] Feelings of shame, guilt, incompetence, and fear of exposure may make physicians extremely reluctant to disclose the occurrence of a medical error. In emergency medicine residents, negative emotions such as remorse, guilt, inadequacy, and frustration were associated with lack of experience, job overload, and lack of institutional support surrounding error.[37] To mitigate these negative emotional responses, physician-educators must attend to the experiences of trainees and develop constructive strategies to enable residents to acknowledge and disclose their medical errors.

Residents and attending physicians may believe that they should disclose medical errors to patients but be reluctant to do so because they lack the training and skills to communicate this sensitive information. In one recent study, only 12% of a sample of residents and attending physicians working in the ED of an academic medical center reported that they had received any formal instruction on how to inform patients about a medical error.[33] The recent inclusion of interpersonal and communication skills as a core competency for all residency programs may encourage efforts to provide formal training in the disclosure of medical errors.[38]

Physicians with anxiety, depression, lack of self-confidence, or lack of confidence in due process may also be reluctant to disclose errors. Character defects such as arrogance or narcissism can make some physicians believe that duties of disclosure and honesty do not apply to them, because such physicians may view the interests of others as subordinate to their individual concerns.[39] Other (hopefully rare) physicians who are slothful or avaricious or who abuse drugs or alcohol may also be unwilling to disclose medical errors.

Many physicians report a fear that acknowledging an error will result in an irremediable erosion of patient trust both in them as individuals and in the medical profession as a whole. This loss of trust may harm patients by decreasing their adherence to treatment plans, creating undue anxiety about their treatment, or deterring them from seeking future care.[23,36,40,41] Other commentators, however, argue that error disclosure does not in fact erode but rather enhances patient trust. These authors maintain that honesty is a cornerstone of the physician-patient relationship, and full disclosure of errors fosters communication, trust, and openness between patients and their physicians.[23,36,40,42]

As noted in the above discussion of system barriers to error disclosure, emergency physicians generally do not have a longstanding relationship with their patients. In addition to a concern that injured patients will be more likely to take legal action against a physician who is a virtual stranger to them, emergency physicians may also feel less inclined to disclose medical errors because the physician-patient bond is new and tenuous and because they are not concerned about protecting and preserving long-term relationships with their patients.

Legal Barriers

In addition to physician concerns about competence, communication skills, and erosion of patient trust, the threat of malpractice liability poses a substantial barrier to disclosure of medical errors.[23,43-46] Without disclosure, most patients will have no knowledge that an error in their care resulted in some harm to them. Physicians' disclosures of error can thus reveal to patients that their injury was a result of the error, not of the disease itself or of an unavoidable complication of treatment. This knowledge may induce patients to take legal action to receive compensation for the harm they have experienced. A physician's disclosure of error and apology may also be admissible as evidence against him or her in a malpractice trial.[47] For these reasons, defense attorneys frequently counsel physicians not to speak with patients and families about medical errors.

One obvious way to remove this legal barrier to error disclosure would be to replace the current medical malpractice system with a no-fault approach to compensating injured patients or an enterprise liability system that ascribes

responsibility for errors to institutions rather than individual practitioners.[10,48] Under these alternative approaches, physicians could identify, report, disclose, and investigate errors without fear of opening themselves to severe adverse consequences. Enacting a comprehensive restructuring of the tort system in the foreseeable future, however, appears to be an uphill political battle.

A number of medical and legal commentators have challenged the widespread perception that disclosure of errors to patients increases the physician's risk of liability.[49-55] These commentators argue that voluntary disclosure of errors and apologies by physicians may, in fact, reduce the likelihood of legal action. Patients and families who have filed malpractice suits cite a variety of reasons for doing so.[56,57] Financial compensation is one reason, to be sure, but so are a desire to learn what caused their injuries, a sense of abandonment by their physician, a perception that the physician is indifferent to their misfortune, and a desire to prevent future errors. Most of these interests can be satisfied without legal action if physicians give patients a full explanation of the reasons for their injury, offer sincere apologies, strive to correct or ameliorate the injury, and describe what is being done to prevent similar errors in the future.

There are, thus, 2 conflicting accounts of the likely effect of disclosing errors and offering apologies on the risk of liability. Unfortunately, there is a dearth of published empirical data to support either account.[58] Proponents of disclosure commonly appeal to a 1999 article reporting the results of 7 years' experience with an aggressive error disclosure policy at the Lexington, KY, Veteran's Affairs Medical Center.[53] With this disclosure policy in place, the Lexington center had a relatively high number of malpractice claims and out-of-court settlements but a low level of overall payments compared with 35 other VA medical centers in the eastern United States. Critics of this study, however, have claimed that it is methodologically weak and is not generalizable, because the VA system does not permit suits against individual physicians.[44,46]

In an effort to overcome one legal obstacle to physician apologies to patients, 18 states have in recent years enacted statutes making physician apologies inadmissible in civil suits.[59] A 2004 North Carolina statute, for example, declares that "statements by health care providers apologizing for an adverse outcome in medical treatment, offers to undertake corrective or remedial treatment or actions, and gratuitous acts to assist affected persons shall not be admissible to prove negligence or culpable conduct by the health care provider . . ."[60] Legal commentators caution, however, that most state apology statutes protect only "partial apologies," that is, expressions of sympathy for a patient's injury but not admissions of fault.[47,49]

Several studies suggest that the legal consequences of disclosure of errors may depend in part on the severity of the patient's injury.[22,51,61] In a survey study of parents of pediatric ED patients, for example, respondents reported that they would be less likely to pursue legal action after disclosure of a moderate error than after disclosure of a severe error.[51]

Although the effect of disclosing errors on liability risk remains unclear, proponents of disclosure cite other moral and psychological benefits of this practice. Cohen[49] argues that apologizing for errors shows respect for the patient and a desire to maintain a positive relationship. Apologizing may assuage the patient's feelings of anger by "subtracting the insult from the injury," and it may also ease the physician's feelings of guilt for causing harm. Finally, disclosure and apology may completely mitigate the patient's desire to sue or open the door to an early settlement, thereby avoiding the burdens on both the patient and physician of a lengthy legal battle.[54]

CREATING A CULTURE THAT PROMOTES PATIENT SAFETY AND DISCLOSURE OF ERRORS

Disclosure of errors is an important practice, but it is only one part of a comprehensive approach to error in medicine. The task of disclosing errors will be less onerous if health care institutions and physicians are able to reduce the overall number of errors. Thus, in addition to disclosing errors when they occur, institutions and individual professionals should seek out ways to prevent errors though improved training, staffing, support, design, and equipment. Department chairs, directors, administrators, risk managers, insurers, and others should also implement policies and procedures that encourage physicians to report errors to appropriate patient safety personnel and to disclose errors to patients. For example, institutions might establish a "safety hotline" to encourage reporting of errors. After receiving such reports, managers should seek out the root cause of the problem and communicate the lessons learned to staff in an effort to prevent reoccurrences.

Joint Commission on Accreditation of Healthcare Organizations standards require that patients and families be informed about unanticipated outcomes of care, including those caused by medical errors.[62] Most physicians and clinical staff practicing today were trained during an era when error disclosure was not encouraged; instead, the medical culture routinely punished those who committed errors. Morbidity and mortality and other conferences, as well as the quality assurance process, were primarily concerned with finding "the bad apples" and assigning blame. Not surprisingly, physicians responded with denial, discounting, and distancing.[26] New educational offerings and other conferences should be aimed at reorienting caregivers to a more constructive approach to error in medicine. One recent report, for example, describes a restructuring of the traditional mortality and morbidity conference to include consideration of systems problems, communication problems, and ethical issues in a nonintimidating and nonjudgmental manner.[63]

Health care institutions and continuing education providers should offer formal training in the skills of divulging errors to patients and reporting them within the system. Institutions should also assure physicians that this is the right thing to do

and should support them when they make reports. Emergency physicians should take an active part in designing and implementing procedures for error identification, disclosure, and investigation in the ED.

Recent discussions of medical error have emphasized the central role of system errors in medicine,[1,32] and so this section has focused on system initiatives to identify, disclose, and prevent errors. We acknowledge, however, that some errors are the result of an individual physician's misjudgment or lack of technical skill and that everyone makes errors from time to time. When such errors occur, physicians should disclose the error and accept responsibility for it. Disclosing errors may not be easy or comfortable, but not all moral responsibilities are easy to discharge.

The current malpractice liability system does a poor job of holding physicians accountable for their performance because it does not identify most negligent errors and it awards damages in many cases in which care was not negligent.[44] It is important, however, that some mechanism be in place to protect patients from injury at the hands of physicians who are incompetent, impaired, or malevolent. When institutional investigations of errors or injuries uncover evidence of physician incompetence, impairment, or malice, patient safety systems should make reports to professional licensure boards for their investigation.

PRACTICAL GUIDELINES FOR ERROR DISCLOSURE IN EMERGENCY MEDICINE

In fulfilling the obligation to disclose medical errors, a good place to start is to develop the habit of error disclosure at every appropriate opportunity. Smith and Forster[26] have stated this eloquently: "The virtue of truthfulness is the habit of telling the truth even when it is inconvenient or involves some personal risk. When professionals develop a habit of telling the truth, every truth told strengthens their inner selves . . . the virtue of truthfulness is ultimately essential for an effective professional-patient relationship because relationships cannot endure failures of truthfulness for long."

Although physicians may not be strictly morally obliged to disclose mistakes of marginal or no impact, it can be argued that there is little to lose and much to gain by doing so.[39] In fact, minor mistakes, which are much more common than more serious errors, may provide a fertile training ground for acquiring the communication skills and comfort level necessary to admit error. For example, a not-infrequent error in the ED is a computerized order for a radiograph on the wrong patient or body part. In such cases, when the study has been completed before the error is discovered, the best practice is to inform the patients of the error and tell them that they will not be charged for the unnecessary study. This practice has uniformly been met with positive feelings. An example of a more invasive error is administration of a medication to the wrong patient. In this circumstance, the error may produce morbidity, discomfort, or inconvenience. Although this information is sometimes less well received by the patient, physicians who have developed the habit of truthfulness will be better prepared to fulfill their responsibility to disclose both major and minor errors to their patients.

Mistakes should be disclosed at the earliest appropriate moment, taking into account the patient's physical and emotional condition at the time, as well as the magnitude and consequences of the error. For instance, a patient experiencing an acute myocardial infarction and anxiously waiting to be taken to the catheterization laboratory need not be told immediately about a minor error. In contrast, if a massive overdose of heparin in the ED caused a hemorrhage that results in the patient's having to be transfused before leaving the catheterization laboratory, the physician should inform the patient of this while obtaining consent for the transfusion.

In some cases, it may be rapidly apparent that an adverse event has occurred but not clear whether the event was the result of a medical error. When such a situation arises, the patient and, if appropriate, family members should be informed that a problem has occurred and told what is known about the problem. The patient and family should also be informed that the problem is being investigated and that further information will be given to them when it is uncovered.

When an error is identified, the physician should begin by simply and clearly stating that a "mistake" or an "error" has occurred, rather than using euphemisms that may be intended or be perceived as efforts to conceal the error. When systems issues result in error (sometimes called latent errors), this also should be communicated, perhaps involving a nursing or administrative member of the team. An example of this might be the mislabeling or loss of a specimen. It is good practice to document this discussion in the written record. An apology should be offered, as well as an assurance that any related medical charges will be cancelled or expenses reimbursed. When a subordinate working under the care of a supervising physician (eg, a house officer or allied health professional) makes an error, the attending physician has a duty to inform the patient along with the supervisee. The attending physician should use this opportunity to educate his or her charge about the ethics and practical application of error disclosure.

DISCLOSURE OF ERRORS MADE BY ANOTHER

Physicians bear primary responsibility for the medical care they provide or direct and for medical errors that occur in the course of that care. We have argued that this responsibility extends to informing patients about significant medical errors made by the physician or under the physician's direction. Does it also extend to informing patients about medical errors that the physician believes were made by a previous physician?

Emergency physicians often discover errors that occurred in care provided to a patient by another physician during a previous (usually recent) ED visit. Radiologists also commonly encounter this situation, as discussed by Berlin.[64] Should the emergency physician mention such a previous error in his or her dictation? Should the physician disclose the error to the patient and to the physician who will assume care of the patient? Or should he or she remain silent, let the previous records speak for

themselves, and restrict any comments to the current findings and situation?

We have proposed above that the professional duty of truthfulness be understood as requiring that physicians share with their patients all medical information that a reasonable person in the patient's position would want to know. On this interpretation, truthfulness may require that physicians disclose information about previous errors because that information may play an important role in patient decisions about whether to seek care from another physician or hospital and whether to seek redress if harmed.

Professional codes of ethics also commonly ascribe to physicians a duty to protect patients from impaired or incompetent physicians. Principle 6 of the American College of Emergency Physicians' "Principles of Ethics for Emergency Physicians," for example, states that "Emergency Physicians shall deal fairly and honestly with colleagues and take appropriate action to protect patients from health care providers who are impaired, incompetent, or who engage in fraud or deception."[19] Carrying out this duty to protect patients may require disclosing to them that an error has been made in care provided to them by another physician so that they can make informed decisions about their future medical care.

Several factors speak against explicitly mentioning the error in the medical record or disclosing it to the patient. It may be difficult for the physician who discovers an apparent error in the past to gather and evaluate all the relevant information about the patient's condition and the treatment provided during a previous visit. Mention or disclosure of the past error may also serve as a stimulus for initiating legal action and may complicate future efforts at defending a lawsuit.[41] Not all errors or omissions constitute negligence in the eyes of the law, however, and unless the patient has experienced real harm, a lawsuit should not be successful. Whether or not a lawsuit ensues, reporting or disclosing another physician's error could lead to strained professional relations.

The factors described above may make the decision to disclose someone else's mistakes more difficult than that of disclosing one's own. Perhaps for this reason, the American College of Emergency Physicians policy is silent on the issue of disclosing to patients other providers' errors.[13] Emergency physicians should not, however, simply ignore evidence of an error made in the patient's previous treatment. Rather, they should discuss the situation with the previous physician and, if an error is identified, urge that physician to discuss the error with the patient. Finally, if the patient asks specific questions about the reason for a complication, the emergency physician should not withhold relevant information or provide false information.

CONCLUSION

After a long period of neglect, the issue of medical error has in recent years captured significant public and professional attention. The ED is the locus of a variety of errors, and emergency physicians must therefore be prepared to identify errors and respond to them appropriately. Physicians have a professional responsibility to communicate truthfully with their patients; that responsibility includes disclosure to patients of errors that occur in their care. Barriers imposed by health care systems, patients, physicians, and the law complicate the practice of disclosing errors to patients. To overcome these barriers, health care institutions and individuals should develop policies and procedures that encourage and support the identification, reporting, and disclosure of errors. To fulfill their responsibility to be truthful with their patients, physicians should consider making the disclosure of error a matter of routine or habit. Physicians should also reflect carefully on the scope of their responsibilities when they discover an error made by a previous physician.

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IMAGES IN EMERGENCY MEDICINE

(continued from p. 522)

DIAGNOSIS:

Activated charcoal aspiration. At autopsy, gross examination of his pulmonary tree revealed activated charcoal in his oropharynx, trachea, and pulmonary parenchyma, described as diffuse and focal black geographic discoloration of both lung fields, with airways containing black particulate matter (Figure 1, white arrow). Histologic slides revealed activated charcoal within bronchiole and in peribronchiolar alveolar spaces, with extensive polymorphonuclear leukocyte infiltration (Figures 2 and 3). Although much is written on indications for activated charcoal, timing of administration, and complications, death is rarely reported. This case illustrates the importance of patient selection for activated charcoal administration and the potentially fatal complications associated with its use.

Resolution from the Greater Greensboro Society of Medicine
Title: Transparency in Patient Communication and Apology in the Professional Context

1

Whereas: Our Society has a commitment to quality of care including the reduction of errors in the medical setting

Whereas: the AMA "Principles of Medical Ethics" states ... " a physician shall be honest in all professional interactions"

Whereas: the US Institute of Medicine in accord with their publication "To Err is Human" encourages an environment of Patient's right that includes disclosure of medical errors

Whereas; the continuation of a relationship of trust between patients and their physician requires full disclosure of positive and adverse events as a part of the long term process of improving medical practice

Whereas: the act of apology is an integral part of the process of full disclosure

Whereas: NCGS 8C-1, article 4, rule 413 provides evidentiary protection for apology in regard to outcome but does not offer similar protection in regard to commission, or act of omission, of an error

Whereas sister states do provide statutory evidentiary protection for apology which may include expression related to mistake(s) or error(s)

Therefore be it resolved that for the enhancement of transparency in communication with patients, in accord with accepted standards of professional ethical behavior in an environment conducive to full disclosure that the NCMS works to amend the language of NCGS 8c-1,article 4, rule 413 such that any and all statements, affirmations, gestures, activities, or conduct expressing benevolence,regret,apology,sympathy, commiseration, condolence, compassion, mistake, error or general sense of benevolence which are made by a physician to the patient, a relative of the patient or a representative of the patient which are made during a designated meeting to discuss the unanticipated outcome shall be inadmissible as evidence and shall not constitute an admission of liability or an admission against interest.

Five Year Old Policies

Ethical and Judicial Affairs – 2014 5 Year Old Policies to Review

Domestic Violence Awareness

RESOLVED, That the North Carolina Medical Society supports increasing clinical awareness of suspected incidences of physical, sexual, or psychological abuse or other means of domestic violence; and be it further

Resolved, That the North Carolina Medical Society supports mandatory reporting of

1. Suspicion of abuse or neglect of a juvenile.
2. Every case of bullet wound, gunshot wound, powder burn, or any other injury arising from or caused by, or appearing to arise from or be caused by, the discharge of a gun or firearm.
3. Every case of illness caused by poisoning if it appears to the physician that a criminal act was involved.
4. Every case of a wound, injury caused or apparently caused by a knife or sharp or pointed instrument if it appears to the physician that a criminal act was involved.
5. Every case of a wound or injury or illness in which there is grave bodily harm or grave illness if it appears to the physician that it resulted from a criminal act of violence.

(Report J-1997, adopted 11/16/97) (revised, Report L3-2004, Item 59, adopted 11/14/2004) (revised, Report I-2009, Item 3-57, adopted 11/01/2009)

Care of the Patient Undergoing Surgery or Other Invasive Procedure

RESOLVED, that the North Carolina Medical Society supports the North Carolina Medical Board position statement "Care of the Patient Undergoing Surgery or Other Invasive Procedure" as amended in September 2006.

(Report K-1988, adopted as amended 5/7/88) (reaffirmed, Report MM-1998, Item 50, adopted 11/15/98) (revised, Report L1-2004, Item 12, adopted 11/14/2004) (revised, Report I-2009, Item 3-15, adopted 11/01/2009)

Medical Evaluation Program

RESOLVED, That the North Carolina Medical Society supports the Medical Evaluation

Program, which provides, limited immunity for physicians and psychologists providing medical information to the NC Commissioner of Motor Vehicles on drivers who the physician or psychologist believe have a mental or physical disability that will adversely affect the patient's ability to safely operate a motor vehicle.

(Report O-1997, adopted 11/16/97) (revised, Report L3-2004, Item 25, adopted 11/14/2004) (revised, Report I-2009, Item 3-52, adopted 11/01/2009)

Law Enforcement Methods to Subdue Persons

RESOLVED, That the North Carolina Medical Society supports educational efforts for law enforcement personnel about the safe use and dangers of capsaicin spray (also known as "OC spray" or "pepper spray"), tasers, and other non-lethal methods to subdue persons and how to respond should an adverse reaction occur.

(Report N-1997, adopted 11/16/97) (revised, Report L1-2004, Item 47, adopted 11/14/2004) (revised, Report I-2009, Item 3-59, adopted 11/01/2009)

Licensure Standards

RESOLVED, That the North Carolina Medical Society supports medical licensure standards based solely on professional competence, conduct, character, and ethics.

(Resolutions 5, 16-1986, adopted 5/3/86) (revised, Report Y-1996, Item 20, adopted 11/17/96) (revised, Report L1-2004, Item 10, adopted 11/1/4/2004) (reaffirmed, Report I-2009, Item 2-21, adopted 11/01/2009)

Foster Care

That the North Carolina Medical Society supports policies and programs to optimize the health and well-being of children in foster care including promotion of medical homes.

(Report E-2009, adopted, 11/01/2009)

Public School Employees

RESOLVED, That the NCMS supports pre-employment health certification and criminal

background checks for all public school employees.

(Report S-1984, Item 9, adopted 5/5/1984) (reaffirmed, Report CC-1994, Item 14, adopted 11/6/1994) (revised, Report L1-2004, Item 69, adopted 11/14/2004) (revised, Report I-2009, Item 3-41, adopted 11/01/2009)

Animals in Biomedical Research

RESOLVED, That the North Carolina Medical Society supports appropriate and humane use of animals in biomedical research as an ethical, effective, and necessary method of improving the health of animals and humans.

(Report P-1990, adopted 11/10/90)(reaffirmed, Report Q-2000, Item 3, adopted 11/12/00) (revised, Report L1-2004, Item 13, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-7, adopted 11/01/2009)

Domestic Violence/Abuse Education

RESOLVED, That the North Carolina Medical Society supports educational efforts for medical students and physicians aimed at improving diagnosis, treatment, and appropriate referral, of physical, sexual, psychological,and other abuse victims.

(Report F-1994, adopted as amended 11/6/94) (revised, Report L1-2004, Item 30, adopted 11/14/2004) (revised, Report I-2009, Item 3-58, adopted 11/01/2009)

School Violence Prevention

RESOLVED, That the North Carolina Medical Society supports educational programs that prevent school violence.

(Substitute Resolution 13-1998, adopted 11/15/98) (revised, Report L1-2004, Item 73, adopted 11/14/2004) (revised, Report I-2009, Item 3-55, adopted 11/01/2009)

Medical Research Involving Animals

RESOLVED, That the North Carolina Medical Society supports civil and criminal penalties for nefarious activities intended to interfere with animal research, including the unauthorized

release of research animals and the theft of data derived from animal research.

(Resolution 35-1990, adopted 11/10/90)(revised, Report Q-2000, Item 49, adopted 11/12/00) (revised, Report R-2006, Item 13, adopted 10/29/2006) (reaffirmed, Report I-2009, Item 2-8, adopted 11/01/2009)

Criminalization of Medical Acts

RESOLVED, That the North Carolina Medical Society opposes the criminalization of medical acts performed by licensed practitioners.

(Resolution 49-1998, adopted 11/15/98) (revised, Report L3-2004, Item 8, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-57, adopted 11/01/2009)

North Carolina Comprehensive Cancer Program

RESOLVED, That the North Carolina Medical Society supports the North Carolina Comprehensive Cancer Program in the areas of cancer treatment for indigent patients and public education about cancer and data gathering through the North Carolina Central Cancer Registry.

(Report S-1984, Item 2, adopted 5/5/84) (reaffirmed, Report II-1995, Item 1, adopted 11/12/95) (revised, Report L1-2004, Item 3, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-84, adopted 11/01/2009)

Tuberculosis

RESOLVED, That the North Carolina Medical Society supports screening and treatment of tuberculosis cases and potential cases in accordance with North Carolina public health guidelines.

(Report E-1975, adopted 5/3/75) (revised, Report D-1986, Item 7, adopted 5/3/86) (revised, Report Y-1996, Item 11, adopted 11/7/96) (amended, Report OO-1997, Item 13, adopted 11/16/97) (revised, Report L1-2004, Item 64, adopted 11/14/2004) (revised, Report I-2009, Item 3-60, adopted 11/01/2009)

Informed Consent

RESOLVED, That the North Carolina Medical Society opposes legislation requiring restrictive informed consent procedures that apply solely to specific diseases; and be it further

RESOLVED, That the North Carolina Medical Society supports providing every patient or person from whom informed consent is sought with clear, scientifically-based treatment options, whenever possible; and be it further

RESOLVED, That the North Carolina Medical Society supports obtaining informed consent at a time when the patient, or person from whom informed consent is being sought, is best able to understand and comprehend the treatment options and associated risks.

(Report U-1984, adopted 5/5/84) (reaffirmed, Report CC-1994, Item 16, adopted 11/6/94) (revised, Report L3-2004, Item 46, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-58, adopted 11/01/2009)

Sexually Transmitted Disease

RESOLVED, That the North Carolina Medical Society supports practicing physicians in providing adequate community services for screening, case-finding, and treatment of sexually transmitted disease and encourage cooperation with public health authorities in the investigation and control of such diseases.

(Resolution 32-1985, adopted 5/4/85) (revised, Report II-1995, Item 27, adopted 11/12/95) (revised, Report L1-2004, Item 72, adopted 11/14/2004) (revised, Report I-2009, Item 3-61, adopted 11/01/2009)

Second Opinion Surgery

RESOLVED, That the North Carolina Medical Society supports the rights of physicians and patients to seek a second opinion freely from any physician of his/her choice; and be it further

RESOLVED, That the North Carolina Medical Society supports the concept that second opinions

should not be required by a third party.

(Report S-1984, Item 4, adopted 5/5/84) (reaffirmed, Report CC-1994, Item 10, adopted 11/6/94) (revised, Report L1-2004, Item 51, adopted 11/14/2004) (revised, Report I-2009, Item 3-20, adopted 11/01/2009)

Emergency Medical Services

RESOLVED, That the North Carolina Medical Society supports the concept of the development of emergency medical services in the State of North Carolina and training of emergency response personnel with (a) the development of minimum level statewide training criteria and evaluation with certification; (b) the development of minimum level standards for emergency response vehicles; (c) the development of an integrated statewide communication program; (d) a categorization of hospitals to assist in identifying area resources and ultimately to assist in coordinating emergency medical care delivery; (e) the development of specialized training programs for such personnel and (f) the coordination and encouragement of efficient, dependable, and safe air emergency response transportation wherever appropriate through the state; and be it further RESOLVED, That the North Carolina Medical Society supports implementation of the statewide program of emergency medical care by the Office of Emergency Medical Services.

(Report B-1975, adopted 5/3/75) (revised, Report T-1987, Item 1, adopted 5/2/87) (amended, Report OO-1997, Item 9, adopted 11/16/97) (revised, Report L3-2004, Item 12, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-72, adopted 11/01/2009)

Funding for North Carolina Office of Emergency Medical Services

RESOLVED, That the North Carolina Medical Society supports adequate funding for the North Carolina Office of Emergency Medical Services to provide emergency medical services across the state and implement the statewide trauma system plan.

(Report N-1987, adopted 5/2/87) (amended, Report OO-1997, Item 10, adopted 11/16/97) (revised, Report L3-2004, Item 11, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-73, adopted 11/01/2009)

Professional Courtesy

RESOLVED, That the North Carolina Medical Society supports the right of physicians to offer professional courtesy to medical colleagues and their families.

(Resolution 31-1998, adopted as amended 11/15/98) (revised, Report L3-2004, Item 47, adopted 11/14/2004) (revised, Report I-2009, Item 3-4, adopted 11/01/2009)

End of Life Issues

RESOLVED, That the North Carolina Medical Society supports public and private efforts to enhance understanding of end-of-life issues so that health care professionals are better able to provide optimal compassionate palliative care of terminally ill patients; and be it further

RESOLVED, That the North Carolina Medical Society supports the use of the portable Do Not Resuscitate (DNR) and Medical Orders for Scope of Treatment (MOST) forms approved by the North Carolina Department of Health and Human Services.

(Report LL-1998, adopted 11/15/98) (revised, Report L1-2004, Item 8, adopted 11/14/2004) (revised, Report I-2009, Item 3-2, adopted 11/01/2009)

Professional Services for Immediate Family Members

RESOLVED, That the North Carolina Medical Society supports the North Carolina Medical Board position statement "Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist" as amended in September 2005.

(Report Z-1988, adopted 5/7/88) (revised, Report MM-1998, Item 20, adopted 11/15/98) (revised, Report L1-2004, Item 9, adopted 11/14/2004) (revised, Report I-2009, Item 3-5, adopted 11/01/2009)

Referrals for Laboratory Services

RESOLVED, That the North Carolina Medical Society supports the position that a physician should be able to utilize lab services from a physician office lab, private pathologists' lab or hospital lab that meets approved lab accreditation standards and is capable of providing

quality, cost-efficient lab services.

(Report X-1997, adopted as amended 11/16/97) (revised, Report L1-2004, Item 14, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-29, adopted 11/01/2009)

Prescribing Regulations in Long-Term Care

RESOLVED, That the North Carolina Medical Society supports timely access to appropriate care for long-term care residents without imposing unreasonable expectations on clinicians providing that care.

(Resolution 8-2009, adopted, 11/01/2009)

Long-Term Care

RESOLVED, That the North Carolina Medical Society supports efforts to develop a system of public and private programs to efficiently address the long term care needs of the citizens of North Carolina; and be it further

RESOLVED, That the North Carolina Medical Society supports the employment of North Carolina licensed physicians as medical directors in all long-term care facilities in North Carolina; and be it further

RESOLVED, That the North Carolina Medical Society supports formal and structured training for personal aides in domiciliary facilities that would include but not be limited to correct and appropriate procedures for administering medications and caring for patients with emotional, mental and physical disabilities, and the use of physical restraints; and be it further

RESOLVED, That the North Carolina Medical Society supports evidence-based treatment for patient behavioral intervention in long term care facilities that does not involve seclusion and limits the use of physical restraints while ensuring safety of all residents and staff.

(Report FF-1996, adopted as amended 11/17/96) (revised, Report L3-2004, Item 20, adopted 11/14/2004) (revised, Report I-2009, Item 3-31, adopted 11/01/2009)

North Carolina Medical Examiner System

RESOLVED, That the North Carolina Medical Society supports ongoing participation and continuing education of North Carolina physicians in the medical examiner system; and be it further

RESOLVED, That the North Carolina Medical Society supports fees for medical examiner investigations and autopsies performed by physicians commensurate with the time and expertise involved.

(Resolution 29-1990, adopted 11/10/90) (revised, Report Q-2000, Item 50, adopted 11/12/00) (revised, Report R-2006, Item 28, adopted 10/29/2006) (revised, Report I-2009, Item 3-49, adopted 11/01/2009)

Access to Shared Medical Information for Victims of Child Abuse and Juveniles in Protective Custody

RESOLVED, That the North Carolina Medical Society supports:

1. In the case of a disabled adult or juvenile under protective custody of the Department of Social Services, the release of medical and psychiatric records maintained by the Department of Social Services relative to that individual to the individual's primary care and/or treating physician.
2. In the case of a disabled adult or juvenile victim, the release of medical and psychiatric records that are necessary for the medical care of the individual to the individual's primary care and/or treating physician.

(Substitute Resolution 18-2001, adopted 11/11/2001) (revised, Report R-2007, Item 3-21, adopted 10/21/2007) (reaffirmed, Report I-2009, Item 2-18, adopted 11/01/2009)

Charges for Patient Record Information

RESOLVED, That the North Carolina Medical Society supports reasonable compensation to cover the costs of providing patient record information.

(Resolution 22-1990, adopted as amended 11/10/90) (revised, Report Q-2000, Item 45, adopted 11/12/00) (revised, Report R-2006, Item 7, adopted 10/29/2006) (reaffirmed, Report I-2009, Item 2-19, adopted 11/01/2009)

Pregnancy Prevention and Sexually Transmitted Diseases Education

RESOLVED, That the North Carolina Medical Society supports patient education, by a qualified provider, for patients presenting for pregnancy testing, regarding pregnancy prevention and sexually transmitted diseases.

(Report H-1996, adopted 11/17/96) (revised, Report L1-2004, Item 44, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-81, adopted 11/01/2009)

Maternal Prenatal Testing

RESOLVED, That the North Carolina Medical Society supports the linkage of clinically significant maternal prenatal testing results to neonatal health information reports for epidemiological and outcomes analysis with full protection of patient privacy and confidentiality.

(Resolution 8-1996, adopted as amended 11/17/96) (revised, Report L1-2004, Item 58, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-80, adopted 11/01/2009)

Human Tissue Donation

RESOLVED, That the North Carolina Medical Society supports public education concerning the need of making anatomical gifts to medical science; and be it further

RESOLVED, That the North Carolina Medical Society supports efforts to achieve maximal organ recovery; and be it further

RESOLVED, That the North Carolina Medical Society supports availability of organ donation registry methods and educational information in health care facilities; and be it further

RESOLVED, That the North Carolina Medical Society supports the efforts of appropriately accredited organ procurement agencies to recover human tissues, organs, and bodies to be

used by transplanting surgeons, hospitals, and medical schools of the State.

(Report M-1973, adopted 5/22/73) (revised, Report II-1988, Item 25, adopted 5/7/88) (revised, Report MM-1998, Item 30, adopted 11/15/98) (revised, Report L3-2004, Item 40, adopted 11/14/2004) (revised, Report I-2009, Item 3-3, adopted 11/01/2009)

Patient Education

RESOLVED, That the North Carolina Medical Society supports incorporating appropriate patient medical education as an integral part of medical services, and that such services should be provided by or under the supervision of a physician and adequately documented in the medical record.

(Resolution 14-1975, adopted 5/3/75) (revised, Report II-1988, Item 27, adopted 5/7/88) (revised, Report MM-1998, Item 23, adopted 11/15/98) (revised, Report L1-2004, Item 48, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-14, adopted 11/01/2009)

Physicians Health Program

RESOLVED, That the North Carolina Medical Society supports the efforts of the NC Physicians Health Program; and be it further

RESOLVED, That the North Carolina Medical Society supports the reporting of suspected impaired physicians to the North Carolina Physicians Health Program as being in the best interest of such physicians and the ethical responsibility of every physician.

(Report U-1988, adopted 5/7/88) (revised Report MM-1998, Item 28, adopted 11/15/98) (revised, Report L1-2004, Item 38, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-10, adopted 11/01/2009)

Physicians' Roles as Patient Advocates

RESOLVED, That the North Carolina Medical Society opposes any measure, from government or the private sector, that compromises the physician's role as patient advocate.

(Resolution 26-1998, adopted 11/15/1998) (revised, Report L3-2004, Item 41, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-9, adopted 11/01/2009)

Prescribing of Drugs for Off-Label Uses

RESOLVED, That the North Carolina Medical Society supports efforts to ensure coverage for medications for off-label use when the prescribing physician deems it to be in the best interest of the patient.

(Substitute Resolution 12-2005, adopted as amended 10/16/2005) (revised, Report I-2009, Item 3-22, adopted 11/01/2009)

Good Samaritan Law Immunity

RESOLVED, That the North Carolina Medical Society supports Good Samaritan immunity for physicians who serve voluntarily and without compensation to care for indigent, uninsured and underinsured patients, regardless of the setting or source of referral; and be it further

RESOLVED, That the North Carolina Medical Society supports Good Samaritan immunity for physicians serving voluntarily and without compensation as medical directors for emergency medical services (EMS) agencies; and be it further

RESOLVED, That the North Carolina Medical Society supports Good Samaritan immunity for physicians serving voluntarily and without compensation at athletic events.

(Report JJ-1998, adopted 11/15/98) (revised, Report L3-2004, Item 45, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-60, adopted 11/01/2009)

Access to Liability Insurance Coverage

RESOLVED, That the North Carolina Medical Society supports medical malpractice immunity for physicians serving as nursing home medical directors except where allegations involve a patient under their direct care, or where allegations involve willful or intentional misconduct, recklessness, or gross negligence in the performance of their medical director responsibilities.

(Report E-2004, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-61, adopted 11/01/2009)

Mandatory Premarital Examinations

RESOLVED, That the North Carolina Medical Society supports premarital counseling and physical examinations; and be it further

RESOLVED, That the North Carolina Medical Society opposes any statutory requirement for premarital examinations.

(Resolution 12-1984, adopted 5/5/84) (revised, Report CC-1994, Item 23, adopted as amended 11/6/94) (revised, Report L3-2004, Item 43, adopted 11/14/2004) (revised, Report I-2009, Item 3-47, adopted 11/01/2009)

Child Maltreatment Prevention

RESOLVED, That the North Carolina Medical Society supports comprehensive efforts to prevent the physical, psychological, sexual abuse, neglect, and death of juveniles; and be it further

RESOLVED, That the North Carolina Medical Society supports the use of medically appropriate investigative methods for victims of suspected physical, psychological, sexual abuse, neglect, and death of juveniles; and be it further

RESOLVED, That the North Carolina Medical Society supports evidence-based home visitation programs to prevent physical, psychological, sexual abuse, neglect, and death of juveniles.

(Report C-1995, adopted 11/12/95) (revised, Report L1-2004, Item 26, adopted 11/14/2004)(Substitute Resolution 16-1998, adopted 11/15/98) (revised, Report L1-2004, Item 50, adopted 11/14/2004) (Report D-1995, adopted as amended 11/12/95) (revised, Report L3-2004, Item 7, adopted 11/14/2004) (revised, Report I-2009, Item 3-27, adopted 11/01/2009)

Health Education

RESOLVED, That the North Carolina Medical Society supports comprehensive health education including behavioral health provided by qualified health educators as a major course in all schools, beginning at the elementary level; and be it further

RESOLVED, that the North Carolina Medical Society supports a statewide comprehensive sexual

education curriculum in all schools that emphasizes abstinence and will provide information about measures to prevent STDs and teenage pregnancy; and be it further

RESOLVED, That the North Carolina Medical Society supports behavioral health and substance abuse education in all schools beginning at the elementary level including alcohol, tobacco, prescription and non-prescription drug, and illegal substance abuse education.

(Resolution 22-1986, adopted 5/3/86) (revised, Report Y-1996, Item 4, adopted 11/17/96) (revised, Report L1-2004, Item 56, adopted 11/14/2004) (revised, Report I-2009, Item 3-35, adopted 11/01/2009)

School Health Education

RESOLVED, That the North Carolina Medical Society supports qualified health educators within the North Carolina School system to provide a program of instruction to include basic health care, preventive health care, first-aid, and cardiopulmonary resuscitation.

(Resolution 11-1984, adopted 5/5/84) (reaffirmed, Report CC-1994, Item 22, adopted 11/6/94) (revised, Report L3-2004, Item 16, adopted 11/24/2004) (reaffirmed, Report I-2009, Item 2-1, adopted 11/01/2009)