The February issue of *JAMA Internal Medicine* featured a clinical review titled “Patients’ Expectations of the Benefits and Harms of Treatments, Screening and Tests: A Systematic Review.”¹ The authors analyzed the results of thirty-six articles (totaling 27,323 patients) about the effect patients’ expectations of the risks and benefits of testing and treatment have on outcomes. On the basis of known statistical outcomes, the authors were able to compare personal conclusions to statistical reality. The study found that 65 percent of participants overestimated benefit outcomes. An estimation of harm occurred 67 percent of the time. Alarmingly, in only two studies of outcome analysis and two studies of harm analysis did greater than 50 percent of the participants estimate accurately. The authors rightly point out that clinicians should be skilled in providing balanced and accurate information to patients when major decisions are required in health care.

It would be prudent for medical practitioners to appreciate the findings of the study as they engage in multiple discussions with patients. Has the physician truly conveyed the benefits of an invasive procedure? Has he or she adequately discussed all the risks and potential harms of treatment? In my own practice, I have struggled to integrate my own bias in “professional judgment” with the obligation to prevent unfiltered information to patients and families. Perhaps nothing is more important in the physician–patient relationship than getting this aspect right. At its core, it is a relational covenant between sufferer and healer. Therefore, integrity, both in fact and motives, is foundational.

Pope Francis’s encyclical on ecology, *Laudato si’*, was released on May 24. All of us are in some way affected by the environment around us, both in the physical

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and spiritual realms. Therefore, I was interested to find an article in the *Journal of Epidemiology* published in March 2015 titled “Acute Air Pollution Exposure and Risk of Suicide Completion.” Amanda Bakian and colleagues researched the association between air pollution and suicide while avoiding any association with meteorological variables. The study was carried out in Salt Lake County, Utah, and examined short-term exposure to particulate matter (nitrogen dioxide, particulates, and sulfur dioxide) and the completion of a suicide attempt. The odds of completing suicide were 20 percent higher with an odds ratio of 1.2 when air pollutants increased in the three days prior to the suicidal incident. This positive association seemed to stand alone even after adjustments for meteorological, geographical, and cultural differences.

I am not sure if this association is biologically or psychologically founded, or even if it is a causative relationship. One can easily postulate that the chemical environment in which we live directly affects and alters brain chemistry and consciousness. Much more research is required to discover if the association is reality or if there is any true causative effect. However, regardless of the science, the study is an exhortation to protect God’s creation, reduce waste, and be mindful of those with whom we share resources.

Everyone is interested in grades, ranks, outcomes, and the latest consumer report. The explosion of internet sites that report the quality of products, including health care systems, is evidence of this fact. The March 2015 issue of *Health Affairs* reported that the national hospital rating systems share few common scores and may generate confusion instead of clarity. J. Matthew Austin and colleagues studied hospitals and their associated systems on the often reported star-rating scale. These performance scores are readily available on the internet. No hospital received a higher rating by all four rating systems at the same rate. In other words, the four most common rating systems available did not show a solid agreement among scores. Moreover, only 10 percent of the 844 hospitals investigated had two of the four rating organizations share a common “high grade.” The failure of hospitals to show high or low scores across the board reveals either a flaw in the ranking system or different areas of quality emphasis. Hence, many hospitals are likely to market themselves in a selective fashion. What individual does not want the public to see only their best side? Admittedly, part of the problem is that different ranking bodies use different clinical parameters to give their final grade. The authors suggest that across the rating systems there may be poorly defined concepts of quality or problematic issues with data quality. Such examples can include missing data or even an error in measurement. As health care makes an attempt to be more accountable to the public, the issue of reliable transparency will clearly come to the forefront. It must also be kept in mind that numbers do not always tell the full story. Intentionality, motivation, and integrity can be elusive in definition and beyond any surveyor’s ability to

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capture. Also, numbers and percentages will fail in any attempt to fully understand something as complex as the health care system. One can only hope that there will be a reliable way to rank in totality and compare and contrast existing hospitals. That information would truly be worthy of institutional marketing.

The correspondence section of the March 19, 2015, installment of the *New England Journal of Medicine* featured a letter from academicians from the University of Brussels documenting recent trends in euthanasia and other end-of-life practices in Belgium.\(^4\) The authors note that since the legalization of euthanasia in Belgium in 2002, a number of surveys have analyzed the demographics of the practice. Questionnaires were sent to 6,188 physicians certifying the cause of death in the first half of 2013 in Flanders, Belgium. There was a total of fifty-eight thousand deaths reviewed. Approximately 61 percent of those surveyed responded. The most common end-of-life practices included intensification of analgesics (24.2 percent) and withdrawal of life-prolonging treatment (17.2 percent). The rate of euthanasia increased from 2007 to 2013 from 1.9 percent to 4.6 percent of deaths. The trends not only showed an increase in requests for euthanasia, but an increase in the percentage of requests granted (77 percent). The researchers found a greater acceptance of physician willingness to grant patient requests for euthanasia. It was concluded that after eleven years of legal permission, euthanasia is becoming a more mainstream option for end-of-life cases in Belgium.

This is a disturbing trend that certainly fits the criteria used to define a “culture of death.” What is permitted is promoted. I find it interesting that the authors refer to life support measures as “life-prolonging” measures as opposed to “life-sustaining” measures. The emotional response to the term “prolonging” is often negative, for instance, the prolongation of suffering. The prior term “sustaining” has a much better cultural interpretation—for example, sustaining the environment. I cannot help but think of the National Public Radio request to have financial supporters opt for a “sustaining” membership. Words are the most powerful weapons in the philosophical arguments raised in the area of the sanctity of human life. One must constantly fight to use words in their truest meaning, especially words that are now often misinterpreted or redefined. The moral practice of medicine should never allow death to be desired as an endpoint of care. Death can be anticipated, accepted, and even welcomed, but it must never be actively pursued, or else medicine loses its focus on the noble goals of promoting health and relieving suffering.

It is easy to see the connection between life risks and patients who suffer with attention deficit hyperactivity disorder (ADHD). Dr. Soren Dalsgaard and coauthors presented a study of interest in the May 30, 2015, issue of the *Lancet*.\(^5\) Using data from a national database in Denmark, 32,061 individuals with ADHD were followed from their first birthday to the year 2013. Mortality rates were estimated on a number


of factors including age, gender, family history, occupation, and educational status. The mortality rate of those with ADHD was directly compared with those without it. As age groups were compared, it was found that those over the age of eighteen had the greatest increased risk of death if diagnosed with ADHD. For instance, the mortality rate for those under age six was 1.58, but it was 4.25 if the patient was over age eighteen. Even after other conditions such as substance addiction, conduct disorders, and Oppositional disorders were analyzed, patients with ADHD had a greater risk of death. Further investigations revealed that deaths resulting from unnatural causes—in particular, from accidents—occurred at a higher rate. It would make sense that those with poor concentration, disorganized thinking, and social turbulence are at risk for accidental death. It is well established that distractions are the leading cause of motor vehicle accidents in the young.

It would be sensible to propose interventions for those diagnosed with ADHD to reduce risk. Enhanced educational opportunities for driving immediately come to mind. Are there legal constraints available to protect society from risky behavior, much like it currently prevents those abusing substances from driving? These are controversial questions because of the tension that exits between autonomy and the public welfare. Moral principles have to be applied in a prudent manner to reduce the risks presented by the population with ADHD and to protect their intrinsic rights.

I have always had an interest in the dynamic association between health and interpersonal relations. The March 2000 Archives of Internal Medicine published “The Influence of Partner’s Behavior on Health Behavior Change: The English Longitudinal Study of Aging,” in which Sarah Jackson, Andrew Steptoe, and Jane Wardle report that couples are highly concordant for unhealthy behaviors; a change in one partner’s health behavior is often associated with a change in their partner’s behavior. The study reviewed perspective data from 3,722 married and cohabiting couples over the age of fifty in this longitudinal study in England. Investigating three chronic health risks (smoking, physical activity, and obesity), the researchers examined the influence of either partner’s behavioral changes on positive health outcomes. When one partner makes a healthy change, the chance of the other altering their lifestyle is markedly increased. For example, there was a much greater likelihood of smoking cessation in the partner of a successful abstainer. The odds ratio was five times greater for increased physical activity and three times greater for weight loss. I could not clearly discern from the article whether marital status was an important variable. I would like to have seen more documentation in that realm since it could be of interest in the social questions that now surround marriage and the common good. Francis has frequently referred to a theology of accompaniment, exhorting persons to guide others to a greater degree of truth and human flourishing. I think this study confirms the great relevance of human relationships in guiding those who love each other to a higher place, not only physically, but perhaps spiritually.

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The Ebola outbreak in Western Africa has not only stretched medical readiness, but also ethical guidelines. The February 2015 *Annals of Internal Medicine* presented an opinion piece titled “Ethical Guidance on the Use of Life-Sustaining Therapies for Patients with Ebola in Developed Countries.” The authors, Scott Halpern and Ezekiel Emmanuel, give a cogent review of some of the moral minefields that have appeared with the serious infectious outbreak of the Ebola virus in countries such as the United States. Using hypothetical cases ranging from intensive care support in a patient with multiple organ failure to easily treatable surgical emergencies, the authors give insightful assistance to clinicians struggling with challenging treatment decisions. The reader should again be reminded of the highly infectious nature of the disease, especially when invasive procedures such as CPR are required. Five key points are emphasized and include risk assessment to clinicians in relation to the life-sustaining therapy, institutional policies that are not simple rules, public reporting of clinician risks of acquiring the disease, the development of oversight committees to maintain individual case decision making, and finally a transparent approach to families and surrogates when therapies are withheld or withdrawn. For those interested, I would encourage them to delve into the full article. I think the authors make reasonable suggestions in what are very difficult scenarios. I also imagine utilizing a similar thought process in other disease cases. Health care workers should have a mandate to care for the ill, no matter the cause of their suffering. If patients present a danger to a health care worker’s own welfare, important decisions have to be made. Yet however strong the duty is to care for those who are suffering, such a duty is never seen as absolute. The patient’s ability to survive the illness with critical support may mitigate that duty. I suspect we will be hearing more on this subject.

The cultural environment in which we live our professional lives can have significant effects on our ethical compasses. An interesting article appeared in *JAMA Internal Medicine* titled “Influence of Institutional Culture and Policies on Do Not Resuscitate Decision Making at the End of Life.” Elizabeth Dzeng and coauthors interviewed fifty-eight internal medicine physicians from four academic medical centers, three in the United States and one in the United Kingdom, on their approach to end-of-life care. There was diversity in the physicians interviewed by years of practice and subspecialty. The researchers discovered that hospitals that prioritize autonomy over a best interest approach were more likely to defer without much reflection to simply prescribing a do-not-resuscitate order based on patient preference. Physicians and institutions who embraced a best interest model were seen to be more comfortable advising against resuscitation when survival was decidedly unlikely. More “senior” clinicians were less influenced by institutional culture and were more likely to recommend against CPR if it was thought to be futile. It is not clear whether more seasoned physicians took this approach because of the wisdom

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of their years or the culture in which they trained. Clearly, medical culture had a
more “paternalistic” flavor in the past. Like all decisions in medicine, there was a
necessary tension between autonomy and beneficence. I have often taught med­
cal students that if such decisions seem too easy, especially with a simple default
to a patient request, they are not reflecting enough on their professional duty. It is
incumbent on clinicians who claim the Christian faith to enliven and promote a very
healthy “medical culture.” Such a culture would not only engender a respect for
human dignity but also for the profound importance and sanctity of human life. As
our secular culture degenerates, small communities of such physicians will attract
patients who desire companionship through illness rather than entering into their
diseases as isolated autonomous units.

In prior reviews, I have expanded on the emotional health of medical profession­
als. Physician burnout and depression can lead good doctors out of their careers and
deprive patients of competent medical care. Leadership in health care organiza­tions
often sets the tone and culture for its workforce. An original article in the April 2015
issue of Mayo Clinic Proceedings explained the impact of organizational leadership
on physician burnout and satisfaction. Physicians and scientists from the Mayo
Clinic were surveyed on the leadership of their supervisors. They reviewed leader­
sip qualities in twelve specific domains using a five-point scale. Domains included
inspirational personality, encouraging conversations, and personal interests in the
associates’ careers. In all, 2,813 physicians and scientists responded to the survey.
After corrections and adjustments for age, gender, and employment duration, the
researchers discovered that more effective leaders were associated with a staff that
was less likely to have burnout and diminished work satisfaction. It is natural that
a talented and service-oriented leader would create a work culture that enhances
the emotional health of their colleagues. Clearly, health systems should search for
future leaders who embody many if not all of the twelve positive characteristics laid
out in this research project.

I think the finding exemplified in the study can be helpful to all other industries
as well. Moreover, in a hierarchical Church, this approach can lead to better ecclesial
choices for pastors, and even the “papal choice” for episcopal office. In the modern,
fast-paced culture of our era, good leadership choices can assist frontline workers
in maintaining their own personal energy, emotional investment, and activities of
self-offering.

Opioid (narcotic) addiction, with its associated medical and social consequences,
has an increasing effect on our American society. As a primary care physician, I have
seen firsthand the personality changes that often accompany addiction. Physicians,
most of them well meaning, are ultimately tied up in the ongoing behaviors associated
with the disorder. The April 28, 2015, issue of JAMA presented an original investi­
gation by Gail D’Onofrio and colleagues titled “Emergency Department-Initiated

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9 Tait G. Shanafelt et al., “Impact of Organizational Leadership on Physician Burnout

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Buprenorphine/Naloxone Treatment for Opioid Dependence.” In a trial of 329 opioid-dependent subjects, they studied the effects of three interventions in the emergency department setting. Interventions were outlined and included: (1) direct referral for treatment after a screening procedure was accomplished; (2) a brief intervention and facilitated referral to a community-based treatment program; and (3) a treatment with buprenorphine/naloxone with referral for ongoing medical treatment to a primary physician.

The medications utilized, opioid agonists, allow for reduction of withdrawal symptoms and better long-term suppression of addictive behavior. After the data was analyzed, the researchers found that participants treated with this medication and primary follow-up had far greater success in reducing their addiction. I should note that the status of addiction was self-reported. In all, 78 percent of the medical treatment group versus 37 percent of the referral group were in active addiction treatment after thirty days of the initial randomization. I found this difference to be impressive. Of course, long-term results will be very much anticipated and needed. The recidivism rate of narcotic addiction is an ongoing concern for physicians and the public as well.

In the moral universe, addiction adds to a number of harmful activities. Petty crime, prostitution, and drug violence are rampant in the community where drug addiction is prevalent. It is not limited to the inner city. I live in a small rural town, a town Norman Rockwell would paint, and have witnessed the death of teenagers from accidental overdose and listened to my older patients tell me how their grandchildren burglarized their homes in search of drug money. I suspect that an existential crisis underlies the drug addiction problem in our culture. Both young and old alike are drawn to transient experiences induced by drugs, which gloss over the emptiness present so often in a secularized life. Dare I say, a greater understanding of metaphysics, personalist philosophy, and perhaps most importantly an appreciation of divine revelation will serve all of us and lead us to a more peaceful and interconnected existence.

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