

Ethical Issues Surrounding the Care of Nursing Home Patients in the Emergency Room

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Abstract

The number of elders in the population is currently increasing. This will result in a proportional rise in individuals living in nursing homes while simultaneously increasing the need for their medical care. Although many nursing home patients may have a high level of physical and cognitive function, most suffer from multiple medical problems, which often consist of multi-system disease, coupled with impairment of cognition due to some form of dementia. When these individuals become ill, they are at high risk for serious consequences, including death. Elderly, frail patients living in the community may also present special challenges to the emergency room (ER) physicians, but those from nursing homes often provide unique clinical and ethical challenges. Part of this may stem from a negative bias towards the frail nursing home patient or a belief, sometimes erroneous, that they are at the end of their lives and dramatic or heroic medical interventions may be of little clinical value.

Often, at the onset of what appears to be a serious illness, nursing home patients are often sent to ERs (1). The ER physician may not have all the pertinent information from which to make an appropriate decision regarding the intensity or extent of treatment, especially if the patient is not able to communicate and if the information provided by the nursing home is of limited value (2,3). Family members may be available for crucial medical information and collaboration in the decision-making process, especially in end-of-life situations, though at times their input may not be timely or constructive due to the emotionally turbulent situation.

Thus the ER physician may be faced with making prompt clinical decisions that often challenge important ethical principles for which there are not always easy answers. Familiarization with the process of ethical deliberation may assist physicians in making urgent clinical decisions that affect frail seniors in general and elderly nursing home patients in particular.

Patient 1

An 87-year-old male arrived from a nursing home to the local ER. The transfer note said: "Collapsed in room at 5 pm while being visited by family. BCLS started and ambulance called". The history included long standing diabetes mellitus, hypertension, a previous major stroke with hemiplegia and aphasia and compensated heart failure due to myocardial ischemic disease. CPR was started five minutes before the ambulance arrived and continued during the 10-minute ride to the ER. The physician was in the ER when the patient and family arrived, along with the paramedics who were performing CPR.

The daughter screamed, "Please don't let my father die, do everything to save him".

Patient 2

A 91-year-old female arrived from a nursing home with acute abdominal pain and distension of about 5-hours duration. She had late stage Alzheimer's disease and had been fed through a gastrostomy tube for more than a year. She was virtually bed-bound with some limb contractures. Although she was not particularly interactive at the nursing home, she seemed to respond to the family's presence and had been

comfortable until the present event. She appeared to indicate pain through grunting and grimacing, especially when her abdomen was touched. Her family could not be located. According to the nursing home, her family sometimes went away for a day or two but usually could be contacted by 'phone but for some reason, at this time, they could not be reached. Examination revealed what appeared to be an acute abdomen and investigations suggested a perforation with free air under the diaphragm. She was hypotensive but responded to fluid replacement. There was no one to consent to the proposed surgery. The surgeon was reluctant to operate on this patient who he believed was close to the end of her life. He was concerned that she would be at high risk for post-operative complications that would likely result in her death.

Patient 3

A 79-year-old male arrived from a nursing home very short of breath. He had long-standing heart disease and diabetes but was cognitively intact. As he came into the emergency room he started yelling, "Leave me alone, I want to be left to die". He was wearing an oxygen mask but pulled it off as the doctor arrived and said, "Please leave me alone, I told them at the nursing home not to send me here, I want to be left alone." While the nurse was trying to start the intravenous he pulled his arm away and said, "I don't want any intravenous." The patient's son arrived a few minutes later and the doctor explained what had happened. The patient's son replied, "My father has been saying for a number of months that he does not want to be treated any more and that he should just be made comfortable the next time he becomes sick. He has had many bouts of heart failure and he has always survived. After the last episode, he pleaded with me to tell the nursing home not to send him to the hospital if he got ill again. We had a psychiatric consultation because we thought he might be depressed but the psychiatrist did not think his wishes were due to depression but rather a thoughtful realization about what the future held and how he wanted to die." The ER physician said that one injection of a diuretic would make the patient feel better and might save his life. The doctor further proposed that, after giving the patient an injection, they could discuss future treatment options. The son presented the doctor's proposal to his father, to which his father replied, "No, just leave me alone."

Patient 4

A 79-year-old gentleman was being assessed for the first time in the geriatric clinic of a nursing home. He had a long history of smoking and diabetes. Two years previously he had undergone a below-knee amputation for gangrene, a result of severe peripheral vascular disease. He described how he became very sick with sepsis and

when seen in the emergency room he was not able to provide consent to the life-saving amputation. He had a prosthesis, which he did not like to use. When told how lucky he was that despite living alone, a neighbor who found him in the terrible state of health had called an ambulance. He replied, "I wish they had not found me and, moreover, I told the surgeon how unhappy I was that he cut off my leg without my permission." Apparently, the consultant was shocked to hear the patient's comments since he felt his treatment was the correct life-saving procedure. The patient said, "I want to make sure that I will not lose my second leg, as I would rather die than be legless." This statement was initially interpreted as requesting advice and treatment to maintain the leg's circulation. However, the patient continued, "I want to do everything possible to make sure that this leg never comes off no matter what happens. Can I write a living will to that effect?" This resulted in discussions and the creation of an advance directive that outlined and documented his treatment wishes.

Introduction

Medical emergencies are inevitable in most nursing home patients (1-3). Whether or not patients are transferred to an ER depends on many factors including whether or not they have indicated what level of care they may desire under the circumstances (4). Even when expressed, the nursing home staff may not honor such sentiments, either because they fear having an acute patient succumb to their illness at the nursing home, or they are not sure how to interpret requests for withholding potentially life saving therapy. It is a challenge to the staff of the ER to consider the requests and circumstances of elderly nursing home patients while trying to weigh the risks and benefits, physically, mentally and ethically, of providing the standard treatments (5,6).

Ethical Considerations in Emergency Medicine

Often in the midst of a medical emergency, the immediate clinical needs and overwhelming urgency to make decisions overshadows the ethical implications of the decision-making process. These pressing clinical needs create situations where the processes that are usually in place to address ethical issues may be forgotten, dismissed or ignored. Such situations are addressed legally through laws and regulations, which are translated from ethical principles, allowing certain medical decisions to be made under urgent circumstances. These generalized procedures, in the form of legal mandates, are justified through the reasonable assumptions regarding the likelihood of how a particular ethical challenge would be addressed if time permitted. For example, the concept of consent is a legal translation of the ethical principle of 'personal autonomy', which requires a patient to be

informed about a proposed treatment before making a personal clinical decision (7). Only if the patient agrees with the proposed treatment, through the process of consent, can the physician provide the therapy.

In ER situations it is common for frail elderly nursing home patients to be unable to discuss proposed potentially life-saving treatments personally. Moreover, family members may not be available to consent to or refuse these proposed medical interventions. The law allows the commencement of life-saving treatments and accepts that the ethically based respect for personal autonomy is put "on hold". The legal premise for this is the belief that most people have a desire to live and as such the patient in retrospect would "gratefully" acknowledge that had she/he been able to respond, she/he would have consented to the life-saving treatment (5).

This scenario is not as clear as it may initially appear. Situations occur where a life-saving treatment is employed and the patient does not desire such medical intervention. Sometimes family members face conflicts where a potentially life-saving treatment is proposed but they believe that their loved one, if able to communicate, might reject the treatment even though they feel it should be carried out. The family may experience a tension between wanting to respect the wishes of the patient and their personal desire to keep him/her alive. Many times their personal commitment to the concept of 'the sanctity of life' and their desire to keep their loved one overshadows the reality of the clinical situation. At times the patient's quality of life seems to be marginal, especially to the healthcare providers but the family believes that their loved one shares their intense desire to be treated based on cultural or religious values (8).

Setting the ethical framework

The traditional secular ethical principles of autonomy, beneficence, non-maleficence and justice are found in Western and Israeli models of ethics (7,9). These principles are useful for categorizing ethical dilemmas but they do not provide comprehensive methods for designing ethical frameworks for the deliberation of decisions regarding elderly nursing home patients. Thus there may be a need to seek direction from elsewhere. Traditional/theological wisdoms of respective societies may fill this void by presenting useful traditional or religious methods of deliberation.

In a country such as Israel, where the predominant theological base is Judaism, the perspective of Jewish Medical ethics, as defined through Halacha or Jewish law, can be utilized as one of the methods to deliberate (10). The main role of examining complex and challenging clinical situations through the ethical lens is to create a deliberative process that works in tandem with clinical

decision-making. The process of ethical deliberation is the hallmark of 'quality care' that assures patients, families and health care professionals that clinical decisions are not determined in isolation of the ethical fabric that enfolds all decisions. Furthermore, irrespective of the difficulties encountered clinically, all health care providers should feel comfortable that the appropriate deliberative process is in place and is followed.

A major driving force in western secular ethics is the principle of autonomy (7), which is often erroneously interpreted as being the overriding ethical principle. The respect for the patient's active participation in the choice of decisions contrasts the historical and traditional practice of paternalism, by which physicians made decisions on behalf of their patients. Ostensibly this was done in the 'best interests' of the patient as interpreted by the physician. The traditional secular focus on the ethical principle of "beneficence" was easily translated into the paternalistic model of medical practice. It is still very common in much of the world and among many older physicians even in highly developed Western countries. Most physicians, when considering careers in Medicine, would cite the desire to 'do good' as one of the main reasons for choosing the profession. This dichotomy may present a conflict for these physicians when faced with a patient or surrogate who refuses life-saving therapy, which contrasts their desire to "do good" (5).

Avoiding harm is clearly an essential principle in clinical medical practice, while non-maleficence has a special meaning when the setting is an ER and the clinical care may coincide with potentially important research questions and possible experimental treatments (11). The ethical principle of 'justice' (distributive justice) has become an imperative focus in health care systems and institutions in all countries around the world. This is due to society's current struggle to meet the increasing needs of those for whom they are responsible in a manner that is deemed as fiscally affordable and socially responsible (12). The translation of 'justice' to meaningful clinical activities results in the concepts of 'resource allocation' and 'priority setting'. In all domains of medical practice and in all venues this is an important topic that must be addressed.

Religious basis for ethical decision-making

In contrast to the secular ethical framework, as expressed in Western medical practice, religious principles may profoundly impact on clinical decision-making in a contrary manner. In Israel, or in other jurisdictions that may treat large numbers of Orthodox Jews, halachic or Jewish legal considerations will also come into play and the interaction between all secular and traditional ethical principles must be understood in order for medical practice

to adequately reflect not only clinical standards, but on the halachic ethical standards as well (13). Important halachic principles that impact decision-making for frail elderly nursing home patients include the concept of sanctity of life, the saving of life (pekuach nefesh) and the requirement to respect a person who is clearly dying, a Goses.

When dealing with older nursing home patients, the same clinical and ethical principles exist as for any emergency patient. Added to these principles is the complexity of the common need for surrogate decision makers, the lack of ability to communicate and/or understand the patient's current wishes and the multiplicity of medical problems (5). In addition, there is the clinical impact of numerous co-morbidities (14) and the fact that end-of-life decisions are often part of the treatment equation.

Caring for the elderly nursing home patient in the ER

One of the prominent difficulties in the decision-making equation that makes the care of this population very challenging is the lack of clear information about their previous illnesses and their presenting clinical problems. The urgency of the situation, coupled with the non-specificity of symptoms in elderly and frail patients, makes it extremely difficult for emergency room physicians to determine the exact nature of the medical problem. Therefore, rather than making assumptions about the likely cause of disturbance based on relatively solid criteria, the physician is often forced to initiate treatment pending a better understanding of the situation. This may make it difficult to change the course of treatment in the future as the clinical picture unfolds. For example, the treatment of sepsis in an older patient who has diffuse malignant disease, which is not initially evident to the physicians, may unnecessarily prolong the dying process.

Within the secular framework it may be difficult for the physician to respect the patient's autonomy because often there is no way of knowing what the patient's preferences might be, either directly through communication or an advance directive or through a surrogate who truly knows the patient's wishes. Halachically, it may be a lesser problem as the sanctity of life and the saving of a life are such powerful ethical principles. ER physicians are often left with their commitment to the ethical principle of 'beneficence' to direct their treatment decisions. As much of the challenge is with end-of-life decisions or treatments for which the benefits may be marginal at best, such as CPR in the frail elderly populations (14,15), physicians often struggle with deciding what is "best" for these frail and vulnerable patients. It is often too easy to make assumptions of non-intervention, which assumes that such lives may not be "worth" salvaging. The latter assumption from the perspective of secular ethics often reflects concepts of 'justice', whereby resources should be used

responsibly. The price that society may pay for an apparently utilitarian approach, even if consistent with secular ethical principles, might be a dismissive and cavalier approach to the emergency needs of this population. A crucial notion that there is no such thing as a life that is not worth living can be found within Halacha (16). The focus when treating this population then becomes the extent of care that can be provided while respecting basic halachic concepts such as the 'respect of a goses', when one is not supposed to interfere in any way with the dying process while dealing with a patient clearly in the very last stages of life and in the throes of dying (17,18).

Patient reviews

By examining the patients presented at the beginning of the article it is possible to focus and evaluate how combining secular and traditional or religious based (as in Halacha) ethical principles might be of assistance in deciding on a professional, sound and ethically defensible approach to emergency care.

Patient 1:

In this patient the clinical issue was whether or not CPR in this population was likely to offer any benefit and what criteria could be used to determine likely survival benefit. The outcomes in this population are universally dismal with very few survivors even when the arrest was witnessed as it was in this patient (19). Although the patient at the time of arrest was not clearly on a terminal trajectory, which would determine that CPR would have no potential benefit, he did have multiple serious co-morbidities, which would greatly decrease any likelihood of a beneficial effect of CPR. Moreover, CPR had been going on for at least 15 minutes when the daughter made her plea. The ethical dilemma that arose for the ER physician lay partly in his/her perceived obligation to respect the daughter's request to continue with CPR. Determining the duration of CPR and the circumstances under which it should have been ethically continued further contributed to this dilemma.

One way to resolve this dilemma is to determine the clinical situation at the time of arrival to the ER. Even though it is clear that this frail nursing home population rarely survives cardiac arrest, there are defined situations where the likelihood of survival exists. That is in those individuals in whom the arrest is witnessed and unexpected (which apply to this patient). The next issue would be the circumstances surrounding the cardiac arrest (20,21,22). The paramedics noted that there was no sustained rhythm at the time of their arrival and this was confirmed within a few moments of arrival at the emergency room when the monitor leads were applied to the patient. The request by the daughter for continued CPR efforts had to be countered with the facts of the situation and the understanding that a physician was not

obligated to provide treatment for which there was no evidence of benefit (23). To continue applying CPR under the present clinical circumstances, despite the surrogate's request for treatment has no ethical basis. Moreover, halachically, it would truly be violating the concept of *goses*, when interventions, which interrupt the process of death, must be avoided in order to allow the soul to depart from the body (17,18). Careful and sensitive discussions with the daughter would have been the ethically sound approach to this patient, while CPR would have been discontinued.

Patient 2:

The ethical issues in this patient included the fact that the patient was unable to manifest her autonomy because of her Alzheimer's disease. The absence of family presence meant that the substitute decision-maker, which would have allowed autonomy to be fulfilled, was not available for assistance (24). In emergency situations most jurisdictions allow physicians to act for the benefit of the patient based on the ethical principle 'beneficence' and using the "best interests" concept of what kind of care should be provided. The ethical dilemma here was compelling as non-intervention would have led to death, yet intervention would have held little hope for benefit (25). In this patient, the likelihood of benefiting from the surgery was remote but not impossible, as the perforation could have been related to the gastrostomy tube and the surgery would have been relatively simple. In view of the fact that she responded to fluid replacement, the surgeon could have accepted the surgical risk until such time as the family was available. The surgeon could have undertaken the minimal resuscitative steps that would have allowed her life to be salvaged. These steps included fluid replacement and perhaps a laparotomy with the goal of only repairing a perforation but not undertaking major bowel resection. The latter would probably not have been tolerated. This could have been ethically defensible in view of the lack of any clear indication to the contrary and the fact that the patient appeared to be in a stable and non-life threatening situation prior to the surgical event. If, on the family's return, it was clear that this was not what she wanted, they could have limited further interventions. This patient is a good example of why advance directives are sometimes helpful (25). This is especially the case when the issue is one of limiting the extent of interventions when a person is unlikely to be able to communicate their wishes and if there are questions as to what the patient might have wanted when they were able to make decisions about their future circumstances.

Patient 3:

In this case the patient appeared to have been cognitively intact and had expressed to his son and the nursing home staff that he did not want to be treated and that he should have been allowed to die. Not only did the request appear to be consistent with previously expressed wishes but also

an assessment was made to determine if clinical depression was behind his wishes, which did not appear to be the case. The son was clearly in a difficult situation because he loved his father and, while wanting to save his life, he also wanted to respect his wishes (26). If this were a case of an Orthodox Jew, the likelihood of refusing life-saving treatment would have been remote and the obligation to save a life so great that treatment would have been undertaken unless it was clear that the patient was *goses* - in the throes of dying - or that no benefit existed from implementing such treatment (27). But, for a secular person, refusal of even life-saving treatment has to be respected as part of the ethical principle of 'autonomy' irrespective of the physician's view of whether treatment might or might not be successful (7). Most Western countries have incorporated the ethical principle of an autonomous person being allowed to refuse or have potentially life-saving treatment withheld or withdrawn into legal standards so that the ethical principle is supported by legislation and legal precedence. Although not universally accepted, the next step in the process of respecting 'autonomy' when it comes to end-of-life decision-making is the legalization of physician-assisted suicide. In 1997 the Death with Dignity Act legalized physician-assisted suicide in Oregon. In 2001 the Netherlands became the first country to legalize voluntary euthanasia, which in the past was practiced and rarely prosecuted (28). Both jurisdictions have taken the respect for 'autonomy' to the next step in terms of physicians' roles vis a vis patients' wishes and values about end-of-life decision-making. Physician assisted suicide has had a number of adverse effects in the Netherlands and resulted in numerous abuses of individual rights and it is unclear whether similar findings will occur in Oregon (29).

For this patient the physician could have chosen to ignore the patient's expressed wishes and those of the surrogate and provided acute potentially life-saving therapy. That might have been interpreted as excessive paternalism on the part of the physician and contrary to the whole notion of respect for 'autonomy'. The physician in good conscience could also have chosen to treat the patient only with palliative comfort measures with the hope that perhaps the patient would have survived the episode and further discussions about the future could have taken place. In all likelihood, the patient would have succumbed to the present illness and fulfilled his wishes for which there was concurrence by his son and most of the staff that has looked after him in the nursing home.

Patient 4:

This patient exemplifies the assumption that saving a person's life is the primary expected goal of a physician and that most people would be gratified if their lives were saved in a situation where they might otherwise have been lost. It is consistent with secular ethical principles of beneficence and the halachic duty of *pekuach Nefesh*.

In the emergency situation most physicians would act with this principle in mind and it would take a very strong contrary position to change the physician's commitment not to undertake a potentially life-saving procedure. This patient asked for an advance directive and assistance from a trusted physician to "protect" him from the loss of his second leg, even at the cost of losing his life (30). It might at first glance appear to be an odd request but one would have to truly understand the patient's perspective to come to terms with why the request was congruent with his value system. In this particular case the patient revealed that he had a deep-seated revulsion to the idea of existing with only one leg and the thought of possibly being legless was completely anathema to his idea of what it meant to be alive. Even discussions about the importance of life and the recognition of his superior intelligence and creativity (he read a serious book almost every day or two which he loved to discuss with his physician) could not dissuade him from his decision.

To implement and support his wishes required that he actually write an advance directive stating his preferences and making sure all those people who potentially might be involved in his care would be informed of his decision so

that they could be communicated to an emergency room physician or surgeon. The need for clear communication and strong advocacy on his behalf would be required for him to have had his wishes respected.

Conclusion

Decisions affecting elderly nursing home patients' care, in an emergency room setting, are inundated with ethical issues concerning their subsequent urgent or emergent care. The primary focus of physicians and other health care staff is rightfully on the medical condition and what can be done to promote well-being and decrease the likelihood of suffering severe morbidity or mortality from the condition in question. In the heat of making the complex medical decisions involved in the ER, it is possible to overlook or ignore some of the complex ethical issues that accompany the decision-making process in these situations. Understanding and acknowledging the ethical issues should help physicians and other health care providers undertake the appropriate medical therapy that is consistent with the highest levels of medical professionalism while at the same time respecting the basic tenets of medical ethics.

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