success is due to patient selection as well as the quality of our intravenous therapy program. A review of our peripheral line experience indicates a phlebitis incidence of approximately 1.3% with no serious infectious complications. Our phlebitis rate with peripherally inserted central (PIC) lines is 5.5%, with most of those resolving without removal. We have had no serious infection problems with over 200 PIC lines [4]. We did note that the experience of the intravenous therapy nurse in placing these lines was clearly related to success and complications.

We also reviewed our experience with endocarditis patients who we treated through our office intravenous therapy program. We found 29 episodes in 27 patients over the last 3 years. Organisms included *Streptococcus viridans* (11 cases), *Staphylococcus aureus* (6 cases), and *Enterococcus* (1 case). Of these patients, one had to be rehospitalized because of digoxin toxicity and another because of thrombosis of a Hickman catheter (which we try to avoid now that we have expertise with PIC lines). There were no other significant complications with home therapy and the patients did well.

The suggestion of the authors to perform a controlled study of outpatient intravenous antibiotic therapy is not a practical one because it is already widely accepted in the practice of medicine—even for endocarditis. In a survey conducted in 1989, 207 of 360 responding Infectious Diseases specialists indicated they had treated endocarditis patients with intravenous antibiotics outside the hospital. Even at UCSF, all seven of Colford *et al*'s patients who could be treated with outpatient therapy were so treated. The cost of continued hospitalization for a study would be great.

We cannot stop the growth of home and outpatient care but we can develop better criteria to select patients for outpatient programs and improve the quality of those programs. Physicians need to take a leadership role in developing safe and effective outpatient therapy rather than to try to stay the hands of time and the third-party payers.

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Submitted November 9, 1992, and accepted November 19, 1992

CRUZAN II

To the Editor:

The article by Emanuel [1] about the *Cruzan* decision was correct as far as it went. *Cruzan* II is even more significant [2]. The simple big news from *Cruzan* I was that patients have a federal constitutional right, acknowledged by the Supreme Court, to refuse treatment. No longer is that right predicated on state common, constitutional, or statute law. Most of the advance directive statutes that restrict withdrawal of food and water are unconstitutional, even the new ones in Ohio and Illinois.

After Emanuel's article was written, more evidence was found of what Nancy Cruzan would want. Subsequently in *Cruzan* II, December 1990, a Missouri probate judge ruled that the evidence presented to prove that she would refuse treatment was clear and convincing. What evidence? An informal, verbal statement to another person that she "wouldn't want to live like that" sufficed.

This decision was by a trial court, not at the appellate level. It was not contested by Attorney General/candidate for governor Bill Webster; it is not binding on lower courts. But given the dicta in *Cruzan* I, *Cruzan* II surely stands for this proposition: An advance directive of any kind, even theoretical, informal, verbal, will be evidence enough to stop giving food and water to the patient. The patient's directive of refusal reaches the level of a fundamental constitutional right.

If we can't find a directive (wish), even as weak as the one in *Cruzan* II, we will have to give up the fiction that the patient wouldn't want to live like that. In order to stop giving food and water to a patient who's never made even a casual verbal wish, we will have to admit that *we* don't want her to live like that, and declare her dead.

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Submitted April 2, 1992, and accepted June 16, 1992

The Reply:

Ms. Hall is correct to note that the Missouri probate court determined Nancy Cruzan's wishes on fairly vague and insubstantial comments to other people. However, it is by no means generally

held that it is permissible to use such comments as the justification for halting life-sustaining medical treatments. In legal decisions, such as the *Jobes* case in New Jersey and the *Drabick* case in California, courts have stated that such vague statements cannot be used. Rather, the family will be entrusted with making the determination of what is in the incompetent patient's "best interests" within certain social determined limits. Thus, as Ms. Hall notes, increasingly it will be our collective determination as to what lives are worth living that will decide how incompetent patients are treated [1]. We need to begin to articulate and justify these collective determinations.

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EVALUATION OF ETHICS CONSULTATIONS

To the Editor:

The recent editorial by Tulsky and Lo [1] correctly urges rigorous evaluation of clinical ethics consultations. Although existing studies provide useful descriptions of clinical ethics consultations in a few hospitals [2–4], these studies do not describe the full range of consultative methods and do not evaluate them with the rigor Tulsky and Lo advocate. The January 1, 1992, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirement that all hospitals provide ethics consultations [5] makes this an opportune time to study ethics consultations widely and rigorously. Many hospitals will initiate their own ethics consultation services, and consultative methods will undoubtedly differ from hospital to hospital. Some methods will be more physician-oriented [2–4]; others, more patient- or family-oriented [6,7]. Future studies should document and contrast the different methods used. Furthermore, before becoming too entrenched in medical care, clinical ethics consultations should prove their worth. Future studies should evaluate ethics consultations for their benefits in terms of patient outcome and patient satisfaction as well as provider satisfaction. Thus, we urge that future studies begin promptly, use multiple hospital sites, contrast the consultative methods at the different sites, and rigorously evaluate consultations for their benefits to patients and providers alike.

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Submitted June 3, 1992, and accepted June 16, 1992

EVALUATIVE MODELS OF ETHICS CONSULTATION

To the Editor:

We appreciate the editorial of Drs. Tulsky and Lo [1], and are grateful for their help. Since Dr. Lo [2] first suggested criteria for the evaluation of ethics committees in 1987, we have looked forward to the publication of his work and that of his colleagues on ethics committees and ethics consultation.

Several additional evaluative models have been proposed and might be tested. The work of Allen *et al* [3], assessing the contribution of geriatrics consultations, might be modified for ethics consultation. Goldman *et al*'s [4] gentle commandments for medical consultation might be empirically tested for ethics consultation. Lee *et al*'s [5] work on communication might also be usefully adapted. More research will build the scientific base of clinical ethics.

In our study [6], the consultant spoke with each (conscious) patient to discuss the ethical issues, and to discuss the recommendations for resolving them. We believe this represents a minimum standard of care. Seeing the patient is a necessary component of ethics consultation [7].

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Submitted June 3, 1992, and accepted June 16, 1992