are receiving lifesaving HIV treatment, thanks primarily to the support of the world community.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) was the key catalyst for world action on the AIDS crisis. It's an example of the kind of leadership that's needed for broader efforts to make the world safer from other infectious disease threats. Because of its strong bipartisan support, PEPFAR has saved millions of lives and shown that national governments can work together to address diseases.

We need a clear road map for a comprehensive pandemic preparedness and response system, because lives, in numbers too great to comprehend, depend on it.

Editor's note: This year's Shattuck Lecture was delivered at the annual meeting of the Massachusetts Medical Society as part of an educational event entitled Epidemics Going Viral: Innovation vs. Nature. Videos of the event, which included two panel discussions, the Gates lecture, and a Q&A session, are available at NEJM.org.

Disclosure forms provided by the author are available at NEJM.org.

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Beyond Legalization — Dilemmas Physicians Confront Regarding Aid in Dying

Bernard Lo, M.D.

"What do you think about physician aid in dying?"

Because 18.2% of the U.S. population lives in jurisdictions where physician aid in dying (PAD) is now legal, physicians need to anticipate that patients may inquire about or request it. Two decades ago, when PAD was illegal throughout the United States, 18.3% of physicians reported ever having received a request for assisted suicide[1]; inquiries are likely to be more frequent now. But physicians may feel unprepared, uncertain, and uncomfortable when confronting these conversations, even if they've thought through their own position on PAD legalization.

Physicians can start by clarifying what patients are asking and why. Some ways in which patients might raise the topic of PAD are listed in the box. Not every question about PAD is a request for assisted suicide. Patients might be seeking information, talking through concerns, expressing distress, or trying to ascertain the physician's views. To clarify the patient's motivation, physicians might say, "I'll be glad to answer that question, but first please tell me what led you to ask."

Next, physicians can explore patients' concerns and identify and address their palliative care needs,[2] regardless of the physicians' own views or the legal status of PAD where they practice. Discussions could cover patients' physical symptoms; psychosocial, existential, and spiritual suffering; hopes and fears; and goals of care. All options for end-of-life care should be discussed, including palliative and hospice care and palliative sedation.

It's also important for physicians to think through what actions they're willing to take. Both physicians who support PAD and those who oppose it should try to relieve patients' multidimensional concerns and distress. After comprehensive palliative care is intensified, 46% of patients who have requested PAD change their minds.[3]

Physicians who support PAD face several decisions regarding patient inquiries. First, are they willing to assist any patient who meets the legal requirements for PAD, or will they participate only in certain circumstances? Physicians are most likely to support PAD in cases of unremitting pain.[4] Many physicians who support PAD legalization may have cases of refractory physical suffering in mind. But perceived loss of autonomy and dignity is now a more common reason for requesting PAD than inadequate pain control.[1] Some physicians may decide they aren't comfortable assisting in a patient's death in such circumstances.[4]

Responses may also be influ-

Examples of Ways in Which Patients Might Raise the Topic of Physician Aid in Dying.

Statements

"A friend of mine with cancer said she is thinking about asking her doctor to help her die."

"My wife and I were discussing what to do if my heart disease gets much worse. One of the things we talked about was medicine to help me die."

Questions

"What do you think of the new state law on assisted death?"

"What is the clinic's policy on helping dying patients end their lives?"

"I hear that some physicians will help patients get a prescription for aid in dying. What is your position?"

"Will you write me a prescription so I can end my life when my cancer becomes unbearable?"

enced by how well the physician knows the patient requesting PAD. It's reasonable for physicians to first assist patients with whom they have an ongoing relationship that facilitates discussion of concerns and assessment of decision-making capacity. Physicians who participate in PAD can also assist patients of close colleagues, who can help identify and alleviate the patient's distress but might be opposed to PAD themselves or who are willing to participate but inexperienced in doing so. In the latter case, comanagement of the patient's care might be desirable. However, many physicians may hesitate to make PAD a prominent part of their practice because of the intense emotional and time commitment required.

Second, physicians who lack experience with PAD might have difficulty determining which medications to prescribe to eligible patients. Evidence in this area is weak. There are no peer-reviewed publications on the effectiveness and proper dosages of new drug combinations being used for PAD or on the adverse effects associated with them. Barbiturates — which have traditionally been used for PAD in places where it's legal — have become difficult to obtain or prohibitively expensive. Inexperienced physicians could try to identify a trusted colleague who is more experienced with PAD and willing to answer questions, provide advice, or comanage care for eligible patients. If such expertise is unavailable, physicians willing to participate in PAD need to contend with being early adopters.

Third, physicians who support PAD need to consider how to address the potential for adverse outcomes, including longer time to death than expected (up to 24 hours or more), awakening from unconsciousness, nausea, vomiting, and gasping.[1] Reports of adverse outcomes don't include specific information on drugs and dosages used, and how a drug will affect a particular patient is always uncertain.

Physicians who participate in PAD can help patients and their families plan for worst-case scenarios, such as deciding whether to call 911 if distressing symptoms develop after lethal medications are ingested. Physicians should clarify whether they or another professional, such as a hospice nurse, is willing and permitted to be present during medication ingestion. Some physicians who support PAD might be concerned that their presence could exert undue influence on patients who might otherwise hesitate or change their mind at the last minute. To mitigate this concern, physicians can meet privately with patients shortly before medication ingestion to explicitly tell them that they can change their mind without repercussions.

Physicians who oppose PAD shouldn't stop caring for patients who ask about or request it. The physician's professional obligation to address a patient's suffering is particularly strong when the two have a long-term relationship. Some patients want to see their current physician for ongoing care, even knowing that the doctor respectfully opposes PAD.

Physicians who oppose PAD understandably don't want to compromise their moral integrity and conscience. Some might fear that discussing PAD with patients signifies support or approval and therefore makes them complicit. Complicity in PAD, however, requires clearly expressing approval, completing legal requirements, or writing a prescription for a lethal medication dose. Many physicians who oppose PAD also consider referring patients to physicians willing to provide assistance with dying to be a form of complicity. Such physicians should instead refer patients to their state's website about the PAD law so that patients are informed of all their options. Physicians who explore patients' needs and concerns, try to alleviate pain and distress, and clearly state their opposition to assisted suicide aren't complicit in PAD. Even continuing to care for a patient who has obtained a prescription from another physician need not make a physician complicit. On the contrary, by discussing the patient's concerns and trying to address the reasons behind a request for PAD, the physician might help the patient find reasons to continue living. According to state reports from Oregon and Washington, 16% and 26%, respectively, of patients who have obtained a lethal medication did not use it.

Finally, physicians should consider how their personal position might affect patients. Patients make decisions about PAD for intensely private reasons, often on the basis of their religious and moral beliefs as well as their values and goals. Physicians should respect the highly personal nature of these decisions and be sensitive that their own views might unduly influence patients. Physicians should not raise the topic of PAD themselves, except in a discussion of all palliative care options, lest patients infer that they are recommending it. As a matter of transparency, however, I believe that physicians who are asked about PAD should state their own position, including whether they would write a prescription for a lethal dose of medication.

An audio interview with Dr. Lo is available at NEJM.org

Some patients might consider finding a new physician when their current physician's views regarding PAD are discordant with their own. In one study, 2% of physicians had a patient leave their practice because of their position on PAD.[5] In another, 19% of patients with cancer reported that they would change physicians if their doctor had participated in assisted suicide or euthanasia.[4] Patients who oppose PAD might fear that a physician who supports it would encourage them to consider it. Conversely, patients who are open to PAD might want to choose a supportive physician early in their illness. In all cases, doctors should elicit and address patients' specific concerns and emphasize their ongoing commitment to relieving suffering.

Responding to inquiries about PAD is new territory for most physicians. To fulfill their obligations to patients and be true to their own values, physicians should think through how they will respond to the challenges raised by these conversations.

Disclosure forms provided by the author are available at NEJM.org.

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Excluding Observation Stays from Readmission Rates — What Quality Measures Are Missing

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For the past several years, health care reform efforts have focused on reducing preventable hospital readmissions. Most notably, in 2012, the Centers for Medicare and Medicaid Services introduced the Hospital Readmissions Reduction Program (HRRP), which penalizes hospitals that have higher-than-expected 30-day readmission rates for Medicare patients with certain conditions. Commercial payers and state Medicaid agencies have increasingly followed suit by requiring hospitals to report data on readmissions and by occasionally linking reimbursement and purchasing agreements to performance.[1] Consequently, although experts continue to challenge the usefulness of readmission rates for assessing quality of care,[2] the rates are now broadly accepted as a measure of hospital quality by payers and policymakers.

Readmissions that occur soon after hospital discharge are thought to reflect the quality of care transitions in particular. Policies that aim to reduce readmissions have thus had the beneficial effect of offering incentives to health systems to pay greater attention to care coordination and discharge processes for patients leaving the hospital.[3] Despite some evidence that these efforts are working — readmissions have decreased for both conditions targeted by the HRRP and other conditions[4] — we believe current readmission measures are missing a key component of the quality equation by