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Inside: 2001 Readers' Survey

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Should you or shouldn't you? What to do when parents ask you to keep secrets

Counseling, support for family can resolve conflicts

When parents of a critically ill child ask a physician to withhold information from the patient, it usually indicates the family needs help coming to terms with the illness. This should be resolved with support and counseling — not a called meeting with the ethics committee, say experts in pediatrics and ethics.

"I don't see it happen that much anymore. When I first started, it was a fairly typical approach that families didn't want kids to know about a really bad diagnosis," says **David Gerber**, PhD, administrative director of patient and family services and chair of the ethics committee at All Children's Hospital in St. Petersburg, FL. "But if it does happen, it is usually not as much of an ethical issue as many people think it is. What it is signaling is an issue that needs to be worked on in that family."

Parents may still be in denial about the seriousness of their child's condition. They may be dealing with feelings of anger at themselves or caregivers for not being able to heal the child, or guilt for having "allowed" the child to become sick. Or in cases of children with an illness that may carry social stigma, such as HIV or AIDS, the parents may want to protect the child from harmful actions by others, says **Mali Mann**, MD, a child psychiatrist and psychoanalyst and member of the clinical faculty at Stanford University Medical Center in Palo Alto, CA.

"In cases such as HIV, the family itself may be very isolated or feel very isolated," she notes. "If a parent is infected, he or she may be dealing with his

COMING IN FUTURE ISSUES

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or her own illness and feelings of shame and isolation, and may want to keep that information a secret, even from the child."

Some parents simply want to protect their children from the emotional burden that comes with having a serious medical condition or to feel significantly "different" from their peers, says **Joel Frader**, MD, professor and interim division head of general academic pediatrics at Northwestern University Medical School in Chicago. Frader also serves as chair of the ethics committee at Children's Memorial Hospital, also in Chicago.

In addition to children with life-threatening or chronic medical conditions, Frader has encountered parents who did not want their children to know they had other conditions, such as epilepsy.

"It is not a request that is received every day," he says. "But certainly, it isn't a rare occurrence."

Counseling should resolve conflicts

In general, getting the parents and, if possible, other family members together to discuss these issues will lead to the parents' decision to tell the child about his or her medical condition, say Mann and Gerber.

"It is often helpful to sit down and have a conference with the parents and physician, perhaps with the help of a psychiatrist or analyst or counselor to address their particular concerns," says Mann.

In cases where the family feels isolated from the community, or is afraid of the reactions of the child's peers at school, counselors can talk about ways that the family can get support or ways that the child's condition can be communicated to school officials to maintain confidentiality. And, they can help the parents and child determine how they want to communicate information about the child's illness to other people.

It should be emphasized to parents, however, that withholding the knowledge that the child has a serious illness, or may even in fact be dying, robs the child of having a voice in medical decisions that are made about his or her care. Further, withholding the truth can diminish or destroy the child's trust in parents and caregivers.

"In 90% of the cases that I have seen, the child already knows by the time he or she is told [of the diagnosis]," says Frader.

Children are very perceptive, agrees Gerber, and, if they are ill or they are often in a hospital or other health care setting and see serious discussions between their parents and caregivers,

they will pick up cues about their condition. "When they are all of a sudden involved in treatment plans that are having some pretty harsh effects on them, or when they begin to start feeling really, really lousy, nine times out of 10, they will ask questions."

Cultural considerations

Sometimes a family's cultural background will preclude caregivers from giving medical information to children, says Gerber.

"What we were talking about before is from a fairly homogenized, Americanized value system," he explains. "Our expectation is that, of course, kids need to be told what the diagnosis is. But, when we see families from other cultures — we are an international referral center — we have some who come from a very maternalistic or paternalistic society, in which the expectation is that we will deal only with the parent and the parent will communicate to the child what they want the child to know."

This may often cause major disagreements between the physician's, caregivers', and the parents' wishes.

"Then, we run into a problem and the ethics committee gets consulted," he says. "Then it is a matter of trying to decide, not what is globally right, but what is right for that particular family."

While efforts should be made to argue the benefits of informing the child, ultimately, caregivers should not supersede their wishes over the wishes of the parents in any situation, including families with different cultural backgrounds, he says.

"The position that we take is that families, having existed well with their coping measures before they came to this hospital [and] in order for them to live well after they leave here, how can we go in and change their value system to make it match our own, just so that we can feel more comfortable about doing something?" he asks.

Even when children are told of their diagnosis and/or that they are terminally ill, it is important the information be communicated in a way that is appropriate to the child's age and allows the child to understand his or her situation, without overwhelming or frightening the child, say experts.

"The idea of death, kids as young as 4 to 7 can begin to grasp that," says **Jacqueline Ater**, MA, a Rochester, NY-based speech pathologist and consultant who helps physicians and caregivers communicate with patients' families. "When you look at someone who is 12 or 13, we are really beginning to think about [that person] as a young adult. You need to determine the information capacity of the child you are talking about."

Considering the level of vocabulary, tone of voice, and speech patterns that are used is very important, she adds. "The information capacity of the child guides you in deciding what type of language that you use; you may just use simple phrases and short sentences with a younger child, but as you get to adolescents and teen-agers, you can use complex sentences with a lot more, 'ifs,' 'whens,' and 'buts.'"

CME questions

1. According to Jeffrey Botkin, MD, professor of pediatrics and medical ethics at the University of Utah in Salt Lake City, use of stored biological materials would likely come from residual newborn screening samples that test for:
   A. hyperthyroidism.
   B. phenylketonuria.
   C. sickle cell disease.
   D. all of the above
2. According to C. Ben Mitchell, PhD, senior fellow with the Center for Bioethics and Human Dignity in Bannockburn, IL, stored biological materials already exists for certain populations, including:
   A. forensic medicine.
   B. convicted sex offenders.
   C. military and federal personnel.
   D. all of the above
3. According to David Gerber, PhD, administrative director of patient and family services and chair of the ethics committee at All Children's Hospital in St. Petersburg, FL, parents of a critically ill child who ask physicians to withhold information usually signals:
   A. problems within the family.
   B. problems with a religious belief.
   C. problems with insurers.
   D. all of the above
4. Parents of critically ill children who wish to hide the illness from the child, according to Mali Mann, MD, a child psychiatrist and psychoanalyst and member of the clinical faculty at Stanford University Medical Center in Palo Alto, CA, may do so because:
   A. they are still in denial of the disease.
   B. they are angry with themselves or at caregivers.
   C. they feel guilty for the child's illness.
   D. all of the above

Who communicates the information also is important. If a physician wants to talk to the child, it may be advisable to have other caregivers that the child feels comfortable with be present as well.

"Usually, there is someone on the care team that the child has especially bonded with, and that person may be able to help," she notes.

The clinicians also should be prepared to read nonverbal cues from the child to determine whether the child is processing the information or is becoming confused, overwhelmed, or frightened.

"You may want to stop periodically and ask questions, like, 'Do you understand what I am saying?" she notes. "You need to remember to check in with the child to see how well they are handling what you are saying."

Ideally, telling a child about his or her condition is a process that takes place over time, so that information is meted out in manageable doses as the child becomes ready to receive it, she adds.

Gerber recommends asking children questions about how they feel about their condition, about the care they are receiving, and if they have any questions for the doctors or nurses.

"What kids are most afraid of, they tell us, is what they do not know," he says. "What they want to know is what they are going to be asking. If we avoid that answer, if we try to sugarcoat it, if we try to handle it in a way that is outside their developing value system, we are only going to increase their fear level."

And, even though it's important to be honest with children about their diagnosis, it also is important to communicate that information gently, he says.

"Even with a 14- or 15-year-old who is fairly mature, if you tell them, 'The doctors have done all they can for you, there is really no hope that you can survive this.' If you do it in a way that is really heavy-handed, the kids can give up," he warns.

"They can just decide to stop living at that point. But, there are a lot of kids in terminal stages who continue to go to school and may have very specific goals about getting to one more prom, or they may want to see a sibling do something very special. It is not so much a medical ethics issue as a family care issue. Don't presume or assume what a family needs, you need to assess," explains Gerber.

Although a lot of attention is paid to family problems with talking to children about terminal illness, a major barrier may be clinicians themselves who are unwilling to accept that the child is dying, says Gerber.

"I am close to a number of pediatricians, and I know that they got into medicine to help children get better," he explains. "When kids die, is that a failure of medicine? Is it a personal failure? That is an issue."

The nation's health care system has not done a good job of dealing with end-of-life issues in children, and many physicians have difficulty "giving up" and switching from curative care to palliative care, Gerber believes. "Very often, the children are there first [in terms of acceptance], the moms and dads get there second, and the physicians get there third in terms of saying, 'Enough is enough.'"

Some of the ethics consultations in the hospital have involved children and parents who were ready to stop pursuing a cure and physicians who still wanted to try, he adds.

"If clinicians would be aware of that, and recognize that a child's dying is not a failure of medicine. And, no matter how good we are professionally or medically or as a facility, some kids are still going to die," Gerber says. "Until we get over our egocentricity that we should be able to cure everything, we are going to have a difficult time talking about this." ■

SOURCES

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Stored tissue samples: Gold mine or land mine?

Bioethics policies not keeping pace with technology

Hospitals across the country may be sitting on a research gold mine and not even know it. Thanks to the "mapping" of the human genome, stored blood and tissue samples from patient screening and research projects could provide a

wealth of information to researchers studying the links between genetic mutations and disease.

"An interesting area that may be of particular importance is the issue of residual newborn screening samples," explains **Jeffrey Botkin**, MD, professor of pediatrics and medical ethics at the University of Utah in Salt Lake City.

Every baby born in the United States has a blood sample taken so that the baby can be screened for a number of diseases. Although the particular tests vary from state to state, most include a screening for hyperthyroidism, phenylketonuria, and sickle cell disease, among other things.

"You virtually never use up all of the sample in conducting the tests," Botkin continues. "So, they may sit around. Laboratories may use them to recheck their instruments for quality control. But, they are also sitting there and available for testing a wide variety of things. Some states in the past have used them to anonymously screen for HIV prevalence in the population. They could potentially be an extremely valuable resource to look for prevalence of genes or infections or environmental exposures."

Is consent even necessary?

Although most hospitals currently are not set up to allow researchers access to the tissue samples, the fact that they exist raises questions about whether these samples could be used in genetic research.

Should hospitals go back to individual parents, or the now-adult donors themselves, for consent to use these samples in research? Or, since the samples are considered the property of the institution maintaining them, is consent even necessary?

These screening samples represent just a fraction of the massive amount of stored tissue samples that could potentially be available to outside researchers, say Botkin and others.

"We have the gathering of information for forensic purposes, storing blood and tissue samples of convicted sex offenders, for example," adds **C. Ben Mitchell**, PhD, senior fellow with the Center for Bioethics and Human Dignity in Bannockburn, IL. Mitchell also is an assistant professor of bioethics and contemporary culture at Trinity Evangelical Divinity School and Trinity International University in Deerfield, IL.

"Also, information from federal employees and military personnel. All of that information is either available or might be available out there. I don't want to sensationalize the issue. But, all of those samples from military personnel and federal employees are stored somewhere inside the Beltway."

Large databases of genetic information are valuable to researchers because they would allow them to study a certain prevalence or occurrence of a genetic trait across a large population, often a population about which significant demographic data already were collected.

At the same time, this also means that very specific information about large numbers of individuals has the potential to become public, points out Mitchell.

"The specificity of our genetic information, the fact that it can be used to identify an individual, kind of raises the stakes," he explains. "It is not just that we are tracing the incidence of breast cancer now. It is that, at some point, we might be able to go down the line and see exactly who that was who had the breast cancer. That would be a potential violation of privacy."

There already have been instances of what many ethicists would consider to be wrongful use of information gained through genetic testing, says Mitchell. Which means that as the amount of stored genetic information becomes more easily available, the potential for abuse increases exponentially.

"That fact demands that we begin to think about how we will use that information, and how we will protect patients' rights with respect to that information," he says. I think it would be naïve to assume there won't be a lot of people who want access to the information."

A precedent-setting lawsuit in California, *Moore v. Regents of University of California*, set a benchmark in determining what rights individuals have with respect to blood and tissue samples after they've been collected. The ruling had an enormous impact on research and development of genetic therapies and diagnostic tests.

A California man, John Moore, was being treated by his physician for hairy-cell leukemia, explains Botkin. His physician, however, also was an investigator. The physician developed and patented a cell line from Moore's blood and tissue samples.

"There were some questions raised about whether additional blood samples were taken that were not necessary for medical care," Botkin continues. "At any rate, the investigator ended up getting a patent for a cell line and a relatively lucrative commercial product. Moore found out about it and sued for a share of the profits."

In 1990, the California Supreme Court ruled that Moore no longer had property rights to his genetic

information. However, it also ruled the physician should have gotten his informed consent before collecting information for research purposes.

"Investigators had an obligation to inform research subjects that their materials might be used in the development of a commercial product," Botkin explains. "If they wanted to opt out, then they could. It came down to more of a consent issue rather than an ownership issue."

Since that time, a number of research projects started including standard language in their informed consent documents stating that information obtained from tissue samples may be used in the development of a commercial product, but that the donor won't have a share in the profits of that development.

"It seems clear, at this point, that samples that enter a laboratory are no longer owned by their source," he says. "But, people should still have the option of opting in or out of the research."

Allowing research using anonymous samples

But what about tissue samples already collected and stored?

The National Bioethics Advisory Commission (NBAC) examined the issue in depth, says Botkin.[1] And its conclusion, and the way that most institutions have decided to handle that issue is by unlinking the tissue samples from identifying information about the donors or tissue source, which eliminates the privacy risk to the individual, he says.

"Thus, the donor no longer becomes a human subject as far as institutional review boards [IRBs] are concerned," he explains. "Now, the IRB may be interested in reviewing your protocol for unlinking the information. But I think that has been a good route to reduce concern."

The potential for unlinked information to still stigmatize large populations however remains and has yet to be dealt with, Botkin adds. "For example, you know your samples are from an African-American or Native American population. You may find certain traits that are more prevalent in that population than others. You can potentially stigmatize the whole population even though individuals have been protected."

Use of linked or coded samples — samples maintained with the identifying information from the source — for new research projects that the donors did not consent for is now very much "frowned upon" by the research community, Botkin says. "If you want to use linked samples, re-consenting seems to be the appropriate way to go."

Some researchers attempt to address the issue of future uses of genetic information by including statements in the informed consent process for one study, which asks the participant to consent to use of the samples and information in future studies.

"That's the remaining area with the most controversy right now," Botkin says. "Basically, the question is whether people can sign away their consent to future research on identifiable samples." Can, for example, a researcher reasonably ask a person to allow his or her identifiable sample to be used for whatever purpose it could possibly be used for?

"NBAC split on that," he says. "Some people said that if people are informed and can make the choice to allow their sample to be used for anything that is their prerogative. But, others felt that you really cannot give informed consent for research unless someone tells you exactly what the research is that the tissues are going to be used in."

Botkin agrees informed consent requires a participant to know and understand the information and effects of a particular study. "I think it is reasonable to ask folks, for example, 'Can we use your sample for this study involving cancer research and other cancer research studies?'" he says. "But, to turn that around and use it for Alzheimer's research without going back for additional consent, I don't think is reasonable."

It is also impossible to know, given the current pace of genetic research discoveries, exactly what kinds of information we may be able to extract from tissue samples in the future, adds Mitchell. Therefore, any sort of "blanket" consent is invalid.

"There is a time span problem in that in 2001 we are not able to determine or predict what we might be able to test for in 2050," he says. "We need to be as scrupulous as possible in protecting

SOURCES

- **Jeffrey Botkin**, MD, University of Utah, Pediatric Administration, School of Medicine, 50 N. Medical Drive, Room 2A152, Salt Lake City, UT 84112.
- **C. Ben Mitchell**, The Center for Bioethics and Human Dignity, 2065 Half Day Rd., Bannockburn, IL 60015. Web: http://cbhd.org.

that information because we do not know what information might be able to be gathered in the future."

Some ethicists have gone even further, arguing that study participants — and even patients submitting to medical testing — should be able to mandate that their biological samples and information be destroyed, Mitchell adds. "Not only must I be able to give consent for a particular test that might include a genetic screening or gathering of genetic information, and consent specifically to that particular use and to no other, it may also be possible for me to say that I want my sample destroyed after that information is gathered so that it is not stored somewhere."

That raises more questions about the rights patients have to their genetic information, and about how much information can be obtained even after the tissue sample is destroyed, he continues. "We need biologists to tell us the answer to that. How much information are we able to gather right now that is above and beyond what is needed for a particular test and what is the best way for that information to be protected."

Unfortunately, say both Botkin and Mitchell, bioethics policy is falling behind the pace of scientific advancement, creating the potential for abuses of genetic information on a large scale.

The NBAC has done a lot of work in this area and written position papers and recommendations, says Botkin. But, the Department of Health and Human Services' Office for Human Research Protections has not released any formal policies or standards to govern hospital ethics committees or IRBs.

"We are stretching our existing structures almost to the breaking point," says Mitchell. "These new technologies are going to demand our rethinking [of] our regulation and policy because the potential power of these technologies for gathering information is of a magnitude greater than we have possessed in the past."

(Editor's note: The National Bioethics Advisory Commission's report, Research Involving Human Biological Materials: Ethical Issues and Policy Guidance, *is available on the commission's web site: www.bioethics.gov.)*

Reference

1. National Bioethics Advisory Commission. *Research involving Human Biological Materials: Ethical Issues and Policy Guidance. Vol I.* Rockville, MD; 1999. ■

Is your ED putting patients in danger?

EDs are on the verge of nationwide crisis

Is your emergency department (ED) going on diversion throughout the entire year instead of just the flu season? Are your diversion rates at an all-time high? When your ED is not able to go on diversion, do you feel that the overcrowded conditions are potentially unsafe and unethical for patients?

If your answers to these questions are "yes," circumstances in your ED reflect a growing trend that can endanger patients, says **Alan C. Woodward**, MD, FACEP, chief of emergency services at Emerson Hospital in Concord, MA.

"The system is under significant duress and on the verge of crisis," Woodward warns. "This is going to continue to get worse and worse." Despite taking steps to address the problem, ED managers report record increases in diversion rates and may turn to ethics committees for help.

The problem is receiving attention from medical groups, too, such as the Chicago-based American Hospital Association (AHA). AHA president **Dick Davidson**, MD, announced recently that ED diversions are part of AHA's 2001 Advocacy Agenda and the association's commitment to seeking regulatory relief to improve patient care.

According to Davidson, ED diversions are the result of a larger health care problem including more patients, fewer beds due to mergers, and fewer nurses and support staff. "Hospitals are overregulated. We need to be taking care of people and not taking care of paper," says Davidson. He pointed out that a number of legislative and funding issues have hurt patients' access to quality care — namely Medicare reimbursements and lack of medical insurance.

You can't stop patients from coming

"Last summer, our diversion rate was almost as high as the previous winter," says Woodward. "In the last eight months, there were only three days when not a single hospital in eastern Massachusetts was on diversion."

The ED at Massachusetts General Hospital in Boston is on ambulance divert up to 45 hours per week, says **Alasdair Conn**, MD, FACEP, chief of emergency medicine.

"However, ambulance divert merely slows but does not stop the flow of ambulances into the ED," he notes. "Physicians continue to ask patients to come to the ED for evaluation and management."

When more than three hospitals are on ambulance divert, the 911 center opens all of them, says Conn. "This really puts a strain on the ED and is putting patients in danger," he adds.

Often, even though the situation in the ED is recognized as unsafe due to overcrowding, hospitals are being denied diversion or are told they must go off diversion, because there is no place to divert patients to, Conn says.

The nursing shortage has compounded the problem, adds Woodward. "The shortage is particularly acute here. Even though we have closed half of the hospital beds in the state, most hospitals can't even fully staff the remaining beds they have," he says.

Here are effective practices implemented at EDs to address the problem of diversion:

• **Decrease patients' overall length of stay.**

Do everything possible to process patients faster, which makes room for the next patient, urges Conn. "We have analyzed patient delays to find out where the road blocks are," he reports.

At Massachusetts General's ED, a satellite lab was opened to improve lab turnaround times, with the goal of staffing it around the clock, he says. "Also, radiology was identified as a bottleneck, so a second helical CT scanner was installed," Conn adds.

However, the ED can't solve the problem alone — length of stay must be decreased hospitalwide, advises Conn. "Every one-tenth of a day decrease in overall length of stay opens up 12 new beds," he says. Conn recommends transferring patients to subacute facilities when appropriate and hiring additional nurses for the intensive care unit.

• **Use hard data as leverage to add additional staff.**

At Massachusetts General, nursing and physician workloads were analyzed with a national benchmarking database from the San Rafael, CA-based QuadraMed Corp., reports Conn. "This is a tool that is used elsewhere in the hospital and by many other hospitals in the U.S., so we are able to use the data for benchmarking," he notes.

It was determined the ED nurses were putting in workloads equivalent to 150% of the nursing workload at similar institutions, says Conn. "We were working at a 'high-risk' percentage," he says. "It's no wonder we had a high turnover rate."

To bring the percentage down, the ED added 20 more full-time equivalents, including two ED physicians, says Conn. "We argued that one cannot add nurses without adding more administrative positions — we asked for 22, but were given eight — and more physicians," he adds.

Conn also has used work-related value units (WRVUs) to compare the physician workload with benchmarks from the Lansing, MI-based Society for Academic Emergency Medicine. "Although provisional, the annual benchmarks for emergency medicine are about 4,000 WRVU per year," he notes. "Our physicians are working at over 6,000."

• **Redirect physician responsibility.**

The ED at Massachusetts General has a trauma acute area with 10 beds, a general area with 16 beds, five pediatric beds, and a fast-track area. Recently, a rapid diagnostic unit with six monitored beds opened.

"We asked that the attending physicians for our other areas now cover these additional monitored beds," says Conn.

Patients are now triaged as needing a monitored bed in the waiting room, says Conn. "Although emergencies, these are not usually life threatening — abdominal pain with stable vitals," for example," he adds. "We may have 10 or even 20 patients at a time in this category. So there is a risk that they may have to wait hours and become unstable."

The additional ED physician resources are used to relieve the other attending staff, treat the patients in the rapid diagnostic unit, and manage these patients at triage, says Conn. "This new position can also initiate labs or X-rays and provide screening exams," he explains.

• **Use an algorithm.**

Using a "diversion decision diagram" enables you to focus on necessary activities when you are already very busy, says **James J. Augustine**, MD, FACEP, CEO of Premier Health Care Services, a Dayton, OH-based physician management group that provides ED staffing and consulting. "You must have a policy, and you must have an expeditious process to carry it out," he stresses. **(See Diversion Decision Diagram, p. 46.)**

Augustine recommends including the following key points in your policy:

— What group of patients is being diverted?

— Are they being diverted to someplace in particular?

— How long will it last?

— Is this diversion consistent with hospital policy and justified by patient care needs (and therefore not an Emergency Medical Treatment and Active Labor Act issue)?

— When and how will diversion status end?

SOURCES AND RESOURCES

For more information about revising or adapting your diversion policy, contact:

- **James J. Augustine**, MD, FACEP, CEO, Premier Health Care Services, 8111 Timberlodge Trail, Dayton, OH 45458. Telephone: (937) 435-1072, ext. 102. Fax: (937) 435-8626. E-mail: jaugustine@phcsday.com.
- **Alasdair K. Conn**, MD, FACS, Massachusetts General Hospital, Emergency Services, 55 Fruit St., Boston, MA 02114. Telephone: (617) 724-4123. Fax: (617) 726-9202. E-mail: aconn@partners.org.
- **Alan C. Woodward**, MD, FACEP, Emergency Services, Emerson Hospital, 133 Ornac, Concord, MA 01742. Telephone: (978) 287-3690. Fax: (987) 287-3674. E-mail: woodward@massmed.org.

Guidelines for Ambulance Diversion are available from the Dallas-based American College for Emergency Physicians (ACEP). The guidelines were published in October 1999 as a policy resource and education paper (PREP) to supplement ACEP's January 1999 policy statement on ambulance diversion. Single copies are free. To order a copy of the policy statement or the PREP guidelines, contact:

- **American College of Emergency Physicians**, 1125 Executive Circle Drive, Irving, TX 75038-2522. Telephone: (800) 798-1822, ext. 6, or (972) 550-0911. Fax: (972) 580-2816. E-mail: pubsorder@acep.org. Web: www.acep.org. For the January 1999 policy statement, click on "Policies/Resources" and then "ACEP Policy Statements." Click on "List all policy statements" and scroll down to "Ambulance Diversion." For the October 1999 guidelines, click on "PREP available."

• **Address diversion as a hospital problem.**

In the Boston area, the number of acute care beds decreased by 35% over the last 10 years, so hospitals are running at very high occupancies, reports Conn.

Because of high diversion rates, a Massachusetts state task force on diversion developed a series of best practices that area hospitals have adopted. Here are some examples that affect the ED, but involve other departments:

— implementing written hospital operational procedures for identifying, monitoring, and managing ED diversions;

— establishing plans and systems for tracking and maximizing the utilization of beds and staff;

— listing specific hospital contracts authorized to convey information regarding status of ED diversions and transfer receiving capability;

— establishing communication and coordination agreements or protocols with other hospitals and pre-hospital providers in the service area.

To reduce diversion rates, the ED requires buy-in from administration and other departments, Conn insists. "Our hospital CEO realizes that this is a hospital problem, not an ED problem," he says. ■

Avoid diversion by looking outside of your ED

Do investigative work first

If your ethics committee is serious about avoiding emergency department (ED) diversion, look outside the four walls of your ED.

"You need to know how busy the paramedics are and what the status is at other EDs," says **Edwin Homansky**, MD, FACEP, chief of staff for the ED at Valley Hospital in Las Vegas. "ED managers must know what's going on at the other facilities to know how busy you're going to get."

Much better use of available information and demand planning systems is needed, says **James J. Augustine**, MD, FACEP, CEO of Premier Health Care Services, a Dayton, OH-based physician management group that provides ED staffing and consulting. He recommends using a system for bed status management, used by the hospitals, the major payers, and the general medical community.

"This would allow the regional health system to operate at a more efficient level while still enabling the community to access excellent care at peak demand times," Augustine says.

A bed status management system was successfully introduced in several metropolitan areas, reports Augustine. "The status of key community resources is communicated to providers," he explains.

Here are ways to avoid diversion by increasing awareness of community resources:

• **Address underlying problems with emergency medical services (EMS) and ED capacity**.

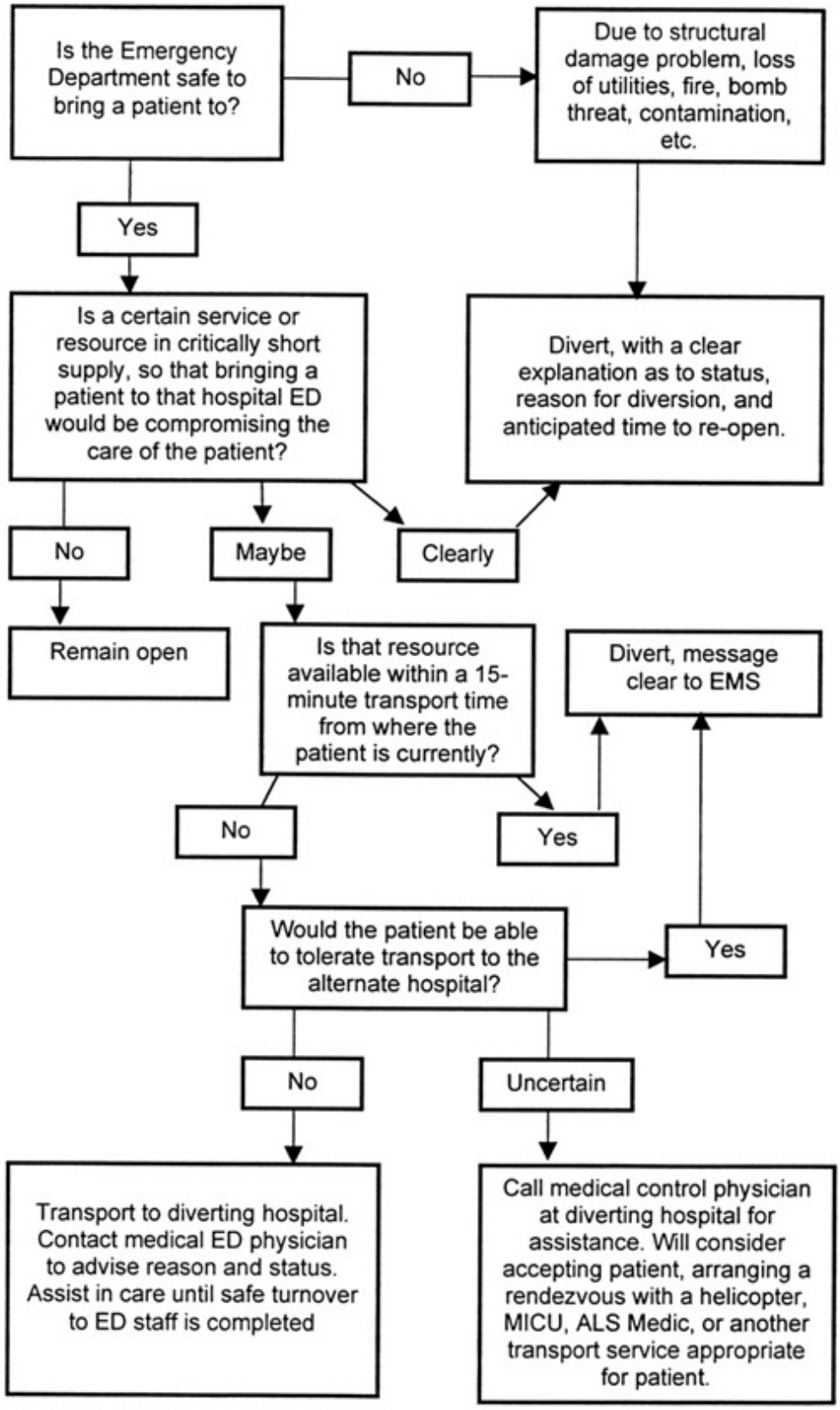
When developing a strategy to reduce diversion, answer the following questions about ED and EMS capacity, recommends Augustine:

— Are these two resources able to manage demand for services 95% of the time?

— Would greater capacity in one or both be able to buffer demands so that diversions are not necessary?

— Can the hospital better manage existing

(Continued on page 47)



Source: Premier Health Care Services, Dayton, OH.

capacity or resources (for example, the CT scanner) so that those resources will be available when peak demands occur?

— Can more of the tightest resources, such as cleaning staff to prepare rooms between patients, be strengthened?

— Can the hospital use information systems to predict peak times and then staff for them?

— Are there regional pools of resources that can be used more effectively?

• **Defer patients or get them to alternative environments.**

Some patients who are going to be admitted might be able to be managed with home care or direct admission to a nursing facility, suggests **Alan C. Woodward**, MD, FACEP, chief of emergency services at Emerson Hospital in Concord, MA.

"We use our transitional care unit to place patients in nursing homes," he says. The thresholds change as it gets more desperate."

Shortages of hospital beds might need to be addressed by using a broader base of beds in the community, says Augustine. "This pool of beds would have to be staffed by a competent and flexible set of hospital employees, who would be providing services in a nontraditional environment."

The hotel and extended care facilities in a community may be the best source of excess capacity for the acute health care system, suggests Augustine.

At the peak of the viral season three years ago, the Dayton area had many of its hospitals at or near diversion status, with EMS units held in the field waiting to find which hospital was open to take a patient, recalls Augustine.

"The EDs were thrust into a leadership position," he says. "My first calls were to the local Marriott hotel for their availability of beds in their

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Editorial Questions

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hotel or into their local extended care facility."

Under this type of crisis scenario, ED managers must take on leadership responsibilities, stresses Augustine.

• **Use EMSystem**.

In the Kansas City metropolitan area, EDs have worked in the pre-hospital community to implement EMSystem, a computerized tracking of the system's availability, which is accessible 24 hours a day.

Dennis Allin, MD, medical director of the Kansas City EMS system and director of emergency medicine at the University of Kansas Medical Center, says, "This system delineates the type of diversions recognized in our community. It also gives the pre-hospital personnel, hospitals, and dispatch centers up-to-the-minute knowledge of available resources."

It is critical that all hospitals in an EMS system have a relationship with each other, he stresses. "The pre-hospital component allows for a discussion of what resources are available and a consensus on what types of diversion will be allowed and how these will be communicated," Allin says.

Community protocols were developed in the Kansas City metropolitan area to establish policies for the use of EMSystem, notes Allin. EMSystem is a web-based, real-time hospital ED diversion and mass casualty incident-reporting system manufactured by Infinity HealthCare in Mequon, WI.

"Through this system, a hospital is held more accountable for how often they divert and for what reasons, since this is tracked throughout the community," he adds. ■

NEWS BRIEF

House honors living organ donors

The U.S. House of Representatives unanimously passed legislation in early March to boost organ donation rates and provide grants to living organ donors.

Sen. Dick Durbin (D-IL) introduced similar legislation in the Senate, but it has yet to vote on the bill.

Included in the House legislation are noncontroversial portions of a broader bill that originally passed the House in 1999. The bill later stalled in the Senate. The primary goal of the failed legislation was to overturn a controversial regulation to require a national waiting list for available organs.

A new contract between Richmond, VA-based United Network for Organ Sharing and the U.S. Department of Health and Human Services settled a fight between the two groups.

The new legislation will authorize the payment of transportation and living expenses of individuals donating a kidney or portion of a liver, or any other organ to low-income recipients. Payments would be made from annual grants of $5 million.

The other provision provides grants to states, starting with $15 million in the first year, to improve public awareness and expand outreach efforts to increase organ donation. ■