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'Covenant' helps families avoid conflicts

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Unlike other medical diagnostic testing, genetic tests reveal not only information about the patient taking them, but also about their relatives, including parents, siblings, and children.

Inevitably, conflicts will arise over how information resulting from such tests will be used and shared.

"This can be particularly difficult when it is a situation like a family physician treating multiple family members," says **David Doukas**, MD, associate professor of family practice and community medicine, and a fellow at the center for bioethics at the University of Pennsylvania in Philadelphia. "The patient can say, 'No, I want this information to be completely confidential,' yet it might have serious implications for other family members who may also be that physician's patients, says Doukas. Or the patient may be willing to disclose the information, but certain family members do not want to know."

It can be helpful if the person advising the original patient about genetic testing gets all of the family members together before any test is performed, to talk about what information might be revealed

Religion at the bedside: Do doctors have a calling?

✓ *Beliefs can have an impact on recovery, studies find*

A 1999 study published in the *Archives of Internal Medicine* finds a significant benefit of 'remote, intercessory prayer' in the treatment of patients admitted to a coronary care unit and recommends such prayer as a 'useful adjunct' to standard medical care. But a similar study conducted by different researchers and published two years later in the journal *Mayo Clinic Proceedings*, reaches the opposite conclusion: 'As delivered in this study,' the authors wrote, 'intercessory prayer had no significant effect on medical outcomes after hospitalization in a coronary care unit.' 54

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by the test, what implications it has for everyone involved, and decide who does and does not want to be informed about the test results, he says.

Last year, Doukas and **Jessica Berg JD**, assistant professor of bioethics at Case Western Reserve University in Cleveland, proposed a model for holding these discussions known as the "family covenant."¹

Under this model, the physician or genetic counselor would ask the person considering genetic testing whether they want other family members to be aware of the testing and if they wish to share information about the results with them.

With the patient's consent, the physician would get all of the family members together for a discussion, Doukas explains. "The intention is to have open communication about how the testing is going to be occurring, how it can potentially affect other family members, and how information can be shared among the family that is in accordance with the wishes and desires of not only the patient, but other family members as well."

Not everyone wants the same news

Even if the patient is willing to share information with other family members, each individual person in that family may feel differently about how much information they actually want, Doukas points out.

"One family member may say, 'Yes, I want to hear about it when you get the test results,'" he explains. "Whereas, another family member may say, 'No, I don't want to know about it. It will make me fatalistic about my life, or I'll get anxious or upset. I don't want to know.' Some people feel very strongly about that."

Having a group conversation prior to any testing helps ensure that all family members are in agreement about who does and doesn't want information and how to honor each person's wishes, Doukas says.

Calming fears about disclosure

Another key reason for initiating a family covenant is to educate the patient and family members and resolve any fears they have about disclosure, he adds.

"Some people do wish to have their information kept very private, and that is their right," Doukas says. "But other people don't want to tell

others because they think there is going to be this horrible reaction on the part of the other family members. What you want to do, is to say, 'No, it is not your fault. It is not like you have this gene and it is spreading like strep throat. It is something that is in the family.'"

And since it does run in the family, the patient may be more at ease with sharing the information so that other family members can do the things they need to do to evaluate their own risk level, he says.

Resolve issues before testing

Many genetic counselors do raise the issue of information disclosure, and ask clients to also consider the impact of genetic testing on other family members prior to the actual testing, says **Logan Karns**, MS, chair of the ethics subcommittee of the National Society of Genetic Counselors, and a genetic counselor with the University of Virginia Health System in Charlottesville.

"These kinds of situations come up quite often," says Karns. "For example, you may have a person whose grandparent died of Huntington's disease who is considering undergoing screening, but the person's parent has never been tested. If the test [on the original patient] is positive, then, by definition, the parent also has the trait."

Or you might have a situation in which a person who is an identical twin wants to undergo testing — which will automatically reveal the same information about the other twin — sort of testing that person "by default," says Karns.

These sorts of awkward situations can be made easier if concerns about possible results of testing and sharing of the information are considered ahead of time, she says.

"If you talk to people ahead of time and say, 'These are the issues that can come up, and how do you want to handle the results?'" Karns says. "It makes the discussion easier if you end up in an awkward situation."

Sometimes, genetic tests may reveal information unrelated to disease risk at all, notes Karns.

"There are some situations in which, through genetic testing, you find out one member of a family is actually not genetically related to that family," she explains. "That can be very awkward. This is an incidental piece of information that you have uncovered. What do you do with that information? Sometimes, it is related to the test results, because sometimes you can't answer the question the patient is asking if that person is

unrelated to the rest of the family."

Most labs that perform genetic testing have consent forms which explain that, in addition, to information about the disease risk sought, the test also may reveal nonpaternity among other things, she notes.

"It is definitely an issue I raise with people prior to testing," she says. "Once you have the information, it is very hard to ignore it."

Who is the patient?

The key ethical dilemma for providers involved in counseling patients who undergo genetic testing is decide who their patients are and where their primary obligations lie, say Karns and Doukas.

As more genetic tests become available, more family physicians will be called upon to help patients decide whether to seek testing and how to interpret the results, says Doukas.

Frequently, these physicians also will be the primary caregiver for other members of the same family. What if, as in the situations mentioned above, the original patients decide they don't want to share information, yet the test results pose significant health concerns for other family members?

"A lot of people struggle with what is the duty to inform," says Karns. "You have a person sitting in front of you who is your patient, but you have these other individuals who may benefit from the information. Do you have a duty to tell them?"

Although the family covenant may help avoid such situations, it doesn't completely eliminate them, notes Doukas. "Sometimes you may have someone pull out of the covenant — that's the thermonuclear situation. You hope that doesn't happen, but it can."

Prior to seeing the results, the patient may be willing to share the information. But after the results are in, that person changes their mind.

"The whole family may then show up and say, 'We never heard the results of the test. We want to know what happened,'" he says. "But, at that point, I think I would have to explain that this person pulled out of the agreement, that I can't divulge the information because it is private information. That is the stand that you would have to take."

Respecting the autonomy and privacy of an individual is supremely important in the practice of health care, Karns agrees.

SOURCES

- **David Doukas**, MD, Center for Bioethics, University of Pennsylvania, 3401 Market St., Suite 320, Philadelphia, PA 19104-3308.
- **Logan Karns**, MS, National Society of Genetic Counselors, 233 Canterbury Drive, Wallingford, PA 19086.

“However, genetic testing can create situations that are unusually ethically complex,” he explains. “Due to the genetic nature of the results, one person’s information may have a significant impact on another family member. You then find yourself in a situation in which two individuals have competing moral interests.”

For example, if one sister tests positive for the BRCA1 gene and did not want to share that information with another sister, Karns says she would strongly feel that the sibling should be told, though she is not sure she would be willing to violate the original person’s confidentiality to do so.

“That person could face significantly higher risk,” she notes. “And it is not as if nothing can be done. There are ways of preventing or decreasing the risk to that person. And unless that person has her family history and is definitely getting yearly exams, she may not get the appropriate follow-up until it is too late. That would be a very difficult ethical dilemma for me.”

If providers are going to bring other family members into the discussion then, in some ways, those family members also become that provider’s patients, she says.

“You have to decide how to work with them as a group and individually, as well,” she says. “You need to make decisions about how information is presented. Some information you can present to the group, and some you may need to present individually.”

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Co-occurring disorders need integrated treatment

Cross-training is key to recognizing dual needs

Patients seeking treatment for substance addiction or mental illness already face a very challenging road to recovery, but almost half of these people do not get the treatment they need for both illnesses.

Faced with what is known as a “dual diagnosis” or “co-occurring” disorder, such patients are often misdiagnosed, don’t receive appropriate treatment, and are at an increased risk for homelessness or incarceration, advocates say.

“There are two distinct systems of care for either addiction or mental illness,” says **Michael Cartwright**, executive director of Foundations Associates in Nashville, TN, a residential treatment program for patients with co-occurring disorders, which also administers the Dual Diagnosis Recovery Network (DDRN), an organization dedicated to providing education and advocacy for these patients.

“You have different trained professionals with different licensure systems and different funding streams from the federal and state governments,” Cartwright continues. “Most states have separate

governing bodies for mental health or substance-abuse treatment programs — there are really two separate systems of care.”

Services divided at hospital level

Most acute-care facilities have either a substance-abuse treatment unit or mental health unit, Cartwright explains. If the hospital has both, they are not integrated, and patients in one program may not get needed services from the other.

“Especially in the mental health field, many providers looked at it [a co-occurring substance addiction] as a secondary diagnosis, and that is not really accurate,” he explains. “If people present in the ER [emergency room] with a broken arm and broken foot, both are considered primary, separate diagnoses. They both need treatment.”

But depending on the provider’s training and background, he or she may not recognize the other coexisting disorder.

“Most mental health professionals do not get very much formal education about addiction. Social workers, psychologists, even psychiatrists get very little formal training in addiction disorders,” Cartwright says.

And people trained to work with substance

addiction often do not have the skills to appropriately diagnose a mental illness or even make an appropriate mental health referral.

“If they have a patient, they may not even screen for it or pick up on it,” Cartwright continues. “And, a lot of primary care doctors, when they see people in ERs or in a clinic, are not picking up on the fact that this person has an addiction.”

Conflicts in treatment methodologies

Mental health professionals and substance abuse treatment providers often do not “talk” to each other, with the result that patients with co-occurring disorders often receive treatment plans that conflict and contradict each other, says **Cecelia Vergaretti**, vice president of community services and advocacy for the National Mental Health Association (NMHA) in Washington, DC.

“Treatment issues and philosophies can be very different,” she says. “Some substance-abuse treatment providers will say you have to have abstinence, whereas in the mental health field, recovery is seen as a journey with many ups and downs.”

If a patient is diagnosed with both schizophrenia and a drinking problem, that person may need certain medication but then also be told by an alcohol recovery program to avoid all controlled substances.

“There really needs to be a community dialogue among people with co-occurring disorders and people who provide treatment,” says Vergaretti.

Improving education, cross-training for different groups of providers, and integration of services are the keys to improving the system, say both Vergaretti and Cartwright.

“We are trying to move toward a system in which there is no ‘wrong door,’” Cartwright says. “No matter which door you walk through, the mental health door or addiction door, you will get the appropriate diagnosis and follow-up.”

A good step would be for health systems to integrate their substance addiction and mental health treatment programs into an behavioral health unit, he adds.

National studies indicate that more than half of patients diagnosed with a substance addiction have a coexisting mental illness, and approximately the same numbers of those diagnosed with mental illness have a coexisting addiction problem, Cartwright explains.

Such significant numbers demand better integration of services, he feels. Although the need will remain for specialty, single-diagnosis tracks

SOURCES

- **Cecelia Vergaretti**, 1021 Prince St., Alexandria, VA 22314-2971.
- **Michael Cartwright**, 220 Venture Circle, Nashville, TN 37228.

within behavioral health units, the need for an integrated program is great.

However, improved provider education is needed to support such a system, he advises. When the DDRN has attempted to establish integrated treatment systems in areas where it offers residential services, they found it took a lot of initial training of providers to get the system off the ground.

“First, we need mental health providers trained in addiction,” he notes. “Not just one course over a four-year period, but continuing education about how to assess. Then, we need to have integration of services.”

More efforts at state and national level

Fortunately, there has been more movement at the legislative and governmental level to improve the system of care for patients with co-occurring disorders.

The U.S. Substance Abuse and Mental Health Services Administration, a division of the Department of Health and Human Services, is preparing a report to Congress on co-occurring disorders that is expected to be released on Oct. 14, says Cartwright.

And state public health systems are beginning to develop plans to integrate funding and systems of care, reports Vergaretti.

In 1998, the National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors held a meeting to discuss co-occurring disorders and developed a framework of recommended treatment, administrative, and funding changes needed to improve the situation. The framework has been published as the *National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders*.

For providers seeking more information, the NMHA also has published a fact sheet on dual diagnosis, and the DDRN maintains a resource library of journal articles and other publications on its web site at www.dualdiagnosis.org. ■

Religion at the bedside: Do doctors have a calling?

Beliefs can have an impact on recovery, studies find

A 1999 study published in the *Archives of Internal Medicine* finds a significant benefit of “remote, intercessory prayer” in the treatment of patients admitted to a coronary care unit and recommends such prayer as a “useful adjunct” to standard medical care.¹

But a similar study conducted by different researchers and published two years later in the journal *Mayo Clinic Proceedings*, reaches the opposite conclusion: “As delivered in this study,” the authors wrote, “intercessory prayer had no significant effect on medical outcomes after hospitalization in a coronary care unit.”²

That’s just the tip of the iceberg. According to the *Handbook of Religion and Health* (Oxford University Press, 2001) more than 1,500 published studies and review articles in the medical literature focus on the complex relationship between religion and health. Yet as with the studies mentioned above, researchers have reached vastly different conclusions about what role religion should play in patient care.

Some question link between religion, health

Now some experts are questioning whether emphasizing a link between religion and health is appropriate — and whether studies attempting to discern “evidence-based” support for specific religious activities may, in fact, do more harm than good.

“There is little empirical support for claims of health benefits deriving from religious involvement,” wrote **Richard P. Sloan**, PhD, and **Emilia Bagiella**, PhD, in the February 2002 issue of *Annals of Behavioral Medicine*.³ “To suggest otherwise is inconsistent with the literature.”

Sloan and Bagiella, colleagues at Columbia University in New York City, conducted an analysis of 266 journal articles published in the year 2000 dealing with the subject of religion. Most of the studies did not actually study the impact of religious beliefs, but the health impact of different practices associated with certain religions instead.

In addition, the authors claim, the studies that did attempt to examine the impact of spiritual beliefs had significant methodological flaws.

“There is just no solid evidence of a relationship between religious activity and health outcomes,” Sloan, director of Columbia’s behavioral medicine program, tells *Medical Ethics Advisor*. “Religion shouldn’t be a part of medicine, except insofar as physicians need to understand all elements of the whole person. Religion is important to some patients, and physicians do need to know that.”

Clinical studies have indeed shown that religious beliefs have an impact on health outcomes — both positively and negatively — and this impact is an appropriate area of study, counters **Harold G. Koenig**, MD, associate professor of psychiatry and associate professor of internal medicine at Duke University Medical Center in Durham, NC, and a co-author of the *Handbook on Religion and Health*.

Koenig’s research has linked religious activities in elderly patients to lower blood pressure rates, improve immune function, and speed recovery from depression. However, other studies have indicated that certain religious beliefs can have negative consequences for patients, he says.

“We published a paper in last year’s *Archives of Internal Medicine*⁴ showing that certain religious beliefs — feeling punished by God or feeling deserted, not loved by God or deserted by one’s religious community — actually increases mortality over a two-year period,” he says. “Those beliefs predicted mortality independent of mental health or physical health.”

Koenig makes a careful distinction between his studies and those that attempt to prove “that God exists,” he says.

“Prayer is being studied in two very different manners,” he explains. “One kind of study involves intercessory prayer studies that are double-blinded — people don’t know who they are praying for, and the people who are being prayed for don’t know who is praying for them. That is not based on any scientific model, nor is it based on any theological model. That way of trying to specifically prove the supernatural, is not very helpful in my estimation.”

Religion ‘a very, very powerful force’

But studies that examine the psychological and social aspects of how praying influences a person’s well-being and recovery are important, Koenig says. “Religion is a very, very powerful force in people’s lives.”

What he and other researchers are trying to understand, he explains, is how prayer and other

religious activities affect people's lives and how this might affect their medical condition and healing.

"We want to understand if people pray for others, and those others know about it, does this make a difference in the lives of those who are doing the praying and those who are being prayed for?" Koenig asks. "I think that kind of research is valid, both in terms of science and theology."

Religion and spirituality do play a major role in the lives of many people, agrees Sloan. And physicians do have a responsibility to learn about their patients' religious beliefs and take those beliefs into account when advising them on treatment decisions, he adds. But physicians should draw the line at attempting to make specific recommendations to their patients about spiritual practices, he says.

"There are some significant ethical problems associated with bringing religion into medicine," he says. "One of which is coercion. If religion is associated with better health, how do you account for the fact that lots of people are sick? Well then, it must mean that they are insufficiently devout or faithful. That is an awful thing to say to a patient, 'You just haven't prayed enough or gone to church enough, or you wouldn't be sick.'"

That's the message that can be conveyed when a caregiver tries to impose certain religious beliefs or practices on patients who may not be religious or who may practice a different religion, he says.

"Then, there is an issue of privacy because, for many people, religion is a personal and private matter, not grist for the physician's mill," he adds.

Physicians should know how to ask questions about a patient's beliefs and values and use that information to help them make decisions that are consistent with those beliefs, notes Koenig.

"The effort has to be patient-centered," he says. "The main intervention is just taking a spiritual history and learning a little bit about the religious beliefs of the patient and how they might influence the situation. How those beliefs help that person to cope and whether that is a resource or whether it is a liability — because it can be a liability for some patients."

If patients are struggling with questions of faith and how it relates to their medical condition, the care providers need to help them address those issues, he says.

"People struggle with this, they ask, 'Why me?'" Koenig says. "'What did I do wrong? Am I being punished for my sins?' People need to resolve that. But sometimes they don't. They get angry and have this spiritual turmoil that no one addresses,

and it probably interferes with immune function and healing."

Physicians do have some responsibility to see that these issues are addressed, says Sloan, but should be wary of assuming this duty themselves.

If a patient were to ask Sloan a question related to his or her religious faith, he would feel most comfortable referring them to a member of their clergy or a healthcare chaplain, he says.

"Physicians should not feel that they must always have the answers to everything," he states. "Certainly, physicians make referrals in other areas of medicine when they lack expertise. I think it shows a lot of respect for a person's beliefs, by not introducing your own belief system and interposing your own beliefs on that person."

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Is our hospital green? Ethics committees ask

A look at the environmental impact of health care

Ethics committees frequently discuss clinical conflicts on a case-by-case basis, helping clinicians make treatment decisions that are consistent

both with accepted standards of medical care and the values and beliefs of the patients cared for.

Some committees take their mandate a step further, examining the organizational ethics of their facilities — what values a hospital's policies and procedures reflect.

But few committees are charged with looking at their hospital's role in the health care system as a whole, and that system's overall impact on our society. In particular, what are the environmental effects of our expensive health care system — which consumes almost 15% of this country's gross domestic product (GDP) — on our population's long-term health?

"An awareness is growing that the environmental impact of health care services is significant, and promoting health and saving lives within the health care system needs to be balanced against the harm done to the environment," says **Christina Kerby Kessinger**, MPA, MA, project coordinator of the Green Health Center (GHC) project at the University of Nebraska Medical Center in Omaha.

The project's main goal is to ensure that concerns about the environment are addressed in the overall national debate about rising health care costs, says Kerby Kessinger.

Funded through a grant from the New York City-based Greenwall Foundation, the project created a panel of national experts on health care and the environment that met over the course of the 1998-1999 academic year, she says.

The panel developed a model plan for providing health care in a way that is respectful of the environment. They also identified and analyzed several case studies of basic health services to be provided, modified, or avoided by a "Green Health Center," she says.

U.S. health care costly in many ways

Not only does health care spending in this country consume almost 15% of our GDP, but also consumes more than 40% of the world's dollars spent on health care.

One out of every seven dollars generated in the U.S. economy is spent on health care, and one of every nine workers is employed in the health care sector.

So where is all this money going?

Much of it is going to support an ever-expanding, highly technological system that consumes vast amounts of physical resources and produces large quantities of waste. And few hospitals and

health systems are stopping to examine how their functions affect the environment, says Kerby Kessinger.

"There are a select few hospitals out there that are looking at this, but many are not," she adds.

Environmental hazards

Hospitals and other health facilities can adversely affect the environment in several ways:

- resource and material consumption — use of polyvinyl chloride (PVC), mercury, latex, silver, needle devices, and energy;
- pollution and waste — inefficient waste management, air emissions, water discharge;
- patient and occupational exposure — infections from visiting hospitals, occupationally derived infections (HIV, hepatitis B and C);
- material allergies and chemical exposures;
- ionizing radiation — from high-tech medical procedures;
- purchasing procedures — purchasing of products with extensive packaging, products that are not recycled or recyclable, and extensive use of building materials in new construction.

On the other end of the spectrum, hospitals can produce large amounts of products and resulting waste that the larger community must absorb, Kerby Kessinger explains.

Hospitals are the source of large quantities of pharmaceuticals, medical equipment and supplies, radioisotopes for nuclear medicine, and disposable medical supplies — not to mention the quantity of radioactive and biohazard "red-bag" waste that must be disposed.

Hospitals should examine overall effects

Hospitals need to examine the overall health effects of their way of doing business, she adds.

For example, PVC plastic is widely used in many hospital supplies, yet carries with it toxic residue that affects both the people making the devices, the hospital workers who routinely handle them, and patients who receive therapy using those products.

Phthalates from PVC plastic can leach into a person's body and are particularly hazardous to infants, the elderly, and those with compromised immune systems.

Most PVC-containing hospital supplies are incinerated due to contamination with human bodily fluids. A by-product of CVC incineration

SOURCES

- Christina Kerby Kessinger, MPA, MA, Department of Preventive & Societal Medicine, 986075 Nebraska Medical Center, Omaha, NE 68198-6075.

For more information:

- **Health Care Without Harm: The Campaign for Environmentally Responsible Health Care.** Web: www.noharm.org.

is the production of dioxin, a known carcinogen, Kerby Kessinger illustrates.

Three million pounds of plastics are used in the U.S. health care industry each year, with PVC products accounting for 25% of all medical products, or 750 million pounds annually.

Use of mercury is another example of environmentally unfriendly hospital practices, Kerby Kessinger says. The element is found in many health care materials and supplies, including thermometers, blood pressure cuffs, esophageal dilators, batteries used to power equipment, and several different laboratory compounds.

The U.S. dental industry alone accounts for 10% of the mercury consumed in this country, the third-largest consumer.

In addition to striving to provide high-quality care to individual patients, health systems have a moral responsibility to examine how their practices affect the health of the environment and, therefore, the larger population, Kerby Kessinger says. "People in the medical profession espouse the principle of 'first, do no harm' all the time," she continues. "What we want to do is take that a step beyond just the individual doctor-patient relationship."

What can hospitals do?

The University of Nebraska Medical Center is serving as a sort of demonstration site for the development of an environmentally and economically friendly Green Health Center.

A new grant project, Exploring Bioethics Upstream, is expanding the scope of the original GHC grant, says Kerby Kessinger.

"In our current hospital, environmental issues are fairly restricted to 'downstream' aspects, such as waste disposal and recycling," she reports. "We want to expand the material flow conversation by learning who makes decisions within the hospital setting related to the environment."

Bioethicists involved with the GHC project will now sit on several different hospital committees that make decisions that influence how the hospital impacts the environment, she says.

"We have become involved with the product evaluation and standardization committee, the construction impact committee, and the pharmacy and therapeutics committee, for example," Kerby Kessinger says. "Our goal is to introduce and promote a sense of ethical responsibility for the environment, in hospital policies, education of providers, decisions regarding patient care, and the allocation of health care resources."

In general, hospitals must become more aware of where raw materials come from and where their products go after disposing of them, Kerby Kessinger advises. "Seminars should be held in hospitals on this very topic to educate doctors, nurses, lab technicians, and other individuals working in this setting."

Will there be a system left in the future?

Although the current health care system is not in danger of a collapse, Kerby Kessinger says many doubt whether the system we have now is sustainable for future generations.

"I don't think the system we have is sustainable if we keep the current pace of using products and services without consideration of where they came from, where they are going, and all the impacts associated with their use," she says.

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NEWS BRIEFS

Claim: Woman is pregnant with cloned embryo

A woman participating in a human cloning effort is eight weeks pregnant, apparently with a cloned human embryo, according to **Severino Antinori**, an Italian fertility specialist who has declared an intention to clone a human being.

Antinori made the claim at a meeting in February held in the United Arab Emirates, according to the publication *New Scientist.com*.

Although the doctor refused to disclose the nationality of the woman or her location, and did not specifically indicate she was carrying a human clone, he said that 5,000 couples are currently involved in the program, the report stated.

Several noted cloning researchers in this country have previously condemned plans by Antinori and Louisville, KY, fertility specialist **Panos Zavos** to produce a cloned human being, citing safety concerns and the high number of miscarriages, malformed newborns, and premature deaths among animals that have been cloned. ▼

Bush asks Senate for total ban on cloning

President Bush asked the Senate on April 9 to pass a bill by Sens. **Sam Brownback** (R-KS) and **Mary Landrieu** (D-LA) that would completely ban cloning of human embryos for research, saying science must not rush ahead "without an ethical compass."

A competing measure, sponsored by Sens. Edward Kennedy (D-MA) and Dianne Feinstein (D-CA), would outlaw reproductive cloning, but permit research into deadly diseases such as Alzheimer's and Parkinson's diseases.

"It would be a mistake for the U.S. Senate to allow any kind of human cloning to come out of that chamber," Bush said.

Senate Majority Leader **Tom Daschle** (D-SD), however, urged lawmakers to heed a call from 40 Nobel laureates who support research cloning, and he said it is possible to bar ethically repugnant uses of cloned tissue without blocking the research. ▼

Australian governments reach agreement on stem cell research

Federal and state leaders in Australia have agreed to a deal that will pave the way for nationwide guidelines on the use of human embryos in stem cell research.

Stay on top of EMTALA with audio conference

Keep abreast of all the latest changes with *EMTALA Update 2002*, an audio conference sponsored by American Health Consultants. The conference, scheduled for Tuesday, June 4, 2002, from 2:30 to 3:30 p.m. Eastern time, will be presented by Charlotte S. Yeh, MD, FACEP, and Nancy J. Brent, RN, MS, JD. Yeh is medical director for Medicare policy at National Heritage Insurance Company. Brent is a Chicago-based attorney, with extensive experience as a speaker on EMTALA and related health care issues.

The conference will outline a new report that puts a national spotlight on inadequate emergency department (ED) on-call coverage. There is a growing trend of specialists refusing to take call for

the ED, partly due to increased liability risks for medical malpractice and violations of EMTALA. If you don't take steps to ensure appropriate on-call coverage for your ED, you're at risk for violations and adverse outcomes. This program also will update you on any legislative efforts to compel managed care plans to reimburse hospitals for EMTALA-related services.

Each participant can earn FREE CE or CME for one low facility fee. Invite as many participants as you wish to listen to the EMTALA Update 2002 audio conference for just \$249 for AHC subscribers and \$299 for nonsubscribers, and each participant will have the opportunity to earn 1 nursing contact hour or 1 AMA Category 1 CME credit. For more information, or to register, call American Health Consultants' customer service department at (800) 688-2421 or (404) 262-5476, go on-line at www.ahcpub.com, or e-mail customerservice@ahcpub.com. ■

Under the agreement, negotiated between Prime Minister John Howard and eight state and territory government leaders, research will be initially limited to about 60,000 frozen embryos left over from in vitro fertilization (IVF) programs, the Associated Press reported on April 5.

Howard agreed to a three-year ban on the use of new embryos rather than the permanent ban originally proposed.

Following the three-year prohibition on the use of new embryos, the use of surplus embryos created through IVF programs after April 5, 2002, could be used, but only if governments are convinced that they can ensure the embryos were not created solely for the purpose of research.

The agreement means that Australia, home to several of the world's leading stem-cell researchers, has more liberal guidelines for using human embryos in research than does the United States, but more restrictive than Great Britain, which allows embryonic stem cell research and therapeutic cloning. ▼

Number of Americans without insurance at 10-year high

More than 2 million Americans lost their health insurance last year, the largest number losing coverage since 1992. The shift brings the total number of people without coverage to more than 41 million — a number that exceeds the aggregate populations of 23 states plus the District of Columbia, according to a report in the April 3 issue of the *Christian Science Monitor*.

The problem is expected to worsen as rising health care costs force more employers to scale back the amount of health coverage they will pay for, leaving the balance to be picked up by individuals, the report claims. And the rising number of uninsured is becoming a vicious circle.

As uninsured people delay care for small problems, then end up seeking care for serious, acute problems in hospital emergency departments — the most expensive place to receive care. Because these patients can often not afford to pay for care, hospitals must absorb these costs, frequently “cost-shifting” to insured patients by charging higher rates for care.

As the insurance costs rise, more employers are unable to provide health coverage, ultimately increasing the number of people who are uninsured. ▼

HCA fraud convictions overturned on appeal

The HCA fraud trials set the stage for the growing emphasis on health care fraud in the past few years, but the story has taken another odd twist with the recent reversal of convictions that put two HCA executives in prison.

For health care executives jittery about the possibility of ending up in jail for fraudulent billing, this could be good news, especially in light of the reasoning that led the court to overturn the convictions. There was no evidence that the executives

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CE/CME Questions

Please save your monthly issues with the CE/CME questions in order to take the two semester tests in June and December.

17. In the article about religion and medicine, Columbia's Richard Sloan, PhD, claimed that there was:
- A. Significant empirical support for religious activities in health care.
 - B. No empirical support for religious activities in health care.
 - C. Little empirical support for religious activities in health care.
 - D. None of the above
18. In the same article, what method did Harold G. Koenig advocate for determining the religious and spiritual needs and attitudes of patients?
- A. Spiritual history
 - B. Spiritual inventory
 - C. Religious inventory
 - D. None of the above
19. A family covenant is:
- A. A written document that legally binds family members to share information about genetic risks for diseases.
 - B. A process of getting a patient's family members together to discuss potential outcomes of a particular genetic test and how information resulting from a test will be handled.
 - C. Both A and B
 - D. None of the above
20. The term "dual diagnosis" means:
- A. A patient who has been diagnosed with co-occurring mental health and substance abuse problems.
 - B. A person with more than one clinical problem.
 - C. A patient has been diagnosed with two different psychiatric diseases by more than one physician.
 - D. None of the above

intentionally made false statements and knowingly defrauded the federal government, the court said.

In July 1999, Jay A. Jarrell and Robert W. Whiteside were convicted in Tampa, FL, of making false statements in Medicaid reimbursement cost reports. The charges related to their work with Fawcett Memorial Hospital in Port Charlotte, FL, part of the HCA hospital chain, one of the biggest in the country. They also were convicted of conspiracy to defraud the government. Prosecutors said Jarrell and Whiteside repeatedly billed expenses as capital outlays when they should have been listed as administrative and general expenses, which would have resulted in lower reimbursement rates.

But in its recent ruling, the 11th U.S. Circuit Court of Appeals in Atlanta said that the government failed "to prove that the alleged statements were knowingly and willfully false." **Walter Dellinger, JD**, attorney for the defendants, called the ruling "a clear vindication of Bob Whiteside, Jay Jarrell, and HCA."

Jarrell was head of HCA's southwest Florida division. He had been sentenced to 33 months in prison and ordered to pay nearly \$1.7 million restitution, along with a fine of \$10,000. Whiteside was a senior reimbursement executive from

Brentwood, TN. He was sentenced to two years in prison and fined \$7,500. Neither man had yet gone to prison, remaining free while their cases were appealed.

The investigation of HCA began in 1997 and illustrated the government's determination in rooting out health care fraud. HCA fired its top executives, and the company pleaded guilty to defrauding government health care programs. The company has paid \$840 million in fines, civil penalties, and damages. ■