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Iowa Planned Parenthood case raises serious privacy concerns

Release of names of pregnant women being challenged

A state district court order requiring an Iowa Planned Parenthood clinic to turn over the names of all women receiving positive pregnancy tests during a designated nine-month period has significant implications for all health care providers, even those not practicing reproductive medicine, say experts in health law and medical ethics.

“This cases raises profound questions about who we serve as health care providers and about trust,” says **Susan Tolle**, PhD, director of the Center for Ethics at Oregon Health Sciences University in Portland. “There is a price to be paid every time we decide to breach patient confidentiality — and we need to carefully examine whether the public will truly benefit from the release of such information in this case.”

In July, law enforcement officials in Storm Lake, IA, sought the test results from the Planned Parenthood clinic and several other clinics in town following the discovery of the dismembered body of an infant at a recycling center there.

The police claim that its only chance of continuing an investigation into the baby’s death is to identify women who had positive pregnancy tests in the hopes of finding the mother.

Planned Parenthood refused to turn over the information on the grounds that the tests were privileged medical information. Law enforcement officials argued that because the tests could be administered and read by personnel who are neither doctors nor nurses, the information was not covered by doctor-patient privilege.

Clay County District Court Judge Frank Nelson ruled in law enforcement’s favor and ordered the clinics to turn over the information. Planned Parenthood officials have appealed to the state Supreme Court, which has agreed to hear the case.

If upheld, the trial court ruling will end up having a detrimental effect on the health of more women and babies in the Clay County

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area, and such a “broad and invasive fishing expedition” provides little chance of finding the dead child’s mother, clinic officials say.

“Immediately after local law enforcement tried to force Planned Parenthood to open its records, the Storm Lake clinic saw a 70%-80% drop in women seeking pregnancy tests there,” reports **Gloria Feldt**, president of Planned Parenthood Federation of America Inc. in Washington, DC. “This poses a serious health concern, considering these women may be pregnant and may not return for early prenatal care or other vital reproductive health services provided at the center.”

Undermining the health care team

Health care providers also should be aware that this case has implications for medical records privacy that extend far beyond reproductive rights, say Tolle and others.

“When patients call and speak to a receptionist, is that information not to be kept private?” asks Tolle. “If a receptionist is asked to call someone about the care they will receive, is there information that should be kept from [the receptionist] in order for it to remain private?”

At a time when health care providers are attempting to build teams of personnel to oversee and coordinate care of patients, this decision undermines their ability to function in the best interests of their patients, she says.

Health care providers are sometimes ethically and legally compelled to violate patient confidentiality to protect either the public health or an identified third party, Tolle admits.

For example, known contacts of patients with tuberculosis are told of their possible exposure. Some states have laws requiring providers to report all gunshot or stab wounds to the police or to report suspected cases of child abuse without obtaining the patients’ consent.

But the price of breaking confidentiality is always an erosion of patients’ trust in the health system, Tolle notes.

“We have to look at the intent here to see

whether this is a matter of protecting the public health, or an identified third party, or whether we are just asked to be agents of the police,” she says. “We should be very careful about agreeing to be agents of the police, because health records have a lot of information that they might find useful if they were allowed to just go on a fishing expedition through patient files.”

Balancing public need with patient privacy

When health care providers violate confidentiality, they should always be able to determine who will benefit from the release of the information and weigh that benefit against the damage that the release of the information will do to the patient.

A key factor in this is the ability to identify a person who will benefit, Tolle says.

For example, patients who present in Oregon emergency rooms with gunshot or stab wounds automatically have their visit reported to law enforcement officials, according to state law, she says.

But in that situation health care providers have an identified victim, the patient, who has obviously been attacked, and both that patient and the general public will benefit from police determining who attacked that person and why.

The patient has already had someone try to shoot or stab them, so there is clear evidence of danger — at least to them, she says.

“In this case, they don’t know who the mother is, and they are not trying to help or protect any specific person,” says Tolle. “They don’t even know that the mother sought prenatal care or pregnancy testing, or whether they will be able to determine this by going through the records.”

What is certain, however, is that thousands of women will have their confidentiality violated, which may cause them significant harm.

“They [law enforcement officials] have said they would focus on women who had positive pregnancy tests, but were unable to produce a baby,” says Tolle. “There could be any number of

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reasons that a woman could not, including pregnancy termination, putting the child up for adoption, or miscarriage.”

Many early pregnancies, and some later ones, end in miscarriage, she notes. It is almost inevitable that, out of thousands of tests, officials will end up knocking on the doors of women who have suffered miscarriages, possibly hundreds of them.

“And that may involve the disclosure to her family, friends, and community this information, which she may have wished to keep private,” Tolle illustrates. “Does the benefit to public health outweigh the damage that violation of privacy will involve?”

Other information vulnerable

Tolle says she has been discouraged at the lack of public reaction in the bioethics community.

“I think a lot of people are looking at the Planned Parenthood angle and don’t see the bigger picture,” she says. “What if police wanted to obtain all the positive drug and alcohol tests performed in a hospital ED? What if they wanted to subpoena medical records of paroled criminals for evidence they used drugs or alcohol — often a parole violation?”

Providers should ask themselves whether they would feel comfortable allowing law enforcement officials to engage in broad searches through their medical records — without an identified patient or an identified third party at risk — in order to find information they might find useful.

For example, people who are not doctors or nurses often conduct mammograms, blood tests, and X-rays.

Physician extenders are also nonlicensed medical personnel and provide a wide variety of services under the supervision of a physician, says **Thomas P. O’Donnell**, JD, a health law attorney with the firm Polsinelli, Shalton and Welte in St. Louis.

“The prosecutor’s rationale in this case has far-reaching implications on any services provided by a non-physician,” he notes. “The position is interesting since many states license or certify physician extenders who are nurse practitioners and physician assistants. In many instances, they must work under the supervision of a physician in order to be reimbursed for the service.”

The argument attributed to the county attorney — that pregnancy tests are not medical records simply because they were not administered by

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physicians or nurses — is a red herring, agrees **Dale Moore**, JD, professor of law and ethics at Albany (NY) Law School at Union University.

However, privacy rights of the sort being defended by the clinic are not absolute, she warns. “A death investigation is under way and official investigations into unexplained or suspicious deaths sometimes must override wishes that would otherwise be respected.”

For example, although an individual’s or next of kin’s objection to the performance of an autopsy ordinarily would be honored, suspicion that the death is a homicide will require that it be investigated and much more likely that the investigation will require an autopsy, she says.

“In such circumstances, as much care as possible should be taken to avoid intruding unnecessarily into the private interests of the decedent and family,” she says.

“If the police are able to demonstrate that having the names is truly likely to help them identify the party or parties responsible for the infant’s death, then I think a balancing of the public interest in death investigation and the private interest in confidentiality of medical information ought to be achievable,” she adds. “It is doubtful, however, that those seeking the names truly need the names for the entire 9½-month window.

Forensic evidence should enable police to identify a much narrower window of time to explore, she says. “In addition, it should be possible to limit disclosure to a very small audience that is charged with protecting it from further disclosure and using it only for the purposes of that particular investigation.

Currently, clinic officials are right about their responsibility to safeguard the information until and unless they are ordered to release it as a result of legal proceedings in which all routes to appeal have been pursued, she says.

“The patients’ expectations and entitlements to

the privacy and confidentiality of the resulting diagnoses are not diminished by the professional status of the personnel who administered the tests, and the same should be true of the information sought in Storm Lake.” ■

Data reveal biases that exist in minority care

OMH conference examines causes, solutions

It's a disturbing but indisputable fact: If you are a person of color in the United States, you are more likely to receive poorer health care.

Even when researchers evaluate their data and control for rates of insurance status, income, age, and severity of medical conditions, significant disparities still exist.

“Disparities in the health care delivered to racial and ethnic minorities are real and are associated with worse outcomes in many cases, which is unacceptable,” **Alan Nelson**, MD, former president of the American Medical Association, now special advisor to the chief executive officer of the American College of Physicians — American Society of Internal Medicine, told attendees at the Department of Health and Human Services (HHS) National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health, held July 10-12 in Washington, DC.

A 1999 study, published in the *New England Journal of Medicine*, followed several black and white actors playing patients in different health care facilities. In the study, physicians were significantly less likely to recommend cardiac catheterization for black females than for white females, white males, and black males.¹

A similar study published in the *Journal of General Internal Medicine* found that male physicians prescribed twice the level of pain medication for white patients than black patients, while female physicians prescribed higher doses of pain medications for black than for white patients.²

Nelson chaired the committee that wrote the recent Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*,³ which detailed evidence of unequal access to care unexplained by traditional socioeconomic factors. He addressed the summit, asking that participants be willing to look for solutions beyond just admitting that access is a problem.

“The real challenge lies not in debating whether disparities exist, because the evidence is overwhelming, but in developing and implementing strategies to reduce and eliminate them,” he continues.

At the summit, government officials, public and private health care providers, and policy experts urged cooperative efforts at rooting out the causes of the disparity and developing solutions at the local level.

“We have got to increase awareness of the public and of our providers, and certainly our policy-makers that our health care system in many respects reflects the rest of this society,” says **Marsha Lillie Blanton**, DrPH, director of policy research and grant making for the Kaiser Foundation. “What we know has got to become what society knows.”

DHHS launches three-point agenda

As part of its goal to eliminate racial and ethnic health care disparities by the year 2010, HHS is focusing its efforts in three major areas, says **Ruben King-Shaw**, deputy administrator and chief operating officer of the department's Centers for Medicare & Medicaid Services (CMS). The three main goals are:

1. Improving access to health insurance.

Health insurance is the most common way people are connected to the health care system, King-Shaw says, and the department wants to improve and shore up the third-party payer system.

“Without insurance, a person's encounters with health care providers are few and far between,” he states. “They lack the ability to access preventive services or wellness services or continuity of care or primary care, diagnostic tests and treatment and education. These things don't happen when you are not connected to the health care system.”

Uncompensated care provided to uninsured patients also is a very significant issue for health care providers, he acknowledges. Continuing to rely on hospitals to provide a safety net is not a workable solution.

“The provision of insurance is an answer, but making sure that those who do not have insurance have access to health care is another part of the answer,” he adds.

King-Shaw also warns against the push in many states to abandon Medicare+Choice programs that place Medicare beneficiaries in structured managed care plans using private health plans.

“Medicare Plus Choice contractors are leaving

these systems for a variety of reasons,” he notes. “The thing here is that a disproportionate number of people of color, African-Americans, Hispanic-Americans, and Asian-Americans, in certain markets are members of the programs.”

These plans may be their members’ only chance at access to prescription coverage, wellness, prevention and education services that would otherwise be too costly, he adds.

“When you hear that an HMO is leaving the program, that the program should be scrubbed and thrown away. When you hear it was a failure and not worth salvaging, remember the abandonment of this program means abandoning disproportionately African-, Asian- and Hispanic-Americans who are relying on these programs.”

Everyone should admit that there are problems with Medicare and Medicaid managed care that need to be addressed, he says, but without abandoning those most in need.

2. Developing community health centers. Part of that solution will be to improve the health care delivery system by expanding community and rural health centers and primary care clinics.

3. Reduce cultural ignorance in the system. HHS has initiated partnerships with community organizations in several areas to develop clinically and linguistically appropriate services for different populations, King-Shaw says.

“This is not just a matter of making sure you can generate a document in a specific language, it is making sure that when you generate a document in English or Spanish or Cantonese or Mandarin, that the communication has integrity when it connects to the individual,” he explains.

For example, the agency has partnered with organizations in the Asian and Pacific Islander communities in New York and Boston to reduce the incidence of hepatitis B and to improve rates of mammography screening. The partnerships have developed Chinese-language public service announcements, conducted focus groups, and funded outcomes research in local populations.

“We hope to go beyond just communicating better. We want to empower community-based organizations to not just impart information, but to take part in the delivery of health care services in the communities in which they live,” he says.

Public-private partnerships needed

Public and private health providers must work together to create sufficient political will to eliminate racial and ethnic health disparities, added

James Gavin, MD, PhD, president of the Morehouse School of Medicine in Atlanta.

He points to the success that private, nonprofit organizations and public health professionals have achieved with linking cigarette smoking and lung and heart disease. Doctors routinely warn patients about the risks of smoking. Insurance companies give discounted premiums to non-smokers, and tobacco manufacturers have been held accountable for the health outcomes of people who use their products.

“Health promotion, disease prevention messages, and strategies to eliminate disparities face a daunting challenge when countered and resisted by the power of marketing and economic incentives of a well-established and profitable retail market enterprise,” Gavin says. “We have seen some hard-nosed creative push back by the tobacco industry. Without the surrender of private industry in the interest of public health, both the successful integration of methods and strategies across the health care system to eliminate disparities will be severely compromised.”

Good science, good intentions, and good will are wonderful, he adds, but “as currencies, they are routinely trumped by economic incentives and tax credits.”

Lawmakers must be convinced to design legislation that gives appropriate incentives to schools, employers, and insurance plans to encourage them to support healthy lifestyles and preventive medicine strategies.

Managed care organizations must be convinced of the benefit of designing cost-effective strategies for achieving and maintaining good health behaviors among their members. And community and faith-based organizations must participate in partnerships with health initiatives to “mold, shape, and inspire” the public’s will to change.

Health care providers must use their considerable power to lobby legislators in support of policies that end racial and ethnic discrimination, adds **Robert K. Ross**, MD, president and CEO of the California Endowment, a nonprofit health foundation that funds health improvement initiatives for Californians.

“The issue of disparity is not on the Top 10 list, or the Top 20 list. It’s not even on the Top 50 list of items that most elected officials are thinking that they are in a position where they must act,” Ross says. “They are not at a point where they believe there is a political price to pay for failing to act.”

In fact, surveys have shown that a substantial portion of the general public is uninformed about

SOURCES

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barriers of access to health care, says Lillie Blanton.

“Perceptions are important because they influence policy-makers and the public’s willingness to take action,” she says.

A national survey of 4,000 adults found that the public has a marginal, at best, understanding of the disparities. And, there are significant differences in the perception of problems between whites and minorities.

“The survey found that the majority of whites perceive that African-Americans and Latinos get the same quality of care as whites,” she says.

“Not surprisingly, that is not the view of most African-Americans or Latinos,” she says. “When people were asked how often they think our health care system treats people unfairly based on language or race or ethnicity, you see closer agreement among the racial groups [about the existence of discrimination], but you still see sizeable percentages of people who don’t perceive that language, race or ethnicity affects their care.”

For African-Americans and Hispanic-Americans surveyed, the most important health care issue was the high cost of insurance and of medical care, followed by a concern about the availability of providers, she notes.

Although research has shown some levels of discrimination exist regardless of income status or insurance coverage, members of minority populations perceive themselves at a disadvantage because of race, but also recognize the economic factors, she says.

“It is not as if in our efforts to change we can focus on one issue to the exclusion of others,” she concludes.

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Documenting the Disparities

The Institute of Medicine report on racial and ethnic health outcomes highlighted a number of startling disparities documented in numerous medical studies across the spectrum of health care.

- **Cardiovascular Disease** — Minorities are less likely to be given appropriate cardiac medications or to undergo bypass surgery.
- **Cancer** — Several studies show racial differences in who receives appropriate cancer diagnostic tests and treatments.
- **Stroke** — Although African-Americans suffer strokes as much as 35% higher than whites do, several studies found that they are less likely to receive the major diagnostic and therapeutic interventions.
- **Kidney Dialysis, Transplants** — Minorities are less likely to be placed on waiting lists for kidney transplants or to receive kidney dialysis or transplants.
- **HIV/AIDS** — Minorities with HIV infection are less likely to receive antiretroviral therapy and other state-of-the-art treatments that could forestall the onset of AIDS.
- **Asthma** — Asthmatic African-Americans are less likely to receive appropriate medications to manage chronic symptoms.
- **Diabetes** — Although minorities have a much higher rate of death and illness from diabetes, the disease is poorly managed among minority patients, says the report. In a study of nearly 1,400 Medicare patients, diabetic African-Americans were found less likely to receive key diagnostic tests. Minorities also are more likely to receive certain less-desirable procedures, such as lower-limb amputations for diabetes and other conditions.
- **Maternal and Child Health** — Despite several federal and state initiatives to promote health care access to pregnant women and their children, racial and ethnic disparities persist in maternal and child health care. For example, minority women are more likely to undergo cesarean deliveries. And minority children are less likely to receive prescription medications.
- **Mental Health** — In psychiatric care, African-Americans are more likely to be diagnosed as psychotic, but are less likely to be given antipsychotic medications. They are more likely to be hospitalized involuntarily, regarded as potentially violent, and placed in restraints. A recent report from the U.S. Surgeon General illuminates the striking disparities in access and availability of mental health services for minorities, and calls for action to improve the quality of mental health care available to racial and ethnic minority populations.

Source: Institute of Medicine, Washington, DC.

about the effects of race and sex on physicians' referrals for cardiac catheterization. *N Engl J Med* 1999; 340:618-626.

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Do cosmetic procedures create ethical dilemmas?

Botox parties alarm dermatologic community

Following the disclosure that institutions as reputable as the Johns Hopkins Hospital in Baltimore have been holding Botox parties — social gatherings where alcohol is served and discount injections of botulinum toxin are administered — the American Academy of Dermatology (AAD) issued a warning to patients and a stern rebuke to providers who are too closely mixing business and pleasure.

“A casual social activity for the purpose of administering *botulinum* toxin, such as a Botox party, is an inappropriate and a potentially dangerous setting for performing medical procedures of any kind,” said academy president **Fred F. Castrow II, MD**, in a statement about the practice. “Adding alcohol to the mix is a bad idea for a number of reasons, especially since bruising can be intensified.”

One form of *botulinum* toxin, the substance that causes the disease botulism, has been approved by the Food and Drug Administration to treat some forms of wrinkles on skin.

“*Botulinum* toxin is a purified form of one of the most potent toxins in the world,” the AAD statement noted. “In high doses, it can cause disease. When carefully injected by dermatologists and dermatologic surgeons in very low doses, it is a modern tool that can reduce the signs of aging.”

However, when performed in unsafe settings, after hours, with food and drink served and, often by untrained medical professionals, Botox injections become much more risky, Castrow warns.

“Patient safety should come first and should not be taken lightly under any circumstances,” the

statement noted. “Because this is a quick method to treat wrinkles with no downtime, many patients may be compromising their safety by having these procedures in inappropriate settings.”

Not just Botox

However, Botox parties are just the latest example of the medical specialty's increasing reliance on promoting cosmetic procedures to increase reimbursement — a trend that raises serious questions about the providers' medical ethics, some dermatologists say.

“Dermabrasion, laser procedures, the use of filler substances — these are not treating a disease process; they are just a means to improve profits,” argues **Eileen Ringel, MD**, a dermatologist practicing in Waterville, ME, and an adjunct clinical professor at Dartmouth Medical School in Hanover, NH. “These procedures carry a significant risk of morbidity and are not in the patients' best interest.”

Following a trip to the annual AAD meeting in 1997, Ringel became alarmed at the increasing number of dermatologists flocking to demonstrations of cosmetic procedures and the comparatively low number attending disease-treatment sessions.

In a paper published in the *Archives of Dermatology* in 1998 and reprinted recently in the August 2002 issue of the watchdog group Public Citizen's *Health Letter*, Ringel asked dermatologists to examine their motivations for performing cosmetic procedures to reduce the signs of aging and to consider the potential impact on society.

“What goals are we trying to achieve? Are these goals worthwhile? What is their impact on patients, on medicine, and on society?” she wrote. “A situation has developed in which there has been ample investigation into what physicians can do, but far less examination of what they should do.”

Cosmetic dermatology treats the signs of aging skin as a disease process, offering treatments such as chemical peels, laser surgery, dermabrasion, injections of filler substances, and sometimes major surgical procedures to treat the illness that is aging skin.

The newer procedures have not been appropriately validated by clinical studies, and all of them have the potential to harm the patient by damaging the skin's function as a barrier to external bacteria and toxins, Ringel tells *Medical Ethics Advisor*.

“As dermatologists, we are supposed to be supporting the maintenance of healthy skin, yet

many of these procedures damage the skin," she notes.

The high cost of vanity

There also is the societal impact to consider. "Every time we perform one of these procedures, we justify it to the patient and to society," she says. "It is saying, 'Yes, you are getting older. You need to go and get all of these procedures done.'"

That is a terrible message for health care providers to convey, she claims. It violates the physician-patient relationship and the physician's obligation to "do no harm," she says.

The primary motive for performing such procedures is money and not, as some would argue, improving patients' self-esteem, Ringel adds. "There has been no argument for funding cosmetic procedures for poor people. This is solely a matter of increasing a physician's revenue."

Publication of her paper in 1998 caused quite a stir at the time, but few dermatologists have shied away from cosmetic procedures as a result, she says.

In fact, the specialty has become even more focused on cosmetic services, she adds.

Recent press releases from the American Academy of Dermatology tout everything from the use of *botulinum* toxin injections to new ablative laser technologies to treat aging skin, with little mention of other services.

Ethics vs. values

The commonly performed procedures to treat the signs of aging have been demonstrated to be safe and effective, and they are procedures that people want to have, notes **David E. Bank**, MD, medical director of the Center for Dermatology, Cosmetic, and Laser Surgery in Mount Kisco, NY.

Many dermatologists began getting involved in cosmetic procedures in the late 1980s and early 1990s with the advent of products such Retin-A, Retinol and Rogaine, which promised to reduce various signs of aging on the skin and/or grow hair.

"There were all of the products on the market, making a variety of claims and promoted by a variety of people," Bank says. "People turned to dermatologists as the acknowledged experts on skin and how to care for it."

Dermatologists performing cosmetic procedures are catering to patients' desires to look their best. But they are responding to society's demands not dictating them.

"I don't think people have cosmetic procedures simply because we are providing them," he says. "If they come to us, they can be confident that the procedures we perform are safe, effective, and will do what we say they will do."

To simply state that aging is a natural process and people should be satisfied with the way they naturally look is to make a personal value judgment and then impose it on another person, he adds.

"I don't think that is about ethics so much as it is about values," he says. "It is interesting that here, there is all this debate over whether cosmetic procedures are right or wrong and whether we should alter our appearance. But in other countries — Brazil, for example — cosmetic procedures are performed all the time and no one bats an eye."

Cosmetic dermatologists do confront ethical dilemmas — they are just not over whether it is to perform cosmetic procedures in the first place, he adds.

"I think that the ethical issues involve ensuring patients understand what the procedure will and won't do and that the provider has the skills to perform the procedure," Bank says.

If a provider is not skilled at a given procedure that a patient wants, he or she must be willing to refer the patient to someone else.

"You have to be particularly careful about patients who may have unrealistic expectations about what a given procedure can do," he notes. "If you have someone who is 60 and thinks they are going to look 20 again, that is not realistic, and they need to understand this."

Patients frequently come in requesting specific procedures that they've heard about through the media, but that don't address their specific needs.

"They will come in and ask for a specific procedure, and it will turn out that that procedure won't do what they are seeking to have done," Bank says.

It is essential that the physician have a discussion, guided by the patient, in which the patient relates what cosmetic problems he or she would like to improve, and the physician suggests procedures that might achieve those goals, he says.

It also is important to take an appropriate psychosocial history of the patient to determine whether cosmetic surgery or procedures to address physical problems is truly what they are looking for.

"A lot of times someone will come in and say they want a face lift because they want to look younger," he says. "But, if you talk to them a little

SOURCES

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- **Eileen Ringel**, MD, Department of Community and Family Medicine, Dartmouth University, One Rope Ferry Road, Hanover, NH 03755.

while, you find out that maybe their marriage is in trouble, or they are having trouble with their kids, and they are focusing on this procedure to fix much deeper problems.”

In these situations, it is important to be blunt if you perceive that the patient really is not prepared to undergo the requested procedure, he says.

“I tell people that liposuction will suck the fat out of your thighs — it won’t make you taller, it won’t save your marriage, and it won’t make your kids go to a good school,” he states. “It will just take the fat out of your thighs.”

He has heard of patients who want cosmetic surgery because they want to deceive employers or significant others about their true age, he notes. Though this could be considered unethical on the part of the patient, that is more of a moral issue than something the health care provider should feel compelled to judge, he feels.

Bank acknowledges that in talking about allocation of scarce health care dollars, no one is going to argue that cosmetic skin procedures are medically necessary or that they should be provided at public expense.

But that is true of a lot of procedures performed, both in dermatology and other specialties.

“If you talk about medical necessity in terms of preventing or treating conditions that are life-threatening or could cause serious illness, then many traditional dermatologic procedures would be excluded, most skin conditions — with the exception of cancer and some others — are not truly life- or health-threatening,” he notes. That doesn’t mean that performing such procedures is inherently unethical, he argues.

“As long as you are performing procedures that are safe and effective, the patient does not have unrealistic expectations about the outcome, and you are not misrepresenting your skills as a provider, I think the decision about whether the procedures are appropriate should be up to the patient,” he says.

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Networks crack down on celebrity endorsements

The major television networks recently announced they will increase scrutiny of stealth health endorsements, those interviews featuring celebrities discussing medical problems and treatments on television news programs, often without disclosing they are paid by pharmaceutical companies or health device manufacturers to promote their products.

In recent months, TV morning news programs have featured musician Ann Wilson discussing the benefits of the weight-loss device, the Lap Band; figure skater Peggy Fleming discussing Lipitor, which she takes to lower her cholesterol; and actress Kathleen Turner talking about her struggle with rheumatoid arthritis and referring viewers to a web site sponsored by Amgen Inc. and Wyeth, companies that market the arthritis drug Enbrel.

What viewers were not told was that Turner is paid by both Amgen and Wyeth for her participation in an unbranded campaign to educate people with arthritis. Ann Wilson is paid to talk about Lap Band surgery by Spotlight Health, a Los Angeles marketing company that contracts with Inamed, the maker of the Lap Band. And Fleming works on the Go for the Gold campaign of the drug company Pfizer, which makes Lipitor, *Reuters Health* reported in August.

Executives at CBS, NBC, ABC, and CNN told *Reuters Health* that they were unaware of their guests’ corporate ties when they booked the spots, and that they will give such segments increased scrutiny in the future.

News programs have a duty to guard against airing essentially paid celebrity endorsements for

health products that appear to be unpaid testimonials, says **Cindy Kennard**, a journalism professor at the University of Southern California. "There is something fundamentally wrong with lining your pockets with money and coming out and speaking about something like this. There is a fakeness about it." ▼

Hospitals limiting contact with pharmaceutical reps

Wary of their influence over physician prescribing practices, some medical organizations are limiting their contact with pharmaceutical sales representatives, the *Miami Herald* reported in September.

The pharmaceutical industry last year spent more than \$16 billion persuading doctors to prescribe their products. Nearly \$10.5 billion went for free samples of many drugs that also were widely advertised to consumers.

Because drug promotions can influence a doctor's prescribing habits, health care managers are hoping that restricting contact with marketers will prompt more physicians to prescribe cheaper generic drugs that are therapeutically equivalent to brand name medications.

This alone could dramatically cut prescription drug spending, which is projected to reach \$161 billion this year. Drug spending, which jumped an estimated 16 percent in 2001 and is projected to grow 13.5% this year, is one of the major factors behind the nation's spiraling health care costs, according to data collected by the National Institute for Health Care Management, a Washington, DC-based non-profit research and educational foundation.

Among the efforts cited by the *Herald*:

- Physicians Access, a Cincinnati medical practice, began charging drug companies \$65 for a 10-minute meeting with its doctors last year. And Time Concepts, a northern Kentucky firm, has signed up 800 physicians nationwide who've agreed to charge drug companies \$50 for the same 10-minute meeting. The encounters were previously free.

- The Polyclinic, a medical practice in Seattle, charges drug reps \$30 for one hour's access to their premises. For \$200, the reps get eight hours. But at no price are they guaranteed a meeting

with a physician. In October, drug reps will be barred altogether.

- The American Medical Student Association approved a new policy in April urging physicians, residents and medical students not to accept promotional gifts from the drug industry. The policy also urges hospitals and residency programs to ban drug company-funded lectures and lunches.

- Massachusetts General Hospital in Boston began barring pharmaceutical reps from its patient and visitor parking garages in July. The reps also are required to have appointments with doctors before they enter the hospital.

- The Providence Medical Group in Portland, OR, no longer allows visits from drug reps and only accepts samples of medications deemed cost effective. The practice also has banned gifts from reps such as catered lunches and office supplies branded with drug company logos and product names.

States also are joining in. In June, Vermont passed a law requiring drug reps to report to the state all gifts to physicians worth more than \$25. Lawmakers in New York have proposed a \$75 limit. ▼

Genetic info could be released in Australia

Australian doctors would be allowed to release details of a patient's serious genetic illnesses to other family members without permission under new joint recommendations from the country's Australian Health Ethics Committee and Australian Law Reform Commission.

After an 18-month investigation, both bodies released a 920-page discussion paper recommending appropriate privacy protections for genetic information.

Among the other proposals is the formation of a new body to be known as the Human Genetics Commission of Australia, which would advise governments and industry on genetics and assist in clarifying and coordinating the existing different laws, guidelines in practices already in place.

Other recommendations include:

- Privacy laws to cover genetic samples and genetic information, with doctors given authority to disclose otherwise confidential genetic information to a genetic relative where failure to disclose

would place that person's life at serious risk.

- Employers be banned from gathering and using genetic information from employees, except in very limited circumstances.
- Existing genetic test information to continue to be made available to insurers for the purpose of underwriting, but not with the approval of the commission. ▼

Nation's capital failing to discipline doctors

On Sept. 4, the consumer advocacy group Public Citizen released new information about physicians who have been disciplined by 10 states and the District of Columbia, but noted the information about Washington, DC, was limited because the board does little to sanction poorly performing doctors.

The database contains the names of doctors who have been sanctioned by various state medical boards over the past decade for offenses ranging from incompetence, prescribing errors, sexual misconduct, to criminal convictions and ethical lapses. Most of the doctors were not required to stop practicing, even temporarily, the report notes.

Although 237 doctors are on the District of Columbia list, the most serious punishment levied against more than 70% of them was a fine. Many were cited for not renewing their medical license — which likely occurred when the medical board forgot to send out renewal notices.

Only one doc sanctioned in DC

In 2000, according to records provided to Public Citizen, the District of Columbia medical board sanctioned only one doctor.

In 2001, the board issued just six orders. In Public Citizen's annual ranking of state medical boards, the District of Columbia came in last. The best medical board, Arizona's, seriously disciplined 14 times more doctors per 1,000 than the District.

"The board simply doesn't do its job, which is to oversee doctors and protect the public from bad ones," said **Sidney Wolfe**, MD, director of Public Citizen's Health Research Group. ▼

Spain leads world in per-capita organ donation

According to data released at a meeting of transplant surgeons in August in Miami, Spain has the highest per-capita rate of organ donation in the world.

In 2001, 32.5 people per million inhabitants in

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CME Questions

CME subscribers: Please save your monthly issues with the CME questions in order to take the two semester tests in June and December. A Scantron form will be inserted in those issues, but the questions will not be repeated.

13. According to the article on a legal dispute involving Planned Parenthood, what factors should providers consider when deciding to violate patient confidentiality?
 - A. Whether the patient will be harmed.
 - B. Whether the benefit to identified third parties or to public health outweighs the breach of trust of the individual patient.
 - C. How the medical information was obtained and stored.
 - D. None of the above
14. The Institute of Medicine study on racial and ethnic disparities in health care access found:
 - A. Poorer access was due to socioeconomic status and poor insurance coverage.
 - B. Some disparities existed that could not be explained by factors such as poverty, income status, or severity of medical condition.
 - C. Disparities existed across the health care spectrum, from cardiac care to cancer treatment.
 - D. All of the above
15. The American Academy of Dermatology:
 - A. Urged its members to stop performing injections of botulinum toxin.
 - B. Urged its members to stop participating in Botox parties.
 - C. Rejects the use of cosmetic procedures to reduce the signs of aging on skin.
 - D. None of the above
16. According to the article, the pharmaceutical industry spent what amount of money last year to persuade physicians to prescribe certain products?
 - A. \$10 million
 - B. \$16 million
 - C. \$16 billion
 - D. \$10.5 billion

Spain were organ donors, compared to 21.4 people per 1 million inhabitants in the United States.

Government facilitates donation

In Spain, organ donation has become a well-accepted notion, supported by the government and the national health system, Bernard Cohen, executive director of the Eurotransplant International Foundation told the *Miami Herald* on Aug. 26.

The Spanish government fully funds education of its physicians and the public on donation and transplantation issues, which have gone a long way to improving rates, he says.

Spain also has adopted presumed-consent legislation, common in several European countries. Under presumed consent, hospitals do not have to seek consent from families for donation. Unless a patient has made arrangements to ensure he or she will not donate, providers assume consent for the procedure.

However, even with these laws, other European countries lag behind the United States: Germany has 12.8 donors per 1 million and Greece has 11 donors per 1 million inhabitants. ■

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