MEDICAL ETHICS ADVISOR®

For 24 years, your practical guide to ethics decision making

AHC Media LLC

IN THIS ISSUE

Statement of Financial Disclosure:
Arthur R. Derse, MD, JD (Board Member/Peer Reviewer), Karen Young (Managing Editor), and Russ Underwood (Associate Publisher) report no consultant, stockholder, speakers' bureau, research, or other financial relationships with companies having ties to this field of study.

AUGUST 2009
VOL. 25, NO. 8 • (pages 85-96)

Chaplains' mission is to address the individual needs of specific patients

The goal is to 'meet the patient where he is'

One of the most significant events in a person's life — one often intertwined with his or her philosophies, values, and spiritual beliefs — is the process of dying and death.

To make the transition as peaceful and comfortable as possible, chaplains play what they consider to be an essential role for the patients they counsel. Now, chaplains and hospitals are being challenged to meet the diverse needs of an increasingly multicultural patient population.

There is a growing awareness in all of health care that due to an increasingly multicultural society — and therefore, multicultural patient population — health care providers, institutions — and above all, chaplains, should practice a high level of cultural sensitivity.

According to **J. Vincent Guss**, DMin and MDiv, and chaplain of Falcons Landing Air Force Retired Officers Community in Potomac Falls, VA, there is a historical link between providing health care and addressing patients' spiritual needs.

"Medicine has always been related to spirituality and religion up until the 18 th century," Guss tells *Medical Ethics Advisor*. Prior to that time, he notes, "most physicians were priests." "And in certainly the Third World and [certain] other cultures, that's still the case."

"With the rise of modern science, the scientific method, and empirical studies for medicine — and the increasing fundamentalism movement in religion [in the late 20th century], the two became suspicious of each other."

The line between spirituality and the healer is strictly separate in most cases today.

"I believe it's more respectful to the patient when physicians, nurses, and other health care practitioners are interested in spiritual dynamics from a holistic healing perspective — I think then there's a much greater openness," Guss says.

And it is not necessarily the responsibility of the chaplain to deal with patients on a spiritual level; the goal is to meet the needs of the

NOW AVAILABLE ON-LINE: www.ahcmedia.com/online.html
Call (800) 688-2421 for details.

patient, whatever the patient may need. And the responsibilities of the chaplain are fairly universal, according to those who fulfill this role.

"I think as a profession, the responsibilities of a chaplain are pretty global," says **David Johnson**, DMin, BCC, president-elect of the Association of Professional Chaplains in Schaumburg, IL. "They supposedly meet patients where they are, regardless of their own spiritual beliefs or value systems. So, it's not that the individual is valueless [himself or herself], but the chaplain is trained to be able to engage the patient or the individual at their need, as opposed to what the chaplain believes is a point of need."

Johnson says that chaplains are also trained to "listen intently" not only to what they hear, but also what they observe in the patient.

"We're trained to listen, and not only to the words, but also to the emotional and unconscious messages that might help patients and families be able to verbalize what they may be feeling or thinking, but are afraid to express," Johnson says.

Guss concurs. He says his responsibilities are slightly different as a chaplain at a retirement facility from those of his previous hospital setting.

"Since I'm in a continuing care retirement community, some of the primary things we get involved in are ethical issues regarding residents who don't feel they are ready to be transitioned to a higher level of care, or, — as I did in the hospital very often — of how aggressive one should be in order to treat the patient, whether that's a do not hospital order, if that's appropriate, or if we can treat things at our health care facility, or is it appropriate to go to the hospital."

Chaplains also often play key roles in ethical decision-making regarding care. They often serve on hospital ethics committees; furthermore, they often play a key role in ethics consults.

Regarding his facility, Guss says, "These are ethical issues and clinical issues that have a spiritual dimension, and it's my duty to identify the spiritual dimension, to identify clergy, or religious scripture, or sacramental resources that might be appropriate for those who are religious — or to find other people in the community who can be supportive to address [the patient's] value systems, what is important to them and to identify how they see themselves in relation to these problems."

Chaplains typically minister not just to patients, but also to the health care team.

Public ministers vs. the chaplaincy

There is a difference between a minister or other religious leader and a trained chaplain, according to those in the profession.

"We talk about public ministry a lot — the difference between chaplains and public ministry, [or] individuals in private ministry with churches, because they are basically tending to their flock, based on certain theological understandings," Johnson says.

One of the challenges faced by the profession, he says, is that many health care administrators don't understand the differences and believe that any minister is qualified to serve as a chaplain,

Medical Ethics Advisor® (ISSN 0886-0653) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to *Medical Ethics Advisor*®, P.O. Box 740059, Atlanta, GA 30374.

AHC Media LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media LLC designates this educational activity for a maximum of 18 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity is intended for acute care physicians, chiefs of medicine, hospital administrators, nurse managers, physician assistants, nurse practitioners, social workers, and chaplains. It is in effect for 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.- 4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media LLC. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. Web: http:// www.ahcmedia.com.

Managing Editor: **Karen Young**, (404) 262-5423, (karen.young@ahcmedia.com).
Associate Publisher: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).
Production Editor: **Ami Sutaria**.

Copyright © 2009 by AHC Media LLC. **Medical Ethics Advisor**® is a registered trademark of AHC Media LLC. The trademark **Medical Ethics Advisor**® is used herein under license. All rights reserved.

AHC Media LLC

Editorial Questions

Questions or comments?
Call **Karen Young**
at (404) 262-5423.

Johnson says.

When the line between the chaplain's own religious or spiritual beliefs and the patient's specific needs are blurred, that is not a good thing to have happen from the standpoint of those in the profession, as the chaplain is there to serve the patient and alleviate his or her discomfort or anxiety.

Sometimes, the patient adamantly refuses to discuss religion.

"I had a student one time who had an atheist as a patient, and the person said I'd love to talk to you, but not if you're going to talk about religion, and so they had a great conversation about some philosophical issues," Johnson says. "So, people, whether they're religious or philosophical or emotional, we have to be prepared to meet people at different levels of how they're experiencing their anxiety, because they may come out of their anxiety in different ways."

Board certification requirements for chaplains

Guss and Johnson say that board-certification is the ideal for chaplains, not only due to educational requirements, but other training and standards requirements, as well as a code of ethics all board-certified chaplains must follow. There also are continuing education requirements for board-certified chaplains.

One more requirement is ecclesiastical endorsement by whatever body of religion the chaplain follows.

"For example, I'm a Lutheran pastor, so the Lutheran Church has to endorse me — or Catholic or Episcopal. There are some religions that don't have those endorsement bodies, so then we provide some sort of ad hoc arrangement that can [endorse those chaplains], so there's accountability," Guss says.

Multicultural patients present challenges

The Joint Commission is proposing revised and additional standards, expected to be part of their typical quality surveys at hospitals, on matters which include the following: staff training on cultural sensitivity; inclusion of health literacy needs in learning needs assessment; non-discrimination in care; and informing patients of their right to receive language access services **(See related story on The Joint Commission on p. 88.)**

"I think the challenges today are the issues of diversity," Johnson tells *MEA*. "As we are becoming more multicultural, less singular in focus, for that reason we have to have a broader understanding of religion . . . and theologies and requirements, so we have to train in [such things as] food requirements and interpret that to the institution."

Guss tells *MEA* that when he was a hospital chaplain, "probably the most challenging thing was defending, supporting, and advocating for people whose religious convictions were not my own — and that it looked like they may have been going against their medical best interests."

Cases in point include those who are Jehovah's Witnesses, who do not believe in the transfusion of blood, or certain Middle Eastern and other cultures where those religions do not allow women to have "the same participation in their health care," he says.

Despite that, Guss says, he would find a way to advocate for that patient, "although it would go against my values, and the values we have here in Western medicine, as well as Western religion, and yet finding a way to create dialogue and respect with those folks."

To address diverse spiritual and non-spiritual needs, the ACP membership now includes chaplains who are Sikhs, Buddhists, Hindu and Muslims and Jews. ACP has its roots in the College of Chaplains, which was originally part of the American Protestant Health Care Association.

"Very soon we saw, as we were becoming the premier group, that we were shortchanging ourselves and our own understanding of what chaplaincy was by limiting ourselves to Protestants and Christians," Guss recalls.

Guss says that while the National Association of Catholic Chaplains and the National Jewish Chaplains still exist, they exist mainly for specifically religious issues and concerns.

Beth Israel Medical Center in New York City has partnered with the New York Zen Center for Contemplative Care to bring Zen Buddhist chaplains into the hospital as a way of offering bedside meditation, interdenominational prayer, and other spiritual support to patients and staff members.

The Zen Buddhist chaplains operate the New York Zen Center for Contemplative Care to train health care professionals in contemplative approaches, which can help both patients and caregivers deal with illness, disease, dying, and living.

The hospital said in a press release that while

the "training is delivered from a Buddhist perspective, the care is accessible and tailored to people of all faiths and traditions."

The Rev. Koshin Paley Ellison, co-founder of the New York Zen Center for Contemplative Care, says in a Beth Israel press release that "there are many patients who may benefit from a different type of spiritual counseling. Our guiding values are compassion, equanimity, courage, inquiry, and learning." **(Editor's note: Look for a story in the September issue of *Medical Ethics Advisor* for a conversation with the Rev. Koshin Paley Ellison, co-founder of the New York Zen Center for Contemplative Care and a chaplain at Beth Israel.)**

Separation of church and state

Earlier this year, the National Secular Society in the UK called for an end to chaplains in the National Health Service, according to a report by the BBC, due to its belief that there should be separation between church and state, as explained by **Derek Brown**, DMin, lead chaplain, NHS Highland, Raigmore Hospital, Inverness, in Scotland.

Brown says he thinks the chaplains in the UK face similar challenges to those in the United States, particularly in convincing some of the value of chaplains.

"I think there are similar challenges in the sense of trying to find a place in the health care system, if you like," Brown tells *MEA*. "And to some extent, we have a place in that, and it's a valued place.

He said this was demonstrated when a "fury" from various elements arose when the National Secular Society suggested ending public funding of chaplains.

"What I don't think they understand…is the breadth and the scope of the chaplaincy in the UK," Brown says. "It is not just about religious people visiting other religious people and getting paid by taxpayers."

Although British chaplains represent diverse religions, they tend to be Anglican in England and those in Scotland tend to be Church of Scotland Presbyterian. However, there also is a Muslim chaplain who heads a very large health trust in London.

"That's one example of the multifaith [approach] that works very well, but it's not just about caring for that particular faith group, although he would be doing that anyway, but it's not his whole job, if you like," Brown says.

In the United States, Guss says there is discussion ongoing within the chaplaincy community here regarding whether chaplains should be licensed by the individual states, much like physicians and nurses.

"We have that [religious] sensitivity, but even then, when you bring that church and state thing up, it's still an issue of, 'Do we want the secular world to be in any control of the spiritual world?'" ■

SOURCES

- **Rev. Dr., Derek Brown**, DMin, Lead Chaplain, NHS Highland, Raigmore Hospital, Inverness, Scotland. E-mail: Derek.brown1@nhs.net.
- **J. Vincent Guss**, DMin, MDiv, Chaplain, Falcons Landing Air Force Retired Officers Community, Potomac Falls, MD. E-mail: vguss@falconslanding.org.
- **David Johnson**, DMin, BCC, Assistant Director for Operations, Pastoral Care Department, Carolinas Medical Center, Charlotte, NC. E-mail: David.Clark.Johnson@carolinashealthcare.org.

TJC proposing new cultural sensitivity standards

Standards would not take effect before 2011

In light of the ever-increasing diversity in patient populations, The Joint Commission (TJC) is proposing revised and additional standards to address communication, cultural competence, and patient-centered care in hospital settings.

TJC accepted public comments on the new requirements from June 8 to July 20. It is anticipated that these ultimately will become part of the typical TJC hospital survey requirements, although they are not expected to be implemented before January 2011.

"Given that racial and ethnic healthcare disparities had been identified and been confirmed by several additional reports, we started looking into this . . . pretty thoroughly, and what we realized was that we weren't really quite sure where healthcare organizations were in term of

how they were addressing" the standards being proposed by the Office of Minority Health, according to **Amy Wilson-Stronks**, project director, health disparities, division of standards and survey methods at TJC.

Through its "Understanding Adverse Events in Limited English Proficient Populations" study, funded by the Commonwealth Fund, TJC was able to establish a link between individuals who had limited English proficiency and the severity of the adverse events they experienced, Wilson-Stronks says.

"So, that is how we've come to now understand what is really important in this issue," she says. "Of course, racial and ethnic disparities are very important [and] we want to ameliorate them, but there are too many other potentially causative factors; and what we can control or improve relates to the actual communication during the health care encounter."

Ethical considerations and input

There was an ethics component to the development of these revised and additional standards, according to Wilson-Stronks.

For example, **Matthew Wynia**, MD, MPH, FACP, who heads the Chicago-based American Medical Association's Institute of Ethics serves on TJC's advisory panel of 25 people, and he was instrumental in "providing effective provider-patient communications, so the link was perfect in terms of the expertise and his work as an ethicist."

Also, the co-director of this project is "highly involved in medical ethics," says Wilson-Stronks. He is also a member of the oversight body for the AMA's Ethical Force program.

And Wilson-Stronks says that even though patient communication is often discussed generally, "We recognize that that communication is influenced by things, such as culture, as well as language, as well as a physical communication barrier, I think. And I think that cultural differences are where some of those new ethical dilemmas can be raised."

Revisions and additions proposed

All of the reports discussed previously and the proposed revisions and additions can be downloaded on TJC's web site, www.jointcommission.org/PatientSafety/HLC.

The issues addressed in the proposed requirements are broken down as follows:

- staff training and cultural sensitivity;
- staff and licensed independent practitioner training on the use of communication tools;
- use of population- and patient-level demographic data;
- identification of patient communication needs;
- address communication needs across the care continuum;
- provision of language access services and auxiliary aids;
- assessment of patient understanding;
- inclusion of health literacy needs in learning needs assessment;
- collection of patient-level demographic data;
- documentation of the need for mobility assistance;
- documentation of the use of language access services and auxiliary aids;
- accommodation of patients' cultural and personal beliefs;
- accommodation of patients' religious and spiritual practices;
- non-discrimination in care;
- inform patients of right to receive language access services;
- unlimited access to designated patient advocate.

From a human resources perspective, the hospital is to provide orientation on sensitivity to cultural diversity of the staff and the patient population, based on their job duties and responsibilities — contained in element of performance , EP 5 of Standard HR.01.05.03.

For Standard HR.01.05.03, which requires that staff participate in ongoing education and training, there are three new EPs: EP 7, EP 8 and EP 9. Together, they address ongoing sensitivity training, primarily focused on how patient culture can affect the provision of care and communication with patients and among staff, as well as utilizing appropriate communication tools.

TJC also is proposing for the Leadership Chapter, EP 4 for standard L.D.04.03.01, which indicates that the hospital should use available population data to help determine the needs of the population served. That may entail more mundane pieces of information, such as census figures, voter registration data, and school enrollment profiles.

However, TJC also is suggesting the use of much more sensitive demographic data, in the medical record, in an effort to deliver care more precisely, including age, sex, disability,

language, race/ethnicity, religion, socioeconomic status, education level, sexual orientation, and gender identity or expression.

Wilson-Stronks acknowledged that certain pieces of this information are sensitive.

"I think what we are going to be seeing as we are considering this and moving forward is — we are really going to have to make sure there is a case that collecting those pieces of demographic information is truly going to have an impact on the provision of care — in a positive way," she says.

That, she notes, may well be a concern of patients, i.e., "Why are you going to collect this — are you going to treat me differently?"

She also said that as physicians and hospitals consider adopting electronic medical records, "protecting the data so that they are not inappropriately made available is very, very important."

A proposed requirement for medical staff indicates that hospitals should educate all licensed independent practitioners on how to use available communication tools, as well as sensitivity to "cultural, religious, and personal values and beliefs."

One of the issues TJC found in its research was that some hospitals may have appropriate policies in place, but the implementation is spotty. When TJC interviewed physicians one-on-one, many were not aware of language services, for example, at their hospitals, even though interpretation services were available to patients. That suggests that there may be problems with training of staff, rather than the policies, she says.

Another proposed requirement specifically addresses communication, in that it requires the identification of the method by which patients want to receive and provide information, which would then be required to be communicated across the continuum of care.

If a patient is a minor or incapacitated, the designated advocate's language preferences would be respected and adhered to.

Proposed requirements for the hospital suggest that institutions should "accommodate the patient's cultural and personal values, beliefs, and preferences." The word "accommodates" was substituted for the previous "respects," Wilson-Stronks says, because the new word "insinuates more of an action."

"And we've also added a note that tried to articulate that this is an action we would expect to be accomplished within reason," she says.

Negotiation in accommodating patient requests is also an area, she says, where ethics consults could come into play. She says that many hospitals have developed negotiated responses to specific patient requests.

The intent of the standards is to encourage hospitals to work with patients to "try to negotiate a reasonable solution to a request, as opposed to, 'That's nice; put it aside."

One of the primary changes involves accommodating a patient's right to have an advocate available in the hospital 24/7.

"There isn't really anything that states that a patient could have an individual available to them," she says. "So, I think what happens is that a patient may be in the hospital, and they may have a health care proxy, for example, but that proxy is only allowed to be with that patient — and have access to that patient — within visiting hours," Wilson-Stronks notes.

Economic implications?

In light of the additional staff training requirements, a natural question is whether — during this current economic downturn — hospitals will have the means to accommodate these requirements.

Although some large, urban or academic hospitals already may be meeting these requirements in their policies, there may be others that would have to implement new policies and new training programs, if these requirements are implemented ultimately by TJC.

"I think that some of the feedback we have gotten from hospitals is: We are already doing this," Wilson-Stronks says, noting that "perhaps they would want to check to see how it is going to be surveyed to make sure that they can demonstrate their compliance during the survey, but there's nothing else they would need to do."

From other institutions, TJC has received feedback "about concerns that education departments have been cut and the resources aren't there — the expertise may not be within the organization."

However, TJC is creating an implementation guide that will "provide hospitals with guidance and resources so that they can do whatever it is that we may ask them," Wilson-Stronks says. Many of those resources will be available to hospitals free of charge. ■

SOURCE

• **Amy Wilson-Stronks**, MPP, Principal Investigator, Hospitals, Language and Culture study and Project Director, Health Disparities, The Joint Commission, Oakbrook Terrace, Illinois.

Study suggests patients don't understand CPR

University of Iowa implements new policy

A study completed by researchers at the University of Iowa Carver College of Medicine suggests that many patients who are hospitalized do not fully understand all the steps involved in cardiopulmonary resuscitation — or their chances of surviving an in-hospital cardiac arrest.[1]

Lauris C. Kaldjian, MD, PhD, associate professor in the Department of Internal Medicine, as well as director of the program in bioethics and humanities, explained the impetus behind the study.

"Code status discussions seem to come out of nowhere; they tend to be dropped into a doctor-patient or doctor-family discussion without a sense of context or framework, and that tends to be the way that most of us, I think, have been professionalized in our careers," Kaldjian says.

Often, he says, the conversation on code status is introduced at the end of a patient history and physical examination process as someone is being admitted to the hospital.

"It usually is scarcely introduced, and it typically is not preceded by a sense of context to help someone understand where the question is coming from," he says.

Although that is sometimes unavoidable, depending on the patient's condition upon admission, in even urgent circumstances, he suggests there would still be another 5-7 minutes a physician could take with the patient to "set the stage and discuss the goals of care and say, 'Mr. Jones, I want to talk to you about what the overall purpose of your hospitalization is. As I understand it, based on what you've told me so far, your goals would be as follows. Have I heard you correctly?'"

The conversation could then proceed from goals of care as indicated by the patient to the physician introducing the subject of code status.

"It's that kind of phraseology where you can first set the stage and then talk about a particular intervention, " Kaldjian explains. "And then the physician can even help the patient walk through the connections that they need to make. And to say, 'Well, if my goal is such and such, does resuscitation in my circumstances make sense or not?'"

Kaldjian says to his knowledge, no other studies have addressed in-hospital patients looking at the "CPR question plus the goals of care."

The study's findings

In introducing the study, the authors write that code status "communication can be difficult, and studies suggest that doctors often misunderstand patients' code status preferences, even in the setting of serious illness."

"There is a need to improve the quality of code status discussions so that patient preferences can be ascertained and implemented," the authors also write.

One possible barrier to the discussion of code status may be that often, physicians are unaware of the patients' goals of care. Without the goals of care as a guide, Kaldjian says, it is difficult to make the correct decisions regarding potential interventions.

In the study, 135 adults were interviewed within 48 hours of admission. Of those, 41, or 30.4%, had discussed CPR with their doctor; 116, or 85.9%, preferred full code status and 11, or 8.1%, expressed code status preferences different from the code status documented in their medical record.[1]

The study found that older patients were more likely to have discussed code status with their doctors but were less likely to want full code status.

There was a discrepancy between patients' perceived knowledge of what CPR entails vs. their actual knowledge. That is, 98 patients, or 72.6% expressed a perceived knowledge, but only 40, or 29.6%, accurately understood the process of CPR.

"I think people tend to associate CPR with what they see on television, and often, that can be seen as something that is less technically involved and more like the kind of life support skills that any citizen can be certified in if they take an approved course to learn how to do basic CPR," Kaldjian says.

He explains the three parts of CPR as follows:

the use of a defibrillator, i.e., applying electricity to the heart externally; chest compressions; and lastly, intubation, or putting a tube in the patient's windpipe and hooking them to a breathing machine.

Of the patients interviewed, 116, or 85.9%, preferred all three components of CPR.

Patients also "greatly overestimated the probability of surviving a cardiac arrest in a hospital. When patients were informed about the true statistics involving survival of CPR, "some patients were less interested in receiving CPR."

In fact, the chance of surviving CPR long enough to leave the hospital is only about 15%.[1]

Two of the barriers to appropriate code status discussions involve knowledge and communication. Regarding the communication barrier, the study authors in the discussion write that "the implications of failures in this domain are reflected by the observation that for 8.1% of patients in our study, there was a discrepancy between their code status preferences and their code status as documented in their medical record."

The study found that "goals of care represent an approach to code status discussions that may improve communication." It also found that, since patients selected an average of 4.9 different goals, patients may have multiple goals at the same time, concluding that "the heterogeneity of patients' single most important goals of care emphasizes the importance of soliciting patients' goals rather than presuming to understand them on the basis of general clinical impressions."

Of the patients, 70% said they found it helpful to discuss goals of care.

University of Iowa's new policy

In May, according to Kaldjian, who also chairs the hospital's ethics committee, the University of Iowa implemented a new policy requiring physicians to discuss goals of care with all hospitalized patients, regardless of their condition or prognosis.

"[The policy] places code status discussions within a framework of goals of care," Kaldjian explains. "And the way we say it is to say, ideally, every patient in our hospital should have a goals of care discussion with their physician."

He admits that some physicians might not feel this is necessary with all patients; however, he says the health care system believes that "as a matter of policy," these discussions should take place.

"By contrast, it's not that every patient in the hospital needs to have a code status discussion," he says. "Some people might disagree with that, but I, as a clinician, think that sometimes when you have people who are otherwise relatively healthy and there's no reason to think that they might not want to be resuscitated in the event of a cardiac arrest, sometimes it can actually be disturbing to the doctor/patient relationship to raise a question that seems to be irrelevant."

SOURCE

• **Lauris C. Kaldjian**, MD, PhD, Associate Professor, Department of Internal Medicine, and Director, Program in Bioethics and Humanities, University of Iowa Carver College of Medicine; Iowa City, IA. E-mail: Lauris-kaldjian@uiowa.edu.

Reference

1. LC Kaldjian, et al. Code status discussions and goals of care among hospitalised adults. *J. Med. Ethics* 2009;35;338-342. ■

Guidelines for physicians in privacy breaches

Obligation to protect info dates to Hippocratic Oath

In light of the growing adoption of electronic medical records — and the fact that its current policy does not address "physicians' ethical responsibilities in the event the security of electronic records is breached," according to a report of its Council on Ethical and Judicial Affairs — the American Medical Association has adopted four guidelines for physicians in such cases.

The guidelines were adopted at the Chicago-based AMA's annual policy-making meeting. They outline four specific steps for physicians to take in the effort to both protect patient information and to respond appropriately should a breach occur.

What the guidelines say

The new AMA guidelines ask physicians to:

1. Ensure patients are properly informed of the breach;

2. Follow ethically appropriate procedures for disclosure;

3. Support responses to security breaches that place the interests of patients above those of physician, medical practice, or institution;

4. To the extent possible, provide information to patients to enable them to diminish potential adverse consequences of the breach of personal health information.

"Protecting the privacy and safety of patient information, whether in a paper record or an electronic medical record, is a top priority for physicians," said AMA board member **William A. Dolan**, MD, in an AMA news release announcing the guidelines. "Physicians need a standard protocol to follow to maintain patient security in the event of a breach of personal information."

The report states, "A physician's obligation to respect confidentiality and guard a patient's privacy is a well-established principle of professional ethics that dates back to the Hippocratic Oath."

The report also notes that health information is critical to the practice of medicine. But while the advent of electronic medical records to "store, access, and transmit detailed patient information accurately and rapidly" among physicians, administrators, and payers can benefit patients, it also poses risks.

"The flow of medical information from patient to health care provider to health insurance industry and beyond is conducted with limited regulation and oversight," the report states. "Existing data security laws and agencies have been characterized as a 'confusing, sometimes conflicting, patchwork' of policies."

The report notes that in 2008, 38.4% of physicians reported using fully or partially functional EMR systems, compared to 2001, when only 18.2% of office-based physicians reported using EMRs.

Dolan said in the AMA release, "EMRs are the wave of the future, so it is important for both patients and physicians to feel secure. These new guidelines prepare physicians to help . . .patients in the unfortunate situation of an information breach."

The extent of harm to a patient as a result of a security breach depends, the report notes, on several factors, including the intent of the person who inappropriately accessed the information, the nature of the information that was breached, as well as with whom the information may have been shared.

"One profound harm may be medical identify theft, the fastest-growing form of identity theft," the report states. That can lead not only to "inconvenience," but impact a person's credit rating and ability to get care — as well as lead to inaccurate information in the patient's medical record.

Aside from those concerns, breaches may impose "dignitary harm" on a patient. However, disclosure is essential.

"Like being candid with a patient about a medical error, being candid with a patient when his or her information has been inappropriately disclosed may be difficult or uncomfortable," the report states. "However, this does not change the fact that it is the ethically appropriate response."

"Inappropriate disclosure of a patient's personal information violates his or her right to 'informational' privacy, a fundamental expression of autonomy," the report states.

From a legal perspective, the report notes that, currently, 44 states require businesses to notify residents if their information has been breached.

The report also notes that studies have indicated that should a breach occur, the patient does want to be informed. ■

NIH announces guidelines on stem cell research

The National Institutes of Health (NIH) on July 6 published federal guidelines for human stem cell research. Those guidelines implement President Obama's executive order to allow federal funding for such research.

The NIH published draft guidelines on April 23 in the *Federal Register* and accepted public comment until May 26.

The agency said it received about 49,000 comments from patient advocacy groups, scientists and scientific societies, academic institutions, medical organizations, religious organizations, and private citizens, as well as from members of Congress.

The guidelines became effective July 7, and according to the NIH, help "ensure that NIH-funded research in this area is ethically responsible, scientifically worthy, and conducted in accordance with applicable law. ■

CDC says 129 older adults in EDs for fractures daily

From 2001 to 2006, an average of 129 Americans ages 65 and older were treated in emergency departments (EDs) each day — a total of more than 47,500 each year, according to a study from the Centers for Disease Control and Prevention (CDC) published in the June issue of the *Journal of the American Geriatric Society*. The study, which examined six years of ED medical records, found that with the injuries related to falls from using canes or walkers for older adults, walkers were the culprit in 87% of cases.

People were seven times more likely to be injured in a fall with a walker as with a cane.

Also, older women sustained 78% of walker-related injuries and 66% of cane-related injuries.

"Walking aids are very important in helping many older adults maintain their mobility. However, it's important to make sure people use these devices safely," said **Judy Stevens**, PhD, the study's lead author. "Walkers are often used by frail and vulnerable older adults; people for whom falls, if they occur, can have very serious health consequences."

According to the CDC, additional studies are needed to better understand fall risk factors for older adults who use walkers and canes, as well as to identify potential design problems and improve the design of walkers. ■

Congresswoman introduces legislation regarding in-office imaging loophole

According to the American College of Radiology (ACR), Rep. Jackie Speier (D-Calif.) recently introduced HR 2962, the Integrity in Medicare Advanced Diagnostic Imaging Act of 2009.

The bill would amend Title XVIII of the Social Security Act to exclude certain advanced diagnostic imaging services from the in-office ancillary services exception to the "Stark laws" prohibition on physician self-referral.

HR 2962 as of early July had no co-sponsors and has been referred jointly to the House Energy and Commerce Committee and the House Ways and Means Committee.

"ACR looks forward to working with Congresswoman Speier to incorporate the discussion of imaging self-referral into the ongoing health debate," said **James H. Thrall**, MD, FACR, chair of the ACR board of chancellors. ■

REPRINTS?

For high-quality reprints of articles for promotional or educational purposes, please call **Stephen Vance** at **(800) 688-2421**, ext. **5511** or e-mail him at **stephen.vance@ahcmedia.com**

BINDERS AVAILABLE

MEDICAL ETHICS ADVISOR has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail **binders@ahcmedia.com**. Please be sure to include the name of the newsletter, the subscriber number, and your full address.

If you need copies of past issues or prefer on-line, searchable access to past issues, go to **www.ahcmedia.com/online.html.**

If you have questions or a problem, please call a customer service representative at **(800) 688-2421**.

Futility Revisited: Practical Strategies for Averting and Resolving Medical Futility Conflicts

Presented By: John Banja, PhD

When: Thursday, August 27 2009 1:00 p.m. - 2:30 p.m. ET
Cost: Only $299 for your entire staff!

In this presentation, John Banja, PhD will explore strategies to diminish factors that lead to conflicts in the hope that professionals and family members might reach agreement about a program of care more rapidly and amicably. You will walk away with practical tips on how to:
• Get clinical relationships off to a good start
• Manage excessively demanding or angry family members
• Appreciate the emotional experience of family members and how it affects their understanding
• Monitor and adjust professionals' relational behaviors that might damage rapport
• Explore a host of empathic strategies that can preserve the therapeutic dimensions of a professional-family relationship, even when the parties disagree

Call 1-800-688-2421 now — while you are thinking about it — to guarantee your spot in this program today! Remember to mention priority code T09362/8509 when you register.

CME instructions

Physicians participate in this continuing medical education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge.

To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity with the **December** issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a credit letter. When your evaluation is received, a credit letter will be mailed to you. ■

CME objectives

After reading each issue of *Medical Ethics Advisor*, you will be able to do the following:

- **discuss** new information about hospital-based approaches to bioethical issues and developments in the regulatory arena that apply to the hospital ethics committee;
- **stay** abreast of developments in bioethics and their implications on patient care, risk management, and liability;
- **learn** how bioethical issues specifically affect physicians, patients, and patients' families. ■

COMING IN FUTURE MONTHS

■ The ethics of neuroimaging

■ Bioethics education: From PhDs to weekend seminars

■ Advantages of the POLST form

■ The ethics of the right to refuse treatment

Editorial Advisory Board

Consulting Editor: **Cynda Hylton Rushton**
DNSc, RN, FAAN
Clinical Nurse Specialist in Ethics
Johns Hopkins Children's Center, Baltimore

John D. Banja, PhD
Associate Professor
Department of
Rehabilitation Medicine
Emory University
Atlanta

Nancy Berlinger, PhD, MDiv
Deputy Director and
Research Associate
The Hastings Center
Garrison, NY

Arthur R. Derse, MD, JD
Director
Medical and Legal Affairs
Center for the Study
of Bioethics
Medical College of Wisconsin
Milwaukee

J. Vincent Guss, Jr.,
DMin, MDiv
Journal of Pastoral Care
Editorial Board for the
Association of Professional
Chaplains
Chaplain of Falcons Landing
Air Force Retired Officers
Community
Potomac Falls, VA

Marc D. Hiller, DrPH
Associate Professor
Department of Health
Management and Policy
University of New Hampshire
Durham, NH

Paul B. Hofmann, DrPH
President
Hofmann Healthcare Group
Moraga, CA

To reproduce any part of this newsletter for promotional purposes, please contact:
Stephen Vance
Phone: (800) 688-2421, ext. 5511
Fax: (800) 284-3291
Email: stephen.vance@ahcmedia.com

To obtain information and pricing on group discounts, multiple copies, site-licenses, or electronic distribution please contact:
Tria Kreutzer
Phone: (800) 688-2421, ext. 5482
Fax: (800-284-3291
Email: tria.kreutzer@ahcmedia.com

Address: AHC Media LLC
3525 Piedmont Road, Bldg. 6, Ste. 400
Atlanta, GA 30305 USA

To reproduce any part of AHC newsletters for educational purposes, please contact:
The Copyright Clearance Center for permission
Email: info@copyright.com
Website: www.copyright.com
Phone: (978) 750-8400
Fax: (978) 646-8600
Address: Copyright Clearance Center
222 Rosewood Drive
Danvers, MA 01923 USA

CME Questions

5. According to most chaplains, the primary goal of chaplaincy is to convey their own religious beliefs to patients.
   A. True
   B. False

6. The impetus for The Joint Commission to propose revised and additional standards to advance effective communication, cultural competence, and patient-centered care for its Hospital Accreditation Program include which of the following:
   A. Complaints from patients
   B. Recognition that there are ethnic and cultural disparities in health care services
   C. Recognition that policies may be in place at hospitals, but not followed
   D. A and B
   E. B and C

7. The American Medical Association has provided guidelines for physicians to guide their response in the event of inappropriate breaches of patient information.
   A. True
   B. False

8. In a study completed by researchers at the University of Iowa Carver College of Medicine, most patients interviewed in the hospital understood the technical aspects of cardiopulmonary resuscitation.
   A. True
   B. False

Answers: 5. B; 6. E; 7. A; 8. B.