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Undocumented immigrant patients in LT-care present challenges to hospitals

Martin Memorial decision an important one

A recent jury verdict in Florida may provide support for hospitals considering sending long-term, high-cost patients back to their home countries.

On July 27, a jury decided in favor of Martin Memorial Health Systems, which in 2003 repatriated a brain-injured patient to his native Guatemala.

The patient, Luis Alberto Jimenez, had "suffered traumatic brain damage and severe physical injuries" as a result of a car accident on Feb. 28, 2000, according to the original complaint, filed in the Circuit Court of the 19th Judicial Circuit by Montejo Gaspar Montejo, Jimenez's guardian. The patient spent nearly three years following the accident at Martin Memorial before being repatriated, with a short stint in a nursing home before he was returned to the hospital for emergency care in January 2001.

The hospital noted in a public statement that the case of Jimenez "has been a challenging situation for Martin Memorial for most of this decade." It also noted that the hospital had spent a "significant amount of resources as a result — resources that could have been used to provide patient care."

The complaint contended that the hospital committed "an action for false imprisonment" when it returned the patient to Guatemala, but the jury decided otherwise.

According to **Carla Luggiero**, JD, senior associate director for federal relations for the American Hospital Association in Washington, DC, hospitals are "watching this [decision] carefully," and she said the jury's decision "may make them a little more comfortable in moving forward" if they decide to repatriate a patient.

Hospital president/CEO issues statement

While the hospital is not granting media interviews following the jury decision, it did issue a public statement from its president and

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CEO, **Mark E. Robitaille**, of Martin Memorial Health Systems.

"We are obviously pleased with the jury's decision. We have maintained all along that we acted correctly and, most importantly, in the best interests of Mr. Jimenez.

"Regardless of the outcome of this case, what is most disappointing is that the issue of providing health care to undocumented immigrants remains unresolved on a state and national level. This is not simply an issue facing Martin Memorial," which is based in Stuart, FL.

"It is a critical dilemma facing health care providers across Florida and across the United States. What is truly unfortunate is that since Mr.

Jimenez was first admitted to Martin Memorial nine years ago, nothing has been done to address this issue by our political leadership."

Luggiero also says that in 2003, the Medicare Modernization Act, which was passed then, included a provision, called Section 1011, that she describes as a "four-year program of \$250 million a year allocated to states and hospitals that had a very high proportion of illegal immigrants in the hospital setting."

"And it did partially compensate [hospitals]," she notes. "When I say partially, it was maybe a quarter to the dollar — you know, it was something, rather than nothing."

"That program expired in . . . September of 2008, and efforts to have it reauthorized have been unsuccessful," she says.

However, Luggiero says the AHA, in an effort to get attention directed to health care costs for undocumented immigrants, has "consistently raised the issue."

"I think it's more of a political issue right now. There are so many strong feelings on both sides of the aisle about health care reform in the districts," she says.

The challenge hospitals face

Although indicating she has no "hard data" on this issue, "anecdotally, there does seem to be more concern about this," Luggiero says. "And 20 years ago, you didn't actually hear of anyone being repatriated, but it has, I think increased — at least it is my sense that it has increased over years."

Her position is that this issue has increased in importance because neither Medicare nor Medicaid pays for undocumented immigrant health care services "except in very, very remote circumstances," she says.

"But hospitals have this challenge: They have to remain viable to be able to offer services to the community at large," she says.

An acute care hospital, Luggiero says, is a very labor-intensive and high-tech environment, and when you have a patient who has reached the point where the acute care that he or she is getting in the hospital has been fulfilled, then the hospital has to find another willing taker. In other words, the patient has reached a "plateau; they are not going to get any better," she says, despite being in the acute care setting.

Because there are no funds for undocumented immigrant care, the hospital has to absorb the cost.

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Editorial Questions

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“And when you’ve got a patient that has reached the point that they cannot get any better with the additional care that’s given in the hospital, they are essentially taking up resources that could go to other patients that might need the bed,” Luggiero says. “So, hospitals are kind of between a rock and a hard place . . .”

EMTALA, she notes, is a federal law that requires that hospitals stabilize patients who come in to their emergency department.

“But you know, we know that sometimes stabilizing a patient means more than making sure that their heart is beating, and their pulse is going, and that they’re breathing,” she says.

The ethics of the matter

William Greenough, MD, argues that the ethics of the patient-physician contract dictate that repatriating patients is an “unacceptable policy,” as he wrote in the American Medical Association’s *Virtual Mentor* publication in July in an article titled, “Treating and Repatriating: An Unacceptable Policy.”¹

Greenough is a professor of medicine and international health at Johns Hopkins University in Baltimore, and who works in long-time care in the division of geriatric medicine, focusing on patients who are on long-term ventilator support, dialysis, and hydration.

Greenough tells *MEA*, that “in most health care systems around the world, if I go to Canada or France, I am taken care of with no cost. And not shipped somewhere else. So, the ethical consideration is: Is the patient going to have an acceptable quality of care at the facility to which they are being referred?”

He maintains that the only way to know anything about the quality of care — and the likelihood of survival of a patient about to be transferred or repatriated to his or her own country from a U.S. hospital — is to have data about the hospital in the country to which the patient is being referred.

“Otherwise, the ethical issues would be that if you do not know what the care will be or else it’s inferior care, you’re basically consigning the patient to inadequate care, which from a doctor’s point of view is unsatisfactory,” Greenough notes. “It’s unethical.”

Physician as patient advocate

“A physician must advocate for his or her

patient even if the hospital administration has debts or is near bankruptcy,” Greenough writes in *Virtual Mentor*. “If this is truly the case, an appeal should be made to the state for financial help.”

Greenough argues that if “the hospital administration insists on an unsafe transfer,” the physician should seek legal counsel and aid vs. the hospital.

While he acknowledges that this could place a physician in an adversarial role vs. the hospital, it doesn’t have to be confrontational, he says, and could be more of a collaborative approach — an approach he has taken at his institution to advocate for safe transfers of his patients.

“In the situation here in Maryland, we’re stepping down people who are on ventilators to what are called skilled nursing ventilator facilities,” he says. “And it’s been done on the basis of paper transactions — paper guidelines — but the outcomes of those transfers, compared to a similar group of patients, have not been made available or are not available.”

Greenough has been tracking his patients who have been transferred to skilled nursing ventilator facilities and has found that “there is a very high mortality rate for patients that are determined to be stable by the state criteria [for transfers].”

“So, I feel they are flawed criteria,” he notes.

At this point, Greenough has worked with Johns Hopkins “to get the hospital to agree not to transfer further patients that are declared stable [based on state criteria] into the facility where they have not survived,” he says.

It is important to note, that most of these patients had indicated previously that they would like to remain on life support, he says.

“In my case, what I’ve done is I’ve gotten the administration to agree that pending more information from the state and legal appeals by my patients, that we would not transfer patients, but would take the cost reduction for caring for the patient, which is the ethical position, although it’s financially adverse for the institution,” he says.

Hope for resolution

In the public statement from Martin Memorial Health Systems, Robitaille indicates that the health system’s “hope is that something positive can come as a result” of the Jimenez case.

“This is an opportunity for leaders at the state and federal levels to find a solution, rather than

relying on individual health care providers to develop solutions on a case-by-case basis," the statement suggests. "Unfortunately, none of the proposed national health care reform bills currently being debated in Washington address the issue of how to adequately provide health care for undocumented immigrants in a way that is fair and equitable to everyone involved."

Greenough indicates that the situation "all boils down to what is the least expensive way you can care for a patient on life support," and his goal is to convince not only his institution, but also "to persuade the insurance companies that they are still responsible for paying for the patient's cost of care."

"We're exploring how best to approach this situation, because clearly the hospital cannot eat a bad debt forever without going bankrupt, and with the current health system, why, there's increasing pressure on hospitals to swallow debt, basically," he says.

Still, the physician-patient contract remains the same, in his view.

"The primary ethical contract is between a patient and [his or her] physician, and the physician is responsible for the best interest of the patient who's in their care — and regardless of what the external pressures may be.

"You do the best you can with the resources you have and the situation you're in, and if you're in a refugee situation, it's different than if you are in a well-funded teaching hospital," Greenough says.

Reference

1. Greenough, W., "Treating and Repatriating: An Unacceptable Policy." *Virtual Mentor*. July 2009. 11;7:502-505. ■

SOURCES

- **William Greenough**, MD, professor of medicine and international health at Johns Hopkins University in Baltimore. Phone: (410) 550-0782.
- **Carla Luggiero**, JD, senior associate director for federal relations for the American Hospital Association, Washington, DC.

The ethics of saying no to patients

No obligation to provide futile treatments

The American Medical Association's policy in Opinion 2.035 on Futile Care clearly states: "Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. . . ."

Likewise, Opinion 2.19 on Unnecessary Medical Services suggests that "Physicians should not provide, prescribe, or seek compensation for medical services that they know are unnecessary."

While the AMA's policy is clear, patient expectations and/or demands for treatment can range from the highly complex to the more common situation, where a patient asks for an antibiotic when the physician thinks his or her ailment is viral. In both cases, physicians can sometimes be challenged by patients.

So, what are the ethics of saying no to patient care?

"I think this is an interesting and a complicated question," **J. Randall Curtis**, MD, MPH, a professor of medicine in the division of pulmonary and critical care at University of Washington. Curtis is the chair of the ethics committee at his hospital, which is Harborview Medical Center.

"And the reason why I say it's complicated is because it depends on the situation and the circumstances. So, I think most physicians believe and practice [with the belief] that physicians are under no obligation to provide therapies that are not indicated just because a patient demands them."

In extreme examples, he says, a patient may demand surgery that the surgeon doesn't think will benefit that patient. Or, a patient requests a bone marrow transplant for a disease "where a bone marrow transplant hasn't been shown to help, then physicians say no to that all the time."

In situations where a requested treatment might cause significant harm or create significant expense — and provide no benefit — it's common for a physician to say no to that treatment.

"I think where it gets more complicated or trickier is when the therapy is not risky and not expensive," Curtis tells *Medical Ethics Advisor*.

“The classic example — there is a patient coming in with what a doctor believes is a viral upper respiratory infection. The doctor doesn’t believe antibiotics are indicated, but the patient insists on getting antibiotics, and the doctor feels like ‘Well, you know what, this is not expensive therapy and I’m not 100% sure there isn’t a bacterial infection. There are some risks involved, but generally, these are pretty safe therapies — and I’m going to go ahead and prescribe them.’”

Curtis says that if you look at the data on the “use of antibiotics for upper respiratory symptoms in otherwise healthy people, the data suggests that doctors will do that, at times,” he says. “Whether that’s good practice or not, I really think it depends on the scenario. In point of fact, a lot of times, we’re not 100% sure that there isn’t a bacterial infection...”

But if it were one of the physician’s family members in that scenario, the physicians probably would not prescribe the antibiotics, he says.

Futile treatment can have exceptions

The same sort of pattern for physicians follows when the questions surround futile treatments. That is, Curtis says, when the patient requests a very expensive or risky treatment and the physician doesn’t feel there will be a benefit, that physician is likely to decline to provide it.

“I think what is more complicated is when the therapy has already been instituted — which happens not infrequently in the intensive care unit — and the situation has worsened. So that, if circumstances have changed where the therapy that’s currently being provided — now thought to be futile — and the doctor feels that this therapy should be withdrawn . . . that is much more complicated,” Curtis tells *MEA*.

In such circumstances, Curtis says that the health care team will enter discussions with the patient, or often, family members, and “try to resolve the conflict without withdrawing life-sustaining treatment against the wishes of a patient or family.”

This type of scenario is a common source of ethics consultations at hospitals, in his experience, he says.

In most of those cases, “the recommendations of the ethics committee are, ‘Gee, futility is a little hard to determine here. It’s hard to be 100% sure if the therapy is futile.’ And it may not be therapy that physicians and nurses would want for themselves or their loved ones, but in fact, in this situ-

ation it’s best just to continue to work on building trust and negotiating with families and continue the therapy,” Curtis suggests.

In those rare circumstances, when a hospital decides it will withdraw futile therapy against the wishes of a family, the process for withdrawing life support is often to advise the family that the medical team suggests withdrawing life-sustaining support and give the family 72 hours to find another provider to take on the case, if the family disagrees with the suggestion.

Curtis says he has seen three cases that came to an ethics committee, in which the team decided that the patient was clearly dying, life support was only prolonging death, and that it would be ethically permissible to withdraw life support.

In two of those cases, the decision was made to withdraw care. In one of those circumstances, “this was a family that felt like they had to do everything they could to keep their loved one alive, because of their own religious and cultural beliefs, but in point of fact, they knew this was the right thing. But they had to fight it, and they couldn’t be involved in the decision. Once the decision was made [and] it was taken out of their hands, they were actually very appreciative for all the care that their loved one got.”

In the third situation, the decision was made to continue care, because otherwise, the family would have been “terribly angry and upset.” The decision by the medical team was that “even though it is futile, and even though we know the patient will die, we’re not going to withdraw life support against the family’s wishes, because it feels like an assault on the family,” Curtis recalls.

Advice for physicians in difficult cases

In dealing with patients or their families who may be demanding care, it is important that physicians focus on using good communication skills and good mediation skills, Curtis says.

“In my experience, one of the most important things in this situation is to focus on building trust, so that when there’s conflict between patients and clinicians or families and clinicians, it’s often a situation where trust has eroded, and I have found it to be very helpful to focus on building trust back, rather than the decision at hand, if that’s possible,” Curtis tells *MEA*.

While some medical decisions need to be made immediately, other medical decisions can wait for this process to occur, even in the ICU setting, he says.

SOURCE

• **J. Randall Curtis**, MD, MPH, Professor of Medicine, Division of Pulmonary and Critical Care at the University of Washington, Seattle. E-mail: jrc@u.washington.edu.

"I think sometimes working on . . . understanding the patient's or the family's perspective and why they're making the decisions or demands that they're making and focusing on that aspect of the relationship — putting the decision-making about treatments aside temporarily while doing that can be very helpful," Curtis suggests. ■

Alzheimer's group supports principles for dignity

Principles result from town hall meetings

In an effort to improve the physician-patient dialogue for patients diagnosed with Alzheimer's disease, the Alzheimer's Association suggests that physicians keep in mind its *Principles for a Dignified Diagnosis*.

The principles are an outgrowth of the association's 2008 report, "Voices of Alzheimer's Disease," which was based on four regional town hall meetings hosted by the association. The town hall forums were attended by more than 800 participants, including 300 people diagnosed with Alzheimer's.

"There are 5.3 million people living in the United States with Alzheimer's disease, and I think there is still much to be understood about how we can serve the folks in the earliest stages of the disease, especially, which is a growing population," says **Shelley Bluethmann**, MA, MPH, director of early-stage initiatives for the national office of the Alzheimer's Association, based in Chicago.

That was the impetus for the town hall meetings — to learn more about the people living with the disease.

"As a way to gauge exactly how we could be most supportive and helpful to that population, we decided to host this series of meetings around the country to really ask the people living with dementia themselves what were their biggest

challenges, and what they thought would be most helpful — especially at those earliest stages," Bluethmann tells *Medical Ethics Advisor*.

Four themes came out of those town hall meetings related to the challenges faced by patients with Alzheimer's. One theme was "about the stigma they face upon being diagnosed and what a burden that is to them, on top of a difficult diagnosis — having to face that stigma with family and friends and co-workers, for those who are under 65 and still in the workplace," Bluethmann says.

The association also found that there was an "enormous amount of angst around the diagnosis experience itself, and along with that, some dissatisfying and challenging interactions with medical providers."

Hence, the principles were developed to serve as a guide for physicians in addressing patients when delivering the diagnosis of Alzheimer's.

The principles offer a "different kind of perspective and insight on that process that they've never had before," Bluethmann says. "You know, this isn't something that they've read about to this point in their medical journals, and it really sheds a light on the importance of engaging that person with Alzheimer's and dementia in the whole process."

Principles and actions

In addressing the matter of stigma and difficult diagnosis experiences, the first principle states: "**Talk to me directly, the person with dementia.** I am the person with the disease, and though my loved ones will also be affected, I am the person who needs to know first."

"A lot of folks said to us [that] as soon as they were diagnosed, then they felt a little bit cut out of the process," or "marginalized," Bluethmann notes. "And this is just a way to sort of bring everybody together and really improve that communication and collaboration."

The second principle instructs physicians to "**Tell the truth.** Even if you don't have all the answers, be honest about what you do know and why you believe it to be so."

The third principle advises: "**Take my concerns seriously, regardless of my age.** Age may be the biggest risk factor for Alzheimer's, but Alzheimer's is not a normal part of aging. Don't discount my concerns because I am old. At the same time, don't forget that Alzheimer's can also affect people in their 40s, 50s, and 60s."

Another point to come out of the town hall

meeting process was that patients often felt, after the diagnosis was made, “a little bit alone about what to do next.”

“So, where we really come in is provide that link to community support resources and other kinds of social support resources that are so important after that diagnosis is made, in addition to the medical treatment and other treatment options that are available,” Bluethmann says.

Prior to the release of the principles, Bluethmann says, the early-stage advisory group met with people living with the disease, as well as “some of our partners and friends in the medical community, and one of those groups was the American Medical Association. So, when we shared with them what we were planning to do, they were very enthusiastic, very supportive . . . Having the AMA be supportive of this was obviously very encouraging for us.”

In announcing the principles in February, AMA President **Nancy Nielsen**, MD, issued a statement that reads: “Patients with Alzheimer’s disease face many challenges as they strive to maintain a normal life, and physicians are committed to helping ease the burden with high quality health care.

“The AMA applauds the Alzheimer’s Association for bringing forward the patients’ perspective on compassionate care, as Alzheimer’s patients, their families, and their physicians battle the disease together.”

Thus far, the Alzheimer’s Association has distributed 70,000 copies of the principles to physician audiences, and the group has plans to translate the document into two other languages, Chinese and Spanish, for starters.

Going forward

Bluethmann thinks “much more can be done to continue to engage people, especially [those] with Alzheimer’s, in their own experience — and it is something that we are working on, as well, to reach out to the physician community and talk to them about what they need and how we can be helpful [to them], as well.”

One of the areas that needs more attention is physicians’ awareness of younger-onset Alzheimer’s disease. One of the co-authors of the principles, **Steve Hume**, MD, was diagnosed with younger-onset Alzheimer’s disease in May 2007 at the age of 61.

“Younger onset is a form of the disease that affects people under 65, so that certainly has unique characteristics to it that we certainly

SOURCE

- Alzheimer’s Association, Chicago. For additional information and the complete list of principles, please visit www.alz.org.

would support more discussions and more collaboration with the physician community [on],” Bluethmann says. ■

Practice guidelines needed for MCI diagnosis

Penn researchers present findings from survey

According to a recent survey of neurologists, “clinicians vary greatly in the education and support they provide or recommend for people with MCI [mild cognitive impairment], suggesting that there is a need for practice guidelines in this area.”

Researchers from the University of Pennsylvania presented the findings at the Alzheimer’s Association 2009 International Conference on Alzheimer’s Disease (ICAD 2009). The survey was completed by members of the American Academy of Neurology to determine how neurologists are diagnosing and treating patients with mild cognitive symptoms, according to a Penn news release.

“Mild cognitive impairment and early Alzheimer’s disease, whatever terms you use to describe late-life cognitive impairment, are really ultimately economic problems,” says one of the researchers, **Jason Karlawish**, MD, associate professor of medicine and medical ethics at the University of Pennsylvania School of Medicine in Philadelphia.

One of the chief risk factors for developing early Alzheimer’s is chronologic age, he notes.

“So, if you put those two facts together, you begin to see projections that tally into the millions to tens of millions of individuals who could potentially have these disorders in the next 10, 20, 30 years,” Karlawish says.

“That, frankly, is the economic urgency with which we have to think about how best to diagnose these people, and how best to treat them in

a way that obviously gets back to making the patients feel better, but also does it in a way that respects the economic challenges that this disease presents," he says.

Another aspect of the urgency for developing diagnosis and treatment guidelines that would culminate in a standard of care for patients with MCI is that most of these patients will go on to develop Alzheimer's disease. But there is a distinction between MCI and Alzheimer's disease, Karlawish notes.

"Mild cognitive impairment describes a clinical condition that can be caused by a variety of different diseases," he says. "In contrast, Alzheimer's disease is a specific disease that causes a stereotypical pattern of clinical problems with pathologic findings," he says.

Patients, family notice cognitive changes

Patients with MCI have a level of severity of cognitive problems that are just that — "mild." In contrast, a patient diagnosed with Alzheimer's disease would be described as having "cognitive problems of greater severity that meet criteria where an expert person would judge that person to be demented. And demented is a term that simply describes a severity of cognitive impairment that interferes with a person's ability to perform their usual and everyday activities," Karlawish says.

The most common cognitive symptom that patients report is a decline in short-term memory, according to Karlawish.

"Oftentimes, this is noted by the individual . . . it may also be noted by someone who is familiar or close to the patient and sees them on a semi-regular basis and can notice this change in cognition," Karlawish says.

Shelley Bluethmann, MA, MPH, director of early-stage initiatives at the Chicago-based Alzheimer's Association, says it is important for individuals who may be experiencing any of the warning signs of Alzheimer's disease to get diagnosed early. That way, patients can get their families involved, not only in care but in legal planning "to allow the person with dementia to continue to be very active in defining how they would want their care to be all along the way."

Key finding was variability in practices

One of the key findings from the survey was

that there is variability in practices among neurologists who treat both MCI and Alzheimer's disease.

"Once you find variability as a researcher, the next step is to explain that variability," Karlawish says. "And our survey doesn't explain the variability, but the first step to doing that, obviously, is to identify it and describe it."

Among the other findings from the survey was that neurologists "regularly see and treat people with MCI, despite the fact that the medications they are prescribing are not FDA-approved," according to a Penn news release on the survey findings and presentation at ICAD 2009.

"I think the next step is to investigate what criteria physicians use to decide that they will or won't offer these medications; and how do they engage in discussions with patients about this; and probably more importantly, from a policy perspective, what are the criteria for deciding if the drugs are making any difference or not," Karlawish says.

The individuals likely to be affected by both MCI and Alzheimer's comprise a large segment of the population, adding even more urgency to "the policy issue that's at stake."

"Depending on how many are on these drugs and for how long they're on these drugs, that's a cost — a cost either to the patient out of their own pocket, or to their prescription plans that are paying for the drugs," Karlawish says.

Karlawish suggests two things need to occur toward developing standard practice — or achieving consensus in diagnosing and treating MCI.

"Number one: gathering better evidence; and number two, expert clinicians — free of bias and conflicts of interest that can sway how they perceive evidence — getting together and deciding what the evidence says we ought to do," he notes. "Now, that's a dream of reason, meaning right now there are patients walking around with memory complaints showing up at the neurologist's office, saying, 'Help me. I'm sick.'"

Until clinicians reach this point, Karlawish says his approach to such patients is to take a patient's complaints and symptoms "very seriously." If a patient indicates that he or she is having problems with memory, he is "inclined to try one of the cognitive-enhancing drugs."

"But my criteria are: to have clear consensus over how we'll decide over the course of the next several weeks that the person is less symptomatic, and therefore, has benefited," Karlawish says. "Because if after several weeks of treatment,

SOURCES

- Alzheimer's Association, Chicago. For additional information about the association, visit www.alz.org.
- **Jason Karlawish**, MD, Associate Professor of Medicine and Medical Ethics, University of Pennsylvania School of Medicine, Philadelphia. E-mail: Jason.Karlawish@uphs.upenn.edu. For additional information on Alzheimer's research at Penn, visit www.pennadc.org.

they're just as symptomatic and haven't felt that they've benefited, I would stop the treatment." ■

Zen Buddhist chaplains practice not knowing

One practice focuses on mindfulness meditation

In an unusual pairing, Beth Israel Medical Center in New York City has teamed with the New York Zen Center for Contemplative Care to apply the approaches of its Zen Buddhist chaplains to the anxieties and pains — spiritual or physical — of hospital patients.

The chaplains serve at the hospital by offering such care as bedside meditation, interdenominational prayer, and other spiritual support strategies not only to patients but also to the medical center's staff.

"One of the things I learned through my chaplaincy training was that many people who have a theology have an idea of how [spiritual guidance] is supposed to go," says the **Rev. Koshin Paley Ellison**, co-founder of the New York Zen Center for Contemplative Care. "And one of our basic tenets in Buddhism is to not know, to work with the awakened mind, which is not having ideas about things but directly experiencing someone."

Some U.S. chaplains steeped in more traditionally Western faiths have suggested that the role of chaplaincy is just that — to meet people where they are and not trying to move them into beliefs or directions where the chaplain would have that patient go, based on his or her own religious or spiritual beliefs (**Please see cover story on chaplains in the August 2009 issue of *Medical Ethics Advisor*.**)

"Our basic practice is to really be intimate with

what's happening right there," Ellison tells *MEA*. "I know from my fellow chaplains from other faiths [that they] have a bit of a struggle, because they kind of have an idea of how it should go."

The Zen Buddhist chaplains may stress such things as meditation, breathing exercises, or conversation to alleviate stress or pain in patients.

The Zen Center for Contemplative Care, which received a \$30,000 grant for its work at Beth Israel, trains students in the chaplaincy from a Buddhist perspective, but as is the goal of many chaplains, their focus is on treating each patient as an individual with unique needs.

"Really, I think that our training is based on not having any ideas about how it's supposed to be for someone," Ellison says. "So, the Buddhology, as we call it, instead of theology — because we don't have a theology — is really based on not knowing and bearing witness to what's happening and trust that if we're really there, that a loving action, or the most appropriate action, will take place.

"So, I think in some ways, it's like our Buddhist training is to me, like chaplaincy training in itself," Ellison says.

As Ellison explains, "Buddhism was founded by the Buddha, wondering how we deal with old age, sickness, and death. So, it's very direct. As the Buddha says, as the story goes, the most important thing is to care for someone."

However, he says there are many ways to be an effective chaplain, and the Zen Buddhist perspective offers just one of those ways.

Appreciation comes from staff

While the Zen Buddhist chaplains have received a grant, as with many chaplains at hospitals across the United States that may be implementing or considering staff cuts due to current budget constraints, the Buddhists need more funding.

As an example, a friend and fellow chaplain at a hospital in Connecticut has seven staff members who serve as chaplains.

"I was like, 'How do you do that,' Ellison says. "And he said, 'Well, we fund-raise.'"

"In some ways it's great that they're doing that, and in some ways," he says it doesn't make sense.

Ellison doesn't doubt that the Buddhist chaplains' services are needed, based on feedback he receives.

"We met this morning with all the nurse managers, and there's this real hunger for our stu-

NEWS BRIEFS

Parents urged to ‘speak up’ for their children

The Joint Commission (TJC) is launching a national campaign to help parents make a difference in their children’s lives by being actively engaged when their children receive health care.

The campaign urges parents to ask the right questions and to be actively involved in their child’s care, whether it’s at the doctor’s office, in the hospital, or even at home. The new education campaign is part of TJC’s “Speak Up” program.

The new “Speak Up” campaign framework urges patients, parents, and guardians of children to:

- Speak up if you have questions or concerns. If you still don’t understand, ask again. It’s your body and you have a right to know.
- Pay attention to the care you get. Always make sure you’re getting the right treatments and medicines by the right health care professionals. Don’t assume anything.
- Educate yourself about your illness. Learn about the medical tests you get, and your treatment plan.
- Ask a trusted family member or friend to be your advocate (advisor or supporter).
- Know what medicines you take and why you take them. Medicine errors are the most common health care mistakes.
- Use a hospital, clinic, surgery center, or other type of health care organization that has been carefully checked out.
- Participate in all decisions about your treatment. You are the center of the health care team. ■

dents and our presence in the hospital, because we’re really, at this point, the only people in the hospital who . . . spend time with patients and staff,” Ellison says.

“Basically, everybody else is really busy, so we have the privilege of our jobs as chaplains to just be with the staff, just be with the patients,” he says.

Ellison recalls a nurse saying that so many of the medical center’s patients come out of surgery, but nurses can only physically care for the patients and provide medication. The nurse told Ellison, “At least your group — your chaplains — can teach them about how to be with themselves, learn how to be with the pain in a different way.”

“For me, that was the best compliment,” Ellison says.

Evolution of the chaplaincy

One of the concerns expressed by chaplains is that they often have to justify their positions on hospital staff to administrators, who may see that position as a cost-center that does not generate revenue.

“We live in a culture where these things aren’t valued by insurance companies, so it’s not reimbursable — and the hospital doesn’t make any money,” Ellison explains. “So, because of their tight budgets, they can’t afford to have a staff chaplain for oncology, a staff chaplain for staff — so it’s a stretch.”

Today, he says, there is also an emphasis — due in part to cost concerns — that requires research to prove that the benefits of chaplains are real.

“What I would like to see is a culture valuing [chaplains] more, because unfortunately, we live in a time where you have to have research in order to prove it actually is doing something about things that are kind of obvious — like, people who feel they are being heard tend to do better,” Ellison says. ■

SOURCE

• **Koshin Paley Ellison**, Co-Founder, New York Zen Center for Contemplative Care, New York City. E-mail: koshin@zencare.org.

CME Answers: 9. A; 10. A; 11. B; 12. E.

Paying for quality care in Medicare demos pays off

The Centers for Medicare & Medicaid Services (CMS) indicated in mid-August that demonstrations being conducted by CMS continue to provide “strong” evidence that offering financial incentives for improving or delivering high-quality care increases the quality of that care and can reduce the growth in Medicare expenditures.

In an Aug. 17 news release, CMS announced new results from three of these demonstrations: one for large physician practices; one for small and solo physician practices; and one for hospitals.

“What we learn from the various Medicare demonstrations [is that they] help to achieve the administration’s goals of paying for high quality and efficient health care in America,” said **Jonathan Blum**, director of the CMS’ Center for Medicare Management and acting director of the Center for Health Plan Choices. “Building on these findings, we will aggressively test new demonstration concepts to continue to meet these goals.”

The CMS value-based purchasing initiative is designed to tie Medicare payments to performance on quality and efficiency and is part of CMS’ effort to transform Medicare from a passive payer to an active purchaser of higher quality, more efficient health care.

More than 560 small and solo physician practices participating in the Medicare Care Management Performance (MCMP) demonstration are being rewarded for providing high-quality care in the delivery of preventive care and care for patients with chronic illness.

CMS also announced the start of three additional value-based purchasing demonstrations.

“We continue to be encouraged by the progress of our ongoing programs that test value-based purchasing across a variety of

health care services,” said **Charlene Frizzera**, acting administrator of CMS. ■

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. ■

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CME Questions

9. What action did the guardian for Luis Alberto Jimenez, once a patient at Martin Memorial Medical Center in Stuart, FL, claim the hospital had done:
A. Conducted false imprisonment
B. Provided inadequate care
C. Offered restitution
D. Offered the highest quality care

10. Carla Luggiero, senior associate director for federal relations for the American Hospital Association in Washington, DC, says that the jury verdict in the Martin Memorial Health Systems case of repatriating a brain-injured patient to Guatemala may make other hospitals more comfortable in taking similar actions.
A. True
B. False

11. Physicians are ethically bound to provide treatments or therapies that are being demanded by their patients in all cases.
A. True
B. False

12. What of the following problems do the implications of increasing numbers of patients diagnosed with mild cognitive impairment present:
A. The availability of quality health care
B. Economic cost of health care
C. Physician payments
D. The number of people likely to develop Alzheimer's
E. B and D only.

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