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IN THIS ISSUE

- Vision of health care reform cover
- Who should own EMRs? 111
- Evolution in thinking on physician-assisted suicide . 114
- Consider patients' cultural beliefs for best outcomes . 115
- Diversity training helps practitioners understand culture . 117
- Film educates Latinos on home health care 118
- Enclosed in this issue:
 - *Swine Flu Insert*
 - *Copyright Letter*

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Vision of health care gets lost in special interest debates

The ethical debate is subdued

Rationing. Responsibility for immigrant health care. Socialism. Death panels. Individual responsibility. Single-payer option. Malpractice reform.

Those are just a few of the hot-button topics that have emerged in what has been the health care reform debate thus far, although no clear resolution has developed as to how to fix what ails the U.S. health care system.

Although there has been a lot of noise, there hasn't really been a national debate, according to some. Instead, there has been enormous effort to get the messages out from particular advocacy groups, says **Nancy Berlinger**, PhD, MDiv, research scholar and deputy director of The Hastings Center in Garrison, NY.

Writing in the April 8, 2009, issue of the *Journal of the American Medical Association*, **Darrell G. Kirch**, MD, president and CEO of the Association of American Medical Colleges in Washington, DC, claims the ethical debate regarding health care reform simply has not risen to the surface.

"While many have described the dysfunctional aspects of the US health care system, the focus has prioritized issues of payment systems and delivery models over a fundamental underlying ethical conflict," Kirch writes.¹

"Within an ethical context, it is important to discuss how the commercialization of medicine has fostered a distortion of emphasis among the basic tenets of medical ethics, and how this unbalanced emphasis has created serious barriers to improving the health care system," he writes.¹

Robert J. Barnet, MD, MA, a cardiologist and senior scholar at the Center for Clinical Bioethics at Georgetown University Medical Center in Washington, DC, bemoans the advent of "medicalization" in the health care system. Medicalization refers to the heavy sway market forces and commercial groups have in determining what is appropriate for health care. Barnet cites the pharmaceutical industry, medical device

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industry, and insurance groups, which, to a large extent, have shaped how health care currently is delivered in this country.

Berlinger notes that while most people, from legislators to physicians to the public, agree on what is wrong with the health care system, there is no one solution to correcting the problems it faces. In part, that is because no one system serves everyone in this country, she says.

"We're a pluralistic country — very, very diverse and very large. We're 50 states plus the District of Columbia and Puerto Rico. We have people who get their health care in a variety of different ways," Berlinger tells *Medical Ethics Advisor*. "It is much easier to talk about a health

care system when there is one system that everybody recognizes as being their system."

"The short answer to this is this is a big country," she says, so just in the diversity alone there are problems in building consensus.

Business or service or profession?

"Physicians have certain privileges that others do not have, because it is assumed that unless physicians hold these rights and responsibilities, the health of society will be compromised," writes Kirch. "This social contract is at the heart of the medical profession. Physicians must use their best informed judgment when caring for individuals who need assistance and in return, physicians must be given appropriate freedom to do so."¹

Kirch notes in the *JAMA* article that "the teaching of medical ethics has long focused on a 4-pillar foundation of the profession: beneficence (provide good care), nonmaleficence (do no harm), respect for autonomy and justice."

"It would appear that in the United States, however, attention to these 4 principles has become unbalanced. Currently, far less emphasis is given to considerations of justice (especially for society as a whole) relative to the other ethical principles," Kirch writes.

Berlinger notes that some argue that health care is a right; others argue that it is a responsibility; and still others argue that it is both a right and a responsibility.

"I don't even want to say that these are arguments — these are ways of looking at health care," Berlinger says. "But because we're talking about doctors in particular, doctors recognize that a core part of their vocation, no matter what specialty they're in — the reality of illness and suffering and pain [coincides] with the fact that there are some people we entrust to be trained to be professionals to help us cure disease, to help us manage diseases that cannot be cured, and to address pain and suffering, and, we hope, to prevent all of these things."

Physicians, she says, are "already inside of an ethical relationship; they've already taken a stand with the idea that health care is a social good. I don't know any doctors for whom that is up for debate."

What physicians may disagree with is how to pay for health care, she says.

However, Kirch suggests in the *JAMA* article that perhaps physicians have become too self-interested from a financial perspective. "In the current

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Editorial Questions

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system, however, and in the face of the powerful commercial forces at work in health care, the expression of physician autonomy at times appears to have become more aligned with independence of practice, especially fiscal independence and the right to enhance physician revenue...."¹

Berlinger says, however, that health care is a business, even though it's not "just a business."

And so, there is this question, she says: "What do you do when there seems to be common agreement that there are a lot of things wrong, but nobody can do without a health care system. You can't just close it all down for a day and then reopen it like you do with a store. It's not a consumer good in the same way as almost any other kind of business is."

The need for a vision

Just as we have entrusted certain public safety issues to others, such as police and fire departments, we as a society in the United States have entrusted physicians to take care of us when we are sick.

But beyond that, there seems to be a world of disagreement, much as there has been in previous iterations of the health care reform debate, such as with the Clinton initiative in the early 90s.

One "enormous difference" in the current debate vs. the debate surrounding the Clinton initiative is the presence of the Internet and the fact of the 24-hour news cycle, Berlinger says. The media have the task of constantly reporting and are fed by the fact that "there are so many sources that have taken a position on a particular issue [and] are really investing themselves in talking."

Mostly, it seems, the Internet allows both individuals and groups to find other individuals and groups who agree with their position, she says.

"So, it's not really a discussion or a debate in the cases that we've been seeing," Berlinger notes. "We've been seeing lots of parallel conversations, but it hasn't been one big national debate."

The discussion, she says, really needs to center around the "values that can sustain health care reform — not just health insurance reform, or this vs. that, but what values sustain them."

For example, she notes, there is currently a great deal of literature on the social determinants of health, and one of the surprising findings is that the quality of an individual's health may have more to do with such things as whether a person smokes, maintains proper weight, or genetics vs. how much access he or she has to health care.

Resolution will come — for the time being — because legislators will vote, and bills may be signed into law.

"It seems like what will happen is that more people will have health insurance. It is debatable whether that constitutes health care reform," Berlinger says.

"If it's health insurance reform, but we haven't really determined how we will change how health care is delivered in this country — that is going to be a continuing conversation," Berlinger notes.

Georgetown's Barnet agrees, suggesting that it may be 10 years or more before this current debate is resolved in any real way, because in a way, it is only the beginning of the discussion.

What is clear to Barnet is that health care resources are finite and must be delivered in line with other social goods, such as food, housing, and jobs. In fact, his thesis in the 70s looked ahead to the possibility of rationing in its title: "Allocation, Scarce Resources, and the Philosophy of Limits."

"The fact that [health care] resources are finite, I agree [with] completely, and we need to look at that and see how we allocate what we have," Barnet tells *MEA*. "One of the positions I've taken is that there are other social needs, and there's a maximum that we as a society can meet to contribute to health care."

Reference

1. Darrell G. Kirch, David J. Vernon, The Ethical Foundation of American Medicine: In Search of Social Justice. *JAMA*. 2009;301(14):1482-1484. ■

SOURCES

- **Nancy Berlinger**, PhD, MDiv, Research Scholar and Deputy Director, The Hastings Center, Garrison, NY.
- **Robert J. Barnet**, MD, MA, FACP, FACC, Senior Scholar, Center for Clinical Bioethics, Georgetown University, Washington, DC.

Who should own electronic medical records?

Arguments surround public vs. private records

The American Recovery and Reinvestment Act of 2009 (ARRA), signed into law earlier this year by President Obama, contained within it about a \$20 billion allocation to increase provider utilization and networking of electronic medical records (EMR).

Most physicians, even if they are not currently employing electronic medical records in their practices, understand that the goal of the allocation is to have patient records networked in such a way that a particular patient's records could be shared by multiple providers, be they other physicians or institutions.

What has not been decided — at least to date — is who should own those EMRs, although there is discussion of the matter.

In recent commentaries in the *Journal of the American Medical Association (JAMA)*, there have been arguments for both public and private ownership.

According to **Mark A. Hall**, JD, professor of law and public health, Wake Forest University School of Medicine and Wake Forest University School of Law, in Winston-Salem, NC, ARRA “fails . . . to resolve who owns this massive increase in electronic information. This legal uncertainty presents a major obstacle to integrating and using information about a single patient from various clinicians and hospitals.”¹

While “ownership of paper records was never much in doubt,” according to Hall “...now that digitizing information frees it from particular storage media, confusion reigns.”¹

Hall notes that patients don't own the records, however.

“Patients have rights of privacy and access to their records, but neither federal nor state law explicitly extends property rights to patients,” Hall writes with co-author **Kevin A. Schulman**, MD, of Duke University School of Medicine in Durham, NC. For instance, patients do not have the right to sole possession or to the destruction of their original records.

Hall tells *Medical Ethics Advisor* that there is a “real logjam of ability to get electronic medical information flowing in a useful way. And that logjam was part economic, but was partly legal

[due to] various costs and barriers to investing in these systems that have been well documented. [Also], some of the legal uncertainties about it were really making people reluctant to make these investments.”

Hall suggests that there are two ways that this logjam could be broken: the government could mandate that all providers participate in such a system, or, the system could rely on “market forces,” which could assign economic value to the access or potential ownership of EMRs.

The case for private ownership

Letting market forces dictate would be a case of “people acting out of a sense of what in their own interest is best for their own situation to motivate them to do these things,” Hall tells *MEA*.

“So, it simply comes down to the question of whether it's in the interest of a provider to kind of start from scratch — actually build the medical record from scratch — or take the information that's previously been collected and use it,” Hall says.

Hall suggests that it would be “more efficient and more accurate” to use existing records, “because you can't collect all the information from the past, even if you tried to.”

Assigning economic value to the records would provide incentive to those who are holding the information to release it and participate in a networked system, he says.

“So, why is money necessary to make that happen? Because there's cost involved in doing things that way. I mean, providers who [utilize EMRs] get less reimbursement, because they're having to invest more resources and time to do that, to make sure the information flows to the places where it has the best use...,” Hall says.

The question of ownership introduces the right of an individual who owns something to control that thing, or prevent access to it, or even destroy it if the individual so desires, Hall notes.

“A lot of emotional significance — social significance — gets attached to owning something. . . and so I think the basic point of the article is one, first of all, we should get over that,” Hall says.

“In some ways, information in a pure sense is not owned by anyone,” Hall says, unless its patented or copyrighted. Otherwise, “It's just information that's out there.”

For example, he says, a patient “can't tell a doctor to destroy their information. They can say, ‘I want a copy of it’; they can say, ‘Send it over

here'; they can say, 'Keep it private' and what have you."

If one considers not whether a patient "owns" his or her records, but instead "what rights of access or control" he or she should have over his or her EMRs, "the law is actually pretty sensible," he says.

For example, according to Hall, HIPAA indicates that patients can simply sell their access rights to their EMRs.

"They may not own the information, but they own the access right," he says.

By assigning economic value to this access, both providers and patients would be incented to allow others to access their EMRs.

The case for public ownership

One of the opposing view to Hall's and Schulman's is by **Marc A. Rodwin**, JD, PhD, of Suffolk University Law School in Boston, and he argues, also in *JAMA*, the case for public ownership of data.

Public ownership of EMRs — which he tells *MEA* would be "anonymized," — would enable advantages such as the FDA being able to ascertain "the percentage of patients who experienced adverse reactions from a specific drug, then warn physicians or take other action."

"Researchers could learn how patients respond to alternative therapies and assess their relative effectiveness and safety. They could study populations and variables not present in clinical trials and compare medical facilities and health care systems," he writes.

Under the current system, Rodwin writes, "organizations with medical, prescription, and billing records treat patient data as if those data were their private property."

For example, he points out that IMS Health, "the largest medical information" company, which operates in more than 100 countries, reported that it earned more than \$2 billion selling medical data in 2006.

"Patients and the public have a strong claim to access aggregate patient data," Rodwin writes. "Patients supply the information. Data are collected because patients and the public finance medical care through fees, insurance premiums, and taxes."

Rodwin tells *MEA* that there is no law that "said these [private] organizations owned the data, or that it was their private property. But there was nothing there that said it wasn't theirs, that it was somebody else's. So, people just

decided, "Why not? We'll sell it.' And by selling it, they're trying to make it private, but the question is, in what sense is it theirs?"

"Certainly, the record may be private, but no one really says who owns the data. And there are technological means to try and restrict you, but we haven't really had a scheme [to cover this]," Rodwin says.

There are two government examples where providing data and making it public are already in effect. One is with Medicare, which collects data on those who use it and makes it public. The state of California also requires health care data reporting, Rodwin says.

In his opinion, all "federal policy makers should require all hospital to report the same data..." as well as other medical institutions such as ambulatory care surgery centers, rehabilitation facilities, nursing homes, and community health centers. Also, clinicians should be required to report drug prescribing and dispensing data to the HHS, he contends.²

This way, the government would be better able than private companies to actually put in place policies to protect the integrity and privacy of patient EMRs, Rodwin says.

"Public ownership of patient data can protect patient privacy and spur its beneficial private uses, while also developing its use for public health and safety, which is not possible if patient data are private property," Rodwin writes.

"Physicians should advocate for such policies to further core medical values," he concludes.

References

1. Mark A. Hall. Kevin A. Schulman. Ownership of Medical Information. *JAMA*. 2009;301(12):1282-1284.
2. Marc A. Rodwin. The Case for Public Ownership of Patient Data. *JAMA*. 2009; 302(1):86-88. ■

SOURCES

- **Mark A. Hall**, JD, Professor of Law and Public Health, Wake Forest University School of Law and Wake Forest University School of Medicine. Winston-Salem, NC. E-mail: mhall@wfubmc.edu.
- **Marc A. Rodwin**, JD, PhD, Suffolk University Law School, Boston. E-mail: mrodwin@suffolk.edu.

The evolving policy on physician-assisted suicide

Article says four groups adopted policy in 2008

Calling it “a significant turning point in American society’s evolution to empower terminally ill patients with information and choices about how they will die,” an article by the director of legal affairs for Compassion & Choices points to four medical professional and health policy organizations that have adopted policy to support physician-assisted suicide.

Compassion & Choices, however, refers to this as “aid in dying.”

The organizations that have adopted such policies, according to the article, include the American Public Health Association, the American Medical Women’s Association, the American College of Legal Medicine, and the American Medical Student Association.

“Certainly, if you look at polling across the country, the public support for the choice of aid in dying . . . has certainly grown over time,” says **Kathryn L. Tucker**, JD, director of legal affairs for Compassion & Choices.

Tucker also stresses that the choice of aid in dying is something she views “as a medical term of art which refers to a physician who writes the prescription to a mentally competent, terminally ill patient [who] can self-administer to bring about a peaceful death, if they find their dying process unbearable.”

“There’s a lot of poll data that reflects that, but apart from that is that there’s growing support for this intervention in the medical community,” Tucker tells *Medical Ethics Advisor*.

Tucker suggests that the support from these medical organizations in 2008 “is very much tied to an evidence-based review of what has happened in Oregon.”

There are organizations, however, such as the American Medical Association in Chicago, that do not support physician-assisted suicide.

Currently, both Oregon and Washington allow physician-assisted suicide (see the cover story of the January 2009 issue of *Medical Ethics Advisor*, which covered the voter approval in Washington).

A third court case, *Baxter v. Montana*, has been heard by the Montana Supreme Court, and the parties are waiting on that court’s decision, per-

haps to be decided by the end of the year, Tucker says.

Going on record

Tucker says she credits the American Public Health Association with “speaking out, because it is a public health issue . . . in a couple of senses.”

“One, we know that where aid in dying is not affirmatively legal, it goes on in the back alley, covertly, and that we know from studies that when that back alley practice happens, it’s more dangerous for patients, there are more complications, and it’s much more stressful for the patient and the family,” she notes.

Tucker says that by “back alley” practice — a term familiar to abortion proponents — she is suggesting that studies that show the practice of physician-assisted suicide “goes on everywhere.”

“What we don’t know is when it happens covertly, meaning, in an extralegal environment or in an environment where there haven’t been boundaries established either by the legislature or by a court decision, then what you have is a completely unregulated, covert practice,” she says.

In unregulated environments, she says, you have physicians who “don’t feel comfortable, and in fact, feel fearful about discussing a particular case with a colleague, for example, and so that doesn’t happen. And you miss that second opinion, or collegial input, that you might otherwise have.”

She points out that in Oregon and Washington, where physician-assisted suicide is legal, both states require a second physician opinion in a lengthy process toward granting the permission to seek a lethal prescription.

“So, you lose that. You lose the opportunity for really candid and open discussion, where the physician feels comfortable exploring whether the patient has considered a full range of options, such as hospice, aggressive palliative care, etc.,” Tucker notes.

A bioethicist’s perspective

Rosamond Rhodes, PhD, is a professor of medical education and director of bioethics education at Mount Sinai School of Medicine in New York City. In the late 90s, she published an essay titled, “Physicians, Assisted Suicide, and the Right to Live or Die.” That essay was included in the book *Physician-Assisted Suicide: Expanding the Debate*, for which she also served as an editor.

One of the aims of the article, she states within

it, is “to show how the concept of a right to life actually supports the case for physician-assisted suicide.”

There are other essays in the book that offer the polar opposite view of any participation by physicians in contributing to a dying patient’s right to end his or her own life.

Rhodes says that there are “significant majorities all over the country [that] support allowing people to make these decisions for themselves.”

She tells *Medical Ethics Advisor* that the Patient Self-Determination Act of 1990, a federal law “requires that every state have a mechanism to allow patients to refuse medical treatment, including life-preserving, life-prolonging treatment.”

“So, as federal law, we recognize that a patient may require a medical treatment to continue living, and we know that discontinuing the treatment will hasten the patient’s death. Yet, people are required — by law — to honor the patient’s request,” Rhodes says.

In a scenario that many doctors face daily with ventilator-dependent patients by making a decision based on the patient’s request to remove the ventilator, there is very little difference with the scenario presented by physician-assisted suicide, Rhodes says.

“As far as I’m concerned, there is no significant moral or factual difference between withdrawing life-preserving treatment and any other way of hastening death,” she tells *MEA*.

Reference

1. Kathryn L. Tucker. At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy Associations. *Harvard Health Policy Review*. 2009. 10; 1:45-47. ■

SOURCES

- **Rosamond Rhodes**, PhD, Professor, Medical Education; Director, Bioethics Education. Mount Sinai School of Medicine, New York, NY. E-mail: Rosamond.Rhodes@mssm.edu.
- **Kathryn L. Tucker**, JD, Director of Legal Affairs, Compassion & Choices. E-mail: ktucker@compassionandchoices.org.

For the best outcomes, consider patients’ culture

Knowledge, understanding help ensure adherence

In an increasingly diverse society, case managers must be aware of the cultural beliefs and practices of the people they serve in order to effectively coordinate their care and help patients or clients adhere to their treatment plan, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy & Associates, a case management training and consulting company.

“Cultural competency is essential to close the widening gaps of disparities in health care. When providers are knowledgeable, respectful, and responsive to the issues surrounding cultural diversity, positive outcomes are much more likely to occur,” Mullahy says.

Refugees and immigrants cannot be expected to give up their cultural and religious beliefs when they come to this country, points out **Lucy Ricketts**, director of public affairs and cultural and linguistic services for Passport Health Plan, a member of the AmeriHealth Mercy family of companies.

“It’s all about negotiation. We can’t force our members to shift their attitudes about health care, but we can negotiate and educate them so they receive quality care,” she adds.

For instance, the Louisville, KY, area, where Passport Health Plan has its headquarters, also is home to a number of agencies that resettle refugees and immigrants, according to Estes.

In fact, students in the public school system of Louisville speak more than 100 languages.

“We have great relationships with the resettlement agencies and work closely with them so when they tell us which new group of people [is] coming into the area, we start doing research on the practices and beliefs of that culture,” Estes says.

The Louisville area has had a huge influx of Somali families in the past two years, Estes adds.

“We found out that the local obstetricians were having difficulty understanding Somali women and their feelings about labor and delivery and prenatal care. We did a lot of research on our own and sought the assistance of experts in the area to help the obstetricians come up with strategies for caring for these women,” Estes says.

The health plan partnered with a local Somali-Bantu women’s empowerment group to gain the

trust of the women, learn about their religious and cultural beliefs related to labor and delivery, and share information about the American approach to pre- and post-natal care.

For instance, the Somali women were upset because when they were admitted to the hospital for delivery, they didn't receive a meal.

"They told us that in Africa, it was very important to eat a large meal during labor so you'd have the strength to deliver," Estes says.

The health plan shared the information with the obstetricians in person during the health plan's annual cultural competency conference and in the plan's provider newsletter.

Passport Health produced audio and hard-copy versions of its booklet "Mommy & Me Basics" in the Somali-Bantu language and instituted a pilot project to educate the Somali-Bantu women on Western medicine standards of care. The women and a facilitator from the health plan read sections of the book and had an open discussion on the cultural differences in prenatal care, labor, and delivery.

Being aware of a member's cultural background helps case managers, disease management nurses, and health coaches come up with effective strategies to keep the member healthy, says **Trish Nguyen**, MD, senior medical director of medical operations.

For instance, while Vietnamese eat a lot of vegetables, they also enjoy salty soups and fatty foods such as pork legs, says Nguyen, who is Vietnamese.

"When the health coaches work with our Vietnamese members to help them manage their chronic illness, they are aware that although Vietnamese and others in the Asian culture tend to eat a diet high in fruits and vegetable, those fatty, salty soups could be interfering with their treatment plan," she says.

"This is very important because they can use key words and messages that will resonate with that member. Telling them just to eat more fruits and vegetables is a very 'vanilla' message, and it may not be effective," she says.

Although Vietnamese tend to be thin, many also have abdominal fat that makes them more likely to become diabetic or die at an early age from heart disease, she points out.

"If our health coaches were not aware of this, they might take it for granted that since the clients are thin, they don't need to modify their diet," she says.

One of the keys to coordinating care with

people of different cultures is to understand their beliefs and practices so you can determine what will resonate with them, Nguyen says.

"Understanding a member's cultural beliefs and practices is important because it impacts health outcomes. If a care manager doesn't understand the person's cultural background, they will have difficulty engaging with that person, whether it's on the telephone or face to face, and they may not be able to help the person modify his or her behavior," she says.

For instance, health care professionals who are trying to communicate something of importance to patients may infer that patients are resistant to the information, embarrassed, or even depressed if they don't make eye contact. However, in some cultures, direct eye contact is perceived as threatening and case managers should be aware of this, Mullahy points out.

"In some cultures, Asian and Christian African-American populations among them, pain and suffering are believed to redeem and purify. Understandably, therefore, a patient may be unable or unwilling to provide a truly accurate assessment of his pain," Mullahy says.

Native Americans consider wellness as harmony and balance among mind, body, and spirit, Mullahy adds.

"That kind of belief may present a challenge for a diabetic patient facing amputation of a limb. How can he be whole in his afterlife if he is buried without his leg?" Mullahy says.

Mullahy relates that in the case of the diabetic man who was reluctant to lose his leg, practitioners made arrangements to ensure that the limb would be buried in the same place as the patient after his death.

Latino patients tend to resist home health services because of a tradition that all of the elders' needs should be taken care of by family members, adds **Janice Crist**, RN, PhD, associate professor at the University of Arizona College of Nursing.

Case managers shouldn't think that their Latino clients are non-compliant if they refuse home health services or it doesn't work out, Crist says.

Crist has received a grant from the National Institutes of Health to produce a short film that can be used to educate Latino families about the benefits of home health care.

Crist advises case managers and home health nurses to spend part of each visit or conversation getting to know their Latino clients before starting care.

“One of the most important things that health care providers can do when working with the Latino population is to talk things over in a personal way, instead of being official and impersonal like they would be with patients in the Anglo culture,” she says.

Achieving cultural competency is not easy, and while your organization may provide information, individual case managers should assume some of the responsibility for learning about and understanding the populations they serve, Mullahy says.

“Fortunately, much of this information is a mouse-click away,” she adds.

Care managers should ask open-ended questions, rather than just telling the member what he or she should be doing, Nguyen adds.

“Care managers need to be able to engage and have rapport with the members. When they ask open-ended questions, the member’s cultural beliefs and perceptions come out and can be addressed,” she says.

For instance, the case manager may ask members to name their favorite foods, then they keep ask about what is in their diet to isolate and understand where to begin working with the member on healthy eating habits.

“People in certain cultures have menus in their diet that are high in fat and calories. The health coaches and care managers can help them find healthy alternatives to some ingredients so the food tastes the same but is healthier,” she says.

For instance, if a member with hypertension eats a lot of chicken noodle soup out of a can, the health coach knows that it is high in sodium and can work to find alternative foods, she says.

“These open-ended questions can help the care coordinator or health coach discover the member’s beliefs and understand why he or she isn’t compliant,” she says. ■

Diversity training helps CMs understand patients

Being aware of beliefs, values is important

Increasingly, health plans and provider organizations are taking steps to understand the beliefs and values in the populations they serve and help gear their treatment plan to accommodate them.

For instance, BlueCross and BlueShield of Florida encourages all employees to go through

diversity training.

“Our case managers coordinate care for a diverse membership and are required to participate in formal diversity training. After that, they are required to present an overview to their peers as how to identify a member’s cultural beliefs and to incorporate them in their role as case managers,” says **Trish Nguyen**, MD, senior medical director of medical operations.

The company has a diverse employee group and attempts to hire staff who mirror its membership and who are fluent in the languages that their members speak.

“We require cultural competency as a skill for all our care managers, so we don’t necessarily pair them with someone from their own culture. We don’t want to label people and make assumptions about their beliefs. After the case manager conducts an assessment and determines the member’s needs, we can align them with someone from their own culture if appropriate,” Nguyen says.

BlueCross and BlueShield of Florida also offers computer-based on-site training and e-learning programs for employees who want to hone their cultural competency skills. Nearly 70 workshops are available on topics that include cross-cultural communication, bridging the generation gap, culturally competent hiring practices, dealing with prejudice and racism, and workshops that speak to specific populations.

“With all of these requirements, it becomes innate to the case managers to become sensitive and to remain cognizant of the needs of the whole person,” Nguyen says.

At AmeriHealth Mercy, all employees who interface with members receive training in cultural and language awareness.

“We serve a large Latino population and an increasing Asian population. We try to be culturally sensitive and language oriented,” says **Jay Feldstein**, DO, corporate chief medical officer for the AmeriHealth Mercy family of companies.

Passport Health Plan offers free cultural competency training to its providers and advocates.

The health plan has assembled a cultural and linguistic services council, a cross-functional group of associates that meets regularly to come up with strategies for providing care for an increasingly diverse population.

Passport Health Plan sponsors an annual professional conference on culturally and linguistically appropriate care that is free to providers and offers providers free continuing education units. The conference focuses on different cultures each year.

For instance, the 2008 conference focused on the Somali and Hispanic/Latin cultures along with a presentation on cultural competency and treating individuals with disabilities. A video presentation entitled "They Bring the World" was produced by Passport Health Plan and is available free to interested organizations.

"We provide a lot of diversity and cultural competency training for our associates and our providers. We offer classes for providers about Title 6 and CLAST standards, diversity, and stereotypes," says **Loretta Estes**, cultural and linguistic services coordinator for Passport Health Plan.

Passport Health Plan has enlisted the help of Spanish-speaking individuals and advocates to provide feedback on diabetes materials so they can be appropriately written and designed for Latino members, according to **Lucy Ricketts**, the plan's director of public affairs and cultural and linguistic services.

Passport Health Plan's disease managers and case managers use the AT&T Language Line, which offers interpreters in 150 languages to facilitate conversations with members.

"We have member services representatives who are bi-lingual and are assessed annually in Spanish and English. If they don't meet the highest levels of proficiency, they are not assigned to speak with members in Spanish until they do," Estes says.

When working with members from Somalia, the health plan often will provide translated printed material along with a professionally recorded CD so the person can hear and read the text at the same time.

Non-English-speaking members receive "I Speak" cards that are about the size of business cards and printed in English and their native language. They receive the cards at outreach events and are encouraged to give the cards to their providers to request an appropriate interpreter and request that the information is documented in their medical record.

The cards are available in Arabic, French, German, Maay, Russian, Somali, Spanish, Swahili, and Vietnamese.

"We also work with our members who aren't fluent in English to make sure they ask for an interpreter, to write down all the questions they have for their physician, and to make sure they understand everything they hear," Estes says.

If case managers feel that language or cultural beliefs are interfering with a member's care and they can't make any inroads telephonically, they

can arrange a home health visit with a qualified interpreter to help bridge the gap, she says. ■

Film educates Latinos on home health services

Goal is to overcome cultural factors that are barriers

Eldery Mexican-Americans have higher rates of chronic illness than their non-Latino counterparts, but many don't receive the care they need because they and their caregivers resist home care services, says **Janice Crist**, RN, PhD, associate professor at the University of Arizona College of Nursing.

Crist has been conducting research and pilot studies on home health services in the Latino community for the past 10 years.

She's recently received a research grant from the National Institutes of Health to fund the professional production of a short film portraying a family considering home health care.

"As a home care nurse, I saw that home care services help improve outcomes for elders and their family caregivers. However, Mexican-American elders do not use home health care as much as they should," Crist says.

When Crist conducted studies to determine the cultural factors that were barriers to elderly Latinos receiving home health, she found that familism, or the belief that all of the elders' needs should be met by their family members — most often grown daughters — was the biggest factor.

"In the Latino culture, family members are expected to take care of their own. Having home health services is asking a stranger to come in. It feels like an intrusion, and family members feel they are letting the elder down by not doing everything themselves," she says.

In the traditional Latino family, several generations lived together, and the daughter, who didn't work outside the home, handled child care as well as elder care, Crist points out.

That's all changed now that many women do work out of the home, and family members can't take care of everything that the chronically ill elder members need.

"We also know that family members don't intuitively know everything that needs to be done, like how to change a dressing or diabetes care. They need experts in the home health field

to come in and teach them how to take care of the elders," she says.

Crist based her proposal for the grant on studies that show that telenovelas, or short dramatizations of a compelling story, can demonstrate the value of home health services in a culturally relevant manner.

"We pilot tested an amateurish version with a group of grandmothers as volunteer actors. We didn't have enough participants for a statistically significant sample, but we did show that people who saw the film had increased knowledge of home care services and were more likely to use them," she says.

Through the National Institutes of Health grant, Crist and her fellow researchers will produce a telenovela that will be shown to Latino elders who are likely to need home care services and their caregivers in the hospital setting. A control group will see a similar film on another subject, such as the benefits of senior health screenings.

"What we want to do is to teach family members about how home health professionals can be their partners in providing care for the elders. We want to show that these services promote the family ideal of keeping the elders at home as long as possible," she says.

In the eight-minute film, an elder is hesitant to have home health services for many reasons. For example, she believes she would have to clean her home to get ready for a visit from a stranger and because she doesn't think she can afford it.

"In the film, her sister tells about her experiences with home health, and we respond to all the barriers to receiving the service," Crist says.

In the end, after talking to a relative who used home health services, the elder says she believes she is able to more fully participate in family activities again.

Crist and her team will track the patients to see if the study group used home care more than the control group.

"Eventually, we want to get a larger grant and test the telenovela at neighborhood associations and community centers. We think that hospitals,

home care agencies, and physician offices might be able to use a DVD to show clients to help promote understanding about the benefits of home care," she says.

The nine-year-old ENCASA (Elders' and Caregivers' Assistance and Support at Home), an advisory council with Mexican-American members, has helped design research questions and recruit study participants.

"A key element of my research has been strong community partnership to ensure that the research is focused on real community concerns," she says. ■

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

13. Nancy Berlinger, PhD, MDiv, research scholar and deputy director of The Hastings Center in Garrison, NY, suggests there had not been a true national debate on health care reform, but only parallel conversations from special interests.
A. True
B. False
14. Robert J. Barnet, MD, MA, senior scholar at the Center for Clinical Bioethics at Georgetown University in Washington, DC, bemoans the advent of medicalization in health care, referring to the influence of which of the following groups, among others, in the delivery of health care?
A. Insurance companies
B. Pharmaceutical companies
C. Both of the above.
D. None of the above
15. Mark A. Hall, JD, professor of law and public health at Wake Forest University School of Medicine and Wake Forest University School of Law, suggests making electronic medical records private.
A. True
B. False
16. Which of the following groups have endorsed policies which respect the autonomy of individuals to choose physician-assisted suicide?
A. The American Public Health Association
B. The American Medical Women's Association
C. The American College of Legal Medicine
D. All of the above

Answers: 13. A; 14. C; 15. A; 16. D.

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