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FEBRUARY 2010

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Are you taking advantage of nursing home opportunities?

Establish good relationships with open communication

Of the 1.4 million Americans receiving hospice care, 319,200 reside in nursing homes. It is encouraging that nursing home patients are electing the hospice benefit, but it also is discouraging that only 6% of the total nursing home population in the United States chooses hospice care, even though 1 in 4 deaths occurs in a nursing home.¹

A nursing home and hospice relationship can be a win-win situation, says **Samira Beckwith**, president and CEO of Hope HealthCare Services in Fort Meyers, FL. "The hospice provides additional resources for the nursing home's patients who require a higher level of care," she says.

Hospice care reduces the number of transfers to the emergency department or the hospital for symptom control, and keeping the patients in the nursing home protects the nursing home's reimbursement, she explains. "The expertise of the hospice staff also provides better pain and symptom control for nursing home patients so the patients and their families are more satisfied with their care," Beckwith adds.

With 50% of her hospice patients residing in nursing homes, **Linda Todd**, RN, executive director of Hospice of Siouxland in Sioux City, IA, knows the challenges and steps to success with nursing home relationships. "We have developed very good relationships with the nursing homes in our area, but these relationships have evolved over time," she reports. As the relationships developed, nursing home staff members were more open to hospice care for their residents and they understood the benefits, Todd says. "It also takes time for our hospice staff members to recognize the special needs of nursing home patients that differ from hospice patients who are in their own homes," she adds.

"Nursing home hospice patients most often have family members who live in other areas, so our staff is communicating long distance with them, rather than face-to-face as they do in the private home,"

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Todd explains. "This requires more time to be sure that family members understand hospice services and are reassured that their family member is receiving the best end-of-life care possible."

Although family members might not be close by, the nursing home staff develops long-term, close relationships with the nursing home patient, so they also must be reassured, says **Martha Barton**, RN, CEO of Pikes Peak Hospice and Palliative Care in Boulder, CO. "As in all areas of health care, there are 'turf wars' when hospice first provides care in a nursing home, but we understand that it is difficult to run a nursing home, then have someone else come in to change the care provided to a patient," Barton says. "We also have to remember that there is a personal connection between the nursing home staff and the patients."

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Editorial Questions

For questions or comments, call **Joy Daughtery Dickinson** at (229) 551-9195.

Pikes Peak has been working with nursing homes since 1990 and has developed some strong relationships, says Barton. One of the keys to success with nursing homes is constant education, she says.

"We take every opportunity to provide inservice education to nursing home staff," Barton says. Topics range from clinical issues such as symptom management to bereavement counseling, she says. **(For tips on nursing home education, see p. 15.)**

When planning staff education, don't forget to address regulatory issues such as the difference between regulatory requirements for nursing homes vs. hospices, "It's important that the nursing home staff members understand that we are required to provide services and documentation that they may not be required to provide, so that they can understand why we do some things differently," Barton says. **(For a description of some differences, see p. 16.)**

Communication and consistency of staff are two other ways to build strong relationships with nursing homes, suggests **Bridget Montana**, MS, APRN, MBA, chief operating officer for Hospice of the Western Reserve in Cleveland.

"We have 10 teams that are dedicated to nursing homes and assisted living facilities," she says. The dedicated staff makes education and training more effective because nursing home patients have unique needs, Montana reports. "The basic needs of hospice patients in the nursing home are the same as patients in their own home, but the staff working in the nursing home needs to understand the nursing home environment," Montana says.

This understanding includes respecting the nursing home staff's expertise with geriatric patients, and the relationship between the nursing home staff and the patients, she says. Although hospice personnel often care for geriatric patients, nursing home staff members have more experience with geriatric care beyond end-of-life care, so they can offer an expertise the hospice nurse might not have, Montana adds.

Nursing home hospice staff members also must be knowledgeable about the hospice Medicare Conditions of Participation and the regulations governing nursing homes, she says. This knowledge is critical in the development of the plan of care, Montana says.

"Plan-of-care coordination between the nursing home staff and the hospice team is critical," she says. If the nursing home nurse is included in

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the development of the plan of care, he or she can communicate more effectively to other nursing home staff members, she says.

Hospice staff members also should interact on a face-to-face basis with nursing home staff, suggests Todd. "Talk with the nurse in charge of the patient, talk with the aides, and don't rely on information written in the charts," she says. Personal conversations about the patient's condition will emphasize the importance of working together as a team rather than separate organizations, Todd says.

Communication is important because the care provided by hospice staff does differ, Barton says. "For example, nursing home staff members have narrower parameters for use of medications such as psychotropic drugs as a safeguard for the nursing home resident," she says. "Hospice staff members' parameters are not as strict because they are using the drugs with more expertise."

If the nursing home nurse is involved in the plan of care and the hospice staff regularly talk with the nursing home staff to answer questions and be available to explain different approaches, there is more acceptance of hospice care, Barton says.

Beckwith says, "If hospice and nursing home staff members have a good working relationship

that involves sharing information and best practices, all nursing home patients benefit, not just those who are receiving hospice care. A study² has shown that pain control for all nursing home patients increased when nursing home staff members were able to see how effectively hospice staff members could control pain for their patients."

Although hospice staff can't provide care for patients other than the hospice patients, their explanations of their care prompt the nursing home clinical staff to evaluate better approaches to pain control, she explains.

Although developing a good relationship with nursing homes takes time, it is worth the effort, says **David Simpson**, president and CEO, Hospice of the Western Reserve. "When we first began working with nursing homes, it was a stigma for a nursing home to allow hospice to provide care to one of the patients," Simpson says. "Now, the nursing home understands the benefits to the patients and the importance of providing care that is needed without having to move to another facility."

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2. Miller SC, Mor V, Teno J. Hospice enrollment and pain assessment and management in nursing homes. *J Pain Symptom Manage* 2003; 26:791-799. ■

Education paves way for hospice support

Nursing home staff receptive to clinical info

Establishing a relationship with a nursing home is not an easy task, especially because the staff members of both organizations don't necessarily understand how the other works.

Staff education is a critical component of a successful relationship between a hospice and a nursing home, says **Martha Barton**, RN, CEO of Pikes Peak Hospice and Palliative Care in Boulder, CO. "We take every opportunity to educate nursing home staff members about issues that help everyone provide better care for the patient," Barton says. "Because a nursing home is so busy, we make ourselves available to slip into planned

meetings and present short information sessions.”

Team meetings, regular inservice meetings for certified nursing assistants, or any other planned meeting provide opportunities for education, she says. “We also have one-page information sheets that can be distributed to nursing home staff members,” Barton says. The one-page sheets address simple topics, such as explanations of what the hospice medical director, pharmacist, or nurse practitioner can do. “These sheets explain the additional resources the nursing home staff can access in a quick, easy-to-read format,” she adds.

Clinical topics that are well received by nursing home staff members include a discussion of which services are included in the hospice benefit as compared to the nursing home coverage, how to have the tough conversations with families and patients about end-of-life options, bereavement care, and how to recognize a patient who might be appropriate for hospice care, says Barton. “We also bring our medical director or a nurse practitioner in for presentations on when to ask for help for control of symptoms such as nausea, constipation, poor appetite, and agitation,” she says.

Because nursing home patients frequently have these symptoms, a nursing home employee might not realize that a hospice nurse often can prescribe more effective treatments for those symptoms in a hospice patient, Barton adds. “These are symptoms we are accustomed to managing with our patients, but we need to know that they are a concern, so we rely on the nursing home staff to let us know early in the symptom’s appearance so the patient doesn’t suffer longer than necessary,” she explains.

Tough decisions to make

The strong relationship that nursing assistants form with patients in a nursing home make some of the decisions that patients and family members make at the end of life difficult to accept, says **Linda Todd**, RN, executive director of Hospice of Siouxland in Sioux City, IA. One of the educational sessions her hospice offers to nursing homes focuses on these tough decisions.

“We talk about ethical decisions and dilemmas that are faced when working with a hospice patient,” Todd explains. “Our medical director walks them through situations that address withholding nutritional support or therapeutic treatment and explains how families and patients

come to these decisions. If nursing home staff members have a chance to hear about these tough decisions before they witness their patient making them, they are easier to accept.” ■

Written agreements set clear delineation of duties

Meet regulations with upfront discussions

One of the challenges to providing hospice care in a nursing home is identifying all of the regulations that govern each organization and, in some cases, might conflict with each other.

A written contract with a nursing home in which a hospice provides care is a requirement of the Conditions of Participation (CoPs) for Hospice, points out **David Simpson**, president and CEO, Hospice of the Western Reserve in Cleveland.

“We use a standard agreement with all of our nursing homes that identifies each organization’s responsibilities and makes sure that we meet the regulatory requirements we must meet,” Simpson says. “We also create a profile of the nursing home that gives our staff information such as how to enter the nursing home at different times of the day, where to document, where medications are kept, with whom to communicate when in the nursing home, and any other tips that will make their patient visits go more smoothly.”

All of the information is communicated to the clinical teams assigned to that facility, and it is also easily accessible on the hospice’s intranet, he adds.

Occasionally, Simpson’s hospice encounters a nursing home that is prohibited by the company’s headquarter policies to enter into a facility-wide agreement with a hospice. “In these cases, we will sign an agreement for an individual patient rather than the facility,” he says. If the nursing home does not want to sign an individual agreement, the hospice cannot provide services unless the patient transfers to another facility, Simpson adds.

CoPs also call for a coordinated plan of care that includes the nursing home but reflects the hospice facility and focuses on the individual patient’s needs. **Bridget Montana**, MS, APRN, MBA, chief operating officer for Hospice of the

Western Reserve, says, "Sometimes the nursing home wants to use us as a resource to provide what they want to patient to have, vs. what the patient needs. We might choose to use different medications than they use because it is better for the patient's situation, but the nursing home staff might want to stay with the medications they know." Because the patient is a hospice patient, it's important to focus on what they need, Montana adds.

Throughout the agreement, the plan of care, and subsequent patient care, make sure hospice staff members strictly follow Medicare regulations, says Simpson. "The Medicare hospice benefit is a

"We are all under increased Medicare scrutiny, especially as the number of hospice patients served in nursing homes increases. Medicare sees the potential for fraud and will be watching closely."

— **Linda Todd, RN**, Executive Director, Hospice of Siouxland, Sioux City, IA.

substitute benefit to the nursing home benefit, so there should not be any 'double-dipping' for duplicate services," he says. "That is why the initial agreement is important."

The hospice and nursing home regulations can be very complex so both organizations have to be diligent about certifications for hospice, recertifications, and discharges, says **Linda Todd, RN**, executive director of Hospice of Siouxland in Sioux City, IA. "We are all under increased Medicare scrutiny, especially as the number of hospice patients served in nursing homes increases," Todd

says. "Medicare sees the potential for fraud and will be watching closely." ■

Legal developments from bioethics conference

Advance care directives among hot topics

At the most recent annual conference of the American Society of Bioethics and Humanities, advanced care directives, access to investigational drugs, and parental nonconsent to medical treatment were considered some of the top legal developments in bioethics in 2009.

A panel discussion on legal developments was conceived and organized by **Thaddeus M. Pope, JD, PhD**, of Widener University School of Law in Wilmington, DE. **Lois Shepherd, JD**, associate professor of public health sciences and professor of law at the University of Virginia in Charlottesville, discussed the trends in advance care planning.

While some states are putting their effort toward having citizens complete advance care directives, that is only one direction, which Shepherd believes is "continuing an older model." "There might be some value in that, but the newer recognition is that we need to have continual conversations, consultations, and these really shouldn't be done in lawyers' offices; they should be done with a doctor's help," Shepherd says.

The reason she selected this particular topic for one of the top legal developments in bioethics is the fact that advance care planning got pegged with the tagline of "death panels" in this year's health care reform debate. **(For more on this**

topic, see "End-of-life discussions portrayed as first step toward death panels," *Hospice Management Advisor*, November 2009, p. 121.)

At the conference, Shepherd discussed a bill set forth by the House of Representatives during the summer. Although it didn't continue through the legislative process, Shepherd thinks the idea of planning for one's death, and having such conversations reimbursed for physicians to incent them to conduct them, gained traction. The bill that was presented during the summer would have reimbursed for advance care planning conversations every five years, or when there was a change in condition, or admission to a facility, Shepherd says. "But it was misunderstood and politically exploited, and so that's out," she says. "But I think we will see that the idea is not over."

The idea is pertinent for those 65 and older, when planning really becomes imperative. "So, it becomes [a situation where] a physician can talk about, 'Look, here's the prognosis, and here's the kind of choices that are going to have to be made in the future. Where are you particularly?' Not an abstract diagnosis, but where is this patient?" Shepherd notes.

She calls the heated debate that occurred surrounding this bill, with the implication that doctors just wanted to hurry up and pull the plug on very ill patients, "so overblown and wrong."

Access to investigational drugs

Shepherd also discussed the relatively new development of patients or parents or surrogates

suing pharmaceutical companies to gain access to investigational drugs.

There was a case two years ago in which a nonprofit filed a lawsuit against the Food and Drug Administration “saying that there was a constitutional right to save one’s own life by getting access to Phase I drugs” for terminally ill patients, says Shepherd. However, the Third Circuit Court said there was no such constitutional right. This lawsuit was intended to gain access for an individual who is terminally ill and has no other available therapies, “except maybe a chance at a clinical trial, and for some reason they can’t qualify for the clinical trial,” says Shepherd.

A recent case centered on a University of Virginia student suffering from head and neck cancer, whose mother sued a pharmaceutical company. In the suit, she charged that a particular drug company had promised access to an investigational drug for her child. In this case, the trial judge had ordered this pharmaceutical company to give the boy an investigational or experimental drug. The appeals court subsequently reversed it, Shepherd says. “But it’s interesting to me that even though that case did not end up winning, ultimately, with the right facts, you can make a compelling case to the manufacturer to supply drugs, if a promise has been made, for example,” she says.

Parental nonconsent to medical treatment

Mary Anderlik Majumder, JD, PhD, an assistant professor of medicine with the Center for Medical Ethics and Health Policy at Baylor College of Medicine in Houston, says the committee decided on this topic as one of the top developments “because there has been just another slew of cases that have made it into the national media.” For example, there was the case of Daniel Hauser in Minnesota, a 13-year-old boy with Hodgkin’s lymphoma, whose mother took him on the run rather than consent to continuing medical treatment, even though the treatment was working.

It was “pretty clear that the judge had authority to order treatment,” she says, and the difficult decision that he had to make was to continue the boy in the custody of his parents after his mother took him on the run. Ultimately, the judge decided to leave him in the parents’ care, and he received appropriate treatment for his illness.

The background to this topic is complex, however, Majumder notes, and it sometimes creates confusion. In 1974, the Department of Health and Human Services regulated that states that

received federal money for child protection services came with the requirement that the states that received money had to have a religious exemption in their law. “So, you couldn’t go after parents for neglect if they were not treating their child medically for religious reasons,” she says.

Still, that regulation didn’t prevent the court from ordering medical services if a child needed it, but you couldn’t charge the parents with neglect, Majumder says. “So, not many states had religious exemptions related to their child neglect or their criminal laws,” she says. “And most of the states [added] them, because that was one of the strings attached to getting federal money.” In 1983, the federal government changed its policy, “but the states haven’t necessarily removed those provisions.”

Regarding the ethical considerations of parental nonconsent for their children to receive medical treatment, Majumder thinks the “American Academy of Pediatrics got it right when it said there shouldn’t be religious exemptions to these laws. On the other hand, you should always try to negotiate with parents, and going to court should be a last resort. So, whether it’s a religious reason or a cultural reason, if parents are refusing treatment, you should try to understand where they’re coming from. You should be open to negotiation — you know, what’s essential, what’s not.” You shouldn’t immediately call child protective services, she says.

There also were two cases discussed that involved parental nonconsent for medical treatment, she says. One in Oregon involving a 15-month-old child with a blood infection. “The parents were charged with second-degree manslaughter and second-degree criminal mistreatment,” Majumder says. “The wife was totally acquitted, and the father was found guilty of criminal mistreatment, which is a misdemeanor. Manslaughter is a felony, so it was a lesser charge.” The father was sentenced to 60 days in jail and five years’ probation. ■

Should providers have right of conscientious refusal?

The Obama administration acted last year to rescind the so-called “Bush rule” regarding the rights of health care providers related to conscientious refusal. Acting on the administration’s

direction, the Department of Health and Human Services (HHS) published in the *Federal Register* the intent to “rescind and study various legal and legislative precedents” related to conscientious refusal.

In the summary published in the *Federal Register* on March 10, 2009, HHS noted that it “believes it is important to have an opportunity to review this regulation to ensure its consistency with current administration policy and to re-evaluate the necessity for regulations implementing the Church Amendments, Section 245 of the Public Health Service Act, and the Weldon Amendment.”

According to the background published in the *Federal Register*, the Church Amendments were “enacted at various times during the 1970s in response to debates over whether receipt of federal funds required the recipients of such funds to perform abortions or sterilizations.” They essentially say that any entity that receives federal money cannot require health care providers to perform treatments or interventions that they find morally objectionable; nor can institutions discriminate against health care providers when they choose to decline to provide certain services to which they object on moral or religious grounds.

At the most recent annual conference of the American Society of Bioethics and Humanities (ASBH) held in Washington, DC, a panel discussion presented varying perspectives and information on current research on the topic of conscientious refusal by health care providers.

Survey finds what physicians think

Farr A. Curlin, MD, assistant professor of medicine at the University of Chicago School of Medicine, is the co-author of widely publicized research based on a survey sent to 2,000 U.S. physicians from all specialties. The survey results were published in *The New England Journal of Medicine* in February 2007.¹

As background, the authors wrote, “There is a heated debate about whether health professionals may refuse to provide treatments to which they object on moral grounds. It is important to understand how physicians think about their ethical rights and obligations when such conflicts

emerge in clinical practice.”¹ A total of 1,144 of 1,820 physicians, or 63%, responded to the survey. The procedures in question on the survey included: administering terminal sedation in dying patients, providing abortion for failed contraception, and prescribing birth control to adolescents without parental approval.¹

The authors wrote: “On the basis of our results, we estimate that most physicians believe that it is ethically permissible for doctors to explain their moral objections to patients (63%). Most also believe that physicians are obligated to present all options (86%) and to refer the patient to another clinician who does not object to the requested procedure (71%).”¹

According to the authors, “Physicians who were male, those who were religious, and those who had personal objections to morally controversial clinical practices were less likely to report that doctors must disclose information about or refer

patients for medical procedures to which the physician objected on moral grounds.”

While most of the physicians in the survey reported that it is ethically permissible to object, as well as to describe the objection to the patient, most respondents indicated they also were obligated to inform and refer. “However, the number of physicians who disagreed with or were undecided about these majority opinions was not trivial. If physicians’ ideas translate into their practices, then 14% of patients — more than 40 million Americans — may be cared for by physicians who do not believe they are obligated to disclose information about medically available treatments they consider objectionable,” the study authors wrote. “In addition, 29% of patients — or nearly 100 million Americans — may be cared for by physicians who do not believe they have an obligation to refer the patient to another provider for such treatments.”

The authors noted that the findings of the study “may be important primarily for patients.”

A perspective in favor

Curlin suggests that the Obama administration, in rescinding the Bush rule on conscientious refusals, “wanted to keep it at the status quo, which was that there remain these federal laws

... The number of physicians who disagreed with or were undecided about these majority opinions was not trivial. If physicians’ ideas translate into their practices, then 14% of patients — more than 40 million Americans — may be cared for by physicians who do not believe they are obligated to disclose information about medically available treatments they consider objectionable.

that prohibit discrimination based on a refusal to participate in something to which doctors, or rather health care providers, have a religious or other fundamental moral objection.”

And while it might be federal law to allow conscientious refusal, Curlin notes that “there are reports of that not being the case in different places. But I think for the most part, there’s a long tradition within the profession of accommodating conscientious refusals.”

Curlin says from its earliest days, the profession of medicine “in its ethical codes has said that doctors are not required to do things that in their judgment are not a part of their obligated medical care, and that they do not think are in the best interests of the patient.”

Speaking before The President’s Council on Bioethics in 2008, Curlin presented his argument: “that if you do away with conscientious refusal, you, in effect, turn the profession of medicine on its head in a way that people are not fully recognizing, because they are only thinking about the conscientious refusals of other people, the people with whom they disagree, rather than imagining themselves in a situation in which they are asked to do something that they think is wrong.”

Curlin says he thinks it is entirely appropriate that health care providers have the ability to refuse to provide services they find morally objectionable, although he notes that it is “conventional wisdom” taught in medical school that physicians, at least, also must inform and refer in such instances. “I think it’s absolutely essential,” Curlin says. “You cannot have a profession of medicine without that — that is, a profession. You can have people who are technicians, who provide [services], but you can’t have doctors thinking about what’s best for their patients and being committed to it, unless you allow them to not do things that they don’t think are best for their patients. There’s no way to have both.”

However, also in his remarks before the President’s Council, Curlin suggested that not every conscientious refusal is justified. “A conscience that is malformed or misinformed will err,” he said. For example, he said, “a conscientious physician may fail in his duties to relieve a patient’s debilitating pain because he has not been trained to pay close attention to and work hard to address pain. Alternatively, he may fail because he incorrectly interprets the patient’s behavior as drug-seeking and malingering.

“The conscience as a human faculty is both limited and fallible. Yet, however fallible,

conscientious refusals are, I think, a logical and necessary consequence of physicians exercising discernment or clinical judgment. It has long been recognized that medical decisions cannot be reduced to doing what patients want or even to clinical algorithms, rules of thumb, and scientific data.”

A different view

Joel Wu, JD, MPH, MA, research fellow, program in professionalism and bioethics, College of Medicine, the Mayo Clinic in Rochester, MN, also a panelist at the ASBH annual conference on this topic, says that while “Dr. Curlin’s position is to expand or extend a very broad right of conscience for health care providers,” Wu’s own view was “to consider limiting it in some ways.”

Wu said “within liberal constitutional society, we have to really find a careful way to balance the rights of the general public and the patients with the conscience rights of health care providers, especially given the particular set of powers and skills that health care providers hold as a class.”

The “concept” that Wu says he brought to the conference was his thought and argument that “in a society where we value the concept of martyrdom, and we might value the concepts and the political histories of civil disobedience, might there be a reason for health care providers to purposefully tolerate a penalty for their refusal to do something they find morally objectionable?”

While it is, Wu says, a “difficult balance,” he is not asking for doctors to “purposefully seek out penalty to prove a point.”

“What I’m asking is for people to consider situations where they find something so morally objectionable, but at the same time, there’s a societal need for people to provide or at least to make that type of action or that type of medical service available or at least inform people of it — whether they are going to be willing to, for the sake of their own conscience and possibly to prove a point, to tolerate a penalty as opposed to shifting the burden onto the public and the patient.”

Wu suggests that the fundamental question really boils down to “the balance of the interests and the liberties of patients, and the interests and the liberties of the health care provider.”

“We live in a liberal constitutional society,” Wu says. “What that really means is that the seat of moral authority resides in the individual, so you want to maximize that. The problem is that health care providers have some special powers,

and they probably also have to have some special obligations and responsibilities.”

Physicians have such special powers “by virtue of licensing and by virtue of their skills,” Wu says.

He describes physicians as legally “the only people who have the skills and power to provide medical care, and the general public has to go to these people to get medical care.” Accordingly, this also gives physicians the power potentially to “restrict or limit the liberties of the general public, because if they start to refuse to inform and educate, or if they refuse to provide those medical and legally relevant medical services to the public, then the public’s liberties are constrained just by virtue of their lack of power and their lack of skills and expertise,” Wu says.

Therefore, the role of the government is to balance these interests, he says, without “overly burdening the conscience of the provider.”

Wu believes physicians should be willing to inform the patient regarding “relevant and legal” medical services, “even though the physician or the health care provider might find that particular option to be morally objectionable.”

Particularly rural areas and their citizens might be unduly burdened if, for example, the sole health care provider in that community refused to provide certain services, Wu notes.

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1. Curlin FA, Lawrence RE, Chin MH, et al. Religion, conscience, and controversial clinical practices. *N Eng J Med* 2007; 356:593-600. ■

Montana is third state to allow aid in dying

The Montana Supreme Court has ruled that terminally ill Montanans have the right to choose aid in dying under state law.

“This case was about the right of mentally competent, terminally ill patients to request a prescription for medication from their doctors which they can ingest to bring about a peaceful death,” said **Kathryn Tucker**, co-counsel to the plaintiffs/respondents and legal director of Compassion & Choices, a nonprofit organization that advocates for improved care and expanded choice at the end of life. “The Montana Supreme Court has determined that this is a choice the

public policy of Montana supports. Montanans trapped in an unbearable dying process deserve, and will now have, this end-of-life choice. This is the first state high court to find protection of this choice and makes clear that in Montana, patients are able to make this choice and physicians can provide this care without risking sanction.”

Roberta King, of Missoula, the daughter of plaintiff Bob Baxter, said, “My father died without the peace and dignity he so dearly wanted for himself and others. He feared when he filed this lawsuit that he would not live long enough to benefit from it. I’m sure he would be deeply gratified that other terminally ill Montanans will have the choice and comfort that aid in dying affords them.”

Stephen Speckart, MD, a Missoula cancer specialist and a plaintiff in the lawsuit, said, “This decision affirms that a terminal patient’s fundamental right to self-determination will guide end-of-life health decisions. I regularly treat patients dying from cancer, and many of these deaths are slow and painful. Terminal patients will no longer be forced to choose between unrelenting pain and an alert mental state as they approach the end of their lives from terminal diseases. The comfort this brings to their last days can have an immeasurable benefit.”

Missoula attorney **Mark Connell**, who argued the case to the Supreme Court on behalf of the plaintiff physicians and patients, described the decision as “a victory for individual rights over government control.” Connell added: “The Montana Supreme Court has now recognized that, where intensely personal and private choices regarding end-of-life care are involved, Montana law entrusts those decisions to the individuals whose lives are at stake, not the government. I know Bob Baxter would be very pleased that the court has now reaffirmed that these choices should be left to the terminally ill people in our state.”

The following groups had urged the court to find in favor of terminal patients’ right to receive aid in dying from their physicians, according to Compassion & Choices: Montana State Sen. Christine Kaufmann, Rep. Dick Barrett, and 29 other state legislators; the American Medical Women’s Association; the American Medical Students Association; the American College of Legal Medicine; the American Civil Liberties Union of Montana; the Montana Human Rights Network; and the Northwest Women’s Law Center. ■

Spiritual support improves well-being at end of life

In a new study of terminally ill cancer patients, researchers at Dana-Farber Cancer Institute in Boston found support of patients' spiritual needs by the medical team is associated with greater use of hospice, less aggressive care, and greater quality of life near death.

"Recent research has shown that religion and spirituality are major sources of comfort and support for patients confronting advanced disease," says the study's senior author, **Tracy Balboni**, MD, MPH, radiation oncologist at Dana-Farber. "Our findings indicate that patients whose spiritual needs are supported by their medical team, including doctors, nurses, and chaplains, have better quality of life near death and receive less aggressive medical care at the end of life."

The study involved 343 incurable cancer patients at hospital and cancer centers around the country. Participants were interviewed about their means of coping with their illness, the degree to which their spiritual needs were met by the medical team, and their preferences regarding end-of-life treatment. Investigators then tracked each patient's course of care during the remainder of his or her life.

Transition to hospice

The researchers found that patients whose spiritual needs were largely or completely supported by the medical team were likely to transition to hospice care at the end of life. Additionally, among patients relying on their religious beliefs to cope with their illness, spiritual support reduced their risk of receiving aggressive medical interventions at the end of life. Support of patients' spiritual needs by the medical team also was associated with better patient well-being at the end of life, with scores on average being 28% higher among those receiving spiritual support.

"Our findings suggest that spiritual care from the medical system has important ramifications for patients at the end of life, including helping them transition to comfort-focused care and improving their well-being near death," said Balboni. "Furthermore, they highlight the need to educate medical caregivers in being attentive to the frequent role of religion and spirituality in patients' coping with advanced illness and

importance of integrating pastoral care into multidisciplinary medical teams."

Financial support for the study was provided by grants from the National Cancer Institute, the National Institute of Mental Health, the American Society of Clinical Oncology, and the Fetzer Institute. ■

Free legal guide available for end-of-life decisions

The *Legal Guide for the Seriously Ill*, a project by the American Bar Association (ABA) Commission on Law and Aging commissioned by the National Hospice and Palliative Care Organization (NHPCO), is designed for the seriously ill individual and those caring for someone who is seriously ill.

The recently released guide addresses societal issues that have gained prominent media attention in recent years, such as paying for health care, managing health and personal decisions, and patient rights. In addition, the *Legal Guide for the Seriously Ill* sheds light on recent legislative and regulatory changes, such as the recently enacted American Recovery and Reinvestment Act of 2009, which provides a 35% subsidy of the COBRA (Consolidated Omnibus Budget Reconciliation Act) premium for up to nine months.

"The *Legal Guide for the Seriously Ill* is a great resource for anyone facing a serious illness," said ABA president **Carolyn Lamm**, JD. "The book provides critical tools that help readers understand their options, make informed decisions, and minimize some of the anxiety they may be feeling about their financial and legal affairs at this stage of life."

J. Donald Schumacher, PsyD, president and CEO of NHPCO, added, "Hospice and palliative care organizations are frequently asked for information regarding end-of-life planning and decision making. This guide will be a tremendous resource to them, as well as faith communities, caregiver organizations, aging service providers, hospitals, and others who work to support people living with a serious illness."

Although the guide does not provide legal advice, it does contain tools and resources that patients and families can use when they face a serious illness. To download a free copy of the publication, go to www.caringinfo.org, select

“Resources.” Choose “Advanced care planning legal issues,” and then scroll down to “Legal Guide for the Seriously Ill.” ■

New hospice manual for volunteers released

More than 550,000 individuals give more than 2.5 million hours of service as trained hospice volunteers each year, according to the National Hospice and Palliative Care Organization (NHPCO).

The newly revised edition of *The Hospice Volunteer Program Resource Manual* is available to help hospices ensure that their volunteers are well trained and that the program meets the newest Conditions of Participation (CoPs) for hospice providers.

The manual has been updated to reflect the 2008 hospice CoPs and includes fresh ideas on recruitment, retention, training, volunteer manager skills development, and program development. The publication includes a CD-ROM that assists managers in personalizing a volunteer program that meets the specific needs of an organization. Materials that can be adapted include competency checklists, surveys, policies and procedures, visit logs, job descriptions, and training outlines.

To ensure that volunteers remain an integral part of hospice care, it is federally mandated that at least 5% of patient care hours be provided by trained volunteers. Providers must track and document this carefully.

The Hospice Volunteer Program Resource Manual (Item #820114) is available from the NHPCO Marketplace. Go to www.nhpc.org and select “marketplace” on the left navigational bar to go to the Marketplace home page. Scroll down the page to “4 Easy Ways to Order” to access the link for the downloadable marketplace order form. The manual also may be ordered online at nhpc.org/marketplace or by phone at (800) 646-6460. The cost is \$79.99 plus \$8 for shipping

for NHPCO members and \$118.95 plus \$12 for shipping for nonmembers. ■

Joint Commission hosts H1N1 forum

The Joint Commission H1N1 forum, a web-based discussion forum, is designed to allow health care organizations to exchange information about the pandemic, innovative solutions, and suggestions that can help other organizations manage patient care during the H1N1 pandemic more effectively.

The Joint Commission has established a web-based discussion forum on H1N1 to allow health care organizations to freely exchange information about the H1N1 pandemic, including innovative solutions they have used and stories of failed attempts that can provide learning experience.

The forum allows peers and experts to share experiences in real time. The H1N1 forum is launched by The Joint Commission with the Centers for Disease Control and Prevention and the Association for Professionals in Infection Control and Epidemiology. Provided as a benefit of accreditation, the forum uses The Joint Commission’s existing WikiHealthCare platform. Individuals interested in participating in the forum will need to register at wikihealthcare.jointcommission.org/bin/view/CommunityPost/DiscussionForum.

Participation on the forum will not affect an organization’s accreditation. Participants who share examples of their organization’s response to the H1N1 pandemic will be asked to provide some basic demographic information, such as organization type and size, but no identifying information about the organization will be requested. The information shared on the forum will be analyzed by The Joint Commission’s Division of Quality Measurement and Research for informational purposes and may be used as a resource to share how organizations across the

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nation respond to challenges related to the H1N1 pandemic. ■

Internet conferences target accreditation

Time and budget pressures can sometimes make attending conferences difficult, so Joint Commission Resources (JCR) now offers conferences and seminars via live video streaming as well as on demand over the Internet.

The live video streaming option allows viewers to participate by submitting questions to presenters via e-mail. The on-demand feature allows users to view a conference or seminar in its entirety, or they may view one session at a time.

“Live video streaming and conferences/seminars on demand provide the same quality learning experience for which JCR is known. And both options provide the knowledge health care professionals need, when they need it, with affordability and convenience,” says **Pam Steinbach**, executive director of education at JCR.

On-demand conferences and seminars include:

- 2010 Home Care Primer;
- 2010 Home Care Accreditation Essentials;
- 2010 Home Care Executive Briefings;
- 2010 Infection Prevention and Control

Standards;

- 2010 Medication Standards.

For the most current listing of live video-streaming programs and conferences and seminars on demand, go to www.jcrinc.com/Virtual-Events-Home. ■

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