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Abortion sparks contentious debate despite legalization in 1973

Not a binary issue

No other bioethics topic stirs passionate debate, political controversy, and religious disapproval quite the way that abortion does — and has since its legalization with a decision by the U.S. Supreme Court in the case of *Roe v. Wade* in 1973.

Perhaps, according to one bioethics expert interviewed by *Medical Ethics Advisor*, that's because abortion — the termination of a pregnancy — has much to do with one's religion, one's sense of when life begins, one's sense of a woman's autonomy, and one's sense of the role of science, among other factors.

“Much of religion — structurally — is about maintaining control and order of time and place and the body,” says Laurie Zoloth, PhD, director, Center for Bioethics, Science and Society and professor of medical humanities and bioethics at the Feinberg School of Medicine at Northwestern University in Chicago. “So, an unexpected pregnancy is a violation of the natural order; it's a natural activity; . . . it's linked to sexuality and to passion. And a pregnancy out of time and out of place is seen by some as a religious problem to deal with, because religion has to do with what should be [and] when it's proper to bring forth life.”

And while that may be true, Zoloth offers three “possible narratives” as an explanation of why abortion continues to be “this deeply unsettled issue within American political life.”

What confers moral status?

“One idea is that it touches on the anxiety that Americans have about the determination of moral status, and one could say . . . or I will say . . . that the moral status issue is an essential American anxiety,” she explains. “And the first way it got played out was when Europeans came to what would be the United States . . . [where] they were confronted with Native Americans, and they didn't know what they were,

[so] there was a big debate — one of the first moral debates in moral philosophy about the New World was whether Indians had souls.”

The debate centered on not only whether Native Americans had souls, but also, Zoloth says, “whether they were humans, whether they were animals, whether they could be saved . . . could they be enlightened? What was their moral status?”

The second moral debate had to do with slavery, when questions were considered, such as “Are slaves persons? Are they three-quarters of a per-

son? . . . How does one treat a slave?

“Note that we spent a century debating Native Americans, a century debating slavery — I mean, these were long, long debates,” she says. “And the third debate is, of course, women. Are women fully entitled? Can they own property? Can they be educated? If you educate their minds, what happens to their bodies? What happens to their fertility? So, the anxiety [existed] around whether women were fully human, in a sense. What’s the moral status of a woman? [And it’s still] an ongoing issue.”

The fourth issue — in contemporary time — has to do with the moral status of the human embryo.

“The anxieties continue to mount when the science follows the anxiety out, [that is] when the embryo couldn’t be seen, couldn’t be visualized, which was largely the case in *Roe v. Wade*,” Zoloth notes. “That [case] was before prenatal diagnosis . . . before sonograms.”

“Two things have happened to continue the debate — to continue the anxiety and uncertainty: One is the fact that you can visualize, from pretty early on in pregnancy, the developing being inside of a woman’s body,” she says. “And now we name babies [in the womb]; you can create a universe around a gender — it’s a boy, and it has a certain color room; it’s a girl, and it has a certain color room. You can sort of pre-imagine. There’s a moral imaginary that takes place that couldn’t have taken place before sonograms.”

But something else has happened that takes the moral status question in a completely different direction, which is the use of the fetal tissue in research and early embryos for research purposes.

“So, there’s a confusion about what exactly you’ve done here,” Zoloth explains. “On the one hand, you’re seeing and prefiguring pregnancy, because you can determine if you’re pregnant within a week of a missed period.”

On the other hand, there’s this idea that blastocysts, because the cells of blastocysts are mutable, that they are an “extraordinary source for science and biomedicine.”

Women’s rights on center stage

The second of Zoloth’s “narratives” as a possible explanation of why abortion continues to be so divisive is that *Roe v. Wade* did not occur in a vacuum of traditional American culture. There was, instead, social upheaval following the 1960s.

“It was not just a beginning of a discussion

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EDITORIAL QUESTIONS

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about abortion — it was the beginning of [something] fundamental and profound that had to do with women’s liberation as an idea.”

That liberation included the birth control pill and the notion that women could work outside the home in a workforce where they had until then largely been absent. Women also began entering colleges and universities in massive numbers, she says.

“I think that when people have anxieties about *Roe v. Wade*, the anxiety has to do with the larger change in what it means to be a family, what it means to be a woman, [and] what motherhood means,” Zoloth says.

A picture existed at that time in people’s minds about what a nuclear family should look like, and it has a father, mother, and children. That picture, Zoloth maintains, was “radically disassembled by not just *Roe v. Wade*, but the birth control pill, the necessity for work, and the ideology that [women] should work.”

The accompanying idea of a woman being able to say “no” to a pregnancy is still “one of the disconcerting features that surround *Roe v. Wade*; it has more to do with anxiety about women’s role and women’s power over their own bodies — that the combination of birth control, your own job, and the ability to end a pregnancy, that gives you an unprecedented power over your body and over your fate.”

Science and suspicion

The third possible narrative for the continuing discontent over abortion is that “there is anxiety around science that goes very deep in American life,” Zoloth says.

“There was a rupture in a progressive embrace of science that went all the way through the polio vaccine era . . . what we allowed [Jonas Salk] to do, I don’t think our IRBs today would have approved it. But there was a bit of a love affair with science; science was seen as redemptive,” she says.

A series of events occurred where science was called into question, however, and a consequence of those events was a “return to the idea of naturalness,” Zoloth explains. “The idea of naturalness plays right into Catholic moral theology around natural law . . . that once pregnancy has begun, it is an act of unnatural violence to end it — a callous abuse of the environment, in some sense.”

Finally, love and sex and ultimately, pregnancy “thus begins a natural/sacred embrace of a natural process” that shouldn’t be tampered with or interrupted, Zoloth says “I think that’s one of the cultural tropes that plays in our continuing discussion about [abortion],” Zoloth says.

An unsettled issue

“For many people, the argument that life begins at the moment of conception, and that such life demands our respect and unequivocal protection, is a religious commitment. I take that seriously as a matter of their sincere understanding of their faith. Such a commitment should never be trivialized,” Zoloth says

“However, it also cannot be a matter of public policy in a pluralistic democracy. Other faiths believe differently about when life begins, and there is no agreement among faiths, and among non-believers, about the moral status of embryos. That disagreement is where *Roe v. Wade* began. Because the matter is a matter of faith, while we can analyze the other issues that animate the debate, we cannot “settle” the question. The argument that abortion is murder of the most innocent of lives, and the argument that abortion is a tragic but imperative part of human free choice are incommensurate arguments,” she says.

SOURCE

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Ethics, religious beliefs blend into political fray

Abortion a bedrock of the culture wars

There’s no doubt that the debate over abortion is an integral part of not only family-centered discussions, but also the debates that occur on the left, on the right, and various points in the center on the political continuum.

Experts steeped in bioethics and philosophy agreed that one of the reasons that abortion continues to be such a hot-button issue is not just the

ultimate decision in 1973 by the U.S. Supreme Court in *Roe v. Wade* to legalize abortion until the point of viability of the fetus, but the fact that it was a decision made by that top judicial body — and not through legislative action.

For example, the abortion battle in England was “fought over a series of parliamentary debates,” says **Bonnie Steinbock**, PhD, professor in the philosophy department at the University of Albany/SUNY in Albany, NY.

“By contrast, the way we often do things in the United States is these things become a constitutional matter rather than a legislative matter; we’ve seen the same thing with same-sex marriage,” Steinbock tells *Medical Ethics Advisor*. “In the case of abortion, I think the unintended consequence was that [*Roe v. Wade*] galvanized the religious right, because with one fell swoop, all of a sudden all of the abortion laws in the country were struck down.”

That point alone Steinbock considers to be “probably the most important factor,” as to why the United States continues to engage in bitter debate at times in the political arena — in more recent public policy debates ranging from health care reform to stem cell research to the confirmation of the newest justice on the U.S. Supreme Court, Elena Kagan.

“So, the end of life and the protection of life has become hugely politically important and politically volatile,” Steinbock notes.

She says there is “no question that abortion has become the touchstone for conservatives generally — not just those who are conservative based on religion.

“I think [the] Schiavo [case] made it very, very clear that this was a rallying point — and that was as much about abortion as anything else,” she says.

Advances in stem cell research “also galvanized it, yet again,” she says.

“The other thing is that people have also said . . . that as we move away from the years when abortion was illegal, young women have forgotten. . . people have simply forgotten about the social consequences of illegal abortion,” according to Steinbock.

Charles C. Camosy, PhD, assistant professor of Christian ethics at Fordham University in Bronx, NY, agrees, noting that “precisely because it was decided by the Supreme Court is part of the reason it’s so contentious.”

“The public debate in Europe, for instance, is there, but it’s not nearly as contentious as it is

here; and part of the reason is because they had a legislative process that determined their policy,” Camosy notes. “In our case, it was a majority of unelected judges imposing a particular view . . . from the top down, and so we have protesters outside of the Supreme Court, instead of people lobbying their politicians, or maybe in addition to lobbying their politicians.

“So, I think that one thing that could really help this go away is if we actually had a legislative process [to decide the issue],” he says. “We never really had a public debate where we put all our reasons and our arguments out there, and then had a majority vote, or even state by state, or however it would go. My suspicion is it would be state-by-state. And then people would feel like, “Well, the democratic process took place; we had the arguments, and we lost.”

“Values to uphold”

Another big reason for the continuing debate on abortion, according to Camosy, is that “there’s a big diversity of opinion.”

He suggests that currently, if you ask individuals if they identify as pro-life or pro-choice, for “the first time ever,” a slight majority of people say they are pro-life.

“That’s a small change; it was always very close — and there are important values to uphold on both sides,” he says. “Actually, I think there are multiple sides; I think one problem is we tend to see this as a binary issue of pro-life and pro-choice, and there are multiple ways you can approach it that don’t fit into those categories.”

Generally speaking, he says that pro-choice individuals “have a really important value to uphold, which is the ability of individuals to make very difficult and morally thick decisions on their own, without it being imposed by the outside,” Camosy says.

This is true “especially for women,” he says, noting that only recently have women “gained control of their right to be in control of their own reproductive life — and in some ways, still don’t have it, as long as there is economic inequality between men and women.”

“In some ways, women aren’t free to make their reproductive choices, because they are financially dependent — many of them — on the men in their life,” Camosy says. “So, even if abortion is available; even if contraception is available, with that sort of inequality, some women are

just not free to make these choices, because of the dependence they have. So, those are all really important considerations.”

Yet, he says, there are important consideration for those individuals who consider themselves pro-life.

“We have to defend the most vulnerable from the powerful, who would otherwise dominate them if you let free choice reign,” he says. “That’s what happens when free choice reigns; the powerful dominate the weak.”

While free choices “have value,” it is also a responsibility to “stand up for those who would otherwise not have a voice,” Camosy says. “And for pro-lifers, they think . . . our prenatal children matter just as much as our post-natal children.”

Camosy says that “when you have those two very strong values in conflict with each other, you know, that’s not going to go away easily.”

Abortion in the Schiavo case

The issue of abortion also played a role in the contentious debate on a person’s end-of-life choices surrounding the Terri Schiavo case, both Steinbock and Camosy say.

“When the Terri Schiavo [case occurred], the people that were arguing about it were actually arguing [and] fighting a proxy war about abortion through . . . [that] case,” Camosy says.

“It was the pro-lifers who said, ‘Oh, you know, you’re saying this human being doesn’t count, and we can kill this human being, because she doesn’t count.’”

The other side’s retort to that argument was, he says, “‘Oh, there you go again, imposing your religious values onto all of us; we should be able to make choices here that aren’t imposed by an outside ideology we don’t share.’”

The same arguments have occurred more recently in public policy debates on health care reform and embryonic stem cell research.

“The contentiousness and polarization have become so pervasive, that we just need to . . . take some steps to try to draw down the rhetoric, find out where we actually disagree, although my suspicion is we don’t disagree nearly as dramatically as — or as fundamentally as — it appears, because of the fog of the abortion wars,” Camosy says.

SOURCES

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Nun resigns following abortion decision

Ethics committee convened, consulted

Earlier this year, a nun, Sr. Margaret McBride, who served on the ethics committee at St. Joseph’s Hospital and Medical Center in Phoenix ultimately “resigned from her position as vice president of mission integration” at the institution, following what was described as a “tragic case” involving the “termination of an 11-week pregnancy,” according to a statement from the hospital.

“At St. Joseph’s Hospital and Medical Center, our highly skilled clinical professionals face life and death decisions every day. Those decisions are guided by our values of dignity, justice and respect, and the belief that all life is sacred,” the statement reads.

“We have always adhered to the Ethical and Religious Directives for Catholic Health Care Services as we carry out our healing ministry and we continue to abide by them. As the preamble to the Directives notes, ‘While providing standards and guidance, the Directives do not cover in detail all the complex issues that confront Catholic health care today,’” the statement continues.

“In those instances where the Directives do not explicitly address a clinical situation — such as when a pregnancy threatens a woman’s life — an Ethics Committee is convened to help our caregivers and their patients make the most life-affirming decision.

“In this tragic case, the treatment necessary to save the mother’s life required the termination of an 11-week pregnancy. This decision was made after consultation with the patient, her family, her physicians, and in consultation with the Ethics Committee, of which Sr. Margaret McBride is a member.”

A follow-up statement from St. Joseph’s indicated that “At the bishop’s request, Sr. Margaret resigned . . . St. Joseph’s Hospital and Medical Center values her highly, respects that this was her decision to make, and we continue to support her.” ■

Practical ethics in neonatal EOL care

“When the beginning is the end”

[Editor’s note: This article is based on a presentation at the 2010 Pediatrics Bioethics Conference hosted on July 23 and 24 by the Treuman Katz Center for Pediatric Bioethics at Seattle Children’s Hospital.]

Marcia Levetown, MD, FAAP, FAAHPM, principal of HealthCare Communication Associates in Houston, chose to begin her presentation to members at the 2010 Pediatrics Bioethics Conference in Seattle with a little perspective on what palliative care actually is.

The goal of her presentation was to help the audience distinguish candidates for perinatal and neonatal palliative care, as well as to help them learn now to integrate the concepts of palliative care within existing health care paradigms, and to “develop, defend and promote ethically viable palliative care plans for this particular group of patients.

“Palliative care might not be what you think it is . . . it’s really the prevention and relief of pain and suffering,” Levetown told the audience.

Providing palliative care requires that caregivers “tolerate ambiguity” regarding the projected outcomes of a diagnosis and allowing the families’ values to play a significant role in the decisions made on that basis, which she described as a “true libertarian value.”

Much of the discussion on the morning of July 23 centered around neonatal resuscitation — when it makes sense and when it doesn’t, and when there is a so-called “gray zone.” The discussion was kicked off by John Lantos, MD, director of pediatric bioethics and professor of pediatrics at the University of Missouri-Kansas City School of Medicine and Director of the Bioethics Center at Children’s Mercy in Kansas City.

Levetown noted that decision-making guidelines exist because the gray zone itself cannot be defined independent of “the application of values” of the patients’ families.

“Almost all decisions end up being made within the family context,” she told audience members.

Why ethics?

Levetown, who is a physician, said she launched

into her interest in ethics and palliative care because of her concern that patients were often receiving care that would not improve their chances for survival and increase suffering for the patient and their families. Too often, health care providers and members of the public don’t really understand palliative care, rather than understanding it as a concurrent effort to prevent suffering and enhance decision-making, many think of palliative care as being pertinent only at the very end of life — missing many opportunities to enhance the quality of life in the face of serious illness or injury.

Parents, particularly, typically want to do everything to preserve the life of their child, which is natural. But what parents need is guidance by the health care team to also be concerned about their child’s quality of life. And in the face of certain death, they sometimes need to focus on a “good quality death,” to help the child and ease their bereavement process, she said.

To achieve a quality dying process, caregivers should focus on timely and effective empathetic communication, effective symptom management and facilitating the “family dynamics” well.

“I submit that we do that pretty poorly,” she told audience members.

Parents’ expectations vs. reality

Upon the birth of a premature or otherwise life-threatening child, parents are faced with “life-altering changes in expectations,” Levetown said, which in and of itself creates suffering. “What they envision [while pregnant] is that they are going to have that wonderful yellow and blue nursery,” but suddenly, instead, they find themselves in the alien and overwhelming environment of the neonatal intensive care unit (NICU).

The work of one researcher (Lautrette), who Levetown said has done “beautiful work on post-traumatic stress syndrome” in members of adult intensive care units, would suggest that the emotional distress of parents could be “dramatically reduced by an orientation on what to expect,” if they have a child admitted to the NICU.

As Levetown explains, “Suffering happens just because you enter a NICU.”

Also, many children who are originally in the NICU, ultimately go on to be cared for in pediatric care intensive care units (PICU). And one-third of the deaths in U.S. children every year occur with neonates, and an additional 20% occur in infancy

(the first year of life). This does not include the 800,000 miscarriages and 33,000 stillbirths that parents may grieve in the United States each year, according to Levetown.

What is palliative care?

Levetown defines palliative care as the active, total care of patients and their families facing serious health problems, by addressing the physical, psychosocial, emotional, and spiritual concerns associated with illness. There is no reason that this care should not be provided along side of attempts to reverse illness.

While care in hospital is generally “multi-disciplinary,” with many caregivers contributing, but each ignoring the input of the others, palliative care is provided as an “interdisciplinary” collaboration, all listening to and incorporating the evaluation of the others to create an integrated and more effective care plan, avoiding the usual silos. However, “transdisciplinary” collaboration — with the individual present addressing the current problem area even if it is not their specialty, then reporting the problem to the expert on the team for follow up, may enhance the timeliness of palliative care interventions, according to Levetown.

Our job is “to help you help these patients and their families (to prevent and relieve their suffering); not to determine whether this child will live or die.”

Care sometimes prolongs suffering

Today, it seems that nationally, health care teams in the United States are too often “prolonging the dying process” in many cases, i.e., where the medical care is not actually benefiting the patient and is often causing unnecessary suffering without offsetting benefit.

For example, Levetown noted, “the outcomes (for extremely premature infants) are not changing, but the time in the ICU (before their deaths occur) is increasing,” she noted.

Suffering occurs, she wrote, “when the burden outweighs the benefit,” and that determination should be made by, and is dependent upon, “the values of the patient and family” — not the values of the health care provider or society at large.

And “uncertainty is harder for parents to cope with than known bad outcomes,” she writes.

For perspective, Levetown shared the following quote from Eric Cassell on “suffering and the lim-

its of medicine”: “The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick.

How physicians can assist

Physicians’ failure to understand the nature of suffering can result in medical interventions that (though technically adequate) not only fail to relieve suffering, but become a source of suffering itself.”

“That’s really what we want to avoid,” she told audience members.

The physician’s role, she wrote, is to:

- determine diagnosis;
- make the best estimate of prognosis;
- determine all relevant medically appropriate, legally and ethically acceptable options;
- elicit family philosophy, overall goals;
- assist families to consider the choices through the lens of their priorities and make recommendations for care goals based on this and the physician’s experience;
- ensure involvement of the interdisciplinary team to address physical, social, emotional, spiritual suffering.

Physician obligations in decision-making include, she wrote:

- To provide clear information, check for understanding.
- [Explain] what is experimental? Conventional?
- [Explain] what is a response to treatment?
- [Explain] what is the expected duration of survival, level of probable short and longer-term disability, and at what cost (social, financial, physical)?
- [Determine] what are reasonable alternatives (there is always more than one choice!).

Ethical communication

From an ethical perspective, she said that communicating prognostic information sometimes takes more than words; sometimes it requires visual or experiential information such as videos of patients and families facing similar conditions, or talking with other affected families with a neonate or child.

Levetown also suggested that it is crucial for health care providers to acknowledge their own biases when discussing treatment options and potential outcomes with patients.

For example, it is important to recognize that

based on what the families' values are determined to be, physicians often have to "counsel people differently than we would act ourselves."

One of the ethical obligations in decision-making with parents, she wrote, is to "remember the family lives with the decisions forever."

SOURCE

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U. of Minn. adopts new ethics policy

University sought transparency in policies

In the wake of Sen. Charles Grassley's efforts to uncover and reduce conflicts of interest (COI) at academic medical institutions, some health care centers are re-examining their COI policies, and one of those is the University of Minnesota.

However, that institution is taking a "layered" approach to its COI policies, according to **Mark B. Rotenberg**, general counsel for the university.

On Aug. 3, the senior vice president for the academic medical center and the medical school administration adopted one of its multiple revised COI policies that will govern COI for clinical staff, or Appendix A, which is titled "Individual Conflicts of Interest: Clinical Care — Patient Contact in the Academic Health Center."

The review of policies has been under way for about two years.

"The field of conflict of interest in major research universities is very dynamic . . . between research faculty and teaching faculty and businesses that fund research and fund other university activities; those relationships have become very complicated," Rotenberg tells *Medical Ethics Advisor*. "And the public's awareness of those relationships has increased dramatically over the past five to 10 years.

"Therefore, the need — especially for a public land grant university — to be transparent and assure integrity in its teaching and research activities has increased over time. And so, it's that dynamic situation of increased public awareness, increased sensitivity to COI issues, and the need for the university to deepen and expand its

relationships with business, while maintaining integrity and transparency, that created a need to . . . look again at [our policies] . . . and then we decided to revise, our COI policies," Rotenberg says.

Previously, the university had COI policies at the Board of Regents level, since 1994. The system also has had administrative policies and administrative committees to evaluate and drive the agenda on conflict of interest at the institution for more than 15 years, he says.

Multiple policies will govern

"The new policies here are layered, so to speak," Rotenberg explains. "At the highest level — at the broadest and most general level — there's a new Board of Regents policy on individual conflicts of interest that was made effective in March; and that was a fairly comprehensive revision of the older conflict of interest policy. So, I would say, at that level, it's a substantial revision. It's not revolutionary, but it's a substantial evolution from the prior policy."

Geared toward implementing the Board of Regents policy is a "draft administrative policy, which is intended to cover the entire institution that covers dozens of our colleges from agriculture to medicine to engineering to business to our campuses in Rochester . . . and so on," Rotenberg says. "And that so-called wall-to-wall administrative policy is in the final stages of review and will probably be adopted by the end of this calendar year."

Leading up to the adoption of Appendix A, Rotenberg says there was a series of faculty meetings, allowing the faculty groups and administrators from those groups to review the draft language.

According to Rotenberg, in 2008, the medical school began its own process of reviewing the university's existing COI policies. The medical school dean established a task force, and in 2009, that task force issued a report with recommendations that would have been applied "solely in that context."

Ultimately, the central administration examined that process, and a decision was made that the medical school should not have its own, independent COI policy.

"That's what has taken so long, because we wanted to revise the institution's COI policies to promote interdisciplinary research, interdisciplinary teaching activity, interdisciplinary collaboration with business and industry . . . we didn't want to have a process that would silo COI policies," Rotenberg tells *MEA*.

The university wanted its COI policies to appear “seamless” and “user-friendly” to the business community, so as to avoid confusion for businesses and faculty who were collaborating.

“We didn’t want to have the face of the university to business to be, ‘Well, now, there’s three different conflict of interest policies; you’re going to have to fill out three different forms; and there are different limitations on what you can do and what kind of funding you take under which circumstances,’” Rotenberg explains.

Details of the policy for clinical staff

All individuals involved in clinical care are now required to complete annually a Report of External Professional Activities (REPA), which will be used to report “financial, equity, royalty and business interests that are related to the covered individual’s University expertise or responsibilities . . .”

Some of the policy details include:

- All remuneration either received or anticipated during a calendar year must be reported on the form in amounts ranging from \$1 to \$1,000. Remuneration “includes salary and payment for services not otherwise identified as salary (e.g., consulting fees, honoraria, and paid authorship).”

- Equity interests includes both publicly traded and non-publicly traded entities, and they must be reported.

- Business interests “to include holding any executive position in a business or membership on a board of a business entity, whether or not such activities are compensated.”

- Clinical staff “must complete a REPA within 30 days of a substantial change in a business interest . . . or in a financial interest . . . that relates to their university expertise or responsibilities.”

- Clinical staff are considered responsible for the “accuracy and completeness” of the information reported in the REPA.

- Clinical staff whose consulting income “exceeds \$100,000 in a calendar year will be forwarded by the Conflict of Interest Program to the individual’s dean for a “Conflict of Commitment” review under the administrative policy.”

“REPA’s will be referred to the conflict of interest program for review when a financial interest in a business entity “annually exceeds \$5,000...” Also, any clinical staff member who holds “an executive position in a business entity or membership on a board of a business entity” will be referred to the Conflict of Interest Program.

Regarding COI management, the policy states that, “When the Committee determines that a conflict of interest exists, it will determine whether the conflict must be eliminated or reduced or whether it can be effectively managed.”

Among a long list of prohibitions for clinical staff is that they cannot “engage in ghostwriting.”

For more information on the specifics of the clinical staff COI policy, visit the University of Minnesota Academic Health Center website.

SOURCE

• **Mark B. Rotenberg, JD**, General Counsel, University of Minnesota. ■

CMS proposes new rules for equal visitation

Same-sex domestic partners included

The Centers for Medicare & Medicaid Services (CMS) has proposed new rules for hospitals that would protect patients’ right to choose their own visitors during a hospital stay, including visitors who are same-sex domestic partners, according to CMS.

With the proposed rules, published in the *Federal Register* on June 28, CMS was responding to an April 15, 2010, Presidential Memorandum to the secretary of the U.S. Department of Health and Human Services. In the memorandum, President Barack Obama “tasked HHS with developing proposed standards for Medicare- and Medicaid-participating hospitals (including critical access hospitals) that would require them to preserve the rights of all patients to choose who may visit them when they are inpatients of a facility.”

According to CMS, “The proposed rules would require every hospital to have written policies and procedures detailing patients’ visitation rights, as well as instances when the hospital may restrict patient access to visitors based on reasonable clinical needs.”

CMS said that a “key provision” of the proposed rules is that visitors chosen by the patient “must be able to enjoy visitation privileges that are no more restrictive than those for immediate family members.” The patient’s proxy — or surrogate decision-maker should the patient lose the capacity to make decisions — can also make patient visitor choices for the patient.

“Every patient deserves the basic right to designate whom they wish to see while in the hospital,” said HHS Secretary Kathleen Sebelius in a June HHS news release. “Today’s proposed rules would ensure that all patients have equal access to the visitors of their choosing — whether or not those visitors are, or are perceived to be, members of a patient’s family.”

The proposed visitation rules would be an update to the Conditions of Participation (CoPs). CoPs are minimum health and safety standards all hospitals, including critical access hospitals, that participate in Medicare and Medicaid must meet.

“The proposed rule is an important step forward in the rights of all Americans to expect equal rights and privileges from the health care system, regardless of their personal family situations,” said Marilyn Tavenner, CMS acting administrator at the time. “In the environment of inclusion that this rule promotes, patients and providers can expect improved patient experiences of care.”

In the Presidential Memorandum, President Obama noted that “...every day, all across America, patients are denied the kindnesses and caring of a loved one at their sides — whether in a sudden medical emergency or a prolonged hospital stay. Often, a widow or widower with no children is denied the support and comfort of a good friend. Members of religious orders are sometimes unable to choose someone other than an immediate family member to visit them and make medical decisions on their behalf.”

“Also uniquely affected,” the memorandum states, “are gay and lesbian Americans who are often barred from the bedsides of the partners with whom they may have spent decades of their lives. . .” ■



Study: CRNAs offer same level of care

A study published in the August issue of *Health Affairs* suggests that there are no differences in patient outcomes when anesthesia services are provided by certified registered nurse anesthetists

(CRNAs), physician anesthesiologists, or supervised by physicians, according to the American Association of Nurse Anesthetists (AANA) in Park Ridge, IL.

The national study, titled “No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians,” was conducted by RTI International.

The study examined nearly 500,000 individual cases and confirms what previous studies have shown: CRNAs provide safe, high-quality care, according to AANA. The study also shows the quality of care administered is equal, regardless of supervision.

Currently, the Centers for Medicare & Medicaid Services (CMS) prohibits Medicare payments to hospitals and ambulatory surgery centers when CRNAs provide anesthesia care in the absence of physician supervision. However, starting in 2001, CMS began allowing states to opt-out of the Medicare physician supervision requirements for CRNAs.

Since then, 15 states — most recently California in 2009 — have chosen to opt out.

The study compared patient outcomes in states where the supervision requirement is in place with patient outcomes in the 14 states that had opted out of the requirement between 2001 and 2005. The research found that patient outcomes did not differ.

“We find no evidence that opting out of the oversight requirement harms patients in any way,” said study author Jerry Cromwell, PhD. ■

People turning to online health info

The latest Harris Poll, measuring how many people use the Internet to look for information about health topics, finds that the numbers continue to increase.

Harris Interactive said that the poll first used the work “cyberchondriacs” to describe such individuals in 1998, when just over 50 million American adults had gone online to look for health information. By 2005, that number had risen to 117 million.

In the new poll, which released results in early August, the number of so-called “cyberchondriacs” had jumped to 175 million from 154 million in 2009. Also, the frequency of usage has

increased.

Thirty-two percent of all adults who are online say they look for health information “often,” compared to 22% last year.

Other findings in the latest Harris Poll include:

- While the percentage of adults who go online (79%) has not changed significantly for several years, the proportion of those who are online and have ever used the Internet to look for health information has increased to 88% this year — the highest number ever.

- Fully 81% of all cyberchondriacs have looked for health information online in the last month. And 17% have gone online to look for health information 10 or more times in the last month. On average, cyberchondriacs do this about six times a month.

- Very few of such individuals are dissatisfied with their ability to find what they want online. For example, only 8% believe that the information they found was unreliable.

- Just over half (53%) of such individuals report that they have discussed information they found online with their doctors. ■

Hospital execs and “meaningful use”

In October, hospitals can start to qualify for Incentive payments for meaningful use of electronic health records (EHRs).

A new survey by CSC Global Healthcare Group of hospital executives revealed that although meeting the requirements for meaningful use incentives is a high priority, executives are also busy planning for other aspects of health care reform, including changes to payment models.

Of the executives surveyed, 90% report that achieving meaningful use of an inpatient EHR is one of their top two priorities; 67% say it is their highest priority.

Some of the other findings include:

- 66% are planning to participate in a health information exchange (HIE); currently, only 11% participate in a statewide HIE, while 26% have established a private hospital-sponsored HIE.

- When more than 30 million newly insured people enter the health care system in 2014, one-quarter of those surveyed expect their organization will experience a significant strain on capacity to provide care, and an additional 43% expect to

experience a slight strain on capacity.

- Hospital executives anticipate the biggest impact will be on outpatient primary care (36%), followed by demand in the emergency department (33%). ■

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

Upon completion of this educational activity, participants should be able to:

- Discuss new developments in regulation and health care system approaches to bioethical issues applicable to specific health care systems.
- Explain the implications for new developments in bioethics as it relates to all aspects of patient care and health care delivery in institutional settings.
- Discuss the effect of bioethics on patients, their families, physicians, and society.

COMING IN FUTURE MONTHS

■ Financial incentives for living organ donors

■ The ethics of neuroimaging

■ *NEJM* study on palliative care

■ More from the presentation at the 2010 Pediatrics Bioethics Conference hosted on July 23 and 24 by the Treuman Katz Center for Pediatric Bioethics at Seattle Children’s Hospital

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CME QUESTIONS

9. According to Laurie Zoloth, PhD, at Northwestern University, one of the likely factors for the continuing debate over abortion is the anxiety over the moral status of the embryo.

- A. True
- B. False

10. According to Bonnie Steinbock, PhD, of The University at Albany/SUNY, one of the primary factors in the continuing debate over abortion is the decision was made through legislation vs. by the U.S. Supreme Court.

- A. True
- B. False

11. What is an important aspect of palliative care that many health care providers do not recognize, according to Marcia Levetown, MD, FAAP, FAAHPM, principal of HealthCare Communication Associates in Houston?

- A. Palliative care is applicable through the course of care and is concurrent with attempts to prolong life.
- B. Palliative care providers try to determine whether a patient should receive life-prolonging care.
- C. Palliative only helps patients face death.

12. The University of Minnesota administrators decided to allow its medical school to establish a separate conflict-of-interest policy for the medical school only.

- A. True
- B. False

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

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