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November 2010: Vol. 26, No. 11
Pages 121-132

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Emergency room medicine and the ethics of boarding patients

Pines: The term boarding "needs to be defined"

The boarding of patients in hospital emergency departments occurs every day across the country and is not atypical, experts suggest. But when a study was published showing that acute coronary patients can be treated in the waiting room of a severely crowded emergency department, **Arthur L. Kellerman, MD, MPH, FACEP**, of the Rand Corporation in Arlington, VA, decided a line had been crossed.

Kellerman, who also holds a clinical appointment in the department of emergency medicine at Emory University School of Medicine in Atlanta, decided to respond with an editorial published online in September in the *Annals of Emergency Medicine* titled "Waiting Room Medicine: Has It Really Come to This?"

"It is the [situation], the ethical dilemma, that emergency physicians face every day and every night: 'Doing the best that I can for the patient in front of me. And by doing that, am I enabling a system that ultimately harms far more patients, because we've not drawn the line on inappropriate behavior?'"

With 30 years of experience in the field of emergency medicine, over this time, Kellerman notes that on the one hand, "there have been remarkable developments in treatments, diagnostics, techniques [and] training — remarkable scientific and clinical progress in three decades in this very young specialty."

"On the other hand, I've seen the environment in which we practice increasingly compromised, and increasingly eroded, and increasingly dangerous to patients and to health care providers through — what I can only conclude — is active neglect on the part of managers of the health care system who really don't want to come to grips with the challenges that are facing emergency care in this country," Kellerman explains.

And while there have been amazing innovations in emergency medicine — all toward the goal of providing "humane and decent care to

patients” — the emergency department environment ultimately “has progressively restrained emergency departments from doing what they were designed to do, which is to promptly evaluate, stabilize, admit, or discharge emergency patients.”

“So, the real question here is: When is enough, enough? And what will the specialty do about it? But far more importantly, what does our country and our society want to do about it?” Kellerman asks.

Despite what he describes as two decades of

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

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

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EDITORIAL QUESTIONS

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“extensive documentation — voluminous documentation of the problem, the deteriorating situation, [and] growing evidence that it produces adverse outcomes including death and disability,” the typical American “still thinks that if you pick up the phone and dial 911 and you roll into a hospital, you get swift, prompt, and efficient care, and everything will be fine.”

“And when that does not happen — and there is no assurance that going to a suburban hospital or a private facility with your platinum Blue Cross card will be any better protection than being a poor patient in an inner-city hospital — they’re shocked, they’re outraged, and they blame the doctor and nurse in front of them,” Kellerman explains.

Defining “boarding” of patients

Jesse M. Pines, MD, MBA, MSCE, director, Center for Health Care Quality, and associate professor of emergency medicine and health policy at George Washington University in Washington, DC, responded in an e-mail to questions from *Medical Ethics Advisor* that the answer to the question of should patients be boarded in emergency departments is “certainly no, but boarding needs to be defined.”

Boarding, Pines writes, is “the time from the decision to admit (or administrative bed request) to ED departure.”

“It would be impossible for the boarding time to be zero in most cases, because there has to be some reasonable time for the hospital to process the bed and transfer the patient to an open, ready room,” he writes.

While recommended maximum boarding times range from one hour by some groups to two hours by other groups, Pines maintains, “Keeping patients boarded in the ED long periods of time (i.e., beyond one or two hours) is unethical, particularly if space exists in the hospital for that patient and what is holding them is administrative inefficiency, such as delays in ‘accepting’ the patient, delays in transport, or delays in cleaning an empty inpatient room.”

Pines suggests that when a hospital “does not have sufficient space for an ED patient, it should look to its policies to understand, why, and . . . look to practices that involve reserving beds for only patients [undergoing elective procedures] and allowing the ED patients to fill in any capacity unused by the elective cases.”

“This practice is unethical for several reasons,” he writes. “The first is that ED boarding is associated with poorer outcomes and higher numbers of medical errors. It is also unethical because boarding is the major cause of ED crowding, which in [and] of itself can be hazardous. As the number of boarders increases, the effective capacity of the ED is reduced, which increases waits, as there are fewer active treatment spaces for the new, undifferentiated cases.

“So, permitting boards is a violation of beneficence, because it is not in the best interest of the patient being boarded, but also not in the best interest of the new, undifferentiated patient in the waiting room. Both can experience negative outcomes from this practice,” Pines writes.

Why the delays in admitting?

In Kellerman’s editorial, he sets forth three theories on why emergency room crowding persists, despite proof of grim outcomes as a result: economics, ignorance, and acculturation.

First, economics. Kellerman writes, “The Government Accountability Office and the Institute of Medicine have observed that when inpatient beds are scarce (as they frequently are), elective cases almost always get priority for bed placement over emergency admissions.”

“Hospital administrators do this because elective admissions can be financially screened in advance, they generally pay higher margins, and accommodating them ensures that the physicians who admit them won’t switch their allegiance to a competing hospital. It is far easier and less financial damaging [under the requirements of EMTALA] to divert inbound ambulances,” he writes.

Pines writes that the practice whereby hospitals reserve bed space for patients undergoing elective treatments and not for the unexpected admission(s) from the ED “varies from hospital to hospital, but in general hospitals do not reserve rooms for ED patients in advance and they do reserve beds for elective patients.”

Boarding occurs, he suggests, when the number of patients who need to be admitted exceeds that hospital’s bed capacity.

“Because elective patients have their spots ‘reserved’ in advance, ED patients are the ones that experience the ‘boarding’ and are exposed to the potential for negative outcomes,” he writes.

“The real ethical question is whether it is uneth-

ical to continue to admit elective cases when there is a hazardous situation in the ED. I would argue that this is unethical, but hospitals may resist cancel[ing] elective admissions because these often result in higher payments. In addition, having an elective admission canceled would probably be inconvenient for the elective patient, and the time-sensitivity of their procedure would need to be carefully considered,” Pines writes.

Second in Kellerman’s reasoning for why this problem exists is ignorance. He writes, “Many hospital administrators approach crowding with the same alacrity Sergeant Schultz (a fictional character from the 1960s TV comedy *Hogan’s Heroes*) approached guard duty. They hear, see, and know nothing. And government regulators let them get away with it.”

He notes in the editorial that “U.S. hospitals still aren’t required to publicly report ED throughput times, ambulance diversions, or the number of patients who leave the ED without being seen.”

Third: acculturation. ED physicians, he suggests, have “become gradually acclimatized to accept conditions that were once unacceptable. Thirty years ago, who among us would have envisioned diverting an ambulance carrying a critically ill patient? Today, the practice is commonplace.”

Treating patients in a waiting room

As to whether treatment in an ED waiting room would constitute the unethical practice of medicine, Pines writes, “That depends. If there is a critical surge of patients, and an ED that is usually well-run is overwhelmed, then it is unethical to leave patients in the waiting room for long periods.

“What is unethical is for hospitals to create a regular situation where ED patients must be treated in the waiting room as part of regular ED operations,” Pines writes.

Possible solutions

Asked what it will take to create a solution to the overcrowding dilemma and whether it requires some sort of pushback or revolt from ED health care providers, Kellerman tells *MEA*, “I don’t know that there will ever be a limit to what physicians and nurses in ERs are willing to try to do to take care of the patients in front of them.”

Kellerman recalled standing up at an Institute of Medicine annual meeting a few years ago and directing a question to a former Secretary of the

U.S. Department of Health and Human Services, essentially asking if this individual thought “it was a good idea to push a group of health care providers to the point of exhaustion every day and every night in order to get the health care system through another 24 hours. And the individual responded by saying, ‘I don’t think it’s appropriate for you to urge that health care providers go on strike.’”

One approach that has been endorsed by the American College of Emergency Physicians is “quite simple,” Kellerman says.

“It just says if you don’t have enough beds in the hospital, and you’re boarding admitted, sick, and injured patients, who clearly are so ill that they require hospitalization in the hallways of your ER, that [it] is both more humane, safer, and more responsible to distribute that burden evenly through the hospital, which means, by definition, putting one or two patients under the nursing station in the hallway of an inpatient unit,” he explains.

Pines suggests changes in the “fundamental way that hospitals function.”

“The first and most effective way to reduce boarding,” he writes, “is to reduce the variability in elective admissions. This is also called ‘surgical smoothing.’”

“Instead of operating on Monday to Thursday and then having few operations Friday and none on the weekend, some hospitals have moved to having a similar number of procedures throughout the week, including the weekends. Or, alternatively, pushing some elective cases to the weekends. What this does is to reduce the incidence of peaks in demand that are a major cause of ED boarding.”

Kellerman tells *MEA* that it is up to HHS to determine solutions to this problem. For example, CMS, he says, is currently “considering adopting additional measures to begin to understand what’s going on. There are some analyses in progress now that will allow one to look at a broad national picture. And there have been a handful of hospitals that have had the courage to study these issues within the walls of their facility.”

“It would be one thing to complain about an unsolvable problem,” Kellerman explains. “The fact is there are ready, current, effective strategies and solutions.”

He says it will take a “collective awareness that this is compromising everyone’s care, not just the poor, not just the minorities, and not just the

uninsured. But, in fact, this is truly a nationwide problem.”

“And second, and perhaps . . . the lever for this is going to be when people realize that you can’t possibly be prepared for a disaster or a national emergency if the critical hospitals in your community can’t even handle tonight’s 911 calls — and that light is starting to come on,” he says.

REFERENCE

Kellerman AL, “Waiting Room Medicine: Has It Really Come to This? *Annals of Emergency Medicine*. Doi:10.1016/j.annemergmed.2010.05.038.

SOURCES

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Cardiac devices present EOL decisions

Ethics principles are similar to ventilators

In recent years, cardiac devices have become a factor in end-of-life decision-making for ethics consultants. When do you turn off a cardiac device that may keep a patient alive after, for example, the patient has become comatose?

Elwood H. “Woody” Spackman, Jr., MDiv, director of the Emory Center for Pastoral Services and co-chair of the Emory Hospital Ethics Committee in Atlanta, says only in the last two or three years has he encountered this dilemma in ethics consultations. And with a burgeoning aging population, such encounters — and the accompanying decision-making — are only likely to increase.

Pacemakers have been around for many years, but the battery life for a pacemaker is short, so there were natural points at which to make EOL and other decisions with those particular cardiac devices, Spackman says.

One of the newer cardiac devices is the left ventricular assist device, or LVAD. LVADs once were used only as a bridge intervention to help patients who were waiting on a heart transplant to survive.

However, now heart patients are living with such devices for months or even years.

The decision-making process — and the associated ethics principles — are similar to the decisions made to remove patients from a ventilator, Spackman says.

One basic ethics principle is to do no harm, but the question becomes, “When do you cross the line from doing good to doing harm?”

Spackman gives the example of a patient with a defibrillator as well as metastatic cancer.

“So, you can keep the heart going almost indefinitely with the defibrillator; but you can’t treat the cancer — for some reason the cancer is untreatable . . . At what point does keeping this person alive — or a heart beating rather than alive — cross the line to doing harm? You’re keeping the body functioning while they’re enduring pain; they may be comatose; they may be in a persistent vegetative state, and is that doing more harm than it is good? [The situation is] not a whole lot different than what you were dealing with in the [Karen] Schiavo [case] and the feeding tube,” Spackman tells *Medical Ethics Advisor*. “It’s very similar.”

For example, with ventilators, “you take a person off a ventilator when it no longer has the potential for restoring a person to a quality of life that they would deem acceptable, or when it becomes medically futile . . . [i.e.] the ventilator is keeping the lungs pumping, but it’s not curing — it doesn’t give you the possibility for curing the underlying disease.

Decision-making process

In cases such as this, as with many EOL circumstances, the physician — along with the family — has to ask basic questions, beginning with an analysis of all the medical facts.

“What do we know factually about the condition of this individual? Then, we at what this person’s express wishes, or their autonomous wishes, would be,” Spackman says “The second thing we look at [is], what do we know about the values of this person’s life? Has he or she ever expressed what he would want if this should happen to him? Is there a living will? Is there a durable power of attorney for health care? . . . Was this a person of faith? Was this person a person of values? . . . Then you look at the third thing . . . What has been expressed in a living will, durable power of attorney, those dinner kind of conversations?”

Then, Spackman says, “you try to define what is

the ethical principle, and we use a conflict between four principles: beneficence, non-beneficence, autonomy, and justice.”

Justice issues significant

Justice concerns can become thorny with EOL issues associated with cardiac devices, just as they might with a resource such as a ventilator.

“If you’re talking about somebody who is, say, in a coma in an ICU bed with no reasonable hope for recovery, and then you have 10 people in your emergency department that need that ICU bed [and who] could have a reasonable hope of recovery, but can’t get there because you’ve locked down that bed,” Spackman explains. “It’s a resource issue.”

Financial issues come into play, too.

“In terms of an LVAD, what we have struggled with is, who pays for it? Many insurances, including Medicare and Medicaid, will pay for the device itself and the implantation of that, but will not pay for the maintenance, drugs, [i.e.] anti-rejection medications that are required, or the batteries. And you’ve got an uninsured patient.”

The question becomes: does the hospital absorb that cost?

“Those are the kinds of justice issues that we’re facing, because the country at large has not decided everybody is entitled to all health care just because it’s available,” Spackman says.

SOURCE

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Palliative care team, CMs help patients

Approach can decrease LOS, patient throughput

When Integris Baptist Medical Center in Oklahoma City began looking at implementing palliative care and end-of-life services, the case management department was the appropriate place to start, says **Anita Bell**, RN, MED CHPN, palliative care coordinator at the 508-bed facility.

“There are so many similarities between palliative care and case management. Hospital case managers

are constantly challenged to decrease the utilization of hospital resources and length of stay while maintaining quality care. Studies have shown that palliative care can decrease the cost of hospitalization and improve a patient's quality of life by advocating for care in the most appropriate setting," Bell says.

In addition to Bell, the palliative care team includes a chaplain, the medical director, a social worker, a pharmacist, and a nurse who does healing touch.

"We've done some research, and healing touch has been able to show a decrease in pain and anxiety," Bell says.

The team is assisted by volunteers who handle data entry and make comfort care shawls that the palliative care team or nurse give to patients or family members, depending on the situation.

Case managers can see the big picture within the hospital and often are the first clinicians who identify patients who might benefit from palliative care services, Bell says.

"Because of the case managers' focus on setting goals with the family, educating them, and looking at their discharge needs, they are instrumental in making sure we meet with patients and families who need palliative care services," she adds.

Palliative care and case management have mutual goals: decreasing length of stay and ensuring that patients receive the care they need at the right place in the continuum, Bell says.

"Many times when patients have problems with pain or symptom management, they have a longer length of stay as the hospital staff try to get the problem under control. Palliative care helps with pain and symptom management, which can improve patient throughput and length of stay in the hospital," Bell says.

Case managers often call in the palliative care team for help in working with patients and family members to understand their options and to set goals of care for the patient, she adds.

"The case managers will say to me that the physicians have talked to the patient and family but they need more help understanding how ill the patient is and options for care. The palliative care team can go in with the doctor's permission and help educate the family and support them as they make choices," she says.

Patients who could benefit from a palliative care consultation often are identified during discharge planning rounds, says **Suzanne Creekmore, RN, CCM**, case manager for the med/surg intensive care unit and the intermediate care unit.

The discharge planning rounds in the ICU are attended by the case manager, the social worker, the nurse taking care of the patient, the chaplain, the ICU clinical director, the palliative care coordinator, and representatives from dietary, pharmacy, and other disciplines and departments if needed.

The team goes through each patient, one by one, starting with the diagnosis, the family support, and the goals for the day, along with individual details such as use of pain medication, ventilator length of stay, psychosocial or family issues.

The team discusses the plan of care and the discharge plan and looks at options if the patient isn't able to go home.

For instance, if a patient has a stroke, is not responding, and isn't likely to recover, the team may call Bell in to help the family through the grieving process.

Bell also may be called in if patients have a lot of pain that isn't being controlled with IV pain medication.

"We want to help the patients have better control of their pain for whatever time they have left, whether it's a matter of months or years. Some patients aren't ready for hospice and want to keep treatment going, but their quality of life will be better if their pain is under control," Creekmore says.

The case managers often call for a palliative care consultation for people who have chronic diseases, such as chronic obstructive pulmonary disorder, who are not necessarily at the end of the life but are getting worse. In those cases, Bell helps them get advance directives in place before they get really sick, Creekmore says.

"We want to bring the palliative care team in as early as possible to help educate the patient and family members of their options for palliative care and comfort care. Our goal is to get the process started sooner so we can help the patient and family make the appropriate choices at the appropriate time," Creekmore says.

Bell gives the unit an extra set of eyes to help determine the best discharge plan for the patient, Creekmore says.

"Her expertise can help us determine if it would be appropriate for us to discharge the patient to hospice or if he should stay in the hospital and receive hospice care here. She helps us determine how best to approach the family and comfort them," Creekmore says.

When a physician orders a palliative care consult, the case manager and the social worker on the unit accompany Bell as she visits with the patient

and family members.

But once Bell gets involved, Creekmore limits her visits with the family.

“If too many people are involved in an emotional situation, it gets to be too much for the family. Once Anita takes over, I back off and go in and talk to the family every day,” she says.

When she is called in on a consultation, Bell works with the chaplain, the social worker, the case manager, and physicians to look at pain and symptom management, develop goals of care, help the family do advance care planning, and to support the patient and family if they decide to withdraw lifesaving treatment, move to hospice care, or continue aggressive treatment.

The team can call on a palliative care-certified physician who can meet with patients and help them understand their options.

“When people are in the ICU, so many things are being done for them. The case managers often hear that the patient never wanted that. They call the palliative care team in to talk with the family and clarify the goal of care and what the person wanted,” Bell says.

In addition to Bell and the palliative care team, the hospital established the position of palliative care resource nurse on most of the units.

The nurses have other nursing duties but have participated in training on palliative care, keep up with current literature on the subject, and know what resources are available.

The palliative care resource nurses are an added level of expertise on the unit level and are able to identify patients who have more complex needs than what the regular staff can provide and who could benefit from a palliative care consultation, Bell says.

“When families are struggling with trying to make decisions, the palliative care resource nurse knows where to find the information they need. They have a higher training and competency than the rest of the staff. If the family needs more help, they may ask the doctor to ask for a palliative care consultation,” she says.

Before establishing the palliative care program, the administration at Integris Baptist researched how the services are provided at other hospitals.

The palliative care process was developed by a committee that included Bell, the case manager director at the time, the director of hospice, and the palliative care medical director, all of whom attended a conference to get ideas for the structures and processes that would work best at Integris Baptist.

“We decided on an approach that embeds palli-

ative care into our culture. We have palliative care resource nurses on most of the units who work along with the palliative care team,” Bell says.

The team held in-service education sessions for the hospital’s clinical staff and developed written material to educate the staff about palliative care.

In the beginning of the program, Bell worked with the case management team to help them understand how palliative care could be helpful to their patients so they could help inform other members of the treatment team about palliative care and how to identify patients and family members who could benefit from a consultation.

The hospital established a palliative care steering committee to keep the process moving forward. The committee includes the palliative care coordinator, representatives from cardiovascular medicine service, the emergency department, the critical care and neurosciences services, chaplaincy services, pharmacy, social services, hospital medicine services, the ethics committee, and the cancer committee.

Before there was a formal process, most of the family consultations on palliative care and end-of-life issues were done by the social worker or the hospice team was called in, Creekmore says.

“The palliative care team is a wonderful resource that can supplement communication and education provided by the treatment team and help the patients and family members understand their options. Health care is so fragmented and patients and families are often overwhelmed with the disease process. All of us want to relieve suffering and improve the quality of life for our patients and family members,” Creekmore adds.

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Working as team boosts community engagement

IRBs can't do it alone

While considering the “community” in community-engaged research may add new issues for IRBs to consider, they’re not in this job alone.

Lainie Freedman Ross, MD, PhD, a professor of clinical medical ethics at the University of Chicago,

says that the nine key functions of human subjects protection are ideally performed by a team of players that includes representatives from the community.

Among them: Investigators, conflict of interest committees, research ethics consultation programs, research subject advocacy programs, data safety monitoring plans (and committees, in some cases) and community advisory boards (CABs).

In a paper published recently in the *Journal of Empirical Research on Human Research Ethics*, Ross and her colleagues delineate the potential roles of all of these groups in ensuring protection of both individuals and communities.

Recommendations specifically for IRBs reviewing community-engaged research include:

- **Minimizing risk** — IRBs can work with CABs to help determine whether a formal data safety monitoring plan is necessary and whether there should be explicit stopping rules.

- **Determining the risk-to-benefit ratio** — Here, the IRB's role is key, although it may consult with other entities, including the CAB, to identify potential risks and benefits, especially to the community. IRBs should revisit this issue on continuing review to make sure emerging risks are identified.

- **Fair selection of subjects** — IRBs can work with CABs to ensure that their perspective is included on this issue. They also help determine whether vulnerable groups should be included, based on potential benefits to those groups.

- **Informed consent, training of research personnel** — In addition to its mandated role of ensuring all required elements of informed consent are present, the IRB can mandate human subjects protection training for any research personnel.

Ross says proper training is especially important in studies that enlist community volunteers to recruit their neighbors. She says one unresolved issue is who should be responsible for monitoring the process to make sure that consent is voluntary and informed.

“IRBs are not required to monitor consent, but from a broader human subjects protection standpoint, we really need to be thinking about how we monitor the things we're asking for,” she says. “When we take this into the community and we train lay people to get consent from their peers, whose responsibility is it to monitor and insure that risks and benefits and alternatives are being clearly articulated?”

- **Data monitoring** — While fulfilling its normal role in reviewing adverse events, the IRB should also consider in its continuing review whether the risk-benefit ratio has changed.

- **Privacy and confidentiality** — As in all research it reviews, the IRB must ensure there are sufficient safeguards of participants' privacy and that the data is secure. In community research, it's important that community members who aid in data collection be trained so that they understand privacy and confidentiality issues.

- **Conflicts of interest** — IRBs should insist on a conflict-of-interest management plan to oversee any reported conflicts. They should be aware that these conflicts may apply to both researchers and to the community partners.

- **Vulnerable populations** — IRB should consider whether the community partner involved in a proposed study is accurately representing those of its members who may be in vulnerable populations.

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SHEA: Time to mandate flu shots for HCWs

‘The evidence is irrefutable’

Influenza vaccination of healthcare personnel is a professional and ethical responsibility and non-compliance with healthcare facility policies regarding vaccination should not be tolerated, argues the Society for Healthcare Epidemiology of America (SHEA).

While the issue touches on a complex intersection of individual rights and public safety, all evidence and ethics point to a moral imperative. Protect frail patients by immunizing yourself against a common seasonal infection, says Neil Fishman, MD, president of SHEA. The SHEA panel included a bioethicist, he adds.¹

“To me personally, and to a lot of the people involved on the task force, it really came down to ethics,” Fishman says. “We believe that when people make the decision to enter the health care profession, that carries a professional and ethical responsibility to prevent the spread of infections to patients. It is an ethical responsibility to make certain that your patients don't get influenza. The ethics of our profession override all of our

issues.”

Thus, the paper goes beyond the current recommendations by the Centers for Disease Control and Prevention (CDC), which call for the use of voluntary strategies that include having workers who turn down vaccine sign off on declination statements. Such strategies, which include making the vaccine free and convenient to receive, have reached a point of diminishing returns at many facilities.

“The overall experience has seen very modest improvements in vaccination rates,” Fishman says. “There are some institutions — some scattered examples that have had a greater success — but the overall national vaccination rates of health care personnel still hover in the 40% range.”

Mounting evidence

The SHEA position paper comes as healthcare personnel and facilities prepare for the upcoming 2010 flu season, and on the heels of the pandemic of H1N1 influenza A. “To be honest, that was not the reason for coming out with this now,” he says. “The impetus for producing this position paper was that we felt the level of evidence supporting mandatory vaccination was adequate to lead to the statement.”

Indeed, the SHEA paper cites several studies since its last flu statement in 2005.²⁻⁴

“The evidence itself is irrefutable,” Fishman says. “Influenza immunization should be mandatory for health care personnel.”

The paper was endorsed by the Infectious Diseases Society of America (IDSA), which agreed that influenza vaccination of healthcare personnel is a core patient safety practice that should be a condition of both initial and continued employment in healthcare facilities.

“The scientific evidence shows significant reductions in the risk of influenza in both acute and long-term care settings as a result of strong immunization policies and programs,” says **Richard Whitley**, MD, president of IDSA. “Vaccination of healthcare personnel saves patients’ lives and reduces illness. It also protects the individual worker from falling ill during influenza outbreaks and from missing work, which further impacts patient care.”

According to SHEA, the recommendations apply to all healthcare professionals in all healthcare settings, regardless of whether the worker has direct patient contact or whether he or she

is directly employed by the facility. The policy also applies to students, volunteers, and contract workers. The only exemptions, say the epidemiologists and infectious disease physicians, should be in cases of medical contraindications.

There is a considerable gap between that ideal and current reality. According to a 2009 RAND Corporation survey, 39% of healthcare professionals stated they had no intention of getting vaccinated despite the heightened concern surrounding influenza with the H1N1 pandemic.

Unions may fight mandates

Mandates certainly increase the number of health care workers vaccinated, but critics say the tactic is unnecessarily punitive. Unions have successfully overturned mandates in some hospitals or health systems because they were not implemented through the collective bargaining process.

The American College of Occupational and Environmental Medicine (ACOEM) also has opposed mandatory influenza vaccination of health care workers, particularly since the effectiveness of the vaccine varies significantly as the prevailing strains change from year to year.

“Current evidence regarding the benefit of influenza vaccination in health care workers as a tool to protect patients is inadequate to override the worker’s autonomy to refuse vaccination,” ACOEM said in its position statement.

To **Bill Borwegen**, MPH, health and safety director of the Service Employees International Union (SEIU), the recent push for mandatory vaccination policies represents skewed priorities. The CDC recently proposed revised guidelines that recommend the use of face masks rather than N95 respirators for health care workers caring for patients with H1N1 influenza.

“The imbalance of protection is really startling,” he says. “We won’t give a health care worker a 50-cent, fitted N95 respirator when they go into a room with a coughing patient with suspected or confirmed H1N1.”

Yet the CDC has stated that the H1N1 vaccine was just 62% effective, he notes. “If the vaccine was effective, we could maybe make the argument that this [mandatory policy] made sense,” he says. “To fire people for not getting a vaccine that’s not all that effective, it’s just massive overreach.”

Meanwhile federal health authorities are taking the first tentative steps toward considering a recommendation on mandatory influenza immuni-

zation of health care workers. Assistant Secretary of Health Howard Koh has asked the National Vaccine Advisory Committee (NVAC), an advisory panel of public health experts, to look into the issue. Current federal vaccine guidelines don't address vaccination mandates. Such requirements, even for school children, are typically set at the state or local level.

The SHEA position paper is available at: <http://www.shea-online.org/>

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Experts recommend newborn screening

The Endocrine Society has released a new clinical practice guideline on the diagnosis and treatment of congenital adrenal hyperplasia (CAH). The guideline features a series of evidence-based clinical recommendations developed by an expert task force.

The guideline, published in the September 2010 issue of the *Journal of Clinical Endocrinology & Metabolism* (JCEM), a publication of The Endocrine Society, is endorsed by the American Academy of Pediatrics, Pediatric Endocrine

Society, the European Society for Paediatric Endocrinology, the European Society of Endocrinology, the Society for Pediatric Urology, among others.

CAH is a genetic disorder of the adrenal glands that affects about one in 10,000 to 20,000 newborns, both male and female. The adrenal glands make the steroid hormones cortisol, aldosterone, and androgens. In individuals with CAH, the adrenal glands produce an imbalance of these hormones, which can result in ambiguous genitalia in newborn females, infertility, and the development of masculine features, such as development of pubic hair and rapid growth in both boys and girls before the expected age of puberty.

“If CAH is not recognized and treated, both girls and boys undergo rapid postnatal growth and early sexual development, or in more severe cases, neonatal salt loss and death,” said Phyllis Speiser, MD, of Cohen Children’s Medical Center of New York and Hofstra University School of Medicine, and chair of the task force that developed the guideline. “We recommend that every newborn be screened for CAH and that positive results be followed up with confirmatory tests.”

“People with classic CAH should have a team of health care providers, including specialists in pediatric endocrinology, pediatric urologic surgery (for girls), psychology and genetics,” said Speiser. “Other than having to take daily medication, people with classic CAH can have a normal life.” ■

Bazon Center lauds GA/U.S. Justice agreement

The Bazon Center for Mental Health Law voiced its support for the U.S. Department of Justice and the State of Georgia for reaching agreement in a lawsuit aimed at moving people in Georgia who have mental disabilities out of “harmful state institutions and serving them instead in the community.”

“While not a panacea, this agreement takes the first step to ensuring that Georgians are afforded mental health services that are fully integrated into the community, as the *Olmstead* Supreme Court decision and the Americans with Disabilities Act demand,” said Robert Bernstein, PhD, executive director of the Bazon Center, in a news release

from the center.

The center represents a coalition of stakeholders that has advised the federal district court in the case, known as *United States v. Georgia*. ■

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

■ The ethics of neuroimaging

■ Financial incentives for living organ donors

■ Physician responsibilities when the family wants everything done for their loved one

■ Jewish medical ethics and EOL care

CME QUESTIONS

17. Jesse Pines, MD, MBA, of George Washington University defines ED boarding as beginning at the time a patient walks in the door of the emergency room.

- A. True
- B. False

18. Arthur Kellerman, MD, MPH, senior researcher at the Rand Corporation, suggests which of the following is a potential factor as to why ED crowding persists:

- A. Economics
- B. Ignorance
- C. Acculturation
- D. All of the above

19. Elwood H. "Woody" Spackman Jr., co-chair of the Emory Hospital Ethics Committee says the dilemma of end-of-life decision-making with patients who have cardiac devices is similar to the principles considered when removing a patient from a ventilator.

- A. True
- B. False

Answers: 17. B; 18. D; 19. A

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United States Postal Service Statement of Ownership, Management, and Circulation

1. Publication Title Medical Ethics Advisor		2. Publication No. D B B 6 - 0 6 5 2		3. Filing Date 10/01/10	
4. Issue Frequency Monthly		5. Number of Issues Published Annually 12		6. Annual Subscription Price \$499.00	
7. Complete Mailing Address of Known Office of Publication (Street, city, county, state, and ZIP+4) 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305				Contact Person Robin Sallet Telephone 404/262-5489	
8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not Printer) AHC Media LLC, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305					

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do Not Leave Empty)

Publisher (Name and Complete Mailing Address)
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12. Tax Status (For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)
 Has not changed during preceding 12 months.
 Has changed during preceding 12 months. (Publisher must submit explanation of change with this statement.)

PS Form 3526, September 1999 See Instructions on Reverse

13. Publication Name: **Medical Ethics Advisor** 14. Issue Date for Circulation Data Below: **September 2010**

15. Subject and Nature of Circulation		Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
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Percent Paid and/or Requested Circulation (15b divided by 15g times 100)		73%	59%

16. Publication of Statement of Ownership required. Will be printed in the **November 2010** issue of this publication. Publication not required.

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