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What to do when kids say no — laws cloudy when minors refuse treatment

Massachusetts court case stirs age-old debate back to surface

Should minors be afforded the same rights to refuse care as adults if it is certain they understand the decisions they are making? At what age should minors be considered old enough to make these choices? What, if any, power should physicians or family members have to override their decisions?

A recent court case in Massachusetts raised many of these questions again, but unfortunately elicited few answers.

In January, a state Superior Court there issued an injunction permitting physicians to perform a blood transfusion, if necessary, on a 17-year-old Jehovah's Witness without her consent.

The hospital had sued to allow the transfusion on the grounds that it was in the patient's "best interests and the interest of the State in preserving life and the protection of a minor." The hospital's attorneys contended that the law was clear that an adult could refuse treatment, but not clear that a minor could do so.

In that case, known as the Rena case, the patient recovered without requiring the transfusion, and a higher court vacated the injunction on appeal because the issue was moot.¹

This decision again left physicians and patients without clear guidance on what to do when a minor refuses treatment, say many ethics experts.

EXECUTIVE SUMMARY

A recent court case in Massachusetts brought to light old questions concerning minors and the right to refuse care but offered few new answers.

In January, a state Superior Court there issued an injunction permitting physicians to perform a blood transfusion, if necessary, on a 17-year-old Jehovah's Witness without her consent.

The hospital had sued to allow the transfusion on the grounds that it was in the patient's best interests and the interest of the State in preserving life and the protection of a minor.

The hospital's attorneys contended that the law was clear that an adult could refuse treatment, but not clear that a minor could do so.

CME

questions

1. A recent court case in Massachusetts raised many of these questions regarding consent and minors, but elicited few answers. The case, according to Rev. John Paris, SJ, Walsh Professor of Bioethics at Boston College in Boston, hinges on:
 - A. The information provided to the parents.
 - B. The concept of "mature minors."
 - C. Documentation that consent was obtained.
 - D. All of the above
2. When evaluating a particular minor patient's request, weight must be given to several factors, says Rosalind Ekman Ladd, professor in the department of philosophy at Wheaton College in Norton, MA:
 - A. The age and maturity of the child or adolescent.
 - B. The medical prognosis and the perceived benefit of treatment.
 - C. Whether or not the minor's decision is made without coercion.
 - D. All of the above.
3. A recent report published by the Centers for Disease Control and Prevention in Atlanta comparing incidence rates of diabetes among Hispanic Americans vs. Caucasian Americans indicates, according to Frank Vinicor, director of the CDC's Division of Diabetes Translation:
 - A. The necessity for comprehensive screenings for diabetes.
 - B. A need to shift the focus of major diabetes education and treatment to specific patient groups.
 - C. Legislation may be required to mandate broader education efforts among health care providers.
 - D. All of the above.
4. The challenge facing health care providers, according to Robert Stone, executive vice president of Nashville, TN-based Diabetes Treatment Centers of America, lies in:
 - A. Encouraging patients to ask questions during counseling sessions.
 - B. Teaching patients how to read glucose monitors.
 - C. Eliminating both barriers to access to care and cultural barriers such as language and perception of disease.
 - D. All of the above.

"These are difficult cases; no one really wants to face this issue," says the Rev. **John Paris**, SJ, Walsh Professor of Bioethics at Boston College in Boston. "No one wants to say to a 16-year-old kid that he must continue chemotherapy because his parents want him to have it and he doesn't. But, what about a 5-year-old who doesn't want an inoculation? With them, you say, 'Hold still.'"

When are minors 'mature'?

The Rena case hinges on the concept of "mature minors," notes Paris, who has followed the case closely.

Laws in most states officially recognize only two classes of minors, emancipated minors and unemancipated minors.

Emancipated minors — those who are married, pregnant, or have a court declaration nullifying the rights of their parents — are legally able to make medical decisions for themselves.

"If you have a 13-year-old who is married and pregnant, she makes all of the decisions for herself and for the baby," explains Paris. "I have seen this in the [neonatal intensive care units], she is making decisions that, if she were not pregnant or a mother, someone else would have to make for her."

Courts and legislatures in some states also have recognized a limited right of young women to obtain birth control or an abortion without the consent of their parents, Paris adds.

"In this country we have put a lot of emphasis on autonomy, particularly for adults, but then it moves down [to autonomy for children]," he says. "It moved down primarily because of issues of birth control and abortion and whether minors could have these without their parents being notified. Some minors were accorded a special status because of these issues."

The expansion of this autonomy for some minors has raised the question of what rights all minors should have, and when and under what circumstances they should be able to make their own medical decisions, says **Rosalind Ekman Ladd**, professor in the department of philosophy at Wheaton College in Norton, MA.

"Under the age of 15, you have a real question about competence. There are lots of assumptions about younger children not being competent psychologically and otherwise to make decisions for themselves," she says. "But, there is a lot of literature that disputes that. Many good psychological studies have been done that illustrate the kinds of

SOURCES

For more information on minors who refuse medical treatment, contact:

Rosalind Ekman Ladd, Department of Philosophy, Wheaton College, Norton, MA 02766.

John J. Paris, SJ, Walsh Professor of Bioethics, Boston College, Chestnut Hill, MA 02167.

things that children would choose for themselves and the kinds of reasons they give for those choices.”

Although not a legal designation in most states, many courts will recognize a physician’s determination that certain patients are “mature minors” as a rationale for allowing them to make some of their own medical decisions.

“There have been no court cases in which anyone has been prosecuted or held liable if they allowed a child over 15 to make a non-consent decision,” she points out. “But the determination depends on the circumstances and the patient.

Indeed, even though the court vacated the injunction in the *Rena* case as moot, the appellate judges did indicate that they felt the original judge should have first heard testimony from the patient herself, says Paris.

When evaluating a particular patient’s request,

weight must be given to several factors, say both Ladd and Paris: the age and maturity of the child or adolescent, the medical prognosis and the perceived benefit of treatment, and whether or not the child’s decision is made without coercion.

The most important consideration, believes Ladd, is the medical prognosis.

“We have had many cases that deal with whether someone might reasonably make the decision not to consent because there is no guarantee that the treatment is going to be successful,” she notes.

In cases where there is no clear-cut benefit to treatment, more weight should be given to a minor’s wish to refuse treatment, concurs Paris.

“In the *Rena* case, there was a clear indication that this was a low-risk procedure with clear and significant benefits to the patient,” he notes. “In other situations, for example, the case of a 13 year-old with cancer, in which all the normal courses had been pursued and the advised treatment was experimental and chances of a good outcome were not as well-known. I think the wishes of that 13 year-old should be listened to with great intensity.”

Reference

1. *Rena*, 46 Mass. App. Ct. 355 No. 99-P-199, Appeals Court of Massachusetts, Berkshire; Feb. 16, 1999. ■

In the eye of the beholder

Considering maturity at different ages

Rely on expert advice when determining the maturity and consent required for minors, say ethicists.

The National Commission on Bioethics in 1977 published a recommendation on consent of minors that has been well-accepted in the medical community, notes **Rosalind Ekman Ladd**, professor in the department of philosophy at Wheaton College in Norton, MA.

“For children under the age of 7, you should try to get assent,” she says. “That means trying to explain the treatment to them and get them to agree. And, the commission makes a distinction between treatment that is therapeutic and nontherapeutic. If the treatment is just for

research that is not going to benefit the child, then even the small child has a veto over participation. If it is something beneficial to them, they don’t have a veto, but you should try to get assent.”

Some ethicists agree that chronological age is unreliable as a determining factor for allowing refusal of consent to treatment.

“The moral guidance should be to always get the input of the child,” says the Rev. **John Paris**, SJ, Walsh Professor of Bioethics at Boston College in Boston. “If the child is older than 14 and able to well-articulate her ideas and beliefs, you should be exquisitely sensitive to those beliefs even though they are not necessarily going to be dispositive. You have to weigh it and judge it and assent it in the context of this family and this situation. Their values in conjunction with the medical assessment has to be a strong component.” ■

New cacophony erupts over cannabinoid

Does marijuana have a role in medical treatment?

The debate over medical marijuana flared up again with the publication of a long-awaited report from the Institute of Medicine (IOM) in Washington, DC. The report, titled *Marijuana and Medicine: Assessing the Science Base*, was commissioned by the White House Office of National Drug Control Policy.

The report backs claims from physicians and patients alike that for years have gone unheard — that marijuana does have a therapeutic value for several indications, including:

- pain relief;
- control of nausea and vomiting;
- appetite stimulation.

Patients with terminal illnesses or debilitating symptoms have lobbied for legalization of the drug citing effective pain relief. The report notes that for patients with severe AIDS or cancer symptoms, such as nausea, wasting, and lack of appetite, the drug has benefits that outweigh the risks.

Some states ahead of the game

Despite the controversy over the risks or benefits, several states passed legislation in 1998 allowing for the use of medical marijuana, but under regulated conditions. States that passed measures in 1998 were: Alaska, Arizona, Colorado, Nevada, Oregon, and Washington. California was the first state to pass a measure legalizing the use of medical marijuana in 1996, but federal authorities have successfully prevented the law from being implemented. (See news brief on the most recent state to legalize marijuana, p. 46.)

The recent passage of bills in several states has increased pressure on the U.S. Food and Drug Administration in Rockville, MD, to remove marijuana from the 'schedule one' list of most dangerous narcotics.

The report did mention existing concerns over the use of marijuana, namely the method of administration and its potential addictive qualities. While the report notes that the practice of smoking the drug is medically dangerous and could cause respiratory disease, it states that "smoked marijuana should not generally be

recommended for long-term medical use." The report later states, however, that "the long-term risks are not of great concern."

Despite opponents who argue that the drug would become addictive, the investigators found that marijuana was not particularly addictive and did not act as a 'gateway' drug to the use of harder drugs, such as heroin.

President Clinton's anti-drug 'czar,' Barry McCaffrey, ordered the report in 1997. McCaffrey is an outspoken opponent of relaxing anti-marijuana laws. The Office of National Drug Control Policy called for more research, but added, "We will carefully study the recommendations and conclusions contained in this report" in a statement.

Sidestepping the politics

Researchers reinforced throughout the report — in an effort to sidestep the political issue — that the brief was to assess the effectiveness of 'cannabinoid' drugs such as THC. THC is marijuana's main active element. Researchers instead call for the development of standardized forms of the drug that could be taken using an inhaler. Development of an inhaler could take several years, researchers noted.

"Marijuana has potential as medicine, but it is undermined by the fact that patients must inhale harmful smoke," says **Stanley Watson Jr.** of the Mental Health Research Institute at the University of Michigan in Ann Arbor, one of the study's investigators.

So far, the only FDA-approved synthetic cannabinoid is Marinol, manufactured by Roxane Laboratories in Columbus, OH. Proponents of the synthetic drugs argue, however, that the raw plant is more effective.

Supporters of medical marijuana claim victory from the results of the IOM report. **Bill Zimmerman**, director of the Los Angeles-based Americans for Medical Rights, the sponsor of the 1998 states' marijuana initiatives, says the findings will radically alter the public image of what has long been a 'demon drug' in the United States.

"They are in effect saying that most of what the government has told us about marijuana is false . . . it's not addictive, it's not a gateway to heroin and cocaine, it has legitimate medical use, and it's not as dangerous as common drugs like Prozac and Viagra," says Zimmerman. "This is about as positive as you can get."

[Editor's note: The complete volume of *Marijuana and Medicine: Assessing the Science Base* is available for sale from the National Academy Press, 2101 Constitution Ave., N.W., Lock Box 285, Washington, DC 20055. Telephone: (800) 624-6242 or (202) 334-3313. World Wide Web bookstore: www.nap.edu.] ■

Diabetes prevention should include minorities

Shift in focus should offer tailor-made treatment

Atroubling trend is forcing many providers — and ultimately ethicists — to determine how to reach patient groups most affected by diseases with severe complications.

Minorities bear a disproportionate share of chronic disease in American society. Health care professionals know that most of these diseases are treatable and manageable, but they have yet to find a way to get more people at the highest risk to comply with a more health-conscious lifestyle.

Hispanic Americans, for example, are currently diagnosed with diabetes at twice the rate of white Americans, with 6% of Hispanic adults in the United States and Puerto Rico having been diagnosed with the disease, according to a report released Jan. 15 by the Centers for Disease Control and Prevention (CDC) in Atlanta.

The data indicate a need to shift the focus of major diabetes education and treatment initiatives and to offer diabetes education that is tailored to specific patient groups, says **Frank Vinicor**, director of the CDC's Division of Diabetes Translation.

For hospital ethics committees, that could mean ensuring that your diabetes education efforts are reaching all patient groups within the community.

"Diabetes is a serious disease affecting 16 million people in this country. These data tell us that efforts to reduce the burden of diabetes must focus on people who are disproportionately affected," he notes in a statement following the report's release.

The CDC study included nationwide data from 1994 through 1997 and is the first to show diabetes

prevalence among all Hispanics in the United States and Puerto Rico. Most previous studies had focused solely on Mexican Americans. **(For a breakdown of diabetes by race, see the chart, p. 42.)**

The new study also found that the prevalence of diabetes among Hispanics increases with age: approximately 2.3% of Hispanics between ages 18-44 have been diagnosed with diabetes; vs. 12% of those ages 45-64; and 21.4% of those ages 65 and older.

Although the study found that 6% of Hispanic adults were currently diagnosed with diabetes, the authors estimate that another 6% may have the disease and not be aware of it.

Education must take culture into account

The new data are merely reinforcing what many experts have known for some time, says **Robert Stone**, executive vice president of Nashville, TN-based Diabetes Treatment Centers of America, a company that contracts with hospitals and health plans to operate and design diabetes treatment and prevention programs and to offer disease management services.

"We have always known that the ethnic minority populations — black, Hispanic, American Indian, Pacific Islanders — have disproportionately high representation in the diabetes population as a percent of that ethnic population," says Stone. **(For a breakdown on the rate of amputations among three ethnic groups with diabetes, see the chart, p. 43.)**

The challenge, he contends, is eliminating both barriers to access to care and cultural barriers such as language and perception of disease.

"With very urban, inner-city populations, a large issue is access to care or access to insurance for care," he says. "But, in some cases, cultural identities present some different issues in terms of helping physicians and patients effectively deal with managing diabetes."

(For more on eliminating racial and ethnic disparities in care, see the related story, p. 43.)

For example, Diabetes Treatment Centers has, over several years, translated its educational material into Spanish three separate times.

"The reason for that is we have centers in southern California, where you have Mexican Spanish spoken or Chicano Spanish, centers in Texas where Mexican Spanish is spoken, and centers in Florida where the Spanish is Cuban," he notes.

"It's still Spanish, but it's different. The way

DIABETES BY RACE in people 20 years or older*

| | Number | Percentage of population | Likelihood compared to whites |
|--|--------------------|--------------------------|-------------------------------|
| Non-Hispanic Whites | 11.3 million | 7.8% | |
| African Americans | 2.3 million | 10.8% | 1.7 |
| Mexican Americans | 1.2 million | 10.6% | 1.9 |
| Other Hispanics** | 1.8 million | 8.0% | 2.0 |
| Native Americans and Alaska Natives | Data not available | 12.2% | 2.8*** |
| Asian Americans and Pacific Islanders | Data not available | | 2.0 (estimated) |

* These figures do not include the approximately 123,000 cases of diabetes in children and teen-agers in the United States.

** Estimated

*** About 50% of the members of the Pima tribe in Arizona between the ages of 3 and 64 have diabetes.

Sources: Centers for Disease Control and Prevention, Atlanta; and American Diabetes Association, Alexandria, VA.

you phrase things, the words you actually use, need to be translated by someone who is familiar with that particular region and type of Spanish, so that you don't find yourself saying anything particularly inconsiderate, or incomprehensible," explains Stone.

Dietary advice must be culturally specific

Care must also be taken to offer a diet that is sensitive to a particular population's traditions, says Stone. "I don't like to make generalizations. But, for the most part, the Hispanic population in south Florida eats differently from the white population, and the Hispanic population in Texas, and the Hispanic population in California."

You cannot give diabetics of a certain population a strict diet that they will have a very difficult time following, says Stone. "You can't just say, 'Have a salad, instead.' Because they won't eat that way. You have to tailor your diet recommendations to their cultural reality."

For example, the American Dietetic Association and the American Diabetes Association offer a free brochure titled "Meal Planning with Mexican American Foods" that offers advice on converting traditional recipes to healthier alternatives, and offers alternative healthy recipes for chicken soup, refried beans, tortilla chips, and chilaquiles. (See list of resources on p. 44.)

For most of the minority populations, the most prevalent form of diabetes is diabetes mellitus type II, says Stone.

"One of the many issues with type II diabetes is it begins very slowly and, frequently — perhaps too frequently — it is diagnosed only as a result of some acute illness that may or may not be related to the diabetes," he emphasizes. "In the course of interacting with the patient to treat the acute condition, the physician discovers that the patient has diabetes, and the patient may have had the disease for years at that point."

If diabetes type II is detected early, it can be successfully managed and most of the most severe complications can be avoided. **(For more on ensuring all patients are screened for diabetes, see the related story, p. 44.)**

Hospitalization ideal time to screen

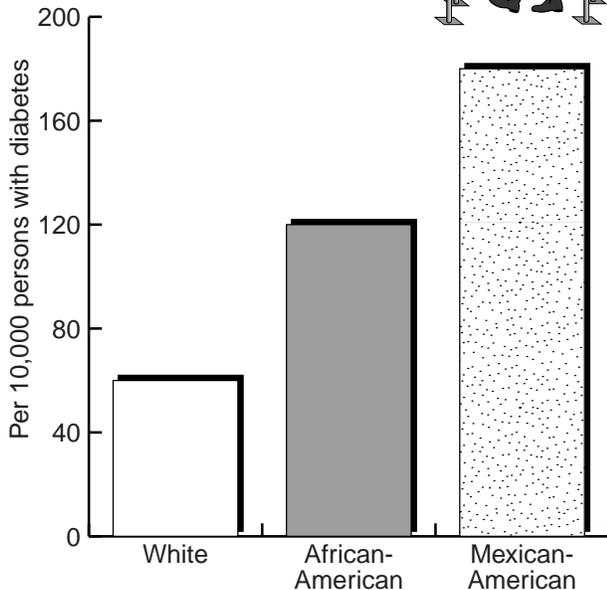
The CDC currently recommends active screening for any person over the age of 25 and Diabetes Treatment Centers of America has guidelines that recommend screening every admitted patient over the age of 18. **(For a breakdown of prevalence of diabetes among women, see the chart, p. 43.)**

"For our [hospital] clients, the patient already is in the medical system, and the cost of doing the additional screen would be a small to nonexistent incremental cost," Stone points out.

If institutions don't feel that they can bear that additional cost, then it would at least make sense for them to screen members of at-risk populations over the age of 18, he adds.

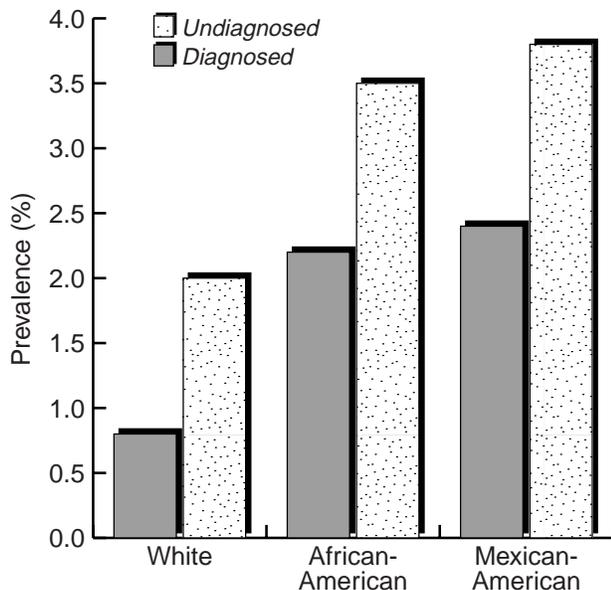
"The earlier you get the diabetic patient effectively self-managing their disease, the better

Amputations in People With Diabetes: Three Ethnic Groups



Source: National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD.

Prevalence of Diabetes: Women 20-44 Years Old



Source: National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD.

outcome of their health or quality of life, and the lower the ultimate cost for society.”

[Editor's note: Copies of the DTCA Inpatient Management Guidelines for People With Diabetes can be ordered from: Diabetes Treatment Centers of America, 1 Burton Hills Blvd., Suite 300, Nashville, TN 37215. Attention: Teresa Mabry. Fax: (615) 665-7697.] ■

Eliminating racial, ethnic disparities in health

Diabetes is one of six major areas covered under the Clinton administration's effort at eliminating racial and ethnic disparities in six major areas of health status by the year 2010. Just over a year ago, the U.S. Department of Health and Human Services (HHS) launched the effort, which targets inequalities in the areas of infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV infection, and child and adult immunizations.

The HHS action plan includes funding research in the area of racial and ethnic health disparities, expanding and improving existing programs to purchase or deliver quality health services, starting programs to reduce poverty and provide children with safe and healthy environments, and expansion of prevention programs.

\$10 million project planned

Through HHS, the Centers for Disease Control and Prevention will administer a \$10 million demonstration project that will test models for reducing disparities in specific minority populations. According to information published by HHS, the project will allow "multiple communities to design and test community-tailored interventions."

The National Institutes of Health's National Institute of Environmental Health Sciences (NIEHS) will sponsor a series of regional workshops in 1999, "Decreasing the Gap: Developing a Research Agenda on Socioeconomic Status, Environmental Exposures and Health Disparities."

The workshops, which have been scheduled for Baltimore, May 26-28 and July 7-9, in

Chicago, will be devoted to issues examining the relationships among poverty, pollution, and health status, and designed to generate ideas and stimulate discussion on research activities that will drive:

- the design of action plans to lessen the adverse health impact of hazardous environmental exposures on populations of low socioeconomic status;
- the development of research directions to enhance our understanding of how socioeconomic status and hazardous environmental exposures interact to contribute to disparities in health.

Environmental health researchers, community leaders, and health care providers are encouraged to take part. For more information, please see the NIEHS Web site at <http://www.niehs.nih.gov/dert/gap.htm> or contact conference coordinator Michelle Beckner at (703) 902-1269 or mbeckner@circsol.com.

For more information on the complete HHS initiative, visit the initiative's Web site at <http://raceandhealth.hhs.gov>. ■

RESOURCES

For more information about developing diabetes treatment programs for all patient groups, contact:

The **American Diabetes Association** has launched an educational initiative focused on Hispanic communities, Diabetes Assistance and Resources (DAR). The DAR program offers risk screening, referrals, community activities, education, and support. For more information, contact the American Diabetes Association at (800) DIABETES or (800) 342-2383.

American Diabetes Association, Diabetes Information Service Center, 1660 Duke St., Alexandria, VA. 22314.

American Dietetic Association, 216 W. Jackson Blvd., Chicago, IL 60606-6995. Telephone: (312) 899-0040.

National Coalition of Hispanic Health and Human Service Organizations, 1501 16th St. N.W., Washington, DC 20036. Telephone: (202) 387-5000.

Robert Stone, One Burton Hills Blvd., Suite 300, Nashville, TN 37215. Telephone: (615) 665-7760.

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1600 Clifton Road, MS D-25, Atlanta, GA 30333. Telephone: (877) CDC-DIAB. World Wide Web: <http://www.cdc.gov/diabetes>.

Watch out for diabetes in hospitalized patients

First-ever advice is offered to all comers

Diabetic patients are hospitalized more often, for longer periods of time, and at greater cost than patients without the disease.

But sometimes the fact that they have the disease is overlooked in the process, often to the detriment of patients and providers alike. Ethics committees can take a proactive approach, however, and ensure that all patients are treated fairly while in the hospital.

"It's a reality. When a diabetic patient enters the hospital for any reason, the focus on diabetes is frequently lost in the inpatient setting," says **Robert Stone**, MBA, executive vice president of the Diabetes Treatment Centers of America (DTCA) in Nashville, TN.

Stone's organization has devised guidelines to help improve outcomes for the 3 million patients with diabetes who are admitted to hospitals each year.

DTCA says diabetic patients make up:

- 15% of all hospital admissions;
- 20% of all hospital days;
- 20% of all hospital costs.

Diabetic patients have longer hospital stays

Diabetics spend two to three days longer in the hospital than nondiabetic patients with similar complaints and they consume 30% to 40% more resources than patients without diabetes, Stone says.

"In 95% of the cases, the admission has nothing to do with glycemic control. People with diabetes go to the hospital for the same reason everybody else does," Stone explains.

DTCA, a provider of diabetes education and management services to 69 customer hospitals in 29 states and contractor with HMOs covering 100,000 diabetic lives, provides something most hospitals don't have: a comprehensive plan for inpatient diabetic management.

"It's a huge need," Stone says. "It's never been done, but we knew when we started this about a year ago that we could help hospital and medical staffs identify issues that contribute to the extra stays and adverse outcomes."

So DTCA assembled a panel of primary care

physicians, specialists, and other health care professionals representing private practice, health plans and institutions to develop a set of guidelines for inpatient care.

The initial recommendations were reviewed by DTCA's scientific advisory council and a panel of faculty specialists at Vanderbilt University in Nashville.

Finally, in November 1998, DTCA convened a consensus conference of nearly 100 physicians and other health care professionals in Key Largo, FL, to modify and endorse the plans aimed at improving diabetic inpatient outcomes.

"Continued inattention to the unique needs of the inpatient with diabetes is both costly and professionally unacceptable," the panel wrote in a report released to *Medical Ethics Advisor*.

The panel noted that metabolic control of diabetes requires detailed attention to the patient's diet, activity, and medications in the outpatient and inpatient settings, but "too often physician orders or even a hospital's standing orders fail to take into account many aspects of the patients' pre-admission status and self-management regimen."

Diabetics 'underlying concern'

Whatever the condition that caused the admission, Stone points out, "Diabetes is an underlying concern. Our goal is to reduce costs by improving the health status of the diabetic population."

In simple terms, Stone says, hospital staffs should be able to discharge patients in better glycemic control and to avoid readmission for infections or other complications. The panel began with five goal recommendations:

- identification of all patients with diabetes;
- special needs of patients with diabetes are identified and addressed;
- improving outcomes by optimizing glycemic/metabolic control;
- raising the level of awareness of the health care team with respect to the unique challenges of diabetes and current standards of care;
- striving for a length of stay equal to that of a patient without diabetes.

The guidelines include a detailed baseline assessment to be performed upon admission by the physician, RN, LPN, CDE, and registered dietitian. It details protocol for identification, assessment and laboratory procedures and lists the health care professional who should be responsible for each step along the way and the

Health care Y2K reference resource

With the year 2000 deadline fast approaching, hospitals, other health care providers and the medical device industry are scrambling to complete a process that in many cases was started too late. What may have once been a logistical issue is burgeoning into an overwhelming problem, compounded by the scarcity of time, rising costs, and a lack of programming resources and expertise.

The health care industry has found itself under increased pressure as the realization dawns that it is behind the curve in preparing for Y2K. According to a recent Modern Healthcare/Pricewaterhouse Coopers survey, the biggest worry among 69% of health care providers is that patients will be "affected due to faulty monitoring gear," followed by concern over "inaccurate lab tests and pharmacy orders" (36%), problems with patient records (34%), and worries about billing and paychecks.

As the Y2K issue moves far beyond a mere "technological" issue, American Health Consultants has published the *Hospital Manager's Y2K Crisis Manual*, a compilation of resources for nontechnical hospital managers. This 150-page reference manual includes information, in nontechnical language, on the problems your facility will face, the potential fixes, and the possible consequences, including:

- Will your computers and software work in 2000?
- What does Y2K mean for patient care?
- What will happen to your medical devices?
- How can you make sure your vendors are Y2K compliant?
- Are you at legal risk due to Y2K?
- Are you prepared if Y2K delays HCFA payments?

The *Hospital Manager's Y2K Crisis Manual* is available now for \$149.

For more information, contact American Health Consultants customer service at (800) 688-2421 or www.ahcpub.com. ■

frequency with which each should be carried out.

The panel recommends screening consistent with the Alexandria, VA-based American Diabetes Association guidelines for all patients over the age of 18 to detect undiagnosed diabetes. In the initial assessment for those with confirmed diagnoses of diabetes, the guidelines recommend a physician performed detailed history, a documentation of symptoms of diabetes-related comorbidities and a physical exam with emphasis on diabetes-associated findings.

The following laboratory tests are also recommended: serum creatinine, ECG, urinalysis, blood or serum glucose, HbA1c, and lipid profile.

Health care professionals are also cautioned to look for conditions that may require special considerations in diabetic patients, including the presence of an insulin pump, pregnancy, coronary and cerebral vascular disease, infectious disease, inpatient surgery, and diabetic ketoacidosis.

The physician and nutritionist also are advised to perform a nutritional assessment for each diabetic patient upon admission, to devise a specific nutritional plan for the patient, to re-assess the nutrition plan frequently, and to devise a discharge nutrition plan with the appropriate instructions and follow-up.

While the patient is in the hospital, the guidelines insist upon optimal metabolic control, with four times daily glucose monitoring, daily review, and with a goal for fasting blood sugars at 80 to 120 mg/dl and bedtime sugars at 100-140. Blood sugars should not be allowed to exceed 200 without intervention, the panel recommended.

The guidelines also call for detailed education, discharge planning, and follow-up by the entire health care team including demonstrations of the use of blood glucose monitors, self-administration of insulin, if needed, and self foot exams.

"This population is under-supported from an educational point of view," Stone says. "Our perspective is that this is an adult learning issue that needs reinforcement, support, and encouragement."

DTCA has printed 15,000 copies of the

guidelines and plans to distribute them to hospitals, physicians, state licensing boards, payer networks, and anyone else who requests them.

"They are a work in progress and we anticipate we will issue updated versions as we get additional input and feedback," he says. ■

NEWS BRIEFS

Alaska implements medical marijuana law

Alaska, which became one of six states in 1998 to legalize the medical use of marijuana, implemented the law in early March. Alaska's law provides a legal shield against arrest for patients who use the drug for a short list of medical ailments.

Voters approved the measure last November, which allows patients to use the drug to treat cancer, AIDS, glaucoma, chronic pain, seizures, and muscle spasms. Patients first must provide a physician's recommendation.

The law also allows patients to grow limited amounts of marijuana and protects physicians who recommend it. Patients can keep 1 ounce of marijuana or grow six plants, including three flowering plants. Alaska joins Washington, Oregon, California, Arizona, and Nevada by legalizing the use of marijuana.

Implementation of the Alaska law has not come without problems, however. The law requires patients to obtain identification cards to prevent being arrested. The Department of Health and Social Services, however, is not yet accepting applications to develop a registry of qualified patients. ▼

COMING IN FUTURE MONTHS

■ Congress dabbles in medical records privacy issue

■ Are nurses taking a less favorable view of abortion?

■ Will a nursing shortage drastically impact patient needs?

■ A patient anti-dumping update

■ Psychiatric disorders among the dying

Sites get research nod for genome project

The National Institutes of Health recently announced three sites where researchers will attempt to unravel the hidden codes in human DNA. A first draft could be possible by the first quarter of 2000.

Originally, researchers were shooting for 2005 to complete the sequencing of the 3 billion chemical unit code of the human genome. Technological advances, however, prompted researchers to push the deadline forward to 2003.

Research of the human genome, which consists of all of the DNA in our chromosomes, will be conducted at the Washington University School of Medicine in St. Louis, Baylor College of Medicine in Houston, and the Whitehead Institute in Cambridge, MA.

The project will allow researchers to decipher the basic units of heredity. It will then focus on how genes determine physical characteristics, such as the way babies develop or what diseases people get — with the ultimate goal of determining ways to prevent the estimated 4,000 genetic diseases in humans. The three institutions will share \$81.6 million in funding over the next year. ▼

Group raises concern over confidentiality bills

Health information confidentiality legislation is gaining speed on Capitol Hill these days, with three bills introduced in mid-March, but not everyone is gung-ho over the measures.

The Chicago-based American Health Information Management Association (AHIMA) has stated its concern over provisions in legislation that could endanger health information, not protect it. At issue are parts of the Medical Information Privacy and Security Act, known in the Senate as S 573 and in the House as HR 1057.

“S 573 and HR 1057 contain provisions that would fail to comprehensively pre-empt state health information confidentiality laws, leaving in place the current patchwork of state laws and rules federal intervention is supposed to remedy,” explains AHIMA Executive Vice President and CEO **Linda L. Kloss, RRA**.

Additionally, the bills would treat various types of health information differently and make it impossible to maintain uniformly high standards for the management of records, Kloss states.

“All health information is important and deserves equal protection. Treating mental health information, genetic information, and other health information differently would add to the confusion and increase the potential for errors,” he says. ▼

Congressional debate goes to heart of the matter

In a battle of insurance companies against physicians and consumers, Congress may have reached the heart of the debate over placing tighter restrictions on managed care organizations. The most contentious issue, it seems, is who decides what treatments or procedures are medically necessary.

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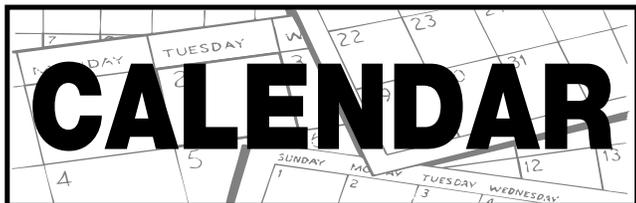
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Insurers argue that physicians are wanting a 'blank check' mentality from them to spend money on what may not even be the best treatment available. Employers and consumers who want additional health care should demand it, and pay for it, when negotiating contracts with insurance companies, lobbyists say.

Physicians and caregivers, however, have a simpler case: patients are denied care they need without legal guarantees. The Chicago-based American Medical Association, for example, cites health insurance contracts that specifically give MCOs sole discretion to determine whether care is medically necessary. Congress could not reach agreement on MCO legislation last year, but several bills have been introduced this year by both parties, and the chances are better for some form of legislation to pass. ■



• **Contemporary Challenges in Health Care Ethics.** June 12-17, 1999. Intensive Bioethics

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