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INSIDE

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Iowa judge withdraws order for pregnancy test results

State Supreme Court refuses to decide protected info issue

An Iowa district court judge has rescinded his order requiring a local Planned Parenthood clinic to turn over the names of women receiving positive pregnancy tests to law enforcement officials investigating the death of a newborn.

On Oct. 24, District Judge Frank Nelson lifted his order at the request of Phil Havens, Buena Vista county attorney, the official who initially sought the clinic files. Fighting the legal appeals over the court order would enmesh the county in an "endless court battle" that the county could ill afford, Havens told the court.

In withdrawing the original order, Nelson also formally dissolved the orders to prevent their being used by law enforcement officials in the future.

In June, Havens obtained subpoenas for five area hospitals and clinics, including the Storm Lake Planned Parenthood Clinic, following the discovery of the body of an infant by a recycling center worker. The baby was in such poor condition that medical officials could not determine the child's gender or whether the child was born alive.

The subpoenas ordered administrators to release identifying information about all women receiving positive pregnancy tests between Aug. 15, 2001, and May 30, 2002, in an effort to help law enforcement officials find the infant's mother.

Although at least one area hospital and several other clinics are known to have complied, Planned Parenthood officials contested the order in court, arguing that the test results were private medical information protected by state and federal privacy laws.

Nelson, however, twice rejected the clinic's arguments and ordered the records turned over. The clinic appealed to the state Supreme Court, which agreed to review Nelson's ruling.

Havens then decided to withdraw the case, and the Supreme Court has since decided not to rule on the matter.

"We are certainly glad to see this case coming to an end, and the

privacy of our clients is protected," **Kendall Dillon**, communications director for Planned Parenthood of Greater Iowa in Des Moines told *Medical Ethics Advisor*. "However, it does not set a precedent for protecting privacy in the future — that is the only negative part of it."

Planned Parenthood officials had hoped that the court would agree to decide the case anyway, says its attorney, **Mark McCormick**, LLB, LLM.

Clinic officials have indicated they have received another broad subpoena for medical information — though this request does not pertain to pregnancy tests — and they hoped this case would decide the issue once and for all.

"We filed a statement noting that the District Court had entered an order allowing the withdrawal of the subpoena and also vacating its two orders in which it refused to quash the subpoena," McCormick says. "We told the court we believed the case was moot and should be dismissed unless they decided to retain it under its 'mootness exception,' in which a case of great public importance and a situation that is likely to reoccur will be decided even if the case is moot."

Clinic officials want a definite ruling on whether Iowa's state statute mandating confidentiality of physician-patient communications covers pregnancy test results. In disputing the efforts to quash the original subpoena, county officials had argued that the test results were not protected medical information because the tests did not have to be given by a physician.

"We have that issue and we have the issue of whether or not our statute on physician-patient privilege is applicable to a county attorney's subpoena," McCormick continues. "And potentially, there is a Constitutional issue of privacy."

Iowa state law requires the targets of a subpoena issued by a grand jury to have certain protections — one being that private medical information cannot be released without the person's consent.

A previous court ruling indicated that county attorney's subpoenas do not carry the same protections.

"We feel that ruling is in error," McCormick says. "The statute itself, that the subpoena is obtained under, specifically says that a witness subpoenaed by the country attorney has exactly the same rights as someone subpoenaed by the grand jury. Apparently, no one called this to the attention of the court when the other case was before it."

Protections not uniform

Contrary to popular opinion, laws governing the confidentiality of medical information are not uniform from state to state, says **Joy Pritts**, JD, research assistant professor at the Institute for Health Care Research and Policy at Georgetown University in Washington, DC.

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 is the only federal regulation dealing with the privacy of

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medical information. Although it does mandate that medical information not be disclosed without the patient's consent, it does contain several exceptions, one of which includes complying with legal subpoenas.

"However, the HIPAA language is largely permissive, indicating that providers may comply with an a subpoena. It does not say they have to," says Pritts. "It also leaves in place any state protections that are stricter than the ones contained in the federal law. If you have stronger state laws, they remain in place."

When someone serves a subpoena on a health care provider, depending on what state the provider is in, he or she is entitled to assert, on behalf of the patient, the concept known as "privilege," she explains. However, the definition of who is considered to be a medical provider and what information and communications may come under the umbrella of privileged information varies widely from state to state.

"Some states limit physician-patient privilege strictly to traditional medical doctors — even chiropractors may not be included," she continues. "Some states do not even recognize physician-patient privilege. In any individual state it must be set out by statute. It is not part of common law and it is not part of constitutional law; it is a statutory creature."

The argument that medical tests must be performed by physicians in order for the results obtained to be considered private is a disturbing one, Pritts says, although she does not think that Nelson's original decision will have wide impact.

"What they are saying is that a pregnancy test is not covered by privilege because it does not have to be administered by a physician," she notes. "That argument would knock out an entire body of medical privilege. When you visit your physician's office, most of the time it is not the doctor giving the diagnostic or screening tests."

However, because Nelson's original ruling was only in the Iowa district court, was appealed, and was later withdrawn, Pritts doubts it will have any widespread impact.

"It doesn't set any legal precedent or legal rules for looking at these kind of cases," she says.

HIPAA issues

A more disturbing problem is how the protections outlined in HIPAA were used in this case, she says. According to some published reports, county officials instructed health care providers that the federal regulations *required* them to comply with the subpoena, which is incorrect, she says.

"That is an inaccurate interpretation of the regulation," she notes. "But I think you may see people try to use it to support these kind of efforts. They can go in somewhere and wave the statute around and say, 'I have this legal authority behind me.' If the [health care administrators] are good, they'll say, 'I'll check it out and get back to you.' But, if they are intimidated they are just going to turn the information over. I think, in the next year or so, we are going to see more and more attempts to use the HIPAA privacy regulation as a sword."

Some providers did comply

Apparently, several health providers and clinics in the Storm Lake area did comply with the initial subpoena and turned over the names of women without their knowledge or consent, says **Randall Wilson**, JD, legal director of the Iowa Civil Liberties Union (ICLU), which filed an *amicus curiae* ("friend of the court") brief in support of Planned Parenthood's action.

In one case, a woman's information was turned over by clinic administrators within 24 hours of receipt of the subpoena and without the knowledge or consent of the woman or her physician, Wilson says.

"They found the baby on the 30th; and by the 31st, her clinic had turned over the records without consulting, according to the clinic administrator, her, or her doctor," he states.

SOURCES

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Want to know what your state law says about the privacy of medical information and physician-patient privilege? Visit the web site of the Health Privacy Project at Georgetown University, www.healthprivacy.org. A database gives a summary of each state's legal protections.

Under HIPAA, had the subpoena been an administrative subpoena, for example, in a fraud investigation, the clinic would have been under federal obligation to make inquiries about whether the subpoena was justified, he says.

"A subpart of the HIPAA regulation on complying with administrative subpoenas for law enforcement purposes says that the subpoena should be reasonably limited in scope and that there should be evidence that obtaining just the nonidentifying information would not be sufficient for the [subpoena's] purpose. But those conditions specifically modify only requests from agency subpoenas."

At any rate, it seems only right that the clinic would at least notify a patient before turning over medical information, Wilson says.

Several other women were contacted by law enforcement officials who went to their homes to inquire about whether they had a baby, according to reports in the *Des Moines Register*. Women without a child were asked to give DNA samples. A match for the abandoned child has not been found.

Whether health care providers believe it is ethical to violate patient confidentiality when asked to do so by law enforcement, they should make sure they are very familiar with the finer points of the HIPAA law and any applicable state laws before doing so, say both Pritts and Wilson.

The woman whose records were turned over a day later contacted the ICLU and was the basis for their *amicus* filing, he says. The woman, known in court documents as Janice Roe, has since consulted her own attorney and is considering legal action against the health clinic in question. ■

DNRs in the field: EMS providers face conflicts

Patient wishes may conflict with provider training

With more terminally ill patients receiving care outside the hospital, in hospices, home health or in nursing homes, it is becoming increasingly common for emergency medical service (EMS) providers to encounter patients with advance directives or living wills that ask that they not be resuscitated or that certain lifesaving measures not be performed should their hearts stop beating.

But complying with the person's wishes may be difficult or often impossible for EMS providers. State laws and local medical supervision policies may place specific restrictions on what decisions EMS personnel can make in the field. And the providers — which can be paramedics, firefighters, or police officers — may lack the training and background to feel comfortable making such decisions, particularly when the issue is what resuscitative measures the patient wants or does not want.

"We have had a lot of difficulty when people want more of a say in what can happen and can't happen in an individual situation," says **Robert R. Bass**, MD, FACEP, chairman of the American College of Emergency Physicians' (ACEP) Emergency Medical Services Committee, and the EMS director for the state of Maryland. "You can't have a five-page document written by a lawyer readily interpreted [by EMS personnel] while someone is in extremis and you're trying to figure out what you can do or can't do."

In some cases, EMS providers are called to the home of a terminally ill patient by the family, which doesn't understand that local policies in their area may require the providers to attempt resuscitation in the event cardiac arrest occurs and there is no immediately available documentation that the patient did not wish it, says **Catherine Marco**, MD, FACEP, chair of ACEP's ethics committee, and a practicing emergency physician in Ohio.

"For example, you have a terminally ill cancer patient at home and the family panics and calls 911 when the person stops breathing," she explains. "The paramedics get there and they say, 'Oh no, he doesn't want to be resuscitated. We didn't know what was going on, and we just wanted some help.' But the paramedics say that unless they can produce the advance directive, they must go ahead and do everything."

Marco has seen many distraught families arrive in hospital emergency departments with a resuscitated patient who are adamant that this was against the person's wishes.

Many states are trying to move to a standard form for do-not-resuscitate (DNR) orders that would be applicable both in hospital settings and in the field, say Marco and Bass.

Maryland currently has a state-approved standard policy for EMS providers, but is moving toward a uniform policy that would be simpler and could be used across settings, says Bass.

"Right now, [EMS] basically puts people in two categories. We have people we will do absolutely

Guidelines for Developing Field DNAR Policy

A comprehensive do-not-attempt-resuscitation (DNAR) policy should be endorsed by the local, regional, and state medical community and EMS governing body. Where possible, legislative support for such a policy should be sought. The DNAR policy should:

1. Establish the fact that basic and advanced life support may not be appropriate and/or beneficial in most clinical settings.

2. Reiterate the need for a presumption in favor of resuscitation when the patient's wishes are not known.

3. Define the conditions under which a DNAR order can be considered.

4. Define which patient is competent to agree to a DNAR order and establish a mechanism for determining a surrogate when the patient is not competent to reach such a decision.

5. Establish that the decision not to attempt resuscitation must be an informed decision made by the patient or his surrogate.

6. Identify the information that should be contained in an out-of-hospital DNAR order and the authority that will be responsible for developing such a mechanism.

7. Identify the clinical procedures that are to be withheld in the execution of a DNAR order (or identify which authority will establish these withheld procedures).

8. Define the exact manner in which the DNAR order is to be executed, including the role of on-line medical direction; each system should have two-way radio capabilities to permit access to that on-line medical direction.

9. Define the procedure for revocation of a DNAR order.

10. Establish a procedure for periodic review of such an order.

11. Establish immunity for health care providers who carry out a DNAR order in good faith.

There should be an option not to observe a DNAR order if:

- The patient is able to express a wish to be resuscitated prior to cardiopulmonary arrest.
- The pre-hospital personnel have any doubts about the authenticity of the DNAR.

A DNAR policy should also include a mechanism for ensuring the proper pronouncement of death, for disposition of the body of the deceased and a mechanism for grief counseling. Prior arrangements should be made with the patient's attending physician, local coroner or similar authority, and funeral directors.

A DNAR policy should also include procedures for ensuring that organs that have been donated by the deceased can be procured appropriately.

Finally, a DNAR policy should include an educational program for patients, their families, and the medical community regarding the appropriate use of the EMS system in the treatment of terminal medical conditions.

Source: American College of Emergency Physicians, Irving, TX.

nothing but provide palliative care, and a second category of people where we will do everything up to a [cardiac] arrest," he says. "Then, if they arrest, we don't resuscitate."

Over the years, he has seen people who wanted to be defibrillated but did not want CPR, or did want CPR but did not want to be intubated, or did not want to be intubated, but did want an IV line, etc., Bass says. Such distinctions may be appropriate for terminally or seriously ill patients in a hospital, but are almost impossible for EMS personnel to conform to.

Maryland currently is revising its standard policy in the hopes of making it easier to understand and apply. The hope is that patients and physicians will use it across the spectrum of care.

"A lot of patients and some of the doctors have trouble understanding why EMS cannot accept a living will," he says.

Ohio also has a state-approved DNR order, instituted just last year, but providers have a long way to go in educating the public, says Marco.

"There is still a big gap in public awareness and utilization of the standardized DNR order," she says. "When the patient takes the initiative to complete the form, it is great because everyone feels happy about complying with that person's wishes. But it is still extremely rare that we see someone with a completed state advance directive."

ACEP has had a policy to guide states and EMS providers on establishing "do-not-attempt-resuscitation" (DNAR) orders in the pre-hospital setting since 1988, Marco notes **(see guidelines, above)**. But the policy has had little impact, she says.

Marco and colleagues recently surveyed EMS providers nationwide for an upcoming study in the *Journal of Emergency Medicine*, she says. They found significant variation among states and providers about how resuscitations were handled.

The ethics and EMS committees will work together on revising and updating the ACEP policy this year, Marco says.

SOURCES

- **Robert Bass**, MD, FACEP, and **Catherine Marco**, MD, FACEP, American College of Emergency Physicians, 1125 Executive Circle, Irving, TX 75038-2522. Telephone: (800) 798-1822.

"It is premature to discuss it in detail, but overall our goal would be to foster more consistency in how we handle the problem," she says. ■

Is nursing crisis health system's perfect storm?

Improved workplace, respect for profession needed

The worsening nursing shortage is a crisis that can completely sink the struggling U.S. health care system if hospitals and other institutions don't do more to address the root causes of the shortage, health executives told government leaders last month.

The current shortage is more than just a recurrence of the supply-and-demand problems that periodically have occurred in the past, they claim, and multifaceted solutions are needed — fast.

"Nurses experience high stress and low job satisfaction, leading to burnout, high turnover rates, and an exodus from the profession itself," says **Barbara Blakeney**, MS, RN, CS, ANP, president of the American Nurses Association (ANA) and director of health services for the homeless at the Boston Public Health Commission.

"These conditions discourage young people from considering nursing as a career choice, thereby further reducing the number of people in the pipeline who will be available to replace the very large number of nurses who will soon be of retirement age. This situation has been dubbed the 'perfect storm' of the American health care system."

According to estimates by the U.S. Health Resource and Services Administration's (HRSA) Bureau of Health Professions, there could be a nationwide shortage as high as 808,000 nurses by the year 2020 — a number greater than the number of existing physicians practicing today. And there is growing evidence that nurse understaffing and high patient-to-nurse ratios result in poorer patient outcomes, higher rates of medical errors, and high levels of nurse burnout and job frustration.

A recent study by Linda Aiken, MD, and colleagues in the *Journal of the American Medical Association*, analyzing data from more than 10,000 nurse surveys and the discharge information of more than 200,000 patients at 168 Pennsylvania hospitals, found that high patient-to-nurse ratios were independently associated with increased patient mortality and more episodes of failure to rescue.[1]

An August report by the Joint Commission on Accreditation of Healthcare Organizations found that insufficient nurse staffing was a contributing factor in almost 25% of unanticipated problems resulting in injury or death to hospitalized patients.[2] Among patients dependent on ventilators, the percentage was almost 50%.

"If the nurse wasn't there to pick up on subtle problems before it became a major problem, the situation got out of control," Blakeney explained.

Blakeney and other experts participated in a forum discussing possible solutions to the nursing shortage on Oct. 17 in Washington, DC, and sponsored by the Alliance for Health Reform.

Recruitment measures not enough

Hospitals must move beyond just stepping up recruitment efforts and perks and do more to improve their working environments and the practice of nursing in general, **Edward H. O'Neil**, PhD, MPA, director of the Center of Health Professions at the University of California-San Francisco, told participants.

"We have to increase overall supply," he emphasized. "The strategies offered up by the profession, by industry, by labor, by education, have essentially focused on increased supply by recruitment — stealing from St. Mary's to staff St. Paul's. But it doesn't add one new nurse; it just makes you feel better."

Surveys of nurses have reported serious dissatisfaction with the work environment — lack of respect, hostile attitudes, mandatory overtime, and lack of training and resources — that must be addressed, he says.

"Right now, we think of nursing as a commodity. We need to think of them as a strategic asset that the hospital or health system deploys."

Throughout the managed care crunch of the early 1990s, hospitals sought to cut costs by reducing nurse staffing — laying off nurses, cutting nurse salaries, and replacing RNs with less skilled assistive personnel, notes Blakeney. That's part of the reason the situation is so critical.

"In the mid-1990s, the average wage of RNs

employed in hospitals actually dropped by roughly $1 an hour," she adds. "And the staff reductions occurred at a time when patient acuity was increasing, sophisticated technology was increasing, and the length of stay of hospital patients was decreasing."

The overall impact of these changes was to drastically increase the pressure on remaining staff nurses who were required to oversee unlicensed assistants while caring for a larger and sicker patient population.

A 2001 ANA survey found that nurses across the country reported experiencing increased patient loads, more floating between departments, decreased support services, and increased demands for mandatory overtime.

"Disturbingly, more than 40% of those nurses reporting in that survey reported that patient care had suffered to a point that they would feel uncomfortable recommending anyone close to them using that hospital facility for their own care," she said.

Hospitals addicted to mandatory overtime

The continued dependence of many health care facilities on mandatory overtime is something that must be addressed, Blakeney said. Hospitals continue to rely on overtime to staff their facilities. "We know that the use of mandatory overtime is not an isolated incident. In fact, nearly 5,000 nurses across the country have revealed that two-thirds of them are required to work overtime — unplanned overtime — on a monthly, if not weekly, schedule."

Tired, overworked nurses are not only unhappy, they also have a direct impact on patient care, she added.

Even proactive hospitals that strive to provide a good working environment and opportunities for advancement for their nurses have a hard time getting away from the use of mandatory overtime, says **Maureen White**, RN, MBA, senior vice president and chief nursing executive for North Shore-Long Island Jewish Health System in New York City, which employs 7,000 registered nurses.

Their system is able to offer tuition reimbursement programs and on-site nursing education classes to their staff, and even provide perks such as on-site dry cleaning and on-line grocery shopping at deep discounts to personnel.

Two of the system's hospitals, North Shore University Hospital and Long Island Jewish Medical Center, have both been named magnet hospitals by the American Nurse Credentialing Center's Magnet Recognition Program. The program identifies health care facilities that have fostered an environment that attracts and retains nurses. But even they have not been able to totally eliminate mandatory overtime, White says.

"We have looked at the issue of mandatory overtime. Sadly, I think it is used too much," she said. "Earlier this year, in January, we initiated a policy in the health care system. The first statement in the policy states that we, the members of North Shore Long Island Jewish Health System, are adamantly opposed to mandatory overtime."

At this point, the system has been able to reduce mandatory overtime usage by 80%, with a goal of eliminating it by the end of the year, she says.

"People need to know that if they are scheduled to work an 8-to-4 shift, they can expect to go home at 4," she says. "They have things outside of work that they need to prepare for."

Help with education

Nursing programs also can do more to encourage and support people who might be talented health care providers or want to be nurses, say O'Neil and White.

In California, two-year training programs have a 44% washout rate, O'Neil says. "We could probably improve on that."

Hospitals need to encourage their nurses to continue their education, obtaining advanced degrees and certifications, says White. And they should make it easier for nonlicensed personnel to pursue nursing education if they are interested.

"To some degree, the nurses of tomorrow are in our hospitals today. Those nonlicensed personnel within our facilities who for whatever reason could not or chose not to pursue a nursing license earlier in their career," she says.

North Shore-Long Island Jewish started a pilot program to recruit employees interested in pursuing a nursing career but who felt unable to return to school. Many people lacked the financial resources earlier in life to attend college, she notes.

The system partnered with a local community college to offer classes at the hospital, and the hospital assumed payment of the tuition for a select number of applicants and provided mentors to the students to help ease the transition, she says.

They also made the commitment without asking that the employees commit to work for the system after graduation.

"The last thing we told our employees is that we

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AACN Nursing Shortage Facts

The American Association of Colleges of Nursing has collected the following data on the current state of the nursing shortage and actions different organizations are taking to address it. More information is available on the association's web site: www.aacn.org.

• Current and projected shortage indicators

— According to American Hospital Association's June 2001 *TrendWatch*, 126,000 nurses are currently needed to fill vacancies at our nation's hospitals. Today, fully 75% of all hospital personnel vacancies are for nurses. **www.aha.org.**

— According to the National Council of State Boards of Nursing, the number of first-time, U.S.-educated nursing school graduates who sat for the NCLEX-RN, the national licensure examination for all entry-level registered nurses, decreased by 28.7% from 1995-2001. A total of 27,679 fewer students in this category of test takers sat for the exam in 2001 as compared with 1995. **www.ncsbn.org.**

— According to the latest projections from the U.S. Bureau of Labor Statistics published in the November 2001 *Monthly Labor Review*, more than 1 million new nurses will be needed by the year 2010. The U.S. Department of Labor projects a 21% increase in the need for nurses nationwide from 1998 to 2008, compared with a 14% increase for all other occupations. **www.bls.gov.**

• Contributing factors impacting the nursing shortage

Schools of nursing are reporting a decline in enrollment and graduations, which translates into fewer nurses in the educational pipeline.

— According to the fall 2001 survey by the American Association of Colleges of Nursing, enrollment in generic (entry-level) baccalaureate programs in nursing increased by 3.7% nationwide since last year, ending a six-year period of decline. Despite this slight increase, enrollments in all programs still are down 17% or 21,126 students from 1995. On average over the last five years, the number of enrollees and graduates from generic programs declined by 1,567 and 1,420 each year, respectively. The 1997-2001 cohort contains 358 schools that reported data every year for each of the past five years. **www.aacn.nche.edu.**

• A shortage of nursing school faculty is restricting nursing program enrollments.

— According to a survey by the American Association of Colleges of Nursing, *2000-2001 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*, more than a third (38.8%) of schools who responded pointed to faculty shortages as a reason for not accepting all qualified applicants into entry-level baccalaureate programs. **www.aacn.nche.edu.**

— According to a study released by the Southern Regional Board of Education (SREB) in February 2002, a serious shortage of nursing faculty was documented in 16 SREB states and the District of Columbia. Survey findings show that the combination of faculty vacancies (432) and newly budgeted positions (350) points to a 12% shortfall in the number of nurse educators needed. Unfilled faculty positions, resignations, projected retirements, and the shortage of students being prepared for the faculty role pose a threat to the nursing education work force over the next five years. **www.sreb.org**.

• With fewer new nurses entering the profession, the average age of the RN is climbing.

— According to the latest *National Sample Survey of Registered Nurses*, the average age of the working registered nurse population was 43.3 in March 2000, up from 42.3 in 1996. The RN population younger than age 30 dropped from 25.1% of the nursing population in 1980 to 9.1% in 2000. **http://bhpr.hrsa.gov/dn/dn.htm.**

— According to a July 2001 report released by the Government Accounting Office, *Nursing Work Force: Emerging Nurse Shortages Due to Multiple Factors* (GAO-01-944), 40% of all RNs will be older than age 50 by the year 2010. **www.gao.gov**.

• The total population of registered nurses is growing at the slowest rate in 20 years.

— According to the preliminary findings of The National Sample Survey of Registered Nurses released in February 2001 by the Division of Nursing within the Bureau of Health Professions, the total RN population has increased at every four-year interval in which the survey has been taken since 1980. Although the total RN population increased from 2,558,874 in 1996 to 2,696,540 in 2000, it was

(Continued)

the lowest increase (5.4%) reported in the previous national surveys. Of the total RN population in 2000, an estimated 58.5% work full time in nursing, 23.2% work part time, and 18.3% are not employed in nursing. **http://bhpr.hrsa.gov/dn/dn.htm.**

• High nurse turnover and vacancy rates are affecting access to health care.

— According to the report *Acute Care Hospital Survey of RN Vacancies and Turnover Rates in 2000* released in January 2002 by the American Organization of Nurse Executives, the average RN turnover rate in acute care hospitals was 21.3%. The average nurse vacancy rate was measured at 10.2% with the highest rates found in critical care units (14.6%) and medical-surgical care (14.1%). Nurse executives surveyed indicated that staffing shortages are contributing to emergency department overcrowding (51%) and the need to close beds (25%). **www.aone.org.**

• Job burnout and dissatisfaction are driving nurses to leave the profession.

— According to a study commissioned by the Federation of Nurses and Health Professionals in April 2001, *The Nurse Shortage: Perspectives from Current Direct Care Nurses and Former Direct Care Nurses*, currently one out of five nurses currently working is considering leaving the patient care field for reasons other than retirement within the next five years. **www.aft.org/fnhp/publications/index. html.**

• Changing demographics signal a need for more nurses to care for aging population.

— According to a July 2001 report released by the Government Accounting Office, *Nursing Work force: Emerging Nurse Shortages Due to Multiple Factors* (GAO-01-944), "a serious shortage of nurses is expected in the future as demographic pressures influence both supply and demand. The future demand for nurses is expected to increase dramatically as the baby boomers reach their 60s, 70s, and beyond." **www.gao.gov.**

— According to a May 2001 report, *Who Will Care for Each of Us?: America's Coming Health Care Crisis*, released by the Nursing Institute at the University of Illinois College of Nursing, the ratio of potential caregivers to the people most likely to need care, the elderly population, will decrease by 40% between 2010 and 2030. Demographic changes may limit access to health care unless the number of nurses and other caregivers grows in proportion to the rising elderly population. **www.kaisernetwork.org/ healthcast/ nursing/may01**.

• The nursing community and other stakeholders are working together to identify strategies to address the shortage.

— The Call to the Profession is a group of top leaders from national nursing organizations who are working together to ensure safe, quality nursing care for consumers and a sufficient supply of registered nurses to deliver that care. The group currently is working on an action plan called *Nursing's Agenda for the Future*. **www.ana.org.**

— The TriCouncil for Nursing, an alliance of four autonomous nursing organizations (American Association of Colleges of Nursing, American Nurses Association, American Organization of Nurse Executives, and National League for Nursing) each focuses on leadership for education, practice and research, issued a joint policy statement in January 2001 on *Strategies to Reverse the New Nursing Shortage.* **www.aacn.nche.edu/ Publications/positions/tricshortage.htm.**

— The Nurse Reinvestment Act (HR 3487 and S 1864), legislation introduced to address the nursing shortage, was passed by Congress in December 2001 and now is in conference committee. Current provisions provide funding for a fast-track faculty scholarship program, student loan repayment program, grants for internships and residencies, and public service announcements. **www.aacn.nche. edu/Media/ shortageresource.htm#legislation.**

— In April 2001, a coalition of 23 national nursing organizations issued a joint call to Congress to stem the nursing shortage and released a comprehensive plan to address the shortage, titled *Assuring Quality Health Care for the United States: Supporting Nurse Education and Training,* that outlined funding priorities and called for new initiatives to recruit and retain nurses. **www.aacn.nche.edu/Media/News Releases/consensus.pdf.**

— Two national media campaigns have been launched recently to help polish the image of nursing. Nurses for A Healthier Tomorrow is a coalition of 35 nursing and health care organizations working together to raise interest in nursing careers among middle and high school students. In February 2002, Johnson & Johnson launched the Campaign for Nursing's Future, a multimedia initiative to promote careers in nursing that includes paid television commercials, a recruitment video, a web site, and brochures mailed to schools across the country. **www.nursesource.org** and **www.discovernursing.com.**

Source: The American Association of Colleges of Nursing, Washington, DC.

(Continued from page 139)

would not require them to sign a service contract," she said. "Because of the size of our organization, we have an accountability and responsibility to the communities that we serve. As long as we can grow one nurse, then we are serving our community at large."

So far, 400 employees are participating in the program, which will see its first 10 graduates next year.

Recruit beyond traditional population

One factor often cited as contributing to the nursing shortage is the expansion of opportunities for women in the workplace.

Whereas women once were steered toward teaching and nursing as career options, they now have a wider variety of opportunities.

The problem, says O'Neil, is that, now, leaders in the profession have not asked themselves why nursing has not attracted nontraditional nurses.

"We need to not focus so much on why women have left the profession," he says. "One of the interesting things is why so many women have stayed in nursing. The more interesting question is why is it still 94%-95% female?"

The vast majority of these women also are still non-Hispanic Caucasians, he added. Why is the profession not attracting more men and racial and ethnic diversity?

"Another big driver that makes this more interesting than previous shortages is the shift in orientation towards work," O'Neil continues. "Workers want a more service-oriented, anti-institutional, non-hierarchical system. They value diversity, technology, and new skills."

Contrast those values with the environment at most hospitals where nurses are employed and it goes a long way in explaining the journey that institutions may have to make to attract a work force in the next generation, he said.

His biggest fear? That hospitals and health systems will scramble around to recruit new nurses, then because the system has institutional "attention deficit disorder," they will move on to the next crisis du jour without solving the key problems.

"It's very important that we think about this transition," he said. "We'll scramble around, we'll do ad campaigns. We'll do signing bonuses. We'll put a few more dollars into the pay rate — and, it is necessary to do that. But it won't solve the problem until we change the work environment."

SOURCES

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NEWS BRIEFS

New committee to advise on protection of human embryos

A new federal advisory panel that will provide ethical guidance for researchers engaged in studies involving human subjects has been charged by the Bush administration to consider human embryos to be human subjects, deserving of the same protections currently afforded fetuses, children, and adults.

The committee will not have the ability to enact legislation. It can only recommend changes to the Department of Health and Human Services (DHHS), which would then choose whether to go through the legislative or rulemaking process to enact a change in policy.

However, depending on whom the administration selects to sit on the committee, it could be the start of a process that could result in greater restrictions on embryo research at some fertility clinics, universities and research labs, experts told *The Washington Post* on Oct. 30.

"I'm very concerned that this addition [of the

word "embryos"] will serve to seriously politicize the reconstituted committee," said **Robert R. Rich**, executive associate dean of research at Emory University School of Medicine in Atlanta, a member of the now-defunct National Human Research Protections Advisory Committee. "Embryos are not included as human research subjects, according to [current federal regulations]. It will be impossible to gain consensus around this issue if appointees to the new committee represent both sides of this very contentious issue since it is governed by emotions and beliefs and is really not amenable to rational or scientific discourse."

The National Human Research Protections Advisory Committee was formed at the direction of former president Bill Clinton to recommend new protections for human volunteers in research trials following several scandals in which people participating in research trials were harmed. Following the change in administration, President Bush allowed the committee's mandate to expire and announced the formation of a new committee, the Secretary's Advisory Committee on Human Research Protections, which will now advise DHHS on similar matters. At press time, no committee members had been appointed. ▼

Tenet hires auditor to examine fraud charges

Santa Barbara, CA-based Tenet Healthcare Corp. has hired an outside medical auditor and sent a team of investigators to Redding (CA) Medical Center, its hospital. The team will look into charges that two cardiac surgeons there performed unnecessary surgeries in generate large medical payments for themselves and the hospital, *The Wall Street Journal* reported on Nov. 5.

The federal government is investigating the accusations against the two doctors, but hasn't filed any charges against them.

Tenet representatives told the *Journal* it hired Mercer Consulting Group to assist in reviewing treatments by the two doctors. Mercer also will retain expert cardiologists to review patient records and internal documents regarding cases of alleged unnecessary surgery and other procedures. The outside cardiologists also will review any future cases the two physicians intend to perform at the hospital.

Tenet added that it will extend its internal review to all of its hospitals where there are heart programs or other specialized programs that generate high levels of outlier payments. Outlier payments are designed to defray losses suffered by hospitals when patients' care exceeds fixed reimbursements. The Department of Health and Human Services said last month that it would review such payments next year as part of its routine work. ▼

Pfizer to pay millions for fraud case settlement

New York City-based Pfizer Inc. has agreed to pay $49 million to settle allegations that subsidiary Warner-Lambert Co., which Pfizer acquired in 2000, defrauded Medicaid by overcharging the government payer program for its cholesterol-lowering drug, Lipitor.

At issue in the lawsuit were the educational grants that Parke-Davis, Warner-Lambert's prescription drug unit, provided to the Ochsner Health Plan, a health maintenance organization with members in Louisiana and eastern Texas, according to an Oct. 29 report in *The Wall Street Journal (WSJ)*.

Pharmaceutical companies are required to provide the best price for their medicines to the government program. Calculation of the best price is supposed to take into account any rebates and price adjustments that drug makers give to health plans to induce them to put their drugs on their formularies. Educational grants to a health plan, payments that are supposed to cover unrestricted educational offerings, are not included in the best-price calculation.

In its lawsuit, the federal government charged that $250,000 in payments sent to Oschner and classified as "unrestricted educational grants" and "program funding" really were rebates in disguise.

The payments came to light as a result of a

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- Defining death

whistle-blower lawsuit filed by a former Parke-Davis national sales manager, David Foster. In 2000, Foster learned his company had offered to provide Ochsner with funds to support educational programs for patients and physicians, underwrite the salaries of pharmacists, and implement a management program to improve patient care.

Foster, however, believed these payments were not educational grants and should be used to figure the best price to be paid by Medicaid. According to the settlement, Foster complained to a supervisor, but was ignored and later placed on administrative leave. He filed suit in 2000, with the federal government joining the suit later.

Pfizer will likely not be the only company required to pay up, **Alice Gosfield**, JD, a Philadelphia health care attorney told *WSJ*. "There are more of these in the pipeline."

Other drug companies, notably Schering-Plough Corp., have disclosed that they are facing federal and state investigations into their Medicaid pricing practices. ■

CME Questions

CME subscribers: *Please use the enclosed Scantron to submit your answers for the July-December 2002 CME test and return the Scantron and CME survey in the enclosed envelope.*

21. Which regulations take precedent in decisions about physician-patient privilege?
A. Federal regulations
B. HIPAA
C. State laws
D. None of the above

22. According to estimates by the Bureau of Health Professions, the United States will lack how many nurses in the year 2020?
A. 120,000
B. 808,000
C. 500,000
D. None of the above

23. What key workplace factor was mentioned as a major problem in improving nurse job satisfaction, morale, and protecting patient safety?
A. On-site dry-cleaning services
B. Day care for children of employees
C. Mandatory overtime
D. Floating shifts

24. State-approved DNR orders:
A. Have the advantage of consistency, standardization of practice, and can be easily understood by EMS providers
B. Are the same as living wills
C. Only can be used if the person does not want a living will
D. None of the above

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