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INSIDE

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Hospital challenges physicians' right to jump ship with program, patients

At issue are reimbursements and federal grant money

When renowned pediatric AIDS specialist **Andrew Wiznia**, MD, and two of his colleagues in the pediatric AIDS clinic at New York's Bronx-Lebanon Hospital Center decided to resign and move to a new program at another hospital, Bronx-Lebanon administrators didn't take it lying down. They took them to court.

Alleging that Wiznia coerced both staff and patients into leaving the hospital's clinic and improperly attempted to move a $1.5 million National Institutes of Health (NIH) grant that largely supported the program, Bronx-Lebanon filed suit in New York asking for $50 million in damages. The lawsuit also sought to bar the defendants from treating patients anywhere else for six months.

The physicians received a judgment permitting them to resign from Bronx-Lebanon and see patients at the other hospital, Jacobi Medical Center. The physicians claim they were ethically obligated to inform their patients about the move and that the research grant would routinely follow them to a new location under NIH guidelines.

Each side claims the other is using these patients as pawns in a larger dispute over much-needed Medicaid reimbursements and federal grant money for AIDS research.

EXECUTIVE SUMMARY

Physicians with pediatric AIDS patients at New York City's Bronx-Lebanon Hospital Center decided to leave the hospital and join another facility, forcing patients and some staff to decide whether to follow them to the new facility. Also at stake is a National Institutes of Health grant for AIDS care.

- When physicians leave one practice or hospital for another, how should they inform their patients?
- What obligations do physicians have to hospitals that have depended on them to support major programs?
- Should physicians employed by hospitals who treat mostly poor patients covered by federally funded programs be held to a different standard than physicians in private practice who treat privately insured patients?

CME questions

1. Bronx-Lebanon Hospital Center in New York City alleges that Andrew Wiznia, MD, and his colleagues:
   - **A.** Coerced staff into leaving the hospital.
   - **B.** Persuaded patients to go with them to the new hospital.
   - **C.** Improperly attempted to move a National Institutes of Health grant.
   - **D.** All of the above.

2. According to Harold J. Bursztajn, MD, co-director of the Program in Psychiatry and the Law at Harvard Medical School, the fighting over patients among health law and ethics experts is meaningless because:
   - **A.** Medical records are considered separate from patients.
   - **B.** Physician/patient relationships supercede other relationships.
   - **C.** Patients belong to no one but themselves.
   - **D.** All of the above.

3. Retrieving sperm from deceased donors, or using sperm collected prior to death, should not be done, according to Michelle Frelich Appleton, professor of law at Washington University in St. Louis, unless:
   - **A.** Proof of consent is documented.
   - **B.** Family members request the procedure.
   - **C.** Patients request it verbally before death.
   - **D.** All of the above.

4. According to Melvin H. Needell, MD, medical director of the Foundation for Bioethics and Philosophy at the University of Miami, all that's needed for consent to posthumous sperm collection is:
   - **A.** A proper surrogate.
   - **B.** Decisions made according to an ethical hierarchy.
   - **C.** Wishes made by the donor before death.
   - **D.** All of the above.

The case has raised other complex questions in the medical community, as well. When physicians leave one practice or hospital for another, how should they inform their patients? What obligations do physicians have to hospitals that have depended on them to support major programs? Should physicians employed by hospitals who treat mostly poor patients covered by federally funded programs be held to a different standard than physicians in private practice who treat privately insured patients?

What happens when physicians leave?

Wiznia came to Bronx-Lebanon and started its pediatric AIDS clinic program 10 years ago. Since that time, he's watched several of his patients — who initially were not supposed to survive childhood — grow from sickly infants to adolescents who must learn to live long-term with a deadly infection.

Dissatisfied with management changes at Bronx-Lebanon and the hospital's approach to treating the children, he decided to leave. **(For more on dissolutions between physicians and hospitals, see story, p. 64.)**

"The whole impetus for moving is that there are services at Jacobi that are not at Bronx-Lebanon that are needed for kids," he explains. "There is no intensive care at Bronx-Lebanon, there are no adolescent services or subspecialties. That was the primary impetus. The other was a change in the administration. Things started happening. The environment became one of a productivity model. It became about dollars and cents. You never heard about quality of care or anything like that."

It is commonly held, and in some states legally required, that physicians should inform their patients of a decision to leave a facility or practice and then either oversee the patients' transition to a new physician or continue to treat them, says Wiznia.

"Particularly with chronically ill kids, I have been treating some of them most of their lives. That is all we tried to do," he explains.

According to court papers, Wiznia and the two physicians mailed letters to their patients' parents informing them that they would be moving to Jacobi and stating that they hoped the patients had been happy with the care provided and the physicians would like to continue treating them.

Most of the parents of the clinic's children wanted to continue with him because they know

he is familiar with their children's cases and that he cares about them, Wiznia says.

Other physicians and staff who had been treating the children for a long period of time also decided to move to Jacobi, he adds.

The dispute is not about the rights of physicians to offer their services at other facilities or about the patients' rights to see who they choose, says **Ram Kairam**, MD, director of pediatrics at Bronx-Lebanon. Instead, Kairam claims, it's about protecting the clinical integrity of the AIDS program in which the hospital has invested over time from being dismantled by one physician.

"Bronx-Lebanon Hospital has the only community hospital-based pediatric AIDS clinical trials unit in the country, and it has flourished for 10 years, and it has flourished not just because we had one charismatic, committed, knowledgeable, and smart doctor," argues Kairam. "He is a very good doctor, but this is not a doctor-patient issue. He is not a private doctor, and these are not his private patients. He was a clinic doctor, a salaried doctor. He did not have a practice by himself. It is not the same as someone who does breast reconstructive surgery or who reattaches earlobes. He was one part of a gigantic operation."

The entire pediatric AIDS treatment program at the hospital is based on a "one-stop model" in which HIV-infected pregnant women and infected children are treated in the same place as their other family members who may or may not be infected, Kairam continues.

"We are one of the largest outpatient pediatric AIDS centers in New York," he says. "Part of that large operation is the NIH-funded pediatric AIDS clinical trials unit. Residing in that unit are staff and protocols that take care of pregnant women. We have one of the largest concentrations of pregnant women delivering HIV-exposed babies in any New York state hospital. By improperly moving some of these women — he attempted to move some of the adults, the pregnant women, and nearly all of the children — he basically attempted to destroy the backbone of this entire operation."

One bone of contention is which party gets to keep the NIH grant to fund the clinical trials. Both Jacobi Medical Center, which is a public hospital, and Bronx-Lebanon treat a predominantly poor population. Forty percent of the Bronx-Lebanon clinic's patients are in foster care, and most are covered only by Medicaid. Consequently, both hospitals are very dependent on grant funding to continue to offer services to patients.

Wiznia, the principal researcher on the NIH-funded study, set up the research protocols and study design at Bronx-Lebanon, and it is common for a grant to follow the principal researcher, he says. However, Kairam contends that the hospital's ability to guarantee a large number of patients for enrollment in the protocol and its ability to provide the infrastructure, support staff, and physical space for the study were the keys to securing funding.

"It takes a significant amount of resources to be able to maintain a 90% to 95% follow-up rate on these children for two and a half years," he says. The hospital fought to prevent NIH from moving the study, and it is still at Bronx-Lebanon, although the hospital had to stop enrolling patients due to the dispute, he says.

Kairam says he has replaced all of the staff who left the clinic and expects the NIH to accept his "transition plan" and permit him to reopen enrollment to new patients in a few days.

However, Wiznia says officials from the NIH have plans to visit Jacobi and decide whether the study can be moved there.

The fallout isn't over

While both the lawsuit and the NIH funding question are being resolved, the physicians, hospitals, and patients are in limbo. "There are still people who have been caring for the kids for years over at Bronx-Lebanon, who I believe would like to come here," says Wiznia. "A lot of the patients have not been able to come; some of the personnel haven't been able to come. They don't want to take risks, and the hospital is not going to hire study nurses until the study is here."

The physicians won a court order to get the patients' records sent from Bronx-Lebanon to Jacobi, Wiznia says, but they will have to return to court because the hospital is not complying, he claims.

There is confusion among the children's caregivers over how to obtain care now, says Kairam. "Foster care agencies are confused because the drugs are here and the doctors are there."

The hospital hopes the lawsuit will set a precedent in terms of how physicians employed by hospitals must deal with patients treated there, he says. "If this were simply about his private practice, it would be idiotic to fight him. We would have lost already. We just want something to say that you cannot take a hospital's patients like that." ■

When physicians leave, who gets the patients?

Dissolutions more fraught with tension

The issue of physicians leaving a practice or a hospital and taking their patients with them has always been a sticky one. However, in an era of stiff competition due to mergers and declining reimbursement from third-party payers, these dissolutions of working relationships are becoming increasingly fraught with tension.

"The reaction of the chief of service [at the hospital] or the practice manager is typically one of disappointment or betrayal," says **Paul Risner**, an attorney specializing in health law and regulation with the firm of Baker, Donelson, Bearman and Caldwell in Memphis, TN.

"Do you want a physician treating your patients who doesn't want to be there, doesn't like you anymore, and could potentially be distracted in care?"

"Their gut reaction is, 'I went out on a limb for this guy, and look at what he is doing to us.' They want to get the person and put him out of business or run him out of town or whatever," adds Risner.

However, most health law and ethics experts say fighting over patients is meaningless because the patients "belong" to no one but themselves. "A patient, any patient, has the right to choose where and from whom they receive care," says **Harold J. Bursztajn**, MD, co-director of the Program in Psychiatry and the Law at Harvard Medical School in Cambridge, MA.

To protect their patients' rights, physicians should not sign any noncompetitive agreements with hospital systems that would violate appropriate continuity of care and appropriate termination, he says. Physicians have a responsibility to inform their patients if they decide to move or leave their practice and offer patients the option of continuing their care at the existing location with another provider or moving with the doctor, he says.

Usually this dispute over patients boils down to who "owns" the medical record, says Risner, who formerly served as general counsel to two hospital systems in Florida. "The answer to that, in most states, is that the patient owns the record, but the hospital or physician owns the paper," he says. "This essentially means that the hospital would have 'custody' of the record and have to maintain it."

However, if a patient requests that the hospital transfer the record to another facility, the hospital is not permitted to charge the patient or require that the patient come to the hospital and get the record, he explains.

Physicians who are leaving a certain institution or practice, however, do have ethical obligations to their former partners and employers, say both Risner and Bursztajn.

"There is nothing unethical about notifying your patients and telling them where you are going, etc.," says Risner. "It is probably not unethical to suggest that you would like to continue to treat them and so forth. What you have to stay away from is saying anything negative about the care at the place you are leaving."

Most physicians are savvy enough to know that or to consult an attorney who does, so patients rarely receive a letter that would violate this concept. However, Bursztajn contends the physician should indicate in the letter that the patient would be able to get good treatment at the site under the care of another physician, or the letter could be deemed coercive.

"I would think that there should be some indication that the choice is completely up to the patient," he says. "I think it should in some way mention that the patient can continue to receive good care at the current institution."

Contracts keep splits amicable

Setting up a detailed employment contract at the beginning of the physician's tenure at the hospital is the best way to avoid these kinds of termination disputes, Risner says. "It depends on what terms the contract sets, when the doctor can leave — on how much notice — and whether he can recruit other employees," he says.

Contracts Risner has drawn up for other hospitals generally stipulated that the physicians are required to give six months' notice and not take any proprietary records.

"Even when we had six-month provisions, you ask yourself the practical question: Do you want a physician treating your patients who doesn't want to be there, doesn't like you anymore, and could potentially be distracted in care?" he asks.

Many of Risner's contracts included a monetary amount known as "liquidated damages," he says. That would be the amount of money the hospital deemed necessary to continue to cover the physician's services if he or she left the institution without six months' notice.

"Both parties agree to this amount on the first day the contract is signed, while everybody still loves each other," he says. "It is a lot easier to do that ahead of time."

As long as the physician meets all the terms of his employment contract, gives proper notice, notifies his patients in an ethical way that he will be leaving, and doesn't "back a truck up to the door and make off with all of the records," then he has fulfilled his duty to the institution, Risner adds.

Someone not involved should negotiate

Once a physician decides to leave, it's best to accept the decision and get someone not directly involved with his employment to negotiate the termination, he advises. When the hospital systems he served had such an occurrence, it was often Risner who worked through the details with the physicians, stipulating time frames for the physician to work and establishing a protocol for allowing the physician to make copies of his or her patients' information if necessary.

"I usually took over the operation when it was a physician [who was resigning] whenever I could," he explains. "I took the practice manager or center manager or vice president in charge of that division out of it because I was not emotionally attached to the situation or the dispute. I would just look at it as, 'He wants to leave; we have some interests that we need to protect. We can easily get these things worked out.'" ■

SOURCES

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- **Ram Kairam**, MD, Director of Pediatrics, Bronx-Lebanon Hospital Center. Phone: (718) 518-5760.
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Use of dead man's sperm raises ethical issues

The birth of a baby girl to California widow Gaby Vernoff in March was a blessed event for her and her family, but for many medical ethicists, it was an ominous warning about the need to establish ethical medical policies that keep up with advances in reproductive technology.

Last month, Vernoff became the first woman in history to give birth to a child conceived with sperm collected after the father's death. Urologist **Cappy Rothman**, MD, medical director of the California Cryobank and the Center for Reproductive Medicine at Century City Hospital in Los Angeles, surgically retrieved sperm from the body of Vernoff's late husband Bruce almost 30 hours after he had died in a Los Angeles Hospital.

Conceived from sperm frozen and stored after this event, the Vernoffs' daughter was born four years after her father's death.

Although the case made headlines across the country — including numerous newspaper and magazine articles and a segment on ABC's newsmagazine *20/20* — such technology and practice apparently isn't new. Rothman himself says he has performed similar procedures 12 times since 1978, although none of the other families decided to use the sperm.

Protocol developed by medical society

According to a March 28 article in the *New York Times Magazine*, the Birmingham, AL-based American Society of Reproductive Medicine has developed a protocol on "posthumous reproduction" to guide clinicians. Additionally, a 1997 survey by the University of Pennsylvania Center for Bioethics found that 14 clinics in 11 states had retrieved sperm from dead patients on behalf of grieving loved ones.

What are the ethics of "posthumous reproduction?" Should physicians and hospitals take part in creating potential human life from people who have died? Does retrieving a man's sperm without his consent and using it to create a child violate his reproductive rights? How should hospital physicians and administrators respond when receiving such a request?

The issue, obviously, has no clear-cut answers.

Many medical ethicists, interviewed by *Medical*

Ethics Advisor and quoted in the numerous articles on the Vernoff case, say that such a procedure cannot be performed on patients without their explicit indication that it would be in accordance with their wishes.

"I think, ethically, that you should not do it at all unless you have some proof of consent," states **Michelle Frelich Appleton**, a professor of law specializing in family and medical issues at Washington University in St. Louis. "In the best case, you would have some written document indicating that they wished to procreate after death."

Appleton cites the case of an attorney in California who committed suicide but willed to his girlfriend sperm that he had frozen, giving explicit instructions that he wanted her to use it to become pregnant.

"He clearly intended for her to have his children after death," she says. "We can say that there are all kinds of ethical reasons why he shouldn't be able to exercise that choice, but at least his intent was clear."

First concern is patient's consent

As providers of health care and as clinicians, the facility and its personnel have a duty to treat the patient, Appleton says. So, the issue of consent to the procedure should be their primary concern. "The patient could put that in some living will or power of attorney," she notes. "The problem is that we are not used to thinking about procreation in those terms, but I think we should start thinking like that. I think that is the better way."

With a sudden death, however, as in the Vernoffs' case and many others, she acknowledges, determining true consent would be difficult. "The surviving widow or family members could present a particularly sympathetic case, and I suppose you could argue that the person is dead, that person no longer has reproductive rights, so you could let the widow or family members have complete control over their reproductive destiny," she explains.

"I just don't see it that way," Appleton says. "Even in an effort to honor what we think the patient's wishes might be, we may actually be violating that individual's reproductive choice."

Although he agrees that determining the patient's own wishes is key to an ethical decision, **Mervin H. Needell**, MD, medical director of the Foundation for Bioethics and Philosophy at the University of Miami, says that in some cases the family's wishes might be compatible with acting in the patient's interest, even without that patient's express consent.

"I think you have to consider this issue in terms of how would you decide to perform an invasive procedure on a patient who, being incapacitated, is unable to give consent," he says.

"If that person were alive and competent, would it be a reasonable thing for him to decide?"

Using that scenario as a framework, Needell says physicians would look to a "proper surrogate," such as a wife or family member, who would be empowered to make other medical decisions for the patient. "The decision that the surrogate makes in this situation has to be made according to an ethical hierarchy," he says.

First, the surrogate should be asked whether the patient ever made any specific statements indicating a preference for the use of his sperm after death. "If we have that information, then, of course, you should follow his wishes. If we don't have that specific information, then we have to move on to substituted judgment," he says. "This means that we have someone who says, 'I knew him well, and given the circumstances in which we want to take semen from him, he would be willing to do it.'"

Keep donor's best interests in mind

Barring a person who can make that kind of statement, the clinicians must decide to proceed based on the patient's best interests or what they think a reasonable person in that situation would do. "If the patient is dead, then he has no interest. So, it falls to what a reasonable person would do," Needell says. "If that person were alive and competent, would it be a reasonable thing for him to decide?"

Needell acknowledges that this methodology does not take into account the legalities involved or the issues of who would be responsible for any child that is created as a result of the procedure. Instead his focus is on the ethical considerations of the caregivers.

"The procedure I have outlined, that is how I ethically think it could be done," he explains. "I think, given specific circumstances, that it would be reasonable to make a judgment that this would

SOURCES

- **Michelle Frelich Appleton**, Washington University, One Brookings Drive, St. Louis, MO 63130-4899.
- **Mervin H. Needell**, MD, Medical Director of the Foundation for Bioethics and Philosophy, University of Miami, Coral Gables, FL 33124. Phone: (305) 243-5723.

be a proper and correct thing to do."

Often, because it is the family making the request for the procedure, and essentially the family is called upon to determine the patient's wishes, there may be an inherent conflict, he says. "The critical decision is the impact on the autonomy of the individual. However, in considering the autonomy of the individual, you would want to take into consideration the family's grief and how this would matter to the individual. It would bring the family and their wishes into the decision making, but only secondarily."

Each patient's situation would be different and should be considered individually. "There is a lot more uncertainty to the specific cases than to the global procedure [for considering the decision]," he says. "You have to weigh individual circumstances and find out whether they fit or not."

Additional reading

Andrews LB. The Sperminator. *New York Times Magazine.* March 28, 1999. ■

State to offer money for organ donation

Stipend to offset funeral costs, spur donations

Advisors to Pennsylvania's governor are devising a plan to pay families of organ donors a $300 stipend to offset funeral costs. The idea is to encourage families to consider donation because the need for organs is much higher than the number of available organs. But the idea may not reach fruition due to potential legal hurdles. The National Organ Transplant Act of 1984, for example, prohibits the exchange of organs for payment.

Officials at the U.S. Health Resources and Services Administration in Washington, DC, concede that Pennsylvania has increased organ donation rates in the state. A recent federal rule requiring hospitals to notify organ procurement organizations of deaths was in fact modeled after a Pennsylvania law.

The program would be voluntary, says **Emilie Tierney** with the Pennsylvania Department of Health in Harrisburg. "The benefit will be made available for a funeral. It will be made available to family members or to whomever is responsible for the funeral, but it's voluntary, and the families don't have to accept the benefit." Funds would go directly to the funeral home and be charged against the funeral expense, Tierney adds.

Pennsylvania's Organ Donation Advisory Committee will present its recommendations early this month, but the health department will decide whether to recommend to implement the program, she says. Funding for the program would come from an existing budget in state finances.

The plan most likely would face opposition from the federal government as well as religious groups, says **Arthur Caplan**, PhD, director of the University of Pennsylvania Center for Bioethics. Caplan would serve as a monitor for the program should it be enacted. Religious groups might view offering a stipend as treating the body like a commodity, he says.

He says money has never served as a motivating factor in organ donation, but in Pennsylvania's case the stipend amount is so small it wouldn't have an impact on someone's decision, anyway. "The main obstacles to donation are religious concerns, aesthetic concerns, and anger over perceived inequities in access to transplants for the poor and minorities," he adds.

Plan greeted with skepticism

The organ donation stipend drew negative, skeptical reactions after it was revealed in a *New York Times* article published May 6. Medical practitioners and ethicists alike argue it could lead to the buying and selling of organs.

Pennsylvania's plan "is drawn from good intentions but is seriously misconceived," wrote **Jerome Groopman**, MD, a professor of medicine at Harvard in Cambridge, MA, in an editorial published the following day in the *New York Times*.

Groopman suggests that, if Pennsylvania adopts the plan, families might withdraw life

support from family members prematurely in order to benefit from the stipend. He also notes that other states could follow Pennsylvania's example but offer higher stipends, creating a "buyer's market" for organ donations.

Caplan disagrees. "I do not think a $300 payment toward funeral expenses will lead anyone to prematurely request withdrawal of a loved one from life support," he says. "Nor is it going to lead to anyone picking a state to die in that offers a subsidy for funerals."

Donations increase overall

Pennsylvania's efforts at increasing donations come on the heels of good news nationally. The number of organ donors increased 5.6% in 1998, according to the U.S. Department of Health and Human Services (HHS) in Washington, DC, and the United Network for Organ Sharing in Richmond, VA.

The national increase follows the launch of the Clinton administration's donation initiative in 1997. The increase also could be attributed to the regulation requiring hospitals to report deaths to local organ procurement organizations.

Preliminary data reveal the number of cadaveric donors increasing from 5,470 in 1997 to 5,788 in 1998. The increase is attributed to 600 additional organ transplants and up to 14,000 additional tissue transplants, according to HHS.

Tax benefit suggested as better option

Creating a fixed tax benefit for which participants could check a box on their income tax forms is one incentive Groopman suggests as a more appropriate method of encouraging donation. He also suggests that states waive the driver's license fee for people who choose to note their wishes of donating organs on their licenses.

Initially, any changes in Pennsylvania's policy may not be well-received among hospital personnel who approach families regarding organ donation, Caplan notes.

"It is hard to introduce incentives of any sort into a system that has been based on voluntary altruism for so long. Some doctors and nurses will, in all likelihood, not raise the issue of funeral expenses. Organ procurement organization personnel will do so, however, since they are more familiar with and comfortable with the new law," he says. ■

Guidance issued on use of restraints, seclusion

Two leading professional organizations have issued guidelines to help minimize the use of restraints and seclusion in behavioral health services. The guidelines suggest it may not be possible, or even necessary, to eliminate the use of restraints and seclusion altogether, and each instance must be carefully justified and monitored.

The advice was prompted in part by a recent analysis of sentinel events by the Joint Commission on Accreditation of Healthcare Organizations. Restraints and seclusion have drawn increased attention from family members and consumers in recent years, and regulatory bodies such as the Joint Commission are increasingly looking at restraint and seclusion as a sign of poor quality of care. Federal hearings on restraints and seclusion are planned for this year.

The Chicago-based American Hospital Association (AHA) and the National Association of Psychiatric Health Systems (NAPHS) in Washington, DC, issued the guidelines recently to help hospitals prevent death and injury related to the use of restraints or seclusion. Ethics committees could play a role in revising or writing policies in hospitals related to restraints.

The AHA and NAPHS serve on the Joint Commission's board-level task force on restraint and seclusion, which is holding public hearings this spring and will make recommendations on any needed changes to current restraint and seclusion standards. The groups also are working with the American Psychiatric Association in Washington, DC, to identify best practices.

This is the advice from the AHA and NAPHS:

- A patient's overall treatment should be based on a comprehensive, individualized treatment plan that includes appropriate patient and family involvement.
- Hospitals and other treatment settings serve individuals with severe mental illnesses and substance abuse problems who are, at times, dangerous to themselves or others.
- Restraint and seclusion should be used as infrequently as possible and only when less-restrictive methods are considered and are not feasible.
- Restraint and seclusion are emergency interventions that aim to protect patients in danger of harming themselves or others and to enable

patients to continue treatment successfully and effectively.

• Prevention of injury and death is essential.

• Hospitals and other treatment settings must ensure that staff are well-trained and continuously educated regarding the proper use of restraint and seclusion. Detailed policies, procedures, and systems must be developed with input from physicians and other mental health professionals, and they must be understood and followed by all staff.

To improve and reduce the use of restraints and seclusion in your facility, the AHA and NAPHS suggest you organize a team to make a systemwide assessment of your restraint and seclusion policies and procedures. The team should include key clinical staff such as the medical director, quality assurance director, program directors, director of nursing, and intake director, along with key administrative staff such as the administrator, marketing or public relations director, security director, and others.

This type of review should be part of your organization's continuous quality improvement process, with the review conducted frequently. Frequent reviews will help ensure that policies are up-to-date and followed by all staff.

Groups favor these program components

The AHA and NAPHS conclude that restraint and seclusion can be life-saving and injury-sparing emergency interventions when used properly. They recommend the following:

• policies and procedures on how to employ restraint and seclusion safely (including understanding the risks and benefits of intervening or not intervening);

• a process for continuously reevaluating the need for restraint or seclusion;

• a process for continuous monitoring to ensure patients' safety and other needs are met;

• a policy requiring that a physician (or other licensed practitioner as permitted by state law) should authorize use of restraint or seclusion in a timely manner. This licensed clinician must be involved in the decision to continue the use of restraint or seclusion;

• consideration of the safe and appropriate use of medication as an alternative to restraint and seclusion and in reducing the length of any episode;

• a system for assessing and understanding the needs of patients before they enter treatment;

• well-trained and adequate numbers of staff to handle the complexity of the patients served;

• a clinical strategy for intervening as early as possible before behavior has escalated to a point requiring seclusion or restraint;

• a system for carefully and routinely monitoring use of restraint and seclusion so you can evaluate ways to reduce its use in the future.

In reviewing your current policies and procedures, the AHA and NAPHS suggest looking at these factors:

• assessment activities (e.g., preadmission screening, history of aggressive behavior or assault, previous experience of restraint or seclusion, history of trauma, review of triggers, and input of family and others);

• development of an individualized, comprehensive, multidisciplinary treatment plan that addresses issues identified during the assessment process with focused attention to the needs of special populations (children, adolescents, elderly, and developmentally disabled);

• role of patients, family, and others, as appropriate, in the development of the treatment plan;

• consideration of the use of medication in the ongoing and emergency treatment of the patient;

• staff development with special emphasis on management strategies, assessment, identification of early signs of behavioral change, early intervention/crisis prevention techniques, de-escalation techniques, specific implementation of restraint or seclusion procedures (with opportunities for regular drills or practice), safe care and observation of patients in restraint or seclusion, review and analysis of restraint and seclusion episodes with attention to impact on patients, staff, and others;

• comprehensive plan for monitoring performance improvement that includes appropriate goals for reducing use of restraint and seclusion, collection and analysis of aggregate data with

SOURCES

- **Kathleen McCann**, RN, DNSc, Director of Clinical Services, National Association of Psychiatric Health Systems, 1317 F. St., N.W., Suite 301, Washington, DC 20004. Phone: (202) 393-6700, ext. 11. Free copies of the guiding principles may be obtained from NAPHS by calling (202) 393-6700, ext. 15.
- **Karen Milgate**, Senior Associate Director of Policy, American Hospital Association, 325 Seventh St. N.W., Washington, DC 20004. Telephone: (202) 626-4628.

attention to trends, and analysis of efficacy and appropriateness;

• review of accrediting and regulatory bodies' requirements (Joint Commission, the Health Care Financing Administration, state law, local departments of health, etc.);

• review of the procedures for reporting routine information as well as for reporting critical and sentinel events;

• plan for soliciting and incorporating feedback, as appropriate, from consumers and families regarding their experience of restraint and seclusion;

• plan for managing concerns or complaints of patients, family members, and consumer groups regarding restraint and seclusion. ■

Congress takes divided approach to confidentiality

AHIMA speaks out on provisions in new bills

Everyone seems concerned about the confidentiality of health information, but no one seems to agree on how to best ensure confidentiality is maintained.

In fact, the current legislative agenda has at least four separate bills dealing with the issue of confidentiality, but nothing has reached the president's office for a signature. The proliferation of bills and heated debates could mean that ethics committees will have no clear guidance on developing a policy that complies with any new legislation until the last minute.

What's more, time is running out: The Health Insurance Portability and Accountability Act of 1996 mandates that Congress pass health information confidentiality legislation by Aug. 21, 1999.

One industry group, the American Health Information Management Association (AHIMA) in Chicago, is becoming outspoken on the issue and saying Congress is taking the wrong approach.

The problem exists in three bills introduced to Congress on March 10. Senate bill 573 and its House of Representatives counterpart, HR 1057, include provisions that ultimately could endanger health information — not protect it, attests **Linda L. Kloss**, RRA, executive vice president and CEO of AHIMA.

S 573 is sponsored by Sen. Patrick J. Leahy, (D-VT), and HR 1057 is sponsored by Rep. Edward J. Markey, (D-MA). The bills, both named the *Medical Information Privacy and Security Act*, aim "to provide individuals with access to health information of which they are a subject, ensure personal privacy with respect to health care-related information, impose criminal and civil penalties for unauthorized use of protected health information, provide for the strong enforcement of these rights, and protect States' rights."

However, S 573 and HR 1057 contain provisions that would fail to preempt state health information confidentiality laws comprehensively, leaving in place the current patchwork of state laws and rules federal intervention is supposed to remedy, Kloss says. She also is concerned that these bills would treat various types of health information differently and make it impossible to maintain uniformly high standards for the management of records.

"Currently, each state has different laws and rules for maintaining health information confidentiality. Some states have none," she says. "AHIMA members know that the confusion caused by this lack of consistency can lead to errors and potentially breaches of confidentiality."

The third bill, S 578, the *Health Care Personal Information Nondisclosure Act*, also known as the PIN Act, fails to include comprehensive preemption language, she says. S 578 is sponsored by Sen. Jim Jeffords, (R-VT) and aims to "ensure confidentiality with respect to medical records and health care-related information, and for other purposes."

"One of the goals in the effort to develop federal confidentiality laws or rules is to create a single national standard that establishes a high level of protection for everyone," Kloss says. "These bills fall short of that goal."

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In addition to the preemption issue, provisions in S 573 and HR 1057 that codify different levels or methods of protection for various kinds of patient information are problematic, she says.

"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. It also incorrectly implies that one type of health information is more important than another," she explains.

"Professionals know that waving a red flag over certain portions of a record in the name of protection may have the opposite effect. People are curious by nature and may be drawn to a record's flagged portions," she says.

Kloss also says that one provision's concept of giving patients the choice of computer or paper-based records is unrealistic. "The premise of this provision is a fallacy. Computer-based patient records are safe and no less prone to confidentiality breaches than paper records," she says. "In fact, it's possible to build safeguards into computer-based patient record systems that limit access to records and / or keep a record of who has attempted to access them. These kinds of safeguards cannot be built into paper-based systems."

The mentioned provision also does not take into account the many benefits of computer-based patient records, Kloss says. Those include:

- enhanced patient care;
- more accurate data for research;
- greater overall efficiency / cost effectiveness;
- technology-based confidentiality protections.

"It's also important to note that no other type of businesses are mandated to give customers a choice between doing business electronically or on paper," she points out.

Even with the problems with the current legislation, AHIMA will continue to work with Congress and the Clinton administration as it has over the past several years. The goal is "to produce meaningful, effective confidentiality legislation," Kloss says.

AHIMA has publicly endorsed a fourth bill, however, which contains language that addresses many of these problems. S 881, the Medical Information Protection Act (MIPA), was introduced in late April by Sen. Robert Bennett (R-UT). Key provisions of S 881 and the reasons they are important, according to AHIMA, include the following:

- **Preemption of state confidentiality laws:** Federal legislation should produce a single national standard for handling patient records. By preempting current state confidentiality laws, MIPA would create strong national standards that patients could understand and health care providers could follow. "Having 50 separate laws creates confusion and puts health information at risk," says Kloss. "As long as the federal law is strict and really protects health information, as a nation we can feel comfortable about preempting state laws."
- **Same treatment for all health information:** Employing unique methods for handling various kinds of health information, such as mental health and genetic information, while perhaps well-intended, in the end makes health information more vulnerable.
- **Patient access to their records:** MIPA would give patients the right to see and obtain copies of their records as well as ensure their accuracy.
- **Patient consent for disclosures to third parties:** Third parties, such as marketers, would be able to gain access to information only if patients give their consent beforehand. ■

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NEWS BRIEFS

Fertility group supports employer coverage

A ruling from the U.S. Equal Employment Opportunity Commission (EEOC) in late April was hailed by the American Society for Reproductive Medicine in Birmingham, AL.

The EEOC ruled that a national publishing company's "exclusion of medically necessary treatments for infertility" violated parts of the Americans with Disabilities Act and Title VII of the Civil Rights Act.

"The EEOC ruling is an important first step in helping the more than 6.1 million American women and their partners, or about 10% of the reproductive-age population, who suffer from the disease of infertility," says **Larry Lipshultz**, MD, president of the American Society for Reproductive Medicine. All patients have the right to seek and receive treatment for their medical problems, he adds. ▼

New York focuses on advance directives

An independent health care quality evaluation organization is promoting patient use of advance directives and encouraging hospitals to provide more information about them in New York state.

IPRO, an independent, nonprofit organization in Lake Success, NY, began the study last year and will remeasure its progress later this year. IPRO abstracted information from medical records on two sample patient groups: those admitted with congestive heart failure (CHF) and those admitted for an elective total hip or knee replacement procedure.

Researchers hypothesized that patients would use an advance directive if their disease was more severe. A total of 58 hospitals are participating in either the CHF or the surgery portion of the study. CHF patients are on average four years older than the surgery patients. Participants are 41% male and 37% female. Also, CHF patients have a longer length of stay, averaging 7.6 days vs. 5.8 days for surgery patients. Key findings from the initial phase include:

• 63% of CHF patients, compared with 64% of surgery patients, received information from hospitals regarding their rights to an advance directive prior to or upon admission. This finding was not, however, related to the severity of diagnosis.

• About one-third of patients in either group had executed an advance directive prior to hospital admission. This finding also was not related to severity of diagnosis.

• Less than 15% of patients without an existing advance directive executed one during their hospitalization.

• Only one-third of preexisting advance directives were placed on the chart at any time during hospitalizations.

• Of the 43 patients who died during the study, 37% did not have an advance directive documented in their chart prior to death. ■