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IN THIS ISSUE

Special Report:
Merging Religious, Secular Hospitals

Continued on next page

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Religious, secular hospital mergers pose challenges for ethics committees

Committees can take the lead in creating harmony

As the market for providing health care gets increasingly competitive, "merger mania" is continuing to sweep the nation. More and more community hospitals are becoming part of larger health systems to take advantage of economies of scale and consolidation of services.

While this may be good for the bottom line, many communities are finding the consequences devastating when the merging organizations don't take steps to develop a common mission before finalizing their agreement.

Special Report: Merging Religious, Secular Hospitals

"My view about hospital mergers is that it is a merger at the level of the business, but it is also a blending of cultures," says **Stephen E. Lammers**, a published expert on medical ethics and religious issues and a professor of religion at Lafayette College in Easton, PA. He also is a consulting humanist for a local hospital, Lehigh Valley Hospital Center, where he serves as a member of the center's institutional review board and ethics committee.

"You may have a religiously affiliated hospital and one that is not. Or it could be a not-for-profit hospital or public hospital and a for-profit system that are merging. Or you may just have two different hospitals, each with a different pace and way of doing things. The important thing for ethics committees to realize is that they are part of a distinct

IN THIS ISSUE

COMING IN FUTURE ISSUES

■ **Special report:** The Human Genome Project and what it means to you.

■ **When do human trials go too far?** Should patients risk their lives for the sake of clinical research?

■ **Informed consent and sham surgeries:** Ethical issues of performing 'fake' surgeries take center stage.

■ **Is it OK to lie to get coverage for patients?** The lengths providers go to when helping patients battle medical necessity.

■ **The role of pharmacists in assisted suicide:** Often not considered a link in the physician-patient chain, pharmacists play a vital role.

hospital culture, and first they need to consider several issues of how their hospital approaches things and how the other hospital approaches the same issues," explains Lammers.

Complicating matters further, the last five years have seen an increase in the number of mergers between religiously affiliated hospitals — particularly larger, not-for-profit Catholic health systems — and secular hospitals. According to statistics from the St. Louis-based Catholic Health Association of the United States, there were 16 mergers or affiliations between Catholic hospitals and non-Catholic facilities in 1994. There were 35 such arrangements in 1998.

Dilemmas go beyond culture clash

The growing frequency of these types of mergers pose problems beyond just a culture clash, notes **Ann Pasley-Stuart,** SPHR. Pasley-Stuart is president of Pasley-Stuart HR Consultants, a professional human resources consulting firm specializing in retaining workers, change management, and conflict resolution.

"There are a lot of issues to consider," she explains. "One is that very often services are going to be limited. The classic case is a for-profit system taking over a not-for-profit; it is highly likely that charitable services will be changed, curtailed, or even eliminated."

Special Report: Merging Religious, Secular Hospitals

Many religious charitable hospitals were founded with a mission to care for the entire community, including providing services to the poor, Stuart notes. A shift to a system that is profit-driven can be stressful for the staff, even leading to large numbers of resignations, if staff feel the hospital no longer meets its mission.

In addition, Catholic hospitals must adhere to a set of rules, established by the National Conference of Bishops, which is known as the Ethical and Religious Directives for Health Care. These rules govern which services may or may not be provided at Catholic facilities, with the issues of physician-assisted suicide, abortion, contraception, and reproductive health services receiving the most public attention. **(For additional information on the debate, see story, p. 128.)**

The merging hospital may be asked to come under the directives in order to affiliate with the sectarian hospital.

"In the case of the Catholic and other religious organizations, the A-word always comes up," Stuart continues. "Will the hospital provide abortion services? What about employee benefit programs? Will these services be covered by health insurance? What about coverage of birth control or sterilization procedures?"

Committee plays a leading role

Hospital ethics committees need to be prepared to play a leading role in facilitating or guiding a merger that its administrators believe should happen, say Stuart and Lammers.

"The classic role of the ethics committee is to educate themselves and then educate others about a particular issue, and that should hold true in this case," Lammers notes.

There are two key areas where "the rubber meets the road" in these mergers, and they should be examined by the committee with an eye toward developing policy for the new organization that both of the original hospitals can live with.

"One is the issue of commitments to charity care and medical education that might be subject to change," says Lammers. "The second would be, as in the example of the Catholic hospital, issues around abortion or reproduction or other services that might be subject to change."

Examine your 'internal culture'

The committee also should be prepared to examine its internal "culture" to determine the institution's core values, goals, and approach to providing medical care and then compare these core characteristics to those of the other organization.

"Examine the differences in mission and philosophy," he advises. "That involves more than reading mission statements. It involves asking yourselves, 'What do they do in areas that we think are important?' and 'What do they not do in areas that we think are important?' etc. That way you can at least lay out the issues for the people on your side."

For the process to work effectively, both experts agree, the committee must be focused on organizational as well as clinical ethics.

"There should already be an organizational or human resources person or component in the ethics committee," says Stuart. "You should have the person in charge of the people at the

CME questions

1. When religious-based health systems and secular hospitals merge, the important thing for ethics committees, according to Stephen E. Lammers, a published expert on medical ethics and religious issues and head of the department of religion at Lafayette College in Easton, PA, is to:
   - **A.** Realize the committee is part of a distinct hospital culture.
   - **B.** Consider several ways to approach conflict.
   - **C.** Consider how the other hospital approaches similar issues.
   - **D.** All of the above.

2. A classic scenario when religious and secular hospitals merge, says Ann Pasley-Stuart, SPHR, president of Pasley-Stuart HR Consultants, a professional human resources consulting firm, involves the likelihood:
   - **A.** Chaplain services will comprise a larger role in patient advocacy.
   - **B.** Charitable services will be curtailed or eliminated.
   - **C.** Patients will be denied certain services.
   - **D.** All of the above.

3. An overlooked effect of a loss of reproductive health services in hospital merger situations, according to Catherine Weiss, director of the American Civil Liberties Union's Reproductive Freedom Project, is:
   - **A.** Missed diagnoses of diseases from lack of preventive screenings.
   - **B.** Higher costs in family planning in community clinics.
   - **C.** Insufficient training in women's health care for residents.
   - **D.** All of the above.

4. The same values that cause the Catholic Health Association to oppose abortion and assisted suicide, according to Dennis Brodeur, PhD, senior vice president of stewardship for the St. Louis-based Sisters of St. Mary Health Care System, also drive:
   - **A.** Its commitment to ensuring universal access to health care.
   - **B.** Its emphasis on providing care to the poor.
   - **C.** Its desire to maintain health facilities in rural, underserved areas.
   - **D.** All of the above.

organization on the committee, and most do, but not all. This is an excellent opportunity for the ethics committee to really shine." **(For additional information on developing a mission statement, see p. 132.)**

'Strong commitment' required

In the best-case situations that Stuart has witnessed, the committee incorporated staff and community focus groups into its discussions to determine the impact of the merger and head off problems.

"The ones that have worked well are those that had a strong commitment for the merger to succeed. Both organizations were committed to excellence and just redefined excellence in terms of the newly merged organization," she relates. "The transitions were handled very well, and it was expensive to do it correctly, but well worth it. If your staff leaves, it is going to be more expensive."

Committee can spot problems

In addition to helping a merger succeed, the ethics committee might be able to foresee irresolvable differences in policy, values, and culture that would make a joint agreement unworkable, adds Lammers.

"The committee is going to have to be very proactive and insert themselves into this process," Lammers advises. "The committees totally focused on clinical ethics are not well-situated to do this. Committees that have started to move into the realm of organizational ethics are more prepared. It is more natural for them to know about the situation and be asked about it because the staff and administration would be aware that there would be ethical issues involved." ■

SOURCES

- **Ann Pasley-Stuart**, Pasley-Stuart HR Consultants, 2301 Hillway Drive, Boise, ID 83702.
- **Stephen E. Lammers**, Lafayette College, Easton, PA 18042-1773. Telephone: (610) 330-5000.

Is restricting services at secular hospitals OK?

Religious freedom vs. impact on public health

The debate over access to reproductive health services, particularly abortion, has seen many battles in the legal and legislative arenas. But the growing number of secular hospitals merging with religiously affiliated health systems may end up making those debates moot.

In many cases, when a hospital decides for financial reasons to merge with a church-run hospital, the administration of the first hospital finds that it must agree to limit or end services the church disapproves. In some communities, that has resulted in a loss of reproductive health services to an entire city or county.

Lorain (OH) Community Hospital, for example, stopped providing elective sterilizations and other reproductive health services after merging with St. Joseph Regional Hospital, according to information published by Mergerwatch, a project of the nonprofit advocacy group Family Planning Advocates of New York State. Mergerwatch monitors health care mergers and acquisitions nationwide for their impact on access to reproductive health care.

Special Report: Merging Religious, Secular Hospitals

According to the Reproductive Freedom Project of the American Civil Liberties Union, Nashville, TN-based Columbia/HCA Healthcare Corporation initially agreed to stop providing abortion services at 18 of its Georgia hospitals and would prohibit physicians who worked at the hospitals from providing abortion services if a joint venture between HCA and Georgia Baptist Medical Center were approved. Although the proposed venture later dissolved, family planning advocates were concerned that such a large health system would readily agree to halt such services in order to merge with a church-owned institution.

"Not only do these agreements signal a loss of reproductive health services to large segments of the population in what may be their health plan hospital or closest hospital, it also means that training is affected, because residents who train for obstetrics and gynecology in these settings are graduating with what many consider to be an

insufficient education in women's health care," says **Catherine Weiss**, director of the ACLU's Reproductive Freedom Project.

The project has funded legal challenges to a number of secular/sectarian hospital mergers on antitrust grounds, as well as challenges that question the legality of religiously affiliated hospitals accepting federal funds in the form of Medicare and Medicaid reimbursement and refusing to provide legal medical services.

However, many states now have "conscience clauses," laws permitting individuals, health care facilities, and, in some instances, health plans to withhold services to which they have religious, ethical, or moral objection.

Weiss says she believes that to be an inappropriate extension of religious exemption from civil duties. "In addition to examining the public health issues in terms of what services should be available, the ACLU is also looking at this in terms of what is an appropriate religious freedom claim and [what is] an inappropriate and unjustified religious freedom claim."

Catholic health care plays leading role

Although access to certain reproductive health services — mainly abortion, sterilization, dispensing of contraception, and infertility treatments — are restricted at many hospitals owned by religious organizations, the focus of many family planning and choice advocates' opposition is on Catholic-owned and operated health systems.

According to statistics from the New York City-based Alan Guttmacher Institute,[1] a nonprofit reproductive issues research organization, Catholic hospitals comprise the largest single group of religiously sponsored hospitals and health systems in the United States. In 1996, five of the nation's 10 largest health care systems were Catholic.

Catholic hospitals are governed by a set of rules established by the National Conference of Bishops. These rules, known as the Ethical and Religious Directives for Catholic Health Care Providers, set out the church's position on providing health care. Among the directives are items prohibiting the performance of abortion and restricting the provision of contraception, family planning, sterilization procedures, and fertility treatments.

The Washington, DC-based Catholics for a Free Choice, a nonprofit pro-choice advocacy organization, estimates that of the 127 Catholic hospital mergers since 1990, half of the secular merging organizations agreed to adopt the Catholic hospital's policy and abide by the *Directives*.

Catholic health care officials emphasize that their position on abortion and other reproductive health services is rooted in their basic mission of preserving life and holding all life as equal in worth.

"Reproductive service issues are very important issues to our community and to our society as a whole, but they are not the most important issues in these joint ventures," contends the Rev. **Dennis Brodeur**, PhD, senior vice president of stewardship for the St. Louis-based Sisters of St. Mary (SSM) Health Care System. SSM is a Catholic system that owns, operates, and manages 19 acute care hospitals and participates in integrated health systems in Missouri, Illinois, Wisconsin, Oklahoma, Georgia, and South Carolina.

"Reproductive services get so much media attention, when the long-standing constant availability of a variety of services to the entire community is a much larger issue," says Brodeur.

He emphasizes that the same values that cause the Catholic health system to oppose abortion and physician-assisted suicide also drive its commitment to ensuring universal access to health care, including an emphasis on providing health care to the poor and maintaining health facilities in rural, underserved areas.

"Those are the things that are most at-risk when health care systems merge," Brodeur explains.

He also disputes the widely disseminated notion that Catholic systems force their secular partners to completely abandon the reproductive health services they previously offered.

"For us, I think the abortion piece they would definitely have to agree to [stop providing]," he says. "On the contraceptive or other reproductive services, if we are working with an other-than-Catholic facility, we have generally not had restrictions on all of those reproductive services. Our intention is not to get those people to all of a sudden to be Catholic or join the Roman Catholic Church."

However, Brodeur sees economics forcing hospitals, both religious and otherwise, to consider which services they should offer that will benefit the most people in the communities they serve.

"We do make decisions on where the focus should be, what the goals should be," he says. "We serve a lot of rural areas. We are probably

not going to spend the money to offer in vitro fertilization at a rural health center that has trouble funding a legitimate CAT scan. We are unlikely to put in a normally noncovered service at $25,000, that most of these people in rural America cannot afford anyway."

He adds that, for many of the communities in which Catholic hospitals operate, access to abortion services already was limited by factors separate from religion.

"If you come to Missouri or southern Illinois for a reproductive program — in Illinois, for example, from Mt. Vernon south you're going to have to go to a program associated with the University of Illinois at Carbondale, its medical school, or you're going to have to go to Springfield and one of its clinics there. That is not a religious or Catholic thing. It is a matter of having a bunch of 3,000-person towns where no one is going to open a reproductive services clinic," he explains.

Legal and ethical questions remain

Weiss of the Reproductive Freedom Project disputes the contention that Catholic hospitals respond to the community mores rather than force their ideals upon the community through economics. For example, most abortions, both she and Brodeur acknowledge, are performed outside the hospital at freestanding health clinics.

"That is true. But, the problem is that in most places, by regulation or by policy, freestanding clinics that perform surgery must affiliate with a hospital," Weiss explains.

"If a patient goes into crisis during the operation, they have someplace to take her immediately where they know she will be taken care of. The Catholic system does not affiliate with freestanding abortion clinics because that is prohibited in the directives.

"If the Catholic hospital and its affiliates are the only hospitals in an area, you cannot open a freestanding abortion clinic. That is why it affects the availability of services in whole regions. When you compound this with the lack of medical education in these services, it starts to present a public health problem of much greater magnitude than it originally looked like, right?" she says.

The ACLU recently sought to challenge the "conscience" claims of religiously affiliated hospitals, because it feels their religious exemption has been applied inappropriately, Weiss adds. "Religious institutions exist in a special place in American civil law, and they are freed and ought to be freed of the requirements of civil law in many of their activities. However, what we have traditionally considered to be an exempt organization was an institution that was a pervasively sectarian organization engaged in religious practices. The institution exists mainly to inculcate religious tenants.

"What we [the ACLU] will not recognize is an institution that asserts an exception and then wants to impose it on everyone else at that institution, regardless of their faith, and that institution is not a pervasively sectarian institution designed for a religious function," Weiss continues.

That category includes nearly every sectarian hospital in the country, she adds. "They all receive public money in the form of Medicare and Medicaid, and they all employ and serve diverse populations; they are not limited to serving and employing people of their own faith.

"Why is it in conformity with either ethics or law to allow that institution to require all of its providers and patients to conform with its religious views?" questions Weiss. "That is out of step with our notions about what conscience is about and that it is exercised at an individual level."

Reference

1. Alan Guttmacher Institute. *Emerging Issues in Reproductive Health: A Briefing Series for Journalists. Fact Sheet: Affiliations Between Religious and Secular Health Care Facilities.* New York City; Jan. 29, 1998. ■

SOURCES

- **Dennis Brodeur**, PhD, SSM Health Care System, 477 N. Lindbergh Blvd., St. Louis, MO 63141.
- **Catholics for a Free Choice**, 1436 U St. N.W., Suite 301, Washington, DC 20009-3997. Telephone: (202) 986-6093. Fax: (202) 332-7995. E-mail: cffc.igc.apc.org.
- **Alan Guttmacher Institute**, 120 Wall St., New York, NY 10005.
- **Mergerwatch**, The Education Fund of Family Planning Advocates of New York State, 17 Elk St., Albany, NY 12207.
- **Catherine Weiss**, Reproductive Freedom Project, American Civil Liberties Union, 125 Broad St., New York, NY 10004-2400.

Catholic groups disagree on impact of mergers

Published report sparks debate among groups

In April of 1999, the nonprofit advocacy group Catholics for a Free Choice (CFFC) released a controversial report, "Caution: Catholic Health Restrictions May be Hazardous to Your Health."

The report is based on a CFFC survey of almost all Catholic hospitals in the United States, as well as an interpretation of data collected by the Baltimore-based Health Care Financing Administration. The report makes several claims about the state of Catholic health care and its impact on the overall availability of reproductive services in the U.S. health system. Statistics from the report have been published widely in the national media, including several consumer magazines. Among the claims are these:

Special Report: Merging Religious, Secular Hospitals

- Emergency contraception is denied to rape victims at most Catholic hospitals.
- Since 1994, there has been a 20% increase in the number of counties in which a Catholic hospital is the sole provider of health care.
- Catholic sole-provider hospitals enjoy higher-than-average rates of Medicare reimbursement and face little competition.

The St. Louis-based Catholic Health Association of the United States (CHA), the national organization representing Catholic health care institutions, contends that CFFC used faulty survey methodology and presented the resulting data in an inaccurate manner. CHA has assembled a response to the report, claiming to contradict its findings. Hospital officials can obtain copies of both reports by contacting the individual organizations. **(See box at right for details.)**

Here are the highlights of some key areas:

CFFC claim: A survey of 589 emergency departments at Catholic hospitals found that most refuse emergency contraception to rape victims.

CHA response: CFFC surveyors called the emergency departments and asked if the "morning-after pill" was available, CHA claims. If the person responding indicated it was not, the surveyor reported that the hospital did not provide emergency contraception. CHA contends that this methodology "confused the issue of abortion and emergency contraception for the purpose of obtaining a preordained result."

Catholic hospitals do provide emergency contraception to rape victims in the form of medications to suppress ovulation or impede fertilization once a physician determines that the patient is not already pregnant, CHA states. This is in accordance with the Ethical and Religious Directives for Catholic Health Care Services.

CFFC claim: The number of Catholic sole providers of care (counties in which the only hospital is a Catholic hospital) grew by 20% since 1994.

CHA response: An independent analysis by The Lewin Group, an organization that tracks health care mergers, reports that the number of Catholic sole providers grew by only four, with 88 Catholic hospitals as the sole provider, representing 5% of all hospitals that are sole providers in any county. In addition, CHA claims that only 11 of the 88 hospitals are located more than 35 miles from an unaffiliated hospital in an adjacent county.

CFFC claim: The Health Care Financing Administration's prospective payment system gives sole community hospitals special payment exceptions. Catholic sole providers receive these payment exceptions while denying legal and needed services.

CHA response: "Sole provider" is not a HCFA designation, and sole-provider hospitals do not receive special payment considerations under Medicare unless they also are the sole community hospital, a different designation, CHA claims; 41 Catholic hospitals are designated as sole community hospitals, a number that has not changed since 1994. ■

SOURCES

- "Caution: Catholic Health Restrictions May be Hazardous to Your Health" costs $7 and may be ordered by writing to **Catholics for a Free Choice**, 1436 U St. N.W., Suite 301 Washington, DC 20009-3997. Telephone: (202) 986-6093.
- **The Catholic Health Association of the United States**' point-by-point response to the Catholics for a Free Choice survey is available by writing to: Catholic Health Association, National Headquarters, 4455 Woodson Road, St. Louis, MO 63134-3797. Web: http://www.chausa.org.
- **The American Civil Liberties Union's** reproductive rights report, "Hospital Mergers: The Threat to Reproductive Health Services," is available on the Web at http://www.aclu.org.

GUEST COLUMN

Mission statements: What should yours do and say?

Students conduct an intensive study

By **Robert T. Hall**, PhD
Professor and Chair
Department of Sociology and Philosophy
West Virginia State College
Institute, WV

What should an organizational mission statement say? The short answer is that a mission statement should reflect the actual goals of the organization and that all organizations don't have the same goals.

Attention is now focusing on health care organizational mission statements in a variety of ways. The leadership standards of the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, call for hospital planning to define an organizational mission (vision, goals, or values) and for leaders to communicate this philosophy throughout the organization and implement patient services consistent with it. The standards are found in sections LD 1.1-1.3 of the Joint Commission's accreditation manual.

Tax officials in some states now also are reviewing the tax-exempt status of not-for-profit hospitals with a view to the social goals contained in their mission statements.

In an effort to find out just what health care organizations were claiming as their mission, students in an applied social research class at West Virginia State College in Institute, WV, collected and analyzed 108 hospital mission statements they found on the Internet.

The statements were not a random sample, but they do give a quick look into the matter of mission statement development. A preliminary review of about twenty statements provided students with a checklist of items. The whole collection was rated and cross-checked for accuracy.

Hospitals were categorized as nonprofit and for-profit, religious or secular, and small (fewer than 200 beds) or large. Although nearly all of the organizations surveyed mentioned quality patient care (94%), only about half saw physicians, professional staff development, community health services, education programs, or employee welfare as important enough to mention.

Only a quarter of the institutions surveyed committed themselves publicly to equal treatment for ethnic and racial minorities, and only

Percentage of Hospital Mission Statements that Included Predetermined Goals

Organizational Goal Statements Covering	Total	Religious	Secular	< 200 Beds	> 200 Beds
Patients	94.4	88	95.9	94.4	89.7
Physicians	54.2	48	53.4	52.8	51.3
Professional Staff	48.6	64	45.2	44.4	56.4
Employees	50	60	48.6	48.6	43.6
Community Health Programs	50.5	56	46.6	44.4	56.4
Public Education Programs	45.8	56	45.2	36.1	48.7
Minorities	26.2	48	20.5	19.4	25.6
Charity Care	20.6	40	15.1	19.4	23.1

Source: West Virginia State College, Institute, WV.

Include these goals

The following model hospital mission statement contains social goals that health care organizations should consider.

It is the mission of model hospital to:

- ✔ Provide the best available medical care to our patients, honoring their rights to determine the course their treatment.
- ✔ Employ open and ethical business practices in our dealings with patients, professional associates, allied service providers, and business partners.
- ✔ Provide a fulfilling place of employment to our professional staff and employees, including appropriate compensation, healthful working conditions, and opportunities for education and advancement.
- ✔ Offer care to all without regard to race, religion, or ethnic identity and to the extent that our resources permit, irrespective of the ability to pay.
- ✔ Offer health and wellness programs and health education to the people of our service area.
- ✔ Use the resources provided by benefactors, foundations, and public entities as efficiently as possible in the pursuit of these goals. ■

20% saw charity care as a significant goal. The results showing the percentage of hospitals that included checklist items as important goals within the mission statement can be found in the **chart on p. 132**.

Unfortunately, many health care organizational mission statements sound as though they were written by college sophomores in a public relations course. Phrases include, in some way or another, "we want to be the best" or "we treat our patients best." There also are a certain number of currently trendy phrases from marketing consultants, such as "the first choice of our customers" or "state-of-the-art" health care.

It is no secret that mission statements are ceremoniously passed out only to be put on the shelf until needed for the next public groundbreaking ceremony or recognition dinner. These mission statements actually say little about the real organizational goals. At best, they are vague ideals that will be have to be fleshed out when the organization faces serious questions about what it stands for. At worst, the mission statements actually are intended to say nothing — to commit the organization to no specific goals at all. If an organization is committed only to satisfying the needs and desires of its patients or to keeping itself in business with a healthy bottom line, it may not want to be on record as committed to many specific social goals.

Don't ignore the community

Of course, organizations can claim that other goals are included in their overriding aim to satisfy patients' needs and desires. Unfortunately, however, it is quite possible to focus on patient service while ignoring community educational needs, underserved populations, and local economic problems or while mistreating employees, suppliers, allied health professionals, and even administrators. Health care organizations can even treat physicians unfairly, although most realize that the physicians who bring in the patients are their real customers.

The fact remains that there is a great number of mission statements, including many that have been formulated by health care management consulting firms, that are worthless. If hospitals and health care organizations are committed to a broad range of social goals, they ought to state them. Otherwise, we are left to presume that their major interest is only to perpetuate the organization.

As a result of the review of hospital mission statement, students developed a model mission statement that lists several social goals. Hospitals and other health care organizations should consider incorporating the goals into existing mission statements or new statements that are in development.

(For a list of the suggested organizational goals, see box, above left.)

A model mission statement is not likely to be very specific or very useful in terms of helping a hospital develop a unique mission statement. A model statement can, however, assist in challenging administrators and governing boards to consider what the organization's real mission is.

(Editor's note: Hall is the author of An Introduction to Healthcare Organizational Ethics, *to be published by Oxford University Press next year.)* ■

NEWS BRIEFS

New cultural guide now available

Created in response to "dramatic changes in the nation's demographics," the American Medical Association in Chicago published a book in September to help physicians understand patients' cultural backgrounds.

The book, *The Cultural Competence Compendium*, includes resources available from organizations that focus on cultural competence, including information about spiritual practices and self-help resources.

The 460-page book can be purchased from the American Medical Association. Telephone: (800) 621-8335. It also can be downloaded from the AMA's Web site free of charge. Access the site at http://www.ama-assn.org/ethic/diversity/contents.htm. ▼

Medication errors worry patients most

Highest of 10 common concerns

The potential for medication mix-ups ranks highest among 10 common concerns of patients in hospitals and components of health systems.

The results of the study, conducted by the Bethesda, MD-based American Society of Health System Pharmacists, indicate that many Americans have a relatively high level of anxiety surrounding hospital or health system visits.

The majority of respondents said they were 'very concerned' about a number of issues, including the following:

- being given the wrong medication (61%);
- being given two or more medications that interact in a negative way (58%);
- complications from medical procedures (56%);
- getting an infection (50%);
- suffering from pain (49%).

"With more and more sophisticated and powerful drugs entering the market today, patients are increasingly worried about the accuracy, safety, and appropriate monitoring of their medications to ensure the best outcomes," says **Bruce Scott**, MS, president of the American Society of Health-System Pharmacists.

The survey was conducted by telephone in July 1999 and involved more than 1,000 adults ages 18 and older. Three out of four respondents (76%) said that speaking to a pharmacist while in the hospital or health system would help alleviate their medication concerns, and 65% said they'd rather speak to the pharmacist in person as the way to receive information about their medications. ▼

DC voters approve medical marijuana

U.S. District Judge Richard Roberts ruled in September on an American Civil Liberties Union lawsuit allowing ballots from last November's election to be counted on a measure permitting the use of medical marijuana in the District of Columbia.

The measure would change current laws in the district to allow the possession, use, cultivation, and distribution of marijuana if recommended by a physician for serious illness. The tally, in which voters overwhelmingly approved the measure, comes almost a year after the election. Congress has 30 working days to approve or override the measure.

Results get mixed reactions

District mayor Anthony Williams (D) maintains his support of the measure, while Barry McCaffrey, director of the Office of National Drug Control Policy in Washington, DC, opposes the policy change. McCaffrey bolsters his argument with the National Academy of Sciences' Institute of Medicine report stating that there is little future for marijuana as a medically approved medication. **(See *Medical Ethics Advisor*, April 1999, p. 40, for details on the Institute of Medicine report.)**

The battle is far from over, says Rep. Bob Barr (R-GA). Barr sponsored the district's medical

marijuana funding ban and says he'll do whatever it takes to ensure that the ban sticks, according to a report in *USA Today*. "Marijuana remains illegal under federal law, and it would send a terrible message to America's young people to allow those laws to be openly flouted in the same city where they are passed," states Barr. ▼

African-Americans not included in trial data

African-Americans face unique barriers that inhibit their participation in clinical trials, according to speakers at a symposium held in September in New York City. The symposium, titled African-Americans and Breast Cancer, was sponsored by the nonprofit Magic Johnson Foundation in Culver City, CA.

There is insufficient information on why African-American women are more likely to die of breast cancer, for example, than their white counterparts. That's because few African-American women participate in clinical trials, the experts state.

Exploring the reasons

There are several possibilities for the discrepancy, researchers suggest, including these:

- lack of information from physicians;
- lack of awareness that trials are available;
- lingering patient mistrust because of the Tuskegee (AL) Syphilis Study, which was terminated in 1972.

"Before coming to the National Institutes of Health [NIH], I did not have an appreciation for how much [the Tuskegee experiment] was a driving force in the African-American community," says **Walter Jones**, deputy director of the Clinical Center at NIH.

Changes also took place at the National Cancer Institute (NCI) in Bethesda, MD. A restructuring over the past year now encourages patient participation from every state. Traditionally, the Northeast, California, and Florida have had the highest referral rates for trials.

NCI now allows patients to refer themselves to a clinical trial. Previously, only physicians could do so. Patients are required, however, to obtain medical records from their physicians to be eligible. ■

CALENDAR

- **Clinical Ethics and Compliance Programs.** Nov. 8-9, 1999. Arlington, VA. A comprehensive program on resolving medical ethics issues in relationship to the compliance program. Sponsored by the Health Ethics Trust, a division of the Council of Ethical Organizations. Contact the Council of Ethical Organizations, 214 S. Payne St., Alexandria, VA 22314. Phone: (703) 683-7916. Fax: (703) 299-8836. Web: www.ethicsandcompliance.com.
- **International Conference on Applied Ethics.** Dec. 28-30, 1999. Chinese University of Hong Kong. Keynote speakers: Peter Singer, Bonnie Steinbock, and Jenny Teichman. A call for papers is being issued for these topics:

1. The ethics of life and death, including abortion, euthanasia, surrogate motherhood, human cloning, genetic engineering, capital punishment.

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Editorial Questions

Questions or comments? Call **Kevin New** at (404) 262-5467.

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Managing Editor: **Kevin New**, (404) 262-5467, (kevin.new@medec.com)
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2. Sexual ethics, including pornography, homosexuality, premarital and extramarital sex, and sexual perversion.

3. Environmental ethics and animal rights.

Contact Hon-Lam Li, E-mail: honlamli@cuhk.edu.hk or Kai-Yee Wong, E-mail: wongg31k@cuhk.edu.hk. Web site for updates on the conference: http://www.arts.cuhk.edu.hk/~phidept/.

• **13th Congress on Medical Law.** Aug. 6-10, 2000. Marina Congress Center, Helsinki, Finland. A call for papers is being issued for these topics:

1. Quality of and priorities in health care ethics, law, and policy.

2. Status and rights of patients.

3. Health care personnel.

4. Liability and enforcement; forensic medicine.

5. Forensic medicine and psychiatry.

6. Biomedicine and human rights.

7. Human dignity and the beginning and end of life.

Contact Eva Lindberg, Stakes, P.O. Box 220, FIN-00531, Helsinki, Finland. Telephone: (358) 9 3967 2173. Fax: (358) 9 3967 2030. E-mail: eva.lindberg@stakes.fi. Web: www.stakes.fi/medlaw. ■