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IN THIS ISSUE

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Are nonprofit hospitals preying on the uninsured?

Coast-to-coast lawsuits allege unfair billing and collections

To the attorneys, the question of whether nonprofit hospitals are living up to their mission to provide health care to those who can't afford it is purely a consumer-protection question. But to a physician who blew the whistle on one hospital, it's much more of a human question.

"How ethical is it to charge sky-high prices to someone who is uninsured and can't pay? Totally unreasonable charges to someone who can't pay it? Significantly discount prices to someone who has insurance, but then harass and hound and sue and bankrupt those uninsured patients?" asks **John Bagnato**, MD, an Albany, GA, physician who exposed what he believes are unfair practices by scores of nonprofit hospital systems throughout the country.

He and a partner in his surgical practice delivered their findings earlier this year to Mississippi attorney Richard Scruggs, known for his tobacco and asbestos litigation, touching off the flurry of litigation.

Pricing and collection methods are two of the factors that have led to the filing of 49 lawsuits against 370 nonprofit hospitals in the United States. The cases have added to a growing debate over charity care provided by the nation's nonprofit hospitals, which represent 85% of the industry.

"Just as the tobacco case looked on its surface to be complex, [the hospital lawsuits] are about one simple issue with three points," says Ridgeland, MS, attorney **David L. Merideth**, MD, JD, MBA, one of the attorneys working with Scruggs. "The nonprofit, tax-exempt hospitals are overcharging uninsured patients while conspiring with the American Hospital Association [AHA] to profit and hoard billions of dollars while suing the uninsureds [to collect medical charges]."

Contacted by *Medical Ethics Advisor* for comment, AHA president **Dick Davidson** forwarded a prepared press release in which he stated, "This assault on community hospitals is misdirected — diverting focus away from the real issue of how we as a nation are going to extend health care coverage to all Americans." The AHA is

named as a defendant in some of the lawsuits, which ask for damages, attorneys' fees, and free care to the uninsured poor.

Davidson's statement describes the reality of nonprofit health care as "far different from the charges outlined in these lawsuits," and he expresses confidence that the cases will be "easily defeated."

Nonprofit or community hospitals emerged in their current form in the 1940s, with the Hill-Burton Act, which exchanged tax exemption or government funding for free care to uninsured people. Merideth says what began as "a truly charitable, above-board system has, over the last 50 years, morphed from the nonprofit idea to a for-profit system."

Nonprofit hospitals are seen as easy targets, observers say, because they usually are visible and well funded, conduct business in a way that appears identical to for-profit hospitals, and enjoy the benefits of tax exemption.

Some experts in health care law say that while some of the practices alleged in the lawsuits seem overly harsh toward the uninsured, they are not actually illegal.

Have nonprofits abandoned their mission?

The plaintiffs in the lawsuits allege that nonprofits have abandoned the mission that created their nonprofit, tax-exempt status in the first place — to provide health care to everyone in their communities who is in need of it. In doing so, Bagnato says, they are creating an ethics breach that can't be defended, even if the legal arguments are debatable.

"The ethical situation boils down to this one weird phenomenon — the uninsured patients, the ones who cannot afford health insurance for whatever reason, is the one group charged the most by nonprofit hospitals," he says. "They're the only group charged full price."

Not so, according to the hospital industry. Every patient, insured or not, is charged the same; what ends up being paid, however, depends on whether an insurer or the government (Medicaid, Medicare) has negotiated a lower rate.

The U.S. House Energy and Commerce Subcommittee on Oversight and Investigations in late 2004 released findings of a yearlong investigation of for-profit and nonprofit hospitals' billing and collections practices. According to Congress Daily (http://nationaljournal.com/about/congressdaily/), the investigation found that overall, hospitals were charging uninsured patients at rates higher than those charged to other segments of the population.

Subcommittee Chair **Jim Greenwood** (R-PA) stated during a meeting on the investigation, "An average working man or woman treated at a hospital can be stuck with a bill that is double what managed care or government programs pay. Then, to add insult to injury, they are sometimes

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Editorial Questions

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aggressively pursued for these inflated debts. This situation is unfair and unjust."

The Sarbanes-Oxley public accounting reform act, passed in 2002, is seen by both sides as a new safeguard to patients. Nonprofits are under clearer, tighter regulation and must demonstrate their eligibility for nonprofit, tax-exempt status.

Several hospital executives testified before the subcommittee that they have modified their billing policies since the House investigation began and blamed the initial billing practices on an unclear section of Medicare and Medicaid regulations. In a February 2004 letter, Health and Human Services Secretary **Tommy Thompson** wrote, "Nothing in the Medicare program rules or regulations prohibit such discounts" to the uninsured. He also said that hospitals should "take action to assist the uninsured and underinsured, and therefore end the situation where, as you said in your own words, uninsured Americans and others of limited means are often billed and required to pay higher charges."

According to the AHA, debt from unreimbursed care totaled $22.3 billion at 4,927 U.S. hospitals in 2002, the last year for which data are available. While hospitals cannot collect a large part of the debt because many patients cannot afford to pay, some debt results from patients with health insurance who fail to pay out-of-pocket expenses not covered by their policies, the AHA points out.

Hospitals pursue collection of unpaid bills from all patients — the uninsured who owe entire charges for hospitalization, or the insured who owe out-of-pocket charges — and if even a fraction of the balances due is collected, it defrays at least some of the debt.

But at least one member of the House subcommittee says the issue goes beyond billing practices and debt collection.

Rep. **Diana DeGette** (D-CO) says, "It would be easy for this body to simply blame hospitals for overaggressive bill collection. But that would miss the larger point: Too many Americans are unable to pay for health services because they do not have health insurance."

Collection practices legal; are they ethical?

Newspapers in major cities have, in recent months, profiled numerous uninsured individuals whose financial security has been ravaged by aggressive collections practices that followed hospitalization. The *Boston Globe* recently profiled an uninsured stroke victim in Massachusetts, for example, who was billed more than $40,000 in itemized expenses for a diagnosis for which the same hospital bills Blue Cross/Blue Shield $8,000.

Merideth says the aftermath of the lawsuits and Thompson's letter to hospitals assuring them that they could give discounts based on ability to pay comes down to the fact that "hospital CEOs and executives got caught with their hands in the cookie jar, and they know it. The best evidence of this is that when they smelled litigation, they started changing their [billing and collection] practices."

Merideth says he believes an argument could be made that nonprofit hospitals were charging premium prices to uninsured patients in an effort to drive them to other hospitals.

"[The lawsuits] are not about willy-nilly giving out free care to people," he says. "It's about the responsibility to let people know that when they are at a charity hospital, they might be due care at a reduced rate."

Money isn't the only cost, MD says

Bagnato says high fees and stressful collections after the care is received are not the only troublesome things he sees in nonprofits' handling of uninsured patients.

"Physicians and nurses see it every day — people being discouraged from seeking medical care," he says. "I saw a patient just the other day — a woman who had put off getting a mammogram because she was afraid of what the hospital would charge her. By the time I saw her, she had locally advanced breast cancer."

Bagnato says he could better accept high bills if they were linked to actual cost.

"But it's never linked to cost, and that's a peculiar thing," he observes. "If we could make health care reflect the tenets of our capitalistic market, we could correct a number of problems in our health care crisis."

Mark Rukavina, director of The Access Project, a national resource center that works with local groups on health care issues, documented the actual experiences of the uninsured through a survey it conducted in 2000 of uninsured people who had received care in local nonprofit institutions.

In the 24-site survey of nearly 7,000 uninsured respondents, 60% said they needed help paying for their medical care, and 46% said they owed money to the facility where they received care.

But Rukavina expressed concern that the pending lawsuits could damage hospitals' abilities to deliver care to their constituents.

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"Scrutiny of billing practices is good, but you have to consider that [the lawsuits] are taking on a vital service — one that we want to preserve, not bring down," he points out.

Scruggs' team already has won a settlement with one hospital system — one that wasn't even named in any of the suits. Tupelo-based North Mississippi Health Services agreed to start providing free care to poor, uninsured patients. Scruggs said under the settlement, patients who earn up to 200% of the federal poverty level will get free health care.

The AHA was not a party to the settlement, and said it would have no bearing on the other pending lawsuits. ■

Flu vaccine for HCWs: Compliance, liability issues

Sick employees risk to themselves and patients

The severe nationwide shortage of killed flu vaccine has put a stop, at least temporarily, to initiatives in some places that would force health care workers to be vaccinated or risk their jobs, but some health care experts warn that the solution advocated by at least one state — that health care workers forego the vaccine entirely so that more is available for higher-risk groups — could be dangerous to the very people it aims to protect.

The Centers for Disease Control and Prevention (CDC) in Atlanta updated the recommendations following the news that the nation's supplies of flu vaccine would fall far short of need. The revised recommendations advise that "health care workers who take care of patients" should be among the population groups to vaccinate against the flu.

The CDC Advisory Committee for Immunization Practices (ACIP), which issues the vaccination recommendations, included health care workers who are in contact with patients in the groups that should be vaccinated because the health care workers are at higher risk of getting sick themselves, and because they are in contact with patients with influenza, are at a high risk of spreading the virus.

"Vaccinating a nurse or physician who is in contact with patients has a much greater effect than just the vaccination of that one individual," says **Jane Siegel**, MD, a University of Texas Southwestern Medical School professor specializing in pediatric infectious diseases, and an advisory member of ACIP and the CDC's Healthcare Infection Control Practices Advisory Committee.

"You don't just protect that health care worker. You protect everyone that health care worker comes in contact with. It has a very broad effect," she says.

Not vaccinating 'a very disappointing thing'

The Minnesota Department of Health determined that vaccinating healthy health care workers is not the best way to utilize the limited resources of vaccine available, and has recommended that all health care workers forego the flu vaccine until the shortage is eased.

"The goal of vaccination is to prevent severe complications in those patients at the highest risk, and we didn't have enough vaccine to reach those high-risk groups and to vaccinate health care workers," says **Kristen R. Ehresmann**, RN, MPH, section chief in the Immunization, Tuberculosis, and International Health Section of the Minnesota Department of Health in Minneapolis. "The state had to step in because the facilities that had [received their full supplies of] vaccine weren't looking at sharing to ensure that as many high-risk patients as possible were covered."

She notes the state has encountered resistance from hospitals who had vaccine and wanted to vaccinate their clinical staff.

"But we in public health had to advocate for the public health in general, not just the health of health care workers," Ehresmann says.

Siegel says the approach taken by Minnesota and other areas and facilities that are not vaccinating

clinicians "is a very disappointing thing."

"I don't think that was at all the intent of the CDC," she says. "It's not appropriate to encourage health care workers to not take the vaccine."

FluMist an option

Ehresmann and Siegel agree that health care workers — such as any healthy adults younger than 50 who aren't in contact with immunocompromised patients or relatives — are good candidates for use of the inhaled vaccine FluMist.

"Use of FluMist is an alternative for anyone not working in a high-risk population, such as bone marrow transplant patients," Siegel agrees.

Minnesota is encouraging health care workers who can take the FluMist vaccine to do so.

"And as we get more flu vaccine — as we hope to do — we'll vaccinate health care workers," Ehresmann says. "We are hoping we're asking them to merely defer getting the vaccine, not forego it entirely."

Making sick patients sicker

Unvaccinated nurses and other health care workers often are the source of influenza for their patients in health care settings. Nurses working in hospitals already strapped for manpower frequently continue to work while suffering with influenza in an effort to not burden their co-workers.

"Health care professionals have a responsibility to receive the vaccine," says **Herman I. Abromowitz**, MD, a member of the American Medical Association board of trustees. "Health care professionals run a high risk of exposure and can transmit the virus to patients. The risks are great to ourselves, our families, and our patients."

Hospital-acquired influenza can be deadly for patients admitted with severe health problems, and in acute care hospitals, studies have shown the median mortality rate for hospital-acquired influenza is about 16%.

"Especially disheartening is the mortality reports of patients with nosocomial influenza as a result of refusal by health care personnel to have their annual required influenza immunization," says **Nancy Bjerke**, BSN, RN, MPH, CIC, a consultant with Infection Control Associates in San Antonio. "Some would classify this occurrence as a sentinel event due to willful noncompliance."

Abromowitz cites studies that indicate vaccination of health care workers in nursing homes has been associated with fewer deaths from influenza in the nursing home populations studied. For this reason, he says, "even healthy people, if they come into contact with those vulnerable [to serious flu-related complications], should receive the vaccine."

A risk secondary to transmitting the disease is the staffing burden worsened by staff who must stay home with the flu.

Because health care workers with the flu are advised to stay home when sick, the result can be added stress to noninfected staff. The manpower shortage translates to reduced delivery of health care, and staffing shortages have been linked to poor patient outcome, Siegel says.

A just-as-unappealing alternative is that health care workers whose facilities already are shorthanded will take over-the-counter medications to ease their symptoms and will come to work sick, risking infecting more co-workers and patients.

There currently are no states that require health care workers to be vaccinated against influenza. Massachusetts is among several states that are pushing for mass immunization of health care professionals. The National Foundation for Infectious Diseases earlier this year issued a call for greater immunization rates among health care professionals, and the Massachusetts Department of Public Health is exploring the idea of making the flu vaccine mandatory for doctors in the state.

Not an easy sell

Even in years when the flu vaccine has been plentiful, the nationwide vaccination rate among health care workers has averaged about 38%. The reasons for the low compliance rate are the same as for the general population — from apathy, fear of contracting the virus from the vaccine, and other side effects.

Because there are no universal mandatory regulations for immunizing clinicians against the flu, mandating vaccinations has not been easy for facilities that have attempted it. While the CDC long has included health care workers on its list of those who should be immunized each year, obstacles include the individual rights of the clinicians, and questions about what happens when a the vaccine is not an option because the clinician has an allergy to eggs (flu vaccine is grown in egg media), has a history of Guillain-Barré syndrome, or is running a fever.

The vaccine shortage came along just in time to derail, at least temporarily, a fight brewing in Seattle that started when Virginia Mason Medical

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Center attempted to become the first hospital in the country to make flu shots mandatory for its staff and volunteers.

In eligible employees (those for whom the vaccination was indicated), compliance with the vaccination was linked to continued employment. The state nurses' union reacted swiftly, filing suit in federal court seeking to stop the vaccination program.

Virginia Mason administrators said the mandated vaccines merely were good medicine — that by requiring the vaccine, it would boost the hospital's overall vaccination rate from 55% of workers to 100%, protecting more patients.

"This new policy will save lives," **Robert M. Rakita**, MD, Virginia Mason infectious disease section head, announced in a press release in early October.

But Virginia Mason received only about one-fourth of the amount of vaccine needed, and Rakita and the hospital were forced to put their staff vaccination program on hold.

"Virginia Mason places a high value on patient safety and believes a medical center staff flu vaccination requirement can save lives," he said. "But because the U.S. flu vaccine supply has been cut in half, we will not implement our 100% staff flu immunization program this year."

Precaution vs. liability

What risks are there for hospitals whose employees become ill, and what legal standing do hospitals have to require immunizations? And what legal recourse do employees have who want to refuse vaccines?

As far as a hospital's responsibility to protect patients and other employees from contracting the flu from a sick worker, "I think the ethical implications are that ill employees must be tested with rapid flu nasal swab; and if they are negative, they work, and if they're not [negative], they do not," says **James R. Hubler**, MD, JD, clinical assistant professor of surgery at the University of Illinois College of Medicine at Peoria.

"Even universal precautions in a high-risk population may not provide enough protection," he adds. "A clinic that does not protect its patients would be at risk for lawsuits, but it would be nearly impossible to prove that they contracted the disease from a health care provider and not [out in the community]."

There is some scant case law pertaining to institutions' responsibilities should employees become ill as a result of a facilitywide immunization process. In one case in Louisiana, *Guillory v. St. Jude Medical Center*, a hospital technician was ruled to be due workers' compensation because she developed encephalomyelitis triggered by a hepatitis vaccination administered by her employer, and the inoculation program was within the scope of her employment. In a related case in Texas, a firefighter who became incapacitated from a swine flu vaccination was awarded workers' compensation, even though he received the vaccination voluntarily because his job was considered critical to the community in the event of a swine flu epidemic, and the city offered the vaccine to these critical employees.

In the case of the Virginia Mason mandatory vaccination plan, a spokesperson for the nurses' union that represents the 600 nurses at Virginia Mason says, while nurses support the idea of vaccinations, the issue in this case is one of workers' rights.

"Federal and state laws require that, if you're going to change a working condition — which requiring this vaccination is — the employer must bargain with the union," says **Barbara Frye**, BSN, RN, director of labor relations for the Washington

State Nurses Association.

The CDC plans to focus attention on the health care community prior to the next flu season, in hopes education will prompt a greater number of workers who come in contact with patients to voluntarily be immunized. ■

Hands off or on when it comes to patient care?

Offering simple comfort can be thwarted

For as long as humans have been taking care of other humans who are sick or hurt, the rendering of solace and physical comfort has been the core from which all other types of aid have grown. But a nurse and ethicist in California says that ignoring the value of giving of solace and comfort amounts to turning away from the prime reason for the practice of medicine.

Rapid advances in technology, cultural differences between nurses and patients, and the current nursing shortage have all contributed to a hands-off approach by some nurses, says **Patricia Benner**, RN, PhD, professor in the department of social and behavioral sciences and department of physiological nursing at the University of California at San Francisco.

"One colleague felt like it didn't occur to nurses to reach out, physically, to patients, and to offer comfort other than medication, and I think that's a real deterioration of the practice," she says. "It's a loss of self and ethos of the practice."

Benner disagrees with the opinion that nurses are not being taught in school the value of being there for patients, or presencing (being present and available to the patient) oneself, and offering comfort.

But she agrees that cultural differences and concerns about the possibility of unwelcome touch possibly offending the patient or family members have led some nurses to not engage in hands-on comforting.

Offering comfort of the human type, and not just medications and technology, is what nursing has always been about, says Benner, a belief echoed by American Hospital Association president **Dick Davidson**.

"There will always be personal contact and caring," he says. "We will always have hands touching patients. Everything we do is about human need. That's the constant over time."

Nursing and medical students still are being taught the arts of gentle touch and hands-on comfort measures, such as simply being present in a reassuring manner, says Benner, who works as a consultant in the development and enhancement of delivery of nursing care. "However, there are threats to this central nursing practice, it is invisible, it is rarely charted, and it is never mentioned in a nursing care plan."

This leaves nurses to decide individually, patient by patient, what role comfort and presencing will play.

Just how much physical comfort a nurse should impart on a patient — if at all — largely will depend on the patient.

"It always — *always* — has to be lodged in the relationship," says Benner. "Just as you can't suggest that you'll do it for all patients, it would also be very wrong to say you won't do it at all."

"And of course, if a patient does not want comforting, it would be wrong to force it," she adds.

Cultural diversity plays a role

Cultural diversity plays a role as well; some cultures have deeply ingrained attitudes toward physical touching.

"You have multiculturalism on the side of both nurses and patients, and both groups are diverse [in their ethnicities]," Benner says. "And the language of presencing and comforting practices are deeply cultural. And there are even status barriers that might prevent a nurse from offering solace, or prevent the patient from accepting it."

She notes that for medical staff to know how to give a patient the comfort and solace he or she needs, and to the degree that he or she needs it, the clinician must first get to know that patient to determine what his or her needs and preferences are.

Staffing can have an impact on what kind of care can be rendered. If manpower is short, so is the time a nurse or physician can spend with individual patients.

SOURCE

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"If you are short-handed, there isn't going to be lots of time for sitting with a patient, listening, just presencing," Benner points out. "But with adequate staffing, there's no reason comfort and caring can't be part of the delivery of care."

Veterinarians as role models?

Delivery of comfort is taught in medical and nursing schools, Benner says, and is an integral part of the ethos of the practice.

"You really couldn't have good judgment or trust without good relational care, at least in some specialties."

One specialty, in particular, gets it right when it comes to giving patients individualized, hands-on, comforting care. "I've always felt it was very sad that veterinarians give much more individualized care to their patients than we who take care of humans," says Benner.

Without that human element — the willingness to sit and hold a patient's hand, to listen, to massage cramping legs or bed-weary backs — "we have nothing but a technical enterprise of delivering goods and services to patients."

When someone is ill, she says, that person needs more than just the best drugs and most advanced treatment available. "They need more than justice and rights — they need comfort and goods."

Simply being there for a patient, even without offering anything in the way of real care, is more and more difficult as hospitals continue to struggle with staffing. But it's a care delivery method that patients really shouldn't have to do without, Benner says.

"Presencing yourself when someone is in distress — not abandoning them — is a very important comfort strategy," she adds. "This is especially true when someone is trying to get his own equilibrium back, regulate his breathing, get his heart rate back in tow.

"Just having someone with them can be a real source of comfort." ■

Taking a history on new physician hires

More states considering background checks

The new staff physician hired by your hospital has more than just years of experience and clinical fluency under his belt. He also has a conviction for felony drug possession. But if you are in one of 35 states that do not require criminal background checks of physicians, you might not find out.

More states are beginning to consider the wisdom of requiring state, or state and federal, criminal background checks of doctors. The Federation of State Medical Boards recommends both state and national checks. California, Florida, Idaho, Illinois, Kentucky, Louisiana, New Mexico, North Carolina, and North Dakota currently require both.

Protecting hospital's investment and patients

Most states that do require background checks, or that are getting ready to enact the requirement, conduct the investigations once an offer of employment has been extended. But many are starting to launch the investigation after the initial interview, before an offer of employment is made.

When hiring a new physician, the hiring hospital often invests a great deal of time and money in the recruitment process and wants reassurance that only suitable candidates are evaluated. In addition, the hospital's legal team is looking to cover any possible liability bases, including making sure that new staff members aren't carrying with them criminal backgrounds that signal behaviors that could come back to haunt the hospital or its patients later.

Pre-employment checks fairly straightforward

The typical pre-employment background check is a fairly straightforward process, usually not involving digging into the distant past. The cost sometimes is paid by the candidate, but most often the check is paid for by the employer. The background check generally starts with the candidate's undergraduate years and involves verification of the following:

- Social Security trace and validation
- State and federal court records and the applicant's driving history
- Employment credit profile
- Primary-source verification of candidate's bachelor's through professional degrees
- Training programs, if applicable, including internship, residency, and fellowship
- Licensure, board certification, and hospital privileges history
- Professional organization affiliations

• References
• Drug Enforcement Agency registration and history
• Possible Medicare or Medicaid program exclusions
• Malpractice coverage and claim history and National Practitioner Data Bank entries
• American Medical Association or American Osteopathic Association profile

South Carolina's quest

South Carolina's board of medical examiners, at press time, was considering mandating background checks for anyone seeking a new medical license there.

If the new plan becomes law, anyone applying for a physician's license would be checked either through the State Law Enforcement Division's database, its counterpart in another state, or the FBI. Applicants would pay for the cost of the checks.

South Carolina is among many states that currently do not require physicians to pass background checks for any possible criminal history.

The proposal under review makes no changes in the secrecy provisions that surround investigations of physicians. Those rules ban disclosure of any information until the board reaches a final decision, and then only if it orders public sanctions (e.g., license suspensions or revocations).

Checking on medical students

Some medical schools believe waiting until a physician is applying for a job is too late to verify a clean criminal record, and are considering mandatory criminal background checks for hopeful future doctors.

"In an age of uncertainty and anxiety, people want to be certain about the qualifications of the professionals who serve them and their families," **Robert Sabalis**, associate vice president of student affairs and programs for the Association of American Medical Colleges, stated in a recent press release.

And according to a recent survey in *USA Today*, a large percentage of physicians with criminal backgrounds are unlikely to voluntarily acknowledge them when filling out an application. In fact, an omission or falsification in regard to criminal background is more likely to occur than one involving medical school or residency records, or previous licensure problems, according to the Federation of State Medical Boards. ■

Readers Write

Medical Ethics Advisor *relies heavily on feedback from readers to guide the content of the newsletter, and we always welcome comments and suggestions on topics of interest to you.*

Following our inclusion of an article on the role of patients' spirituality in their medical care ***("Patients' spirituality: Should it play a role in their care?" October 2004)****, we received a letter from Chaplain* ***Steve Pyle****, director of pastoral care at Baxter Regional Medical Center in Mountain Home, AR.*

Chaplain Pyle made some insightful comments about our article and included suggestions that we intend to incorporate into future articles on the topic of patients' beliefs and their health care.

Letters and suggestions about articles we've published or topics you would like to see can be sent to Managing Editor Jayne Gaskins at jayne.gaskins@thomson.com.

Dear Editor:

I serve as the director of pastoral care in the hospital in which I serve. As a board-certified, professional chaplain, I want to thank you for the article in *Medical Ethics Advisor,* October 2004 issue, titled "Patients' spirituality: Should it play a role in their care?"

I am especially thankful for the paragraph recommending referring to a chaplain.

I would like to make some observations, however:

First, you recommend "calling in a hospital chaplain, if the patient agrees, is one resource for meeting patients' spiritual needs." A professional, board-certified, clinically trained chaplain is a member of the health care team, as any ancillary department. I would recommend making the referral if there are triggers about spiritual distress in the same way the physician or nurse would make referrals to, say, respiratory therapy if the patient is having breathing difficulties. The physician or nurse wouldn't say, "I see you are having breathing difficulties. Would you mind if I contacted respiratory therapy?"

My point being that we are not talking about a member of the area clergy coming from the outside into the hospital. Asking permission for such a referral is appropriate. However, we are talking about a member of the health care team

who specializes in assessing and addressing spiritual needs of the patient. The physician and nurse certainly can do a simple spiritual screening, but not a spiritual assessment.

Second, there is confusion between "faith" and "spirituality." It is reflected in conversations in society in general and in your article, in specific. Faith and religion are one of several components that can make up a person's spirituality. Spirituality is that which gives life meaning, offers a sense of self-worth and purpose — that which is transcendent and helps one cope with life. Even an atheist has spirituality — he/she derives strength from somewhere — it may not be religion, but it is from somewhere, and the question that needs to be asked is, "How is that working for you, right now?" Whether one is religious or not — how are their coping resources handling the crisis at the moment? A professional, board-certified chaplain is uniquely equipped to handle that issue in depth. As your article stated, the physician and nurse often don't have the time to "hear the patient's story," but the chaplain does. It is not unusual for the chaplain to have a pastoral conversation with a patient and never have "religion" come up, yet they may talk about spiritual issues.

I mentioned "spiritual triggers about spiritual distress." **Glenn Sackett**, a board-certified chaplain, has defined spiritual suffering [as follows]:

> "Spiritual suffering has a parallel to physical pain; it is a warning that something destructive is occurring or that an injury has occurred. This would be an injury to, or an assault on one's spirit. Likely causes would be:
> • Unmet spiritual needs (love/belonging, meaning/purpose, reconciliation/freedom from guilt/shame, hope/hopelessness).
> • Conflicts related to spiritual beliefs.
> • Unresolved spiritual issues (guilt, grief, shame, alienation, despair).
> • Collapse of a spiritual/world view."

Charles Barley, another board-certified chaplain, has defined spirituality as a continuum:

> • **Spiritual strength:** Healthy belief system that helps them cope well with one's life setting and relationships.
> • **Spiritual concerns:** Experiencing mild stress/anxiety, yet has a moderate to high level of spiritual resources and coping skills intact.
> • **Spiritual distress:** Experiencing some loss of balance/harmony in life, which includes personal and or relational problems in one or more areas of their lives.
> • **Spiritual despair:** Characterized as feeling like life is meaningless, socially and spiritually alienated, low self-worth, and is experiencing deep hopelessness and possibly depression.

There is much discussion out there, in society in general, and in medical circles, about spirituality. The great thing is that there is a resource that is available and trained to deal with these issues. The professional, board-certified chaplain brings much to the table and needs to be utilized as the resource he/she is.

With kindest regards,

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CDC appoints ethicists to study flu vaccine shortfall

For the first time in its history, the Centers for Disease Control and Prevention (CDC) has created a permanent panel of ethicists to help the agency navigate the life-and-death questions of who should get flu vaccines in the current crisis and how the agency should cope with any future epidemics.

John Arras, a professor of bioethics at the University of Virginia and a member of the panel, said that the panel, which began deliberating in mid-October, might have to decide whether crucial professions — perhaps even undertakers — should receive priority. Such questions, he said, are explosive.

The CDC already has decided that, in broad terms, only the very young, the very old, and the chronically ill should receive the limited supply of flu vaccines. State and local health officials complain that their shortages are so dire that they do not have enough vaccines to inoculate everyone covered under these guidelines and have been making decisions themselves about who should receive priority, but say they want better guidance from the CDC about who is the highest of the high risk. ▼

Internet-brokered kidney transplant raises questions

A Colorado man who had waited for a new kidney for five years underwent surgery in late October at a Denver hospital to receive the kidney of a Tennessee man who responded to an ad posted on a commercial web site, marking what is believed to be the first transplant brokered through a commercial web site.

Bob Hickey had needed a transplant since 1999 because of kidney disease, and joined the commercial Internet service MatchingDonors.com; he paid the service more than $200 per month for several months, and through the service met Rob Smitty, who was cleared by physicians to donate a kidney to the Colorado man.

The transplant, originally scheduled for mid-October, was temporarily delayed after the transplant surgeon slated to perform the surgery at Presbyterian/St. Luke's Medical Center in Denver learned of the means by which the two men had been matched. The hospital's ethics committee was convened, and after both men signed statements that neither was profiting from the transplant, the hospital granted a "compassionate exception" and the surgery was performed without complication.

The United Network for Organ Sharing, the nonprofit, government contractor that allocates organs donated from deceased donors, has been critical of for-profit groups such as MatchingDonors.com, saying they prey on a vulnerable population and may put less affluent patients at a disadvantage to patients who can afford to solicit for organs. Both Hickey and Smitty have denied that any money exchanged hands in the match, and Presbyterian/St. Luke's says it will critically examine any future transplants to ensure the organs are procured ethically.

(For more information on the ethical issues surrounding new methods of donor organ procurement, see *Medical Ethics Advisor,* November 2004, "Soliciting for 'gift of life' causes controversy," p. 126.) ▼

New stiff penalties for violating HIPAA rules

In sentencing the first person convicted of violating the privacy portions of the Health Insurance Portability and Accountability Act (HIPAA), a federal judge has delivered a message that violations of the privacy rules will be met with severe penalties. In sentencing former cancer treatment center technician Richard W. Gibson, of SeaTac, WA, U.S. District Judge Ricardo Martinez added four months to the 12-month plea-bargained sentence agreed to by prosecutors. Martinez sentenced Gibson to 16 months in prison and charged him with at least $15,000 in restitution.

Gibson's conviction was the first in the country involving a breach of the privacy portion of the HIPAA act, which went into effect in April 2003. Gibson admitted that, while he worked at Seattle Cancer Care Alliance, he used a patient's personal information to get four credit cards on which he charged more than $9,000. Penalties for violating the HIPAA privacy rule range from up to $50,000 and a year in prison for wrongful disclosure of private information, to up to $250,000 and 10 years in prison for selling or trying to sell private health information. ■

COMING IN FUTURE MONTHS

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- Guidance for intervening with impaired clinicians
- Who's minding the ED?
- Are high liability insurance premiums affecting the quality of medicine?

CME instructions

Physicians participate in this continuing medical education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge.

To clarify confusion surrounding any questions answered incorrectly, please consult the source material. **The semester ends with this issue.** After completing this activity, you must complete the evaluation form provided at the end of each semester and return it in the reply envelope provided to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CME Questions

21. In facilities where the supply of killed flu vaccine is inadequate to cover both high-risk patients and healthy employees, those healthy employees who are younger than 50 years and are not in contact with immunocompromised patients or relatives should consider the inhaled vaccine FluMist as an alternative.
A. True
B. False

22. According to the Federation of State Medical Boards, what negative information are physicians more likely to intentionally fail to acknowledge on job or license applications?
A. Medical school records
B. Residency records
C. Prior licensure problems
D. Criminal history

23. Which of the following is NOT an obstacle to offering patients physical comfort and solace, according to nurse ethicist Patricia Benner?
A. Cultural views
B. Time pressures
C. The desire of the patient to receive comfort and solace
D. Fear of offending the patient

24. Nonprofit hospitals may be easily targeted for private legal action and public scrutiny for what reasons?
A. They are large, visible, and well funded.
B. They display behaviors that are difficult to distinguish from for-profit hospitals.
C. They benefit patently from tax-exempt status.
D. All of the above

Answers: 21. A; 22. D; 23. C; 24. D.

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