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## Caregivers of terminally ill patients benefit from education and support

*Intervention sessions with hospice nurses improve coping skills*

For many patients dying of cancer, home is where they want to spend the last weeks of their lives. Their caregivers — often spouses, life partners or children — may be willing to give whatever care their loved one needs, but can find themselves overwhelmed, unsure, and at risk for depression and other health problems themselves.

"In today's health care system, patients simply don't have the option of being hospitalized for long periods, including at the end of life. And most patients tell you they want to be able to die comfortably at home in their own beds," says **Susan McMillan**, PhD, RN, FAAN, a professor at University of South Florida College of Nursing. "But that can only happen if we adequately prepare family members to provide extensive care for their loved ones at home."

McMillan recently completed a study in which caregivers were given supportive educational intervention by veteran hospice nurses, in an effort to measure what effect that would have on the caregivers.

McMillan says people taking care of dying cancer patients at home significantly benefited from the interventions, in which they were taught how to cope with distressing patient symptoms. She knew of the COPE (creativity, optimism, planning, and expert information) model developed by Peter Houts, PhD, described in "The American College of Physicians Home Care Guide for Cancer," and was sure it could be modified to benefit those caring for terminal cancer patients at home. The COPE approach, on which McMillan based her project, includes clearly defining a problem, gathering expert information about it, brainstorming a range of solutions, devising a plan, anticipating potential obstacles, adjusting the plan accordingly, implementing the plan, and evaluating the results.

COPE was provided to family caregivers of hospice patients with cancer over a seven- to nine-day period, and outcomes were compared with hospice care alone and hospice care plus emotional support.

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## More become caregivers every year

At any one time, as many as 52 million Americans assist family members with an illness or disability, including many who provide extensive care for relatives with cancer. That figure is expected to grow as the population ages.

Previous studies have shown highly stressed family caregivers are at higher risk for depression, health problems, and increased death rates. (See box, p. 15.)

"There has been little prior data to describe which caregivers are at greatest risk for distress and which interventions are likely to relieve that distress," according to McMillan. "We found that

## SOURCE

- **Susan McMillan**, RN, PhD, FAAN, professor, University South Florida College of Nursing, Tampa. E-mail: smcmilla@hsc.usf.edu.

caregivers benefited from even a small number of sessions with the interventionists, above and beyond the benefits gained from hospice care alone."

Family caregivers are central to end-of-life care because they offer emotional support, help with activities of daily living and medications, and communicate with the patient's health care team about his or her condition. Yet, caregivers — many of whom are elderly spouses with their own health problems — may experience significant strain and anxiety from taking care of seriously ill patients, McMillan says.

With cancer patients, there are some symptoms that are nearly universal, and so three of those — pain, dyspnea, and constipation — were selected as the symptoms that caregivers would receive support for. Hospice nurses visited caregivers and patients three times, and during the visits focused on identifying, accepting, and managing the sometimes distressing symptoms.

"The nurses worked with the caregivers during those visits on managing the symptoms using the patient as the model," says McMillan.

Another component to the study was a set series of visits in which the nurse did not address symptom management, but talked at length with the caregiver about his or her relationship with the patient.

"The 'friendly visit' was designed for the nurse to spend time with the caregiver and to talk about specific topics that we gave the intervener to use, such as 'How did you meet [the patient]?' or 'How long have you known the person?' It's more focused on being supportive of the caregiver, not on managing the patient's symptoms."

McMillan says the results of her study indicate that the addition of COPE intervention for the caregiver was crucial for the caregiver. Researchers compared the group of patients and caregivers who were receiving standard hospice care alone with those who were receiving hospice care along with supportive visits for the caregivers.

With intervention, McMillan says, the caregiver's quality of life increased while the burdens from caregiving and caregiver distress were significantly reduced.

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# Impact of Caregiving on Caregivers

## **Physical health**

Studies have found that caregivers may have increased blood pressure and insulin levels, impaired immune systems, and may be at increased risk for cardiovascular disease, among other adverse health outcomes.

A study of elderly spousal caregivers (age 66-96 years) found that caregivers who experience caregiving-related stress have a 63% higher mortality rate than noncaregivers of the same age.

Many caregivers are themselves in poor health; studies show that about one-third of caregivers provide intensive care although they are themselves in "fair to poor" physical health.

## **Mental and emotional effects**

Studies consistently report higher levels of depressive symptoms and mental health problems among caregivers than among their noncaregiving peers.

Depression appears to be the most common psychological disorder, with 20% to 50% of caregivers reporting depressive disorders or symptoms. The higher levels of depression are mostly attributed to people caring for individuals with dementia. Studies show that 30% to 40% of those dementia caregivers suffer from depression and emotional stress.

Several studies have shown that caregivers use prescription and psychotropic drugs more than noncaregivers.

Stress in family caregivers is inversely correlated to income: The less income a caregiver has, the more stress he or she is likely to experience.

Particularly stressful caregiving situations may put caregivers at risk of engaging in harmful behaviors toward care recipients. One study has shown that spousal caregivers who are at risk of clinical depression and are caring for a spouse with significant cognitive impairment and/or physical care needs are more likely to engage in harmful behavior toward their loved one.

While caregiving can be a very stressful situation for many caregivers, studies also show that there are beneficial effects, including feeling positive about being able to help a disabled spouse, feeling appreciated by the care recipient, and feeling that their relationship with the care recipient had improved. ■

*Source:* Family Caregiver Alliance National Center on Caregiving.  
[www.caregiver.org](http://www.caregiver.org).

"Their distress at the patients' symptoms lessened with intervention," she says. "Part of it has to do with the ability to accept and manage the symptoms and the feeling of self-efficacy. They felt more in control, better able to manage the symptoms and accept and not be so distressed about [the symptoms]."

## **Benefits seen for patients, as well**

While at first she was disappointed to see that the intensity of patients' symptoms did not decrease with educational intervention for their caregivers, McMillan was pleased to note that there was a decrease in patients' distress about their symptoms.

"Initially it distressed me that their symptoms did not decrease in intensity, but then these are cancer patients within days or weeks of death, so

it is to be expected that their symptoms would not decrease in intensity," she points out.

McMillan says the findings of the hospice intervention study are "immediately translatable" to the bedside of end-of-life hospice patients, regardless of what they are dying of.

"Usually, when you talk about studies of intervention, you need additional research and confirmation, but this is something that can only help," McMillan explains. "There's no hazard to it, and no need to not use it immediately in other patients."

Patients with end-stage heart disease, chronic obstructive pulmonary disease or dementia are populations for which hospice support and education intervention should be expanded, McMillan and her colleagues recommend. Their findings on benefits to caregivers appeared on-line Dec. 2, 2005, in *Cancer*, the journal of the American Cancer Society, and in the January 2006 print issue.

## ***Creative approach to HIPAA concerns***

In designing her study, McMillan avoided potential ethical and privacy issues by teaming with the hospice and hiring its staff, making them employees of the study.

“When you come from the university in to the hospice, where you don’t belong, it can be iffy whether you can get a sample or not,” she explains. “We overcame that by hiring the staff, reimbursing the hospice for the staff we used. Only hospice staff participated [in the interventions and sample gathering].”

The nurses retained their positions with the hospice for purposes of raises and promotions. The precaution of making the hospice nurses employees of the study provided reassurance to the hospice that only hospice nurses would be gathering data, thereby reassuring the hospice that researchers would not interfere with patients; it also ensured that patients could expect that the nurses calling on them would be the hospice nurses they were used to.

### ***Resources***

McMillan S, Small B, Weitzner M, et al. Impact of coping skills intervention with family caregivers of hospice patients with cancer: A randomized clinical trial. *Cancer*. On-line, December 2005, at [www.cancer.org](http://www.cancer.org).

Houts P and Bucher J, eds. *Caregiving: A Step-By-Step Resource for Caring for People With Cancer at Home*. Atlanta: American Cancer Society; 2000. ■

## **Panel issues guidelines for practice on the newly dead**

*Respect for the person, loved ones should be priority*

**T**hey are considered one of the most valuable teaching tools for doctors in training, yet they also are the topic of a highly charged ethical debate — the bodies of newly deceased patients.

No model or diagram can duplicate the realism of practicing a medical procedure such as intubation on a human body. But even when agreeing that cadavers are valuable teaching tools that offer training benefits that carry over to the student physicians’ living patients, ethicists say strict limits should be placed on the use of dead people as research subjects.

For the first time, a consensus set of ethical

guidelines has been published to give individual medical institutions — and the medical community at large — a foundation on which to launch debate or consider studies with the newly deceased.

A multidisciplinary expert panel, led by **Rebecca Pentz**, PhD, professor of hematology and oncology in research ethics at the Winship Cancer Institute at Emory University in Atlanta, agreed unanimously on specific recommendations to balance the potential benefits of research with dignity and respect for the subjects.

### ***Guidelines provide some ethical direction***

The term “recently dead” includes cadavers with no heartbeat as well as brain-dead cadavers still on ventilators and other technological supports.

The panel, known as the Consensus Panel on Research with the Recent Dead, comprises 15 ethicists, clinicians, researchers, patient and religious advocates from around the United States. After developing the initial set of recommendations, the panel will review or raise new issues as appropriate.

According to Pentz, the guidelines published in the November 2005 issue of *Nature Medicine* are based on the overriding principle of respect for people, which the panel believes should extend to the dead. Therefore, the individual’s goals and wishes are to be honored in the research in which they participate.

“With the panel, we hoped to create dialogue among the institutions who currently review research with the recently dead, as well as answer and anticipate questions from individual researchers and institutional review boards [IRBs] at research institutions that are considering programs,” explains Pentz. “We want the guidelines to give the research centers a confidence to properly address and assure patients and families that they and/or their loved ones will be treated with respect and dignity, and that their participation in the research will be not only completely voluntary, but highly valued.”

For example, fears that wide acceptance of the use of the newly dead for training or research could result in the maintaining of “biomort emporiums,” where cadavers would be kept on life-support equipment for days or weeks, would be allayed by adherence to the consensus panel’s recommendation that studies using recently deceased patients be limited to one day, unless

there are strong scientific reasons to extend the study.

“The prospect of prolonged storage of ventilated and profused bodies for research is deemed abhorrent to many and risks undermining public support for research with the recently deceased,” the guidelines state.

The eight guidelines created by the consensus panel are:

- ***Review and oversight***

Jurisdictions differ on whether research with the newly dead must be reviewed. In the United States, federal regulations define human subjects as living human beings; thus, the requirement that all human research undergo review by an IRB does not extend to research with the deceased. Regardless of regulatory requirements, the panel recommends that research with the dead should proceed only after approval by a properly constituted review board.

Review of proposals for research with the dead should assess the scientific validity and value of the research, and the research should address a significant question, use methods likely to produce valid results, and, to the extent possible, employ procedures similar to those used with living subjects to facilitate subsequent clinical application.

In addition, the degree of invasiveness to the corpse must be minimized and justified in terms of expected scientific benefits. Because such research could be burdensome to families, for example, by delaying funerals or disfiguring corpses, the panel recommends negative consequences should be minimized and any delay or disfigurement justified by a likely yield of scientific knowledge.

- ***Community involvement***

The panel recommends community involvement in review, approval, and oversight of studies involving the dead, with representation from the pool of potential research subjects; from ethnic, minority, and religious groups prominent in the geographic area; and “articulate and interested lay persons.”

- ***Eligibility***

Investigators who propose research on or educational use for cadavers must justify having chosen this subject population, considering potential risks and benefits to survivors, scientific advantages, the potential for harm to alternative subjects (including animals), and feasibility.

Importantly, the consensus panel rejects the notion that research with the deceased be a last

resort, “as the dead may be preferable to living humans or animals as subjects for some research, such as research with potentially painful procedures.”

One thing that takes ethical priority over research, the panel emphasizes, is organ procurement. Because organ donation’s benefit to living individuals is immediate, organ donors should be considered ineligible for research unless: the research will not interfere with organ procurement; the individual had consented prior to death to being a research subject in preference to organ donation; or, in the absence of clear directives from the deceased, family members consent to postmortem research in preference to organ donation.

Likewise, legally required autopsy takes precedent over both transplantation and research, the panel notes.

To instill confidence and trust in the use of the deceased in postmortem research, physicians not involved in the training exercise or research should be the ones to determine that death has occurred.

- ***Research procedures***

The guidelines state that procedures on the newly dead must be conducted with respect, but need not be identical to those used with the living. The body should be kept covered to the extent possible, and procedures should be as minimally invasive as possible. If disfigurement is unavoidable, family members should be informed in advance, and the possible disfigurement should be described in the consent document.

Cultural standards should be considered in determining respectful treatment. Likewise, time considerations should be taken into account, with research and training procedures limited to one day unless more time is demanded for valid scientific reasons.

When training or research is conducted in patient facilities such as hospitals or clinics, the research should not compromise the care of living patients. Protocols must establish whether family members will be permitted to visit during a study.

- ***Consent***

The panel writes that the “bedrock ethical requirement for research on all human subjects, including the recently dead, is to obtain informed consent from competent prospective subjects or their legally authorized representatives.” If there is no directive from the deceased and his or her

legally authorized surrogates disagree, the panel recommends intervention by the institution's ethics committee to help resolve the dispute, but discourages proceeding with research with the dead in cases of disagreement.

To avoid any appearance of conflict of interest, the panel suggests that if surviving family members are to be approached about consenting to the use of a deceased person for research or educational purposes, it should be done by physicians who did not participate in caring for the person while he or she was still alive.

- **Confidentiality**

Review boards should approve proposals for research with the recently dead only if confidentiality protections are satisfactory. Respect for the dead and their living relatives and friends require that information about them not be openly shared, the panel notes, and all requirements for use of protected health information under the Healthcare Insurance Portability and Accountability Act (HIPAA) be met.

- **Resource use and cost**

Posthumous whole-body research should not impose extra costs on the subject's estate, family or surrogates, and there should be no payments or incentives offered for participation.

- **Conclusion of research**

The return of remains to the family should be observed per the agreement and requests established at the time of consent.

## **A long-debated subject**

Legal, but debated over the last 25 years, the issue of research on dead individuals has emerged in recent years with two major institutions publishing data from research programs with the recently dead, and with each institution developing separate ethical standards.

Such research, which today is considered a rare practice due in part to ethical considerations, is expected to increase in the coming decade as new technologies such as nanodevices and targeted therapies evolve and require sophisticated research methods. In addition, researchers report that "fresh" tissue is critical in the study of human degenerative diseases such as cancer, Alzheimer's disease, and multiple sclerosis.

The authors for the consensus panel note that there are several reasons for requiring that the bodies of the recently deceased be treated with dignity. First, many people have strong preferences about how they want their bodies disposed

## **SOURCE**

- **Rebecca Pentz**, PhD, professor, hematology and oncology in research ethics, Winship Cancer Institute, Emory University, Atlanta, GA. E-mail: rebecca.pentz@emoryhealthcare.org.

of after they die, and an aversion to disrespectful treatment — considered "desecration" by some — is commonly among those feelings.

Honoring those preferences after death is a mark of respect both to the deceased and to surviving loved ones. Respectful treatment of the dead also demonstrates to those still living that their wishes about the disposition of their bodies will be honored and that bodies used for medical study will be respected.

The University of Texas M.D. Anderson Cancer Center in Houston and the University of Pittsburgh have research programs under way for the recently dead, and have ethical guidelines for their individual programs in place. Representatives from both institutions participated in the consensus panel.

## **Resource**

Pentz RD, Cohen CB, Wicclair M, et al. Consensus Panel on Research with the Recently Dead. Ethics guidelines for research with the recently dead. *Nature Medicine* 2005; 11:1145-1149. ■

## **Medical student behavior: A sign of things to come?**

*Should professionalism be required to graduate?*

When hiring new physicians, health care practices might want to look beyond grade transcripts, according to a medical school professor in California who has determined that medical students who were disciplined in school for irresponsible attendance or patient care are nearly nine times more likely to be disciplined by their medical boards when they become practicing physicians.

Or, to look at it another way, physicians disciplined by state medical boards were three times more likely than their colleagues to have exhibited unprofessional behavior while in medical school.

“These data support the growing movement to make the demonstration of professional behavior a requirement for graduation from medical school in the United States,” says **Maxine A. Papadakis, MD**, professor of clinical medicine at the University of California at San Francisco and associate dean of student affairs at UCSF School of Medicine. “It is one way that we can improve health care quality by focusing on human factors that ultimately affect physician performance.”

Papadakis led a team of researchers who looked at hundreds of cases of physicians disciplined by state medical boards, and compared their behavior as practicing physicians to their conduct as medical students. Papadakis, lead author of the report that appeared in the *New England Journal of Medicine* in December 2005, says the findings may help identify and correct behaviors while doctors are still in training.

The researchers looked for early warning signs during medical school that were associated with a higher risk for disciplinary action when the students became practicing physicians.

Behavior for which physicians were disciplined included use of drugs or alcohol, unprofessional conduct, conviction for a crime, and negligence. Unprofessional behavior in medical school was the strongest risk factor for later disciplinary action by a state medical board. In contrast, more traditional measures of academic success, such as performance on the Medical College Admission Test and early medical school grades, were much weaker risk factors for later disciplinary action, according to the study.

Papadakis cautions that because the study is retrospective, it is not predictive of future behavior of current medical school students. “However, we have at least established a risk factor for disciplinary action against practicing physicians,” she points out.

This is the first national study that links performance in medical school with later disciplinary action, and, therefore, with a potential threat to patient safety, according to Papadakis.

The study included 235 graduates since 1970 of three medical schools — UCSF School of Medicine, University of Michigan Medical School in Ann Arbor, and Jefferson Medical College of Thomas Jefferson University in Philadelphia — who were disciplined by one of 40 state medical boards between 1990 and 2003. They were matched with 469 control physicians according to medical school and graduation year.

“We looked at these three schools because they’re geographically diverse, represent both public and private institutions, and have very thorough records of their own students,” explains Papadakis.

The study looked at a broad range of unprofessional behaviors in medical students. The strongest association with disciplinary action was seen in students who were irresponsible in attendance or patient care. These students were nearly nine times more likely than their colleagues to be disciplined when they became practicing physicians.

### ***Graduation contingent on professionalism?***

Papadakis found that of former UCSF medical students who had faced disciplinary action by the Medical Board of California between 1990 and 2000, 95% of the cases involved deficiencies in professionalism. After looking at the physicians’ academic files, she discovered that many of them had received comments about unprofessional behavior in medical school. She also found that the students who received such comments were more than twice as likely to be disciplined by the medical board.

“Professionalism can and must be taught in medical school,” notes the study report. As part of this, the study recommends that medical school admissions and graduation standards be reviewed to make sure they contain explicit language about professional behavior and that professionalism should be an important part of the curriculum. It also recommends that standardized methods be implemented for both assessing the personal qualities of medical school applicants and predicting their performance.

Papadakis emphasizes the importance of early identification and remediation of unprofessional behavior among medical students. “We want to identify people who have trouble in this domain as early as possible,” she explains. “We all grow up, and most of us become more professional as we mature. However, for the rare student who cannot demonstrate professional behavior, we need to think long and hard about whether he or she should graduate from medical school.”

Papadakis noted the collaborative nature of the research, saying, “This study brings together the licensing and disciplinary branch of the medical system, represented by the Federation of State Medical Boards, with the medical schools, so that we can all help patients in the long run.”

## Schools already making efforts

Medical schools are already involved in efforts to assess and record their students' professional behavior. One system currently used by many institutions has been dubbed the "critical instances report," in which two or three reports on a single student prompt a close tracking of the student's behavior and potential disciplinary action.

Professionalism-related efforts used by other schools include lectures on ethics, small group work on professionalism topics, standardized patient exercises that include ethical and professionalism components, and coursework that promotes reflection on professional behavior.

Papadakis urges educators to place as much emphasis on professionalism as they do on other academic competencies.

"Most physicians take great pride in their professionalism and this is a quality that must be cherished," Papadakis stresses. "Our study shows that the tradition of professionalism must begin in medical school and that standards for professionalism in students are as important, or perhaps more important, than other measures of success." ■

### SOURCE

- **Maxine A. Papadakis, MD**, professor of clinical medicine, University of California at San Francisco; associate dean of student affairs, UCSF School of Medicine. E-mail: papadakm@medsch.ucsf.edu.

## Stung by bad publicity, hospitals alter practices

*Billing changes have little impact on bottom line*

Many hospitals have adopted more generous charity-care guidelines for uninsured patients after a barrage of publicity about aggressive hospital billing and collection practices and a spate of lawsuits alleging hospitals overcharged uninsured patients, according to a health care policy expert.

Hospitals in more than 50 health systems

across the country were named as defendants in class-action lawsuits alleging that not-for-profit hospitals charged uninsured patients full billed charges for care, when other payers, including private insurers, Medicare, and Medicaid, received large discounts from billed charges. Virtually all of the suits against hospitals filed in federal court have been dismissed without merit, but state court action is still possible.

Nonetheless, many hospitals have modified billing and collection practices for low-income, uninsured patients following a campaign by hospital associations to encourage hospitals to create formal policies for billing uninsured patients, the Center for Studying Health System Change (HSC) has found.

"Many uninsured patients are poor and unable to afford care, while others may have the resources to pay for their care, leaving hospitals the task of determining who is financially needy," says **Paul B. Ginsburg**, PhD, president of HSC. HSC is a nonpartisan policy research organization funded principally by The Robert Wood Johnson Foundation.

"What we found is that hospitals generally have adopted guidelines to help make those calls in a more organized and structured way," Ginsburg says.

The center's findings are detailed in a new HSC issue brief — *Balancing Margin and Mission: Hospitals Alter Billing and Collection Practices for Uninsured Patients* — available at [www.hschange.org](http://www.hschange.org). The study is based on site visits to 12 nationally representative communities: Boston; Cleveland; Greenville, SC; Indianapolis; Lansing, MI; Little Rock, AR; Miami; northern New Jersey; Orange County, CA; Phoenix; Seattle; and Syracuse, NY.

"In every community, most hospitals have either recently changed their pricing, billing, and collection policies or tried to improve the clarity of the information provided to patients," according to HSC research analyst **Andrea B. Staiti**, co-author of the study.

Staiti reports that among the findings of the study was the discovery that changes in billing and collection policies have had a negligible impact on hospital finances. Uncompensated care is comprised of both bad debt and charity care. Almost all of the hospitals interviewed that had adopted more generous charitable policies indicated expenses previously classified as bad debt have shifted to charity care write-offs, with little impact on hospital bottom lines.

Other key findings of the study:

- It is now common for hospitals in the 12 communities to provide charity care to uninsured persons with incomes under 200% of the federal poverty level, or \$38,700 for a family of four in 2005, and offer sliding-scale discounts beyond this income threshold, in some cases up to 400% or 500% of the poverty level.

- The impact of more generous pricing or discounting policies on access to care for the uninsured remains unclear. Market observers in some communities believed that charity care is now easier to obtain and that hospitals' efforts to better identify people up front who are eligible for charity care has helped patients and spared them the aggressive collection practices some hospitals used.

- However, hospitals in some cases have adopted more generous pricing policies but also have engaged in other activities to manage their payer mix that inhibits access to care for some uninsured. For example, some public hospitals now limit nonemergency care for uninsured out-of-county residents and are working to attract more insured patients.

For more information on the HSC findings, call (202) 484-5261. ■

## FSMB toughens sexual boundaries policy

*Scope of misconduct, disciplinary procedures change*

The Federation of State Medical Boards (FSMB) plans to revise the sexual boundaries policy used by state medical boards in determining sexual boundary violations by physicians. The federation began offering an on-line course on sexual boundaries and violations in January for use by medical board officers, and will present a beefed-up version of its sexual boundaries policy at its annual meeting in April.

According to the federation, an association of 70 medical boards in the United States, state medical boards took action on 242 sexual abuse or misconduct cases against physicians in 2004, up from 216 in 2000.

As drafted, the rewrite of the federation's sexual boundaries guidelines, first issued in 1996, propose expanding the scope of sexual misconduct to include third parties, not just patients,

and would be more comprehensive in addressing discipline and physician evaluation.

### **Misconduct: Sexual impropriety, violation**

The federation recognizes two types of professional sexual misconduct: sexual impropriety and sexual violation. Both types are the basis for disciplinary action by the physician's state medical board if the board finds that the physician's behavior exploited the physician-patient relationship.

*Sexual impropriety* includes behavior, gestures, or expressions that are "seductive, sexually suggestive, disrespectful of patient privacy or sexually demeaning to a patient," according to the federation.

The definitions of sexual impropriety, according to the proposed new guidelines, may include, but are not limited to:

- Neglecting to use disrobing or draping practices that respect the patient's privacy, including watching the patient dress or undress;
- Subjecting the patient to an intimate examination in the presence of medical students or other parties without the patient's informed consent;
- Examination or touching of genitals without the use of gloves;
- Inappropriate comments about or to the patient, including making sexual comments about the patient's body or underclothes, making sexualized or sexually demeaning comments to a patient, criticizing the patient's sexual orientation, or making comments about potential sexual performance during an examination;
- Using the physician-patient relationship to solicit a date or romantic relationship;
- Initiation by the physician of conversation regarding the physician's sexual problems, preferences or fantasies;
- Performing an intimate examination or consultation without clinical justification and without explaining to the patient the need for it, except when the examination or consultation is pertinent to the issue of sexual function or dysfunction;
- Requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of examination or consultation.

*Sexual violation* may include physical sexual contact between a physician and patient, whether or not initiated by the patient, and engaging in any conduct with a patient or the patient's surro-

gate (parent, spouse or other person designated by the patient to make decisions for him or her) that is sexual or may be reasonably interpreted as sexual.

Sexual violation includes, but is not limited to:

- Sexual intercourse, genital to genital contact;
- Oral to genital contact;
- Oral to anal contact, genital to anal contact;
- Kissing in a romantic or sexual manner;
- Touching breasts, genitals or any sexualized

body part for any purpose other than appropriate examination or treatment, or where the patient has refused or has withdrawn consent;

- Encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present;

- Offering to provide practice-related services, such as drugs, in exchange for sexual favors.

Individual state medical boards, as well, are adopting new policies on sexual misconduct, or retooling existing ones. Among those taking recent action to discourage sexual misconduct by physicians are Washington (forbids all physicians from dating patients); Texas (gives priority to complaints of sexual misconduct); and California (sex offenders are not allowed to practice medicine in that state). ■

## NEWS BRIEFS

### Threat of pandemic leads to 'Ethics of Vaccines' project

*Panel will craft ethical guidelines*

The Center for Bioethics at the University of Pennsylvania School of Medicine has begun an 18-month project to examine the field of vaccine development and use and to propose an ethical framework to help guide researchers, pharmaceutical companies, public health agencies, health care providers, and citizens regarding vaccines and their safe, effective, and ethical use.

A team of physicians, public health officials, academics from the University of Pennsylvania

and other leading institutions, media representatives, and others have begun deliberations to lay the groundwork for the project.

"Just as Hurricane Katrina uncovered a number of very unacceptable realities associated with our nation's preparedness and our response to the poorest of our citizens, the prospect of an avian flu pandemic — and it is still a prospect — is bringing into sharp focus where we need to prioritize our energies in terms of the ethics around the role of vaccine in global public health," says **Arthur Caplan**, PhD, director of Penn's Center for Bioethics and chair of the department of medical ethics at the medical school.

To that end, the Ethics of Vaccines project has

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assembled a team of experts from the academic, governmental, and private-sector communities to provide an in-depth examination of the issues. "Our goal is to develop a robust ethical framework to help move this area of our public health infrastructure forward," notes Caplan.

Caplan says the record of accomplishment in the vaccines field is extraordinary, and vaccines will continue to play a significant role in reducing or eliminating infectious diseases globally. "But the headlines, editorials, and talk-show analyses on the 'avian flu pandemic' underscore the long-overdue need to develop a supporting and coherent ethics framework around vaccines," he explains.

After monitoring the global vaccines field for the past year, Penn's Center for Bioethics received initial funding to launch a series of interdisciplinary seminars to engage issues surrounding the ethics of vaccines.

For more information about the project, go to <http://www.bioethics.upenn.edu/vaccines/>. ■

## Swiss hospital to allow on-premise assisted suicide

*Suicide not viewed as 'routine'*

Beginning this year, the main hospital in Lausanne, Switzerland, will allow assisted suicides to take place on its premises under carefully monitored conditions.

Although assisted suicide is legal in Switzerland in cases of incurable disease involving mentally competent patients, no hospital in the country has permitted the practice on site. Moreover, hospitals have denied access to the Swiss voluntary euthanasia group known as Exit.

After almost three years of discussions, however, Vaud University Hospital officials determined that permitting the practice on site is

proper under the guidelines established by the Swiss Medical Association and the National Committee on Ethics. Both organizations acknowledge that while assisted suicide should never be viewed as a routine procedure, it should be permitted in exceptional situations to respect the independent decision of a competent patient.

The conditions imposed by the hospital are that an assisted suicide will be permitted on site provided the patient is competent, too ill to return home, and has consistently expressed the wish to die.

The new rule at University Hospital will also allow the individual patients wishing to terminate their lives to have access (at the hospital) to a doctor from the outside or a member of Exit. ■

## Rhode Island might extend hospitals' ethics codes

Rhode Island is the latest of several states taking steps to extend strict ethics codes beyond hospitals' clinical personnel, to CEOs, boards of directors, and trustees.

Rhode Island lawmakers are pursuing legislation imposing a strict code of ethics on hospital administrators, in the wake of the disclosure of questionable expenses by the president of Roger Williams Medical Center in Providence.

Lt. Gov. Charles J. Fogarty plans to submit legislation to hold executives and directors of Rhode Island hospitals to higher standards of "transparency and accountability." Fogarty's comments followed reports in the media of luxury travel taken by hospital President Robert A. Urcuioli that were billed to the hospital. In addition, Urcuioli and the hospital are targets of a federal grand jury investigation into the hospital's hiring of a former state senator as a consultant.

### COMING IN FUTURE MONTHS

■ Sham peer reviews

■ Advances in palliative care

■ What dying patients can teach doctors

■ 'Dial-a-doc' services drawing fire

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## 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. 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. ■

## CE objectives

After reading each issue of *Medical Ethics Advisor*, you will be able to do the following:

- discuss new information about hospital-based approaches to bioethical issues and developments in the regulatory arena that apply to the hospital ethics committee;
- stay abreast of developments in bioethics and their implications on patient care, risk management, and liability;
- learn how bioethical issues specifically affect physicians, patients, and patients' families. ■

## CME Questions

- According to data from the Family Caregiver Alliance, a study of elderly spousal caregivers age 66-96 years found that caregivers who experience caregiving-related stress have a 13% higher mortality rate than noncaregivers of the same age.  
A. True  
B. False
- According to new guidelines on sexual misconduct proposed by the Federation of State Medical Boards, sexual misconduct by a physician is broken down into two categories, which are:  
A. sexual assault and sexual harassment  
B. sexual impropriety and sexual assault  
C. sexual impropriety and sexual violation  
D. none of the above
- In determining whether research or training using a recently deceased person can go forward, the review board learns that before death, the person indicated a desire to be an organ donor. Organ procurement:  
A. takes precedence over research.  
B. does not necessarily preclude research, if research does not interfere with procurement.  
C. is deemed a more immediate benefit than research.  
D. all of the above
- In the study by Papadakis, et al, the strongest association with disciplinary action against physicians in later years was seen in medical students who were irresponsible in attendance or patient care.  
A. True  
B. False

**Answers: 5. B; 6. C; 7. D; 8. A.**

"Unfortunately, as we have seen with Blue Cross in Rhode Island and Enron and WorldCom nationally, some of these higher-ups think that a company is their private domain," explains Fogarty, who adds that he is asking state regulators to increase financial disclosure requirements on hospitals regarding executive pay and expenses. ■