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IN THIS ISSUE

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XDR-TB case exposes health officials, public to ethical aspects of quarantine

Ethicist: Public welfare can mean loss of individual freedoms

The public health threat posed by Andrew Speaker, the Georgia lawyer who traveled to Europe and back as he learned that he not only had tuberculosis, but an extremely drug-resistant tuberculosis (XDR-TB), warranted the first federally ordered quarantine in 44 years.

What it probably also deserved, one public health ethicist says, was quicker action to isolate Speaker sooner, and the director of the Centers for Disease Control and Prevention (CDC) says the case has revealed some potential for improvement in handling future quarantine cases. And though the CDC and National Jewish Medical and Research Center later announced, in early July, that additional testing had revealed that Speaker is suffering from multidrug-resistant tuberculosis, not XDR-TB **(see editor's note)**, those lessons remain viable.

Depriving an individual of his or her liberties for the sake of the public good is not entirely uncommon in the United States, or the rest of the world. The Atlanta-based CDC, which made attempts to persuade Speaker to refrain from travel in May before he left for Europe, and then obtained the federal order forcing him into isolation when he returned to the United States, has said events unfolded in a way that allowed Speaker to leave on his own before the government had what it believed was enough evidence to curtail his movements.

Emphasizing that he has no first-hand knowledge of the CDC's actions, and that hindsight is 20/20, public health ethicist **Marc Hiller,** DrPH, an associate professor of health management and policy at the University of New Hampshire, says the actions taken by the CDC to isolate Speaker "were fully appropriate."

There have been a few criticisms suggesting the government overreacted, given that Speaker was not symptomatic and, according to CDC Director **Julie Gerberding**, MD, MPH, posed "a low transmission hazard — but not zero." But most questions have been directed at how Speaker — who was known to have tuberculosis, and at least drug-resistant tuberculosis (but not XDR-TB) before he left the country — could leave the country, travel through Europe, and then fly back to North America and

drive into the United States from Canada without being apprehended.

That's the question Hiller says is foremost to him, as an ethicist — not whether Speaker's individual rights were threatened as he planned a wedding trip to Europe, but whether more could have been done to protect the public earlier.

"It's a struggle to balance promoting and assuring the public's health and well-being while protecting individual rights and liberties," says Hiller. "While the preservation of individual liberty is a long-cherished ideal in a democracy and in health care, it must be viewed as secondary when an individual's health (or disease) status threatens the health — and in this case, possibly the lives — of others, particularly potentially large populations." **(See box, p. 87.)**

"If one reviews the history of public health in the United States, whether it be extreme pandemics such as the Spanish influenza outbreak in 1918 or the infamous case of Typhoid Mary, clearly the need to restrict individual rights and spread of contagion is merited in order to protect the health and lives of the public, or the overall social good of society."

The pursuit of Andrew Speaker, and the potential exposure of dozens of people on the flights he took back to the United States, could have been avoided had he been placed in isolation — an everyday practice in health care settings in which someone with a staph infection, meningitis, or TB is removed from the general population and isolated from contact with others.

Quarantine is a more population-based approach that seeks to separate exposed individuals, who still appear perfectly healthy even though they've been exposed, for a period of time to see if they develop symptoms.

"Why was he not isolated and treated for the disease prior to his being able to expose other people?" Hiller asks. The federal quarantine order that the CDC obtained to allow it to force Speaker into isolation "was a wise, prudent, protective measure, but could have been prevented if he'd been isolated sooner."

CDC relies on 'covenant of trust'

In media briefings in late May, after Speaker had been placed in isolation in Denver's National Jewish Medical and Research Center, Gerberding said in most cases, people diagnosed with tuber-

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- **Centers for Disease Control and Prevention**, transcripts of briefings by Director Julie Gerberding, MD, MPH; May 29, 30, and June 1, 2007. Available online at www.cdc.gov/tb/xdrtb.
- Jain S, Rodrigues C, Mehta A, et al. High prevalence of XDR-TB from a tertiary care hospital in India (abstract). American Thoracic Society International Conference, May 2007, San Francisco, CA.

culosis are trusted to isolate themselves.

"[W]e influence them through a covenant of trust so that they don't put themselves in situations where they could potentially expose others," Gerberding explained. "In this case, the patient had compelling personal reasons for traveling and made the decision to go ahead and meet those personal responsibilities."

Speaker and Gerberding have issued somewhat differing accounts of what Speaker knew at the time he and his fiancee flew to Greece: The CDC says he was told he had drug-resistant TB and should not travel; he says he was told he was not a contagion risk and thought the decision to travel was up to him.

A federal isolation order was issued, allowing the CDC to put Speaker into quarantine when he was found; that order, the first of its kind since a 1963 order was issued for a person exposed to smallpox, was vacated once he was in isolation in Colorado and state quarantine powers took over.

"It did not become known to CDC until after the patient had left the United States that his bacteria were resistant not only to the first-line drugs [but also] the second-line drugs, which categorizes in the extremely drug-resistant category," Gerberding explained.

"Again, our job here is to balance the need to protect people from exposure to this very, very serious organism with the recognition that, as an individual, the patient needs and wants and should have the very best medical treatment."

Hiller says isolation and quarantine of people with infectious disease has been around throughout history, and has always been a subject of debate. That debate is perhaps greatest in the United States, where any imposition on personal freedom is eyed carefully.

"It puts one of our most cherished values — personal liberty — at odds with an equally cherished value, that of protecting the public welfare," he points out. "What public health tries to do is to prioritize that second value, protecting public welfare. But it's easier to look back and say we have been over-aggressive in protecting the public welfare than to say we erred when we could have prevented an unnecessary public risk."

TB case may be first of many

The precautions taken in the case of Andrew Speaker — federal and state intervention to contain a potential contagion threat — may be something the public becomes more familiar with in coming years, Hiller says.

"I think as far as where we're going, public attention has been focused far more on this in recent years due to the SARS epidemic and threats of bioterrorism," he points out. "Efforts are under way to broaden a more common, standardized approach to these questions, and to develop and promote some standardized legislation."

Public education, he says, "should be the pri-

About Extremely Drug-Resistant Tuberculosis

- MDR-TB (multidrug-resistant TB) describes strains of TB that are resistant to at least the two first-line TB drugs, isoniazid and rifampicin. Extremely drug-resistant TB (XDR-TB) is MDR-TB that is also resistant to three or more of the six classes of second-line drugs. XDR-TB leaves patients (including many people living with HIV) virtually untreatable using currently available anti-TB drugs.
- From 1993 through 2006, there were 49 persons in the United States who met the definition for XDR-TB. Seventeen of those cases have been reported since 2000, according to Centers for Disease Control and Prevention (CDC) statistics.
- The World Health Organization and CDC found that XDR-TB has been identified in all regions of the world, but occurs most frequently in the countries of the former Soviet Union and in Asia.
- Symptoms of XDR-TB are the same as for any kind of tuberculosis. The difference is that the particular mycobacterium cannot be killed by any drugs currently in use. XDR-TB can only be determined in laboratories, but results take 6-16 weeks to obtain.
- TB surveillance in countries most affected by TB is poor; however, the CDC says a safe estimate of XDR-TB would be fewer than 500,000 cases in the world (the number of multidrug-resistant tuberculosis cases reported in 2004).
- The death rate of XDR-TB patients in a study in India was 42%. XDR-TB is of special concern for persons with HIV infection or other conditions that can weaken the immune system; these persons are more likely to develop TB disease once they are infected, and also have a higher risk of death once they develop TB. ■

Sources: Jain S, Rodrigues C, Mehta A, et al. High prevalence of XDR-TB from a tertiary care hospital in India (abstract). American Thoracic Society International Conference, May 2007, San Francisco, CA; Centers for Disease Control and Prevention, Division of Tuberculosis Elimination. www.cdc.gov/tb.

mary conversation."

"It is critical for the public at large to be aware of the importance of prevention as well as the necessary steps to prevent spread of infection to the greatest degree possible," he adds.

Quarantine is a strong, blunt approach to protecting public health, Hiller points out. Because it can affect large numbers of people in a very disruptive way, educating the public on the need for adherence when quarantine restrictions are in place, and putting protections in place that will prevent those who are subject to the restrictions of a quarantine from being penalized, either by discrimination or loss of employment and other rights.

"It is absolutely important to promote transparency, for public health officials to bear the responsibility of communicating a justification for their actions when quarantine action is taken," Hiller concludes. "The public deserves to know why a quarantine might be necessary and why certain individuals may be required to sacrifice some of their liberties.

Gerberding says the CDC learned much in this regard from the Speaker case.

"We acknowledge, certainly, that CDC and many others have learned a lot in this process," she said. "We´ve already conducted one after-action analysis [in early June] to go through what happened as of the end of last week, and we will be continuing to go through this kind of analysis to … learn from this so that, if we are ever in this situation again in the future, it will be easier for everyone involved."

Gerberding says some legal questions arose, particularly around use of the federal quarantine action, since the CDC was dealing with a U.S. citizen who wanted to *leave* the country, rather than someone wanting to enter the United States or move around within the country. And international regulations (agreed on by the CDC, World Health Organization, and others) "are wonderful statements of principle, [but] the operational details of things like who should pay to move a patient, or who should care for a patient in isolation or quarantine, are not spelled out in those regulations."

Editor's note: Speaker's latest diagnosis, MDR-TB, vastly improves his prognosis as well as the outlook for anyone who might have been exposed during his flights in Europe and to the United States, doctors at National Jewish say; however, the CDC says the amended diagnosis does not mean the CDC and federal authorities reacted inappropriately in searching for and detaining Speaker, and warning his fellow travelers.

Hiller concurs, pointing out that the goal of quarantine is often to isolate people who appear healthy, to determine if they are carrying a contagion. A definitive diagnosis is not part of the criteria for ordering quarantine, he says.

***Mitchell Cohen**, MD, director of the CDC's Coordinating Center for Infectious Diseases, says that's the case in this particular patient.*

"[R]egardless of the revisions of the patient's drug susceptibility at this time, the public health actions that CDC took in this case, and are continuing to take, are sound and appropriate," Cohen says. "After all, the public health response to drug-resistant TB infections, either MDR-TB or XDR-TB, is the same under the World Health Organization's TB and airline travel guidelines that were published in 2005.

"Without question, people with these infections should not be flying on commercial airlines and if they do, an effort should be made to notify and evaluate passengers who are seated near them." ■

Medical blogs: Potential minefield for writers

Careers can be enriched, derailed on-line

Blogger beware — some on-line medical diarists have found the benefits of sharing experiences and observations via their web logs ("blogs") can come at a cost.

Dr. Flea and Barbados Butterfly are two of the most-recognized recent examples of "don't-do-this" clinical blogging, and their travails led one group of doctor/bloggers to create a "Healthcare Blogger Code of Ethics" to help guide blog authors in making sure their on-line diaries don't hurt anyone, including themselves.

Two recent cases testify to the need for such guidelines, the author of the code of ethics points out.

Dr. Flea — Natick, MA, pediatrician Robert P. Lindeman, MD — had a popular blog in which he used humor and rapier-sharp observations to educate and editorialize. However, those qualities his

SOURCE

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- "Healthcare Blogger Code of Ethics" available on-line at www.medblogcode.blogspot.com.

readers appreciated turned into a huge liability in May when he blogged about a malpractice trial he faced that arose from the death of one of his patients (a trial Lindeman blogged that he expected to go in his favor). His mistake — blogging *during* the trial, posting entries that ridiculed the plaintiff's attorney, made fun of the jurors and judge, and revealed his defense strategy. When he took the stand, the plaintiff's lawyer asked, "Are you Flea?"[1]

The question told Lindeman's attorney that the opposing lawyer was prepared to reveal to the judge and jury the existence — and contents — of the blog. Lindeman's lawyer proposed a settlement, and Lindeman shut down his blog.

Just two months earlier, Melbourne, Australia, surgical resident Jillian Tomlinson found that her highly popular blog, Barbados Butterfly, was not anonymous enough, at least as far as her employer was concerned. Tomlinson was suspended by her hospital for one week, and her blog, while still in existence, is now accessible by invitation only.[2]

Australian Medical Association President Mukesh Haikerwal, MD, told the Melbourne *The Age* that there are risks involved in trying to "de-identify" patient information. "There's more to it than just rubbing out the name," he said.

Stories like those of Dr. Flea and Barbados Butterfly have sent a chill through the rapidly growing medical blogosphere. Estimates of the number of health care blogs on the Internet vary depending on who you ask; it is safe to say that the number of blogs written by doctors went from just a few less than 10 years ago to somewhere in the neighborhood of 1,000, according to several networking sites.

'De-identify' with care

Some precautions necessary to safely blog about medicine are obvious — for example, naming patients, or giving enough details to identify patients, is a clear privacy violation.

"De-identification" is a hot topic among medical bloggers. According to the U.S. Department of Health and Human Services' Summary of the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule, de-identified health information "neither identifies nor provides a reasonable basis to identify an individual." But de-identification can be more complicated than merely changing names and dates. **(See box, this page.)**

Other problems arise when bloggers who post anonymously, so as to be free with opinions and information about colleagues and their employers, suddenly find their identities uncovered. Angry co-workers and disgruntled employers and medical societies are among the least of the problems that can arise from careless blog posts — litigation can be initiated or, as Dr. Flea discovered, impacted by a clinicians' blog activity.

On a more positive note, blogs are widely appreciated as a means of quickly sharing advice, gaining informal consults, and alerting peers to important literature. A form of web-based "grand rounds" is a popular format, with some bloggers forming networks and rotating the role of "host" of the grand rounds. Some blogs resemble miniature poster sessions, with scans, ECG tapes, and unusual presenta-

How to De-Identify Health Information

To safely use health information in a blog — or anywhere else — and ensure the "safe harbor" of de-identification, the person using the information (the "entity") must:

1. Have a formal determination of the information made by a qualified statistician,

OR

2. Remove specified identifiers of the individual and of the individual's relatives, household members, and employers. This is adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual.

The identifiers that must be removed to achieve the "safe harbor" of de-identification are:

- Names.
- All geographic subdivisions smaller than a state (including city, county, and ZIP code).
- All elements of dates, except year, for any dates directly relating to the individual (birth, admission or discharge date, death); and all ages over 89, including anything that would indicate the person's age.
- Telephone and fax numbers.
- E-mail addresses.
- Social Security numbers.
- Numbers relating to medical records, health plans, accounts, or license numbers.
- Vehicle license plate numbers.
- Web addresses (URLs) and Internet protocol (IP) numbers.
- Finger and voice prints.
- Full-face photographs and comparable images. ■

Source: U.S. Department of Health and Human Services. Summary of the HIPAA Privacy Rule. May 2003. Available at www.hhs.gov/ocr/privacysummary.pdf.

The Healthcare Blogger Code of Ethics

Clear representation of perspective — Readers must understand the training and overall perspective of the author of a blog. Certainly, bloggers can have opinions on subjects outside of their training, and these opinions may be true, but readers must have a place to look on a blog to get an idea of where this author is coming from. This also encompasses the idea of the distinction between advertisement and content. *This does not preclude anonymous blogging*, but it asks that even anonymous bloggers share the professional perspective from which they are blogging.

Confidentiality — Medical bloggers must respect the nature of the relationship between patient and medical professionals and the clear need for confidentiality. All discussions of patients must be done in a way in which patients' identity cannot be inferred.

Commercial Disclosure — The presence or absence of commercial ties of the author must be made clear for the readers. If the author is using the blog to pitch a product, it must be clear that they are doing that. Any ties to device manufacturer and/or pharmaceutical company ties must be clearly stated.

Reliability of Information — Citing sources when appropriate and changing inaccuracies when they are pointed out.

Courtesy — Bloggers should not engage in personal attacks, nor should they allow their commenters to do so. Debate and discussion of ideas is one of the major purposes of blogging. While the ideas people hold should be criticized and even confronted, the overall purpose is a discussion of ideas, not those who hold ideas. ■

Source: www.medblogcode.blogspot.com

tions posted for comment and educational value.

One blogger, interested in preserving the integrity of medical blogs while offering guidance for bloggers to protect themselves, created medblogcode.blogspot.com, home of the Healthcare Blogger Code of Ethics. **(See box, this page.)**

The code addresses confidentiality, privacy, and bias, and is mainly intended to protect medical bloggers who post anonymously, says **Rob Lamberts,** MD, an Augusta, GA-area pediatrician and internist who launched the blogger's ethics site. Lamberts is himself a blogger (distractiblemind.ambulatorycomputing.com), though not an anonymous one.

"I do not want the whole medical blogging community to post with their identities open," he stated in introducing the code of ethics. "There is a part of the life of someone that becomes closed to the public when they lose anonymity."

And in some cases, he says, blogging anonymously protects the people and institutions being written about. Having a code not only gives bloggers a checklist to go by, but can be useful in demonstrating to employers and colleagues that the blogger intends to adhere to a certain standard.

The ethics code — and whether it actually can have meaning — is still in development, Lamberts points out. One proposal would have those who opt to adhere to the code list it on their sites, and in turn they would be listed on the medblogcode site. Violators of the code would be subject to having their sites "de-listed" from the ethics code site.

References

1. "Blogger unmasked, court case upended," by Jonathan Saltzman. *Boston (MA) Globe*, May 31, 2007.
2. "Surgeon's blog vents her guts and spleens," by Suzanne Carbone and Lawrence Money. Melbourne (AU) *The Age*, March 29, 2007. ■

Disclosing information: How much is too much?

Patients gain little from doctors' disclosures

Physicians say they sometimes struggle to strike a balance in their doctor-patient relationships — not too personal, not too aloof. In trying to be warm and empathetic, however, "physicians should always keep the focus of the conversation on the patient," says **Diane Morse**, MD, an associate clinical professor at the University of Rochester (NY) School of Medicine and Dentistry.

But a study she and several colleagues completed recently provides proof that sometimes when a physician shares personal information with a patient, it amounts to too much about the doctor and not enough about the patient.

The researchers "listened in" by gathering transcripts of audiotaped patient visits to 100 Rochester-area internists. The "patients" were standardized subjects who were trained to depict specific patient presentations. Each physician

agreed to two unannounced, undisclosed audiotaped patient visits; a few of the 193 recordings obtained were discarded for quality, and 76 were discarded because the physician detected that the patient was a standardized subject. But from the 113 good recordings, and the surveys completed by physicians during the research period, the investigators drew some conclusions about the usefulness of physicians' self-disclosures (MD-SD) to their patients.

'Less about you, more about me'

"A lot of time, we found that the focus of the conversation didn't originate from or go back to the patient, and that focus is important," says Morse.

One example mentioned in the study:[1]

Physician: No partners recently?

Patient: I was dating for a while and that one just didn't work out. . . about a year ago.

Physician: So you're single now.

Patient: Yeah. It's all right.

Physician: [laughing] It gets tough. I'm single as well. I don't know. We're not at the right age to be dating, I guess. So, let's see. No trouble urinating or anything like that?

The problem with this exchange, the authors explain, is that the physician shifted the focus to himself, then abruptly changed the subject, not allowing the patient the chance to respond.

"Our observation, from reading and listening, is that the focus didn't go back to the patient as much as it should have," Morse says.

In fact, the authors of the paper on the study said that out of all 113 transcripts, there was no example of a physician making a transition statement leading *back* to the patient's concern and no example of a patient stating explicitly that the MD-SD was helpful in any way.

"What you need to ask yourself, if the idea to share personal information pops into your head, is why you are thinking of doing it?" Morse suggests. "Is there a reason to do it, or is there something else you could say that would be more helpful?"

Physicians' motives in sharing personal disclosures are often good; however, it doesn't always turn out that the disclosure is good for anyone but the doctor, Morse adds.

"A lot of time, those good feelings [physicians] are getting after sharing their personal information is a one-sided good feeling," she says. "They project that good feeling onto the patient when it really might not be there."

In fact, the Rochester study indicated that only three of the MD-SDs (4%) were coded by the researchers as potentially useful — providing education, support, explanation, or acknowledgment, or prompting some indication from the patient that it had been helpful.

SOURCE

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Check your motives, then keep it brief

In some cases, physicians' motives seemed to be to gain support from their patients, rather than to give it — for example, one doctor described her concerns over her daughter going to camp and her loneliness at her absence. Another physician, seeing a patient who might have had weight concerns, pointed out his own weight (which was 30 pounds less than the patient's) and described his own athletic abilities as a runner.

Neither of those encounters, the authors conclude, were to the benefit of the patient.

In some cases, describing a unique shared experience — personal experience with a family member having life support withdrawn, for example, or with an unusual similar disease — might seem to be supportive and welcomed by the patient. Morse says even those kinds of disclosures need to be examined first.

"Sometimes, it's better to think about what else you could do; maybe empathy would be more effective," she suggests. "Instead of saying 'I have had that happen to me, too,' say, 'I know how hard this is for you.'" This keeps the focus of both patient and physician where it should be — on the patient.

"Also, keep it short. You can be empathetic, but be brief," Morse continues. "A lot of these conversations can be time-consuming, so given the fact that your time is limited, how ethical is it for a doctor to decide how that time is spent unless it's spent on the patient?"

Reference

1. McDaniel SH, Beckman HB, Morse DS, et al. Physician self-disclosure in primary care visits: Enough about you, what about me? *Arch Intern Med* 2007; 167:1,321-1,326. ■

Hypothetical errors easier to 'confess' than real ones

Study: Most MDs say they'd disclose, but few have

While most doctors might feel good about the idea of disclosing medical errors to patients, a University of Iowa researcher says fewer than half of the physicians and medical students his team surveyed actually have disclosed real medical errors.

"To come in as the healer and then realize that you have harmed is a difficult thing to accept, let alone admit," finds **Lauris Kaldjian,** MD, PhD, director of the biomedical ethics and medical humanities program at the University of Iowa Carver College of Medicine in Iowa City.

In a survey of faculty physicians, resident physicians, and medical students, researchers found that while nearly all respondents indicated that they would disclose a hypothetical error, less than half reported having disclosed an actual minor or major medical error.[1]

While to a lay reader those figures might indicate that fewer than half of the 538 physicians, residents, and medical students had ever made a mistake, Kaldjian dismisses that interpretation.

"It seems fair to assume that all of us have made at least a minor error, if not a major error, sometime in our careers," he insists. Kaldjian acknowledges biases can influence survey data like this — for example, a respondent's reluctance to reveal information that may be embarrassing or unflattering.

The point remains, however, that there appears to be a discrepancy between how physicians and trainees believe they would act when faced with a medical error situation and how they have acted when in those situations, he continues.

"Our goal was to learn more about clinicians' attitudes but also what they actually have, and have not, done," Kaldjian explains. "We were interested in what factors or beliefs might be motivating physicians who are more likely to disclose errors to their patients."

Kaldjian and his colleagues asked questions about minor errors, such as "Have you ever made a mistake that prolonged treatment or caused discomfort and told the patient [or the patient's family] that a mistake was made?" and major errors, such as "Have you ever made a mistake that caused disability or death and told the patient [or the patient's family] that a mistake was made?"

The survey participants also were presented with a hypothetical case in which a physician failed to note a patient's allergy to cephalosporins and gave him one of the drugs to treat pneumonia. They were then asked how they would respond to each of three possible outcomes: no harm to the patient; minor harm (diffuse itching and a rash); or major harm (respiratory distress, anaphylactic shock, and myocardial infarction).

Ninety-seven percent of the faculty and resident physicians indicated that they would disclose the hypothetical medical error that resulted in minor medical harm (resulting in prolonged treatment or discomfort) to a patient, and 93% responded that they would disclose the error if it caused major harm (disability or death) to a patient.

However, only 41% of faculty and resident physicians reported actually having disclosed a minor medical error, and only 5% responded as having disclosed a major error. Moreover, 19% acknowledged having made a minor medical error and not disclosing it; 4% indicated having made and not disclosing a major error.

"Most doctors recognize that they're fallible, but they still strive for perfection and, for the most part, hold each other accountable to a high standard of practice that approximates perfection," Kaldjian notes.

Fear of malpractice has been cited as a reason why doctors do not disclose medical errors, but the study authors report that their survey found that physicians who had been exposed to malpractice litigation were not less inclined to disclose errors. The researchers also found differences among the survey respondents based on training level. Physicians with more experience were more willing to disclose medical errors, suggesting that with increased clinical competence and confidence, doctors become more comfortable with error disclosure, according to the study. **(See "Malpractice fear only one barrier to disclosing errors," *Medical Ethics Advisor*, September 2006, p. 100.)**

Kaldjian also noted preliminary survey data showing that physicians who indicated that forgiveness is an important part of their spiritual

SOURCE

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and religious belief systems were more likely to disclose medical errors to their patients.

"This is not to say that forgiveness should be a course in medical school," he says. "But it does suggest that medical schools should consider ways to encourage trainees to draw upon the deeper personal beliefs they bring to the practice of medicine that may be relevant to the challenges of disclosing medical errors."

Reference

1. Kaldjian LC, Jones EW, Wu BJ, et al. Disclosing medical errors to patients: Attitudes and practices of physicians and trainees. *J Gen Int Med* 2007;22:988-996. ■

'Hopefulness' contributes to good end-of-life care

More education and experience also are benefits

Researchers at a large children's hospital found that nurses who were comfortable working with dying children and their families were also nurses who reported high levels of hopefulness.[1]

"The study was prompted by our desire to see why it appeared that some nurses were more comfortable with end-of-life care and, in particular, talking to the families and having difficult conversations with them," says **Gina Santucci**, MSN, RN, nursing coordinator, Pediatric Advanced Care Team (PACT) of the Children's Hospital of Philadelphia.

Investigators analyzed nurses' work experience, education levels, and hopefulness, and compared these to their self-assessment of competence in palliative care.

The study found that nurses with more nursing experience tended to express higher levels of comfort working with dying children and their families, and the same was true with nurses who had more years of education and higher levels of hopefulness, according to the Adult Dispositional Hope Scale.

Santucci wanted to include "hopefulness" in the study due to her own personal experiences as a nurse.

"I've worked on the floor and taken care of patients, and when I look back at my experiences, I can remember situations where I didn't feel hopeful about what I was doing," Santucci says. "Then there were other experiences that were equally difficult, but I felt everything was working well, and I felt hope had something to do with it."

SOURCE

For more information, contact:

• **Gina Santucci**, MSN, RN, nursing coordinator, Pediatric Advanced Care Team, Children's Hospital of Philadelphia. E-mail: santucci@email.chop.edu.

The study was a web-based questionnaire, and 932 nurses at the hospital were invited to participate, via e-mail. Nurses also were reminded of the survey at staff meetings.

In all, 410 nurses completed the questionnaire, which is a 44% response rate, Santucci says, adding, "We were happy that the response rate was over 20%.

"Our most substantial finding was with education," Santucci says. "Specifically, in palliative care; that was the highest."

Nurses who had more hours of palliative care education were the most comfortable in providing palliative care and talking about death and dying with their patients and families, Santucci says.

The Web-based survey included these kinds of questions — asking for a rating from four, which means extremely competent to zero, meaning not competent — to assess a nurse's opinion of her/his own competency in each of these areas:

- proving nursing interventions to improve the child's quality of life;
- managing pain;
- managing other symptoms;
- talking with children and families about dying;
- emphasizing goals, not limitations;
- understanding the role of hospice;
- recognizing impending death;
- understanding advance directives;
- being sensitive to spiritual needs;
- being sensitive to cultural values and issues;
- understanding ethical issues surrounding end-of-life care; and
- knowing where to find help within the hospital when faced with an ethical dilemma.

Also, nurses with the most education reported feeling more competent, she adds.

The second highest correlation was between experience and feelings of comfort and competence in dealing with dying patients.

Researchers found that nurses with more experience expressed being comfortable with talking to dying patients and their families, Santucci says.

"But once nurses had five to six years of expe-

rience, their comfort level hit a plateau," she adds. "Also, their difficulty in talking with families was higher if they were new nurses, and would gradually decrease with years of practice, reaching a plateau at about 10 years of practice."

The study found that there also was a slight increase in comfort with higher levels of hope, Santucci says.

"With increased hopefulness, there was a significant decrease in difficulty in talking to families about end-of-life challenges, and there was a slight increase in confidence," she says.

While the solution is fairly obvious with education and experience, enhancing hopefulness among nurses is more of a challenge, Santucci says.

"The question is, 'How do you engender hope and how do you change things to make nurses more hopeful?'" Santucci says. "How do you eliminate those things we do to take away hope."

There likely will be another study that looks at this issue, she adds.

"My ideas are that when people are dying at home, sometimes they get less and less visitors because people are not comfortable around death," Santucci says.

Although nurses in a children's hospital are wonderful, it's difficult sometimes for them to sit and be with a family, not saying much, but just being present, she explains.

"It's having an understanding of what the family may want, and that can only be done when you sit and listen for a long time," Santucci says. "It's hard to express, but when a child is dying, knowing what you need to do and being in tune with the child and family takes a lot of time, and it's difficult for everybody."

Reference

1. Feudtner C, et al. Hopeful thinking and level of comfort regarding providing pediatric palliative care: A survey of hospital nurses. *Pediatrics*. 2007;119:e186-e192. ■

Ethics of residents working unsupervised in the ED

Unprofessional and risky, some physicians say

Are residents in training who moonlight in emergency departments (EDs) more likely to experience clinical errors and oversights? The answer is a definite yes, say experts, and to allow them to practice unsupervised is unethical, they add.

"There is absolutely no doubt [that the practice increases the risk of errors]," says **Tom Scaletta**, MD, FAAEM, chair of the ED at Edward Hospital in Naperville, IL, and president of the American Academy of Emergency Medicine (AAEM).

A position statement issued in 2000 by the Society for Academic Emergency Medicine, the Council of Emergency Medicine Residency Directors, and the AAEM concludes that ED moonlighting is a form of dependent medical care.[1] The statement concludes such residents must be actively enrolled in an emergency medicine program approved by the Accreditation Council for Graduate Medical Education or American Osteopathic Association, with supervision that is continuous, on-site, and provided by fully licensed physicians who are board-certified and prepared in emergency medicine by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine.

"There are several articles that make it clear that board certification or residency training in emergency medicine enhances the quality of care," says Scaletta.[2,3]

Moonlighting residents may take the "ignorance is bliss" approach, but this is legally risky and dangerous for patients, says **Carey D. Chisholm**, MD, director of the emergency medicine residency program and clinical professor of emergency medicine at Indiana University School of Medicine. "I'm not as worried when they realize they are in over their heads in that environment, but more so with the items they don't realize they are missing," he says.

Chisholm recommends that faculty members ask themselves the question, "How often do you have no input whatsoever when a resident, particularly a second year one, is managing a case in the ED?"

Unsupervised residents practicing in EDs continues to be a "significant problem" for the specialty of emergency medicine, says Chisholm. "It continues to propagate the impression within the global medical community that anyone can practice emergency medicine," he says.

It is unethical for a resident in training to practice emergency medicine unsupervised, says Scaletta. "It has been two decades since the practice-track, which amounted to learning-on-the-job, has been closed," he says.

CE/CME answers

5. B; 6. D; 7. C; 8. B.

SOURCE

For more information on residency and the risks of moonlighting, contact:

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- **Bruce David Janiak**, MD, FACEP, FAAP, vice chair, department of emergency medicine, Medical College of Georgia, Augusta. Phone: (706) 721-7144. E-mail: bjaniak@mcg.edu.

Chisholm feels strongly that the practice is unprofessional, both for the practitioners involved and the specialty of emergency medicine. "Residents who moonlight in solo practice settings have made a decision to place their financial well-being ahead of the patient's. And you denigrate the specialty by saying it's OK to go out and practice it before you're fully trained," he says. "We don't see that happen with obstetricians or surgeons or dermatologists. They don't go out and practice before they complete their training."

However, **Bruce David Janiak**, MD, FACEP, FAAP, vice chair of the department of emergency medicine at Medical College of Georgia in Augusta, argues there is no ethical problem as long as the institutions in which they moonlight credential them appropriately.

"Requirements regarding board certification and residency completion are institution-specific," he says. "As it turns out, large urban hospitals can attract more ED docs; thus they usually require board certification. Small, rural hospitals do not have this luxury."

A bigger dilemma is that you can be sued for restraint of trade if you do not allow your residents to moonlight, says Chisholm. "Because if the state says they can work there and they have a fully accredited license, why can't they?" he says.

Allowing moonlighting in urgent care settings and double coverage EDs with a more experienced physician reduces the risks involved, says Scaletta. "Urgent care settings are not EDs. There is much less at risk," he says. "I think a senior ED resident would be fine in this type of setting."

Residents are more inclined to accept inappropriate recommendations from consultants, and this is one of the major liability risks involved, says Chisholm.

A physician who is a member of the medical staff working alongside the resident will be able to give input when the resident gets advice he or she doesn't feel comfortable with, says Chisholm.

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 credit letter. When your evaluation is received, a credit letter will be mailed to you. ■

CME 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. ■

COMING IN FUTURE MONTHS

- ■ Ethical conflicts when testifying
- ■ Does death end patient confidentiality?
- ■ Genetic discrimination
- ■ Chaplains: Consultants or health care providers?

The physician also would be able to assist with patient dispositions such as transfers that may be rarely encountered in the academic center.

Though there are no concrete data to support this, most residents moonlight in low-volume institutions; therefore, their exposure to risky situations is likely to be lower, says Janiak.

References

1. American Academy of Emergency Medicine, Society for Academic Emergency Medicine, and Council of Emergency Medicine Residency Directors. Landmark AAEM, SAEM, and CORD consensus position reached. Available on-line at www.aaem.org/boardcertification.
2. Taylor SF, Gerhardt RT, Simpson MP. An association between emergency medicine residencies and improved trauma patient outcome. *J Emerg Med* 2005;29:123-127.
3. Holliman CJ, Wuerz RC, Kimak MJ, et al. Attending supervision of nonemergency medicine residents in a university hospital ED. *Am J Emerg Med* 1995;13:259-261. ■

CME Questions

5. According to the Centers for Disease Control and Prevention in Atlanta, XDR-TB carrier Andrew Speaker was highly contagious when he was traveling internationally in May 2007.
A. True
B. False

6. When disclosing health information, which of the following alone is enough to de-identify the subject of the information, according to HIPAA?
A. Delete the person's name.
B. Delete the person's address.
C. Change the person's age.
D. None of the above alone is enough to adequately de-identify someone, according to HIPAA privacy rules.

7. A University of Iowa study on physicians' views on disclosing errors found:
A. Nearly all said they would disclose a minor or major error.
B. Fewer than half said they actually have disclosed an error.
C. Both A and B are correct.
D. Neither A nor B is correct.

8. The Society for Academic Emergency Medicine, the Council of Emergency Medicine Residency Directors, and the American Academy of Emergency Medicine have endorsed the use of unsupervised residents in hospital emergency departments as an ethical, professional means of "fast-track" training.
A. True
B. False

Clarification

In the July issue, we referred to Jack Kevorkian as a former physician. This is incorrect as he holds an MD. He is not currently in practice.