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IN THIS ISSUE

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Tandem research may herald way around embryonic stem cell dilemma

Conversion makes adult skin cells act very much like embryonic cells

Researchers in Japan and the United States, in simultaneous and nearly identical findings, may have doused one of the most heated controversies in health science research by discovering a way to transform adult human skin cells into cells that closely resemble and act like embryonic stem cells. If their work lives up to the promise indicated in the announcement made in November, the need for embryonic stem cells — and the emotional fight over their use — may evaporate, ethicists say.

Japanese researchers, who announced their findings in an early release publication of the journal *Cell* in November, said their process converts skin cells into cells that have many of the physical, growth, and genetic features of embryonic cells, and can differentiate to form other tissue types, including heart and nerve tissue.[1] Scientists at the University of Wisconsin-Madison (UW-M), using a nearly identical process to yield the same results, announced their findings in the journal *Science* at the same time the Japanese team reported their findings.[2]

The "induced pluripotent stem cells" (iPS) are very close — though not identical — to embryonic stem cells, the researchers say. The Japanese research team used the same recipe to produce iPS cells from adult mouse cells a year earlier, they said.

Shinya Yamanaka, of Kyoto University in Japan, said in statements accompanying his team's report that the findings mark a hopeful step in finding an alternative to embryonic stem cells, but added that it is too soon to tell if iPS cells will completely replace embryonic cells.

Besides ethical objections, the use of human embryonic stem cells poses practical challenges in that it is difficult to generate patient-specific or disease-specific embryonic stem cells. One way to circumvent these issues is to induce pluripotent status in other cells of the body by direct reprogramming, Yamanaka said.

R. Alta Charo, JD, a UW-M professor of law and bioethics, says the scientific findings by UW-M researchers and in Japan could have far-

reaching effects on the progress of stem cell research.

"This is a method for creating a stem cell line without ever having to work through, at any stage, an entity that is a viable embryo," Charo says. "Therefore, you manage to avoid many of those debates with the right-to-life community."

Yamanaka says using his research, science should now be able to generate patient- and disease-specific iPS cells, and then make various cells, such as cardiac, liver, and neural cells.

"These cells should be extremely useful in understanding disease mechanisms and screening effective and safe drugs," he adds. "If we can overcome safety issues, we may be able to use human iPS cells in cell transplantation therapies."

The Japanese research team includes scientists from Kyoto University in Japan and the Gladstone Institute of Cardiovascular Disease in San Francisco.

Findings affect cloning, funding

The new source of iPS cells also resounds in the area of cloning research. Charo says it means researchers can make customized, pluripotent cell lines without having to create an intermediate embryo that is a "clone" of an adult person.

In fact, when the Japanese research was announced, University of Edinburgh reproductive biologist **Ian Wilmut**, who cloned "Dolly" the sheep and is considered the pioneering leader of cloning, announced he would abandon cloning in favor of the cell conversion technique developed in Japan.

Wilmut, in a statement released shortly after the iPS announcements, says his decision is not motivated by ethics as much as evidence that the cell conversion approach holds better chances for success.

Ethicist **David Stevens**, MD, MA, CEO of the Bristol, TN-based Christian Medical & Dental Associations, hailed the announcements by the U.S. and Japanese researchers — as well as Wilmut's change of direction — as good news on both ethical and practical levels.

"This is very good news, because for those clinical trials using adults cells for 70 something diseases, this will give those interested in embryonic cells a relatively cheap, easily obtainable source of cell lines," says Stevens. "Labs can start up this week doing it. It opens up the research door, and without the ethical restrictions, there will be federal dollars available to do it."

Charo says the cell conversion findings may throw into question government funding for traditional embryonic stem cell research, which has been a political hot potato for some time. The Bush administration has twice vetoed legislation

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that would overturn its ban on embryonic stem cell research.

The discovery is likely to expand avenues of research that are already eligible for federal funding because they do not involve embryonic cell lines.

"This takes care of all the ethical issues that many have been concerned about," predicts Stevens. "It might be easy to say that ethical objections [to embryonic stem cell use] just involve a vocal minority, but when we get down to it — when you reach the point where embryonic stem cells are available for use in treatment — you would have 25 to 30% of the population saying, 'I can't do this; it's morally wrong.'"

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2. Yu J, Vodyanik M, Smuga-Otto K, et al. Induced pluripotent stem cell lines derived from human somatic cells. *Science* 2007; doi: 10.1126/science.1151526. Abstract available on-line at www.sciencemag.org/cgi/content/abstract/1151526 (accessed 11/26/2007). ■

Know your potential limits in the event of disaster

Priorities will guide providers

It wasn't years of medical education, AIDS research, and experience that especially prepared **Ruth Berggren**, MD, to accept her appointment as interim director of the Center for Medical Humanities & Ethics at the University of Texas at San Antonio — it was, specifically, six days in New Orleans.

Berggren, an AIDS and infectious disease specialist, was a faculty member at Tulane University and was the teaching physician assigned to the infectious disease ward of New Orleans' Charity Hospital in August 2005 when Hurricane Katrina's floodwaters ripped through the city and stranded Berggren, her colleagues, and their patients for six days and nights in the flooded, hot, dark hospital.

"That experience was a really profound one for me, and made it easy for me to take this position [as director of the ethics center]," says Berggren.

Many lessons were learned during and after Katrina, she agrees, but perhaps none so profound as the realization that every person "will draw their line — the line they won't cross — in different places, depending on who they are, what their beliefs are, maybe how they were brought up."

"And when you're going into a disaster, it's important to know where those lines are."

Some need to stay, others need to go

The daughter of two public health physicians, Berggren grew up in rural Haiti. She has particular interest in clinical AIDS and viral hepatitis research, and in implementing HIV care in resource-poor settings. "Resource poor" was just one of the conditions at Charity Hospital after Katrina hit.

At Charity, as at other New Orleans hospitals crippled by the storm, health care providers were discovering where their own personal lines were drawn in the ethical sand.

"One thing I observed as the hurricane bore down on us was that there was an incredible diversity of responses among the health care professionals there," she recalls. "Some thought, clearly, that their first priority had to be to their families, their dependents, and that led them in some cases to abandon some commitments they'd made to be on call for the Code Gray [emergency response team].

"Others felt their families were secure, and that they needed to stay even though they were not on the Code Gray team, because they felt an obligation to their patients, their colleagues, and in some cases, to their career-long research."

The latter describes her husband, Tyler J. Curiel, MD, MPH, who at the time was chief of oncology at Tulane University Hospital, just across the street from Charity. Curiel opted to stay at Tulane with the couple's young son not only because Berggren was staying, but also to care for patients and in hopes of saving irreplaceable research cell lines.

Berggren is quick to say that she does not judge clinicians whose commitments caused them to leave the hospital and secure the safety of their dependents. For some, staying at their posts while unsure of the welfare of their families hindered their ability to do their jobs.

"We were there for six days, and by day three or four, those who didn't know where their loved ones were had serious trouble functioning, and were unable to remain the calm, professional decision makers they wanted to be," she points out.

Berggren says Katrina proved that even among the most dedicated and ethical health care providers, "human response is hard to predict."

Some who might have justified leaving "demonstrated unbelievable commitment to staying," she says, while others who might have been predicted to stay turned out to be among those who left the hospital.

These responses have obvious implications for future disaster planning, says Berggren, who along with Curiel (now professor and director of the San Antonio Cancer Institute) is often asked to speak to ethics and disaster planning conferences on what Katrina revealed about health care response.

"One of the things I did at Tulane after Katrina was to work with committees redesigning disaster plans, and there was a consensus agreement that there should be better pre-selection of emergency response team members," she says. "You need to say, 'Don't sign up if you know you have dependents who will become helpless in a disaster.'"

In planning a facility's disaster response, Berggren says potential emergency responders should think carefully about committing to what could be a one-day disaster — or a two-week "cataclysmic response."

"They should ask themselves, 'Can I secure my dependents? Can I commit to staying?'" she says. "If you can do that sort of preparation with your team, you will help people self-select who can be there and who can stay."

Where's your 'line in the sand'?

Katrina and its aftermath — particularly the conditions health care providers and patients found themselves in, and the life-altering ethical decisions some physicians had to make when it came to rationing care and supplies — was a "huge" wake-up call for medical ethics.

"When we have discussions on ethical dilemmas in medicine, there is a spectrum of ethical solutions — right and wrong is not black and white," she suggests. In times of crisis, people's limits are based on their individual ethics and where they draw their lines in that spectrum.

"When you're suddenly in the valley of the shadow of death, which is where some people felt they were [following Katrina], if you don't know where those lines are on those spectra, you become confused and prone to make impulsive decisions that you haven't had time to think through," she says.

Those in training to go into a health care profession should be exposed to challenges that cause them to think through ethical dilemmas that show them where their limits are.

SOURCE

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The team approach to facing ethical challenges was particularly supportive to Berggren at Charity, and it's an approach she encourages anytime she's asked to talk about lessons learned from Katrina, she says.

"What sustained me was knowing I was part of a team of professionals I knew and I trusted," she says. "We could go to each other with questions, and so no ethical decision was ever made in a vacuum by one person who had to take complete responsibility."

As Berggren visits ethics centers around the country, she says she notes that medical schools are making progress in training students to consider disaster scenarios and the ethical implications they might hold.

"There's a tremendous amount being done today compared to 20 years ago, and I would like to see it spread and involve all our medical schools," she says. "When medical students discuss dilemmas in a bio-ethics seminar, they not only learn where their lines are drawn on certain issues, they also experience the team approach to decision making.

"It is an experiential learning process — they are learning by doing when they discuss a problem together and reach a solution. My belief is that the more they have been through this process, the more willing they will be to replicate the team approach when pressed into grave decision making in real life." ■

Legal trend? No charge for adverse events

Legislation passed in Massachusetts, Minnesota

It's bad enough when a patient suffers an adverse event from a wrong-site surgery or a medication error; it only adds insult to injury

when the patient or his insurer is billed for the procedure in which the error occurred. Hospitals in Minnesota and Massachusetts have become the first in the country to adopt policies that say patients harmed by certain adverse events won't be charged for them.

Minnesota announced in September that patients at hospitals in that state won't be billed should they experience any of 27 specified adverse health events. The 116 hospitals and health systems belonging to the Massachusetts Hospital Association followed in November with the announcement that they have adopted a uniform policy to not charge for nine adverse events

No billing for adverse events

Massachusetts hospitals won't bill for the following adverse events:

- wrong-site surgery
- wrong surgical procedure
- air embolism-associated injury
- artificial insemination/wrong donor
- infant discharged to wrong home
- wrong-patient surgery
- retention of foreign objects (sponges, instruments, etc.)
- injury from a medication error
- injury from incompatible blood

Patients at Minnesota hospitals won't be billed for these adverse events:

- wrong-site surgery
- wrong surgical procedure
- death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance
- patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended (includes catheters, drains, infusion pumps, ventilators, and other devices)
- infant discharged to the wrong person
- patient suicide or attempted suicide (except when the self-inflicted injuries were the reason for admission)
- injury or death from incompatible blood or blood products
- death or serious disability directly related to hypoglycemia onset while the patient is under care
- stage 3 or 4 ulcers (bedsores) acquired after admission to a facility
- electric shock while being cared for in a facility
- burn incurred from any source while being cared for in a facility
- death or serious injury from use — or lack of use — or restraints
- abduction of a patient of any age
- death or injury to a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility
- wrong-patient surgery
- retention of a foreign body
- patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product
- air embolism-associated death or injury
- patient disappearance resulting in death or disability
- medication error
- maternal death or serious disability associated with labor or delivery in a low-risk pregnancy
- failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life
- death or injury due to spinal manipulative therapy
- wrong gas/oxygen or contaminated gases
- falls occurring while being cared for in a facility
- any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
- sexual assault on a patient within or on the grounds of a facility

Sources: Massachusetts Hospital Association and Minnesota Department of Health Division of Health Policy.

RESOURCES

For more information, contact:

- **Massachusetts Hospital Association**, 101 Arch Street, Suite 1741, Boston, MA 02109. Phone: (617) 367-9667.
- **Minnesota Department of Health**, Division of Health Policy. P.O. Box 64975, St. Paul, MN 55164. Phone: (651) 201-3564.
- **Minnesota Hospital Association**, 550 University Ave. W., Suite 350-S, St. Paul, MN 55114. Web: www.mnhospitals.org.

as defined by the National Quality Forum. **(See table, p. 5, for events the two states won't bill for.)**

It's a growing trend being adopted at various levels across the country, often starting at the single-hospital level. But Medicare is putting some teeth into the push for greater provider accountability for preventable errors. Medicare announced earlier in 2007 that, starting in October 2008, it will no longer pay hospitals for care resulting from eight complications, including falls, foreign objects left inside patients after surgery, bedsores, and three types of hospital-acquired infections.

"This represents a major step forward and builds on several groundbreaking transparency and quality initiatives that have put us ahead of the curve nationally," says **Lynn Nicholas**, FACHE, president and CEO of the Massachusetts Hospital Association. "This policy sends a strong message to patients that their hospital is committed to doing everything possible to eliminate these types of events."

In both Minnesota and Massachusetts, the newly adopted policies codify what many in those states already were doing. In addition, both states have adopted processes of disclosure and apology following adverse events, and hospitals in both states report adverse events to public health authorities.

"Obviously, the ultimate goal is to reduce these errors," Nicholas says. "But as human error is inevitable, we'll attempt to learn from our mistakes, acknowledge the profound effect they have on patients, and ultimately expand the list of serious adverse events that should not occur and for which hospitals should not charge." ■

Who owns patient images following patient's death?

Control of images, consent can be murky issues

You and a colleague have authored a clinical monograph on pelvic fractures, and the article is with the journal's editor, being prepared for publication. The editor contacts you asking for one or two more images, to add visual appeal to the layout; a search through your facility's database yields a black-and-white photograph and an X-ray that apply, so you forward them and they are used in the article.

Is it necessary to ensure that the patients whose injuries are depicted in those images gave consent to have them published? Because of the nature of the images, are they so anonymous that confidentiality is not a concern? Who owns patients' images when consent cannot be obtained, particularly when the patient has died?

"When you have a clinical image, such as a medical photograph, whether or not that patient has given consent for that image to be used, once you upload it into a database and it gets downloaded, it's gone," says **Erika Goble**, MA, an anthropologist and researcher with the University of Alberta Relational Ethics in Healthcare Program in Canada.

Goble, who has for several years researched the use of images of the dead, says she has found that there is uncertainty among clinicians on the issues of consent (when it's necessary, how broadly it applies), anonymity, and the value of education vs. the need for consent when using "unidentifiable" images.

"Education and research are held up as the single most important reason to use images," she says. "I have heard people say researchers and teachers should be able to use the images with proper acknowledgement" even if consent has not been obtained.

Approaches tried for consent

When an image is of a dead person — whether the person died in a disaster and his photograph appears in newspapers or died in a hospital and her images remain in the database — is it possible to secure consent?

Obtaining consent from a grief-stricken family can be troublesome, says Goble, because they are

being asked to consent during a time of stress. The same applies to a patient who grants permission for educational use of images obtained during surgery, for example, but who decided months or years later that he no longer wishes the images to be used.

"But once the image is out there, how do you regain control?" asks Goble, who says this is a fundamental weakness behind one approach to consent, called "ongoing consent," in which the person depicted in the image can "cancel" consent at any time. But once the image has been published or downloaded, it is difficult, if not impossible, to recapture.

"Cross-usage is when ethical issues tend to pop up," Goble continues. "Part of the problem is that what we expect from people who get these images is different, and the expectations of the people giving consent is different. And if someone is dead, how do you negotiate it?"

Clinicians are becoming more aware that use of "anonymous" images does not necessarily replace privacy or consent obligations, Goble says.

The *British Medical Journal* set strict policies a few years ago on use of pictures of patients. Authors must have patients' written consent for any photos, or they are not accepted for publication.

"This applies even when an image only shows something that seems unlikely to lead to identification of the patient — for example, a small skin lesion or a single toe," *BMJ* wrote in a 2005 editorial.[1] "Patients can and do recognise themselves, especially those with unusual or rare conditions. And we know that masking someone's eyes does not prevent them from being recognised, a practice we abandoned years ago."

Anonymity difficult to achieve

The touring exhibit Body Worlds, created by German scientist and physician Gunther von Hagen, is controversial not only because of the graphic exhibition of "plastinated" human bodies stripped of skin, but also for questions about the consent issues it raises.

Best thing to do is to get people to be more conscientious and thoughtful, in putting these images out there in the first place. Public displays of the dead, whether physical exhibits or published photos, are so commonplace that we scarcely notice them, Goble asserts; for example, when a disaster occurs and photos of the dead are included in newspaper accounts, she says, "we hardly notice."

The Body worlds site (www.bodyworlds.com) states that the bodies included in the exhibit "belonged to people who declared during their lifetime that their bodies should be made available after their deaths for the qualification of physicians and the instruction of laypersons."

"Von Hagan says he has made his models anonymous by stripping them of their skin, but I was able to put the skin back on one of the figures on my computer using Photoshop, and it was really quite easy to see what the person might have looked like," she recalls. "It's very hard to make an image completely anonymous, so it's easier to treat an image as if it's not anonymous. People are familiar with their bodies, so even if you cut off the head [in using photos], it's possible someone flipping through a journal might recognize themselves."

Exercise care in use of images

Goble says clinicians can find themselves in an ethical bind when deciding on the use of images from their institution's database. While the medical photographer might have the responsibility of securing consent, once the image is in a database accessible to many people, some control over that image is lost.

"X-rays, MRIs, CT scans — they are unidentifiable in most cases, and researchers can use them however they choose, but they are still scans of someone's body," Goble points out. "I came across a study where people in an emergency department were asked if they would give consent for use of medical photos of themselves. Eighty-four percent said they would, but 53% of those said they would refuse if the photo ended up on the Internet."

In delivering presentations about the use of images, Goble says she uses images to illustrate her program, and no one has ever asked her to justify using the pictures.

SOURCE

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"It is startling that no one asks — it seems so natural and a given that the images would be used," she says. "I think we should question that it is so natural, and be more attentive.

"There is a shift in North American culture to being more visual. When you hear about a disaster, you turn on the [television] news, because you want to see it to believe it, as proof it happened. But the images around disasters tend to be of the dead, and we need to question how easily we accept those images, and what that means to us as a society."

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1. Groves T, Croot J. Using pictures in the *BMJ*. *BMJ* 2005;330:916. ■

Don't use rigid approach for spiritual assessment

Search for clues, elicit what inspires patients

A 2004 study published in the *Annals of Family Medicine* analyzed when patients want a discussion about spirituality and what they want done with the information.[1] The authors found that of the 800 people who answered the survey, 83% wanted some sort of discourse about their spiritual selves.

Whether the patient feels his or her spirituality or religious beliefs are crucial to health and recovery, or simply has certain things that bring feelings of hope and comfort, that information is important for the health care provider to know. Eliciting that information — or taking a spiritual assessment or spiritual "history" — takes a deft hand, and not a rigid question-and-answer session.

"It's not like taking a [medical] history, with a checklist," says **J. Vincent Guss Jr.**, MDiv, a pastoral care and bioethics consultant in Alexandria, VA, and advocacy commissioner for the Association of Professional Chaplains. "It needs to be done in a sensitive and caring way as one looks for clues about what is spiritually significant."

And it is not something that should wait until the patient is at the end of life.

"A spiritual assessment is not just for the end of life, even though our sense of ultimate concern certainly comes to the fore at such a time," Guss says. "But the holistic approach to health care certainly does include attending to the spiritual needs in treating all people at all levels — even in promoting wellness."

Spirituality not always religion

Guss says sometimes a patient will respond to questions of spirituality less than enthusiastically, particularly if the patient does not consider himself or herself to be "religious" and perceives the conversation to be about religion. The person attempting the spiritual assessment should make clear that the purpose of the inquiry is to determine what is important to that patient in particular.

"The spiritual dimensions of a person are those values he holds dearest, his ultimate concerns, whether he has a God or gods, the source of meaning in his life," Guss explains. "What is their sense of grace and providence? What do they consider holy? What is their sense of hope or despair, their sense of vocation or calling in life? These relate very much to our emotional, mental, and physical well-being."

The ethics literature urges clinicians to bear in mind that their own sense of spirituality or religion can affect the doctor-patient relationship, and physicians who hold strong feelings of being very religious or very non-religious should exercise care with patients whose feelings are the opposite.

The involvement of a clinically trained chaplain — either as the lead person making the spiritual assessment or as a member of the team that gathers the information from the patient and family — can be key to a successful assessment, Guss suggests.

"A clinically trained chaplain, with the background training to not confuse religion with spirituality, should be part of the health care team to help nurses, doctors, and social workers in making those assessments," he says.

A spiritual assessment is a search for clues about a patient's spiritual needs and preferences; it might be done by a physician, nurse, or chaplain. It might involve direct questions and answers, or

SOURCE

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be more conversational in nature; it might be done in one sitting, or in bits and pieces. Information might be gleaned by more than one person, particularly if the patient has a relationship of trust with someone on the health care team. Family members or clergy might provide insight.

"However it is conducted, the patient should be made to feel that the person talking with him or her is interested in the patient, and is comfortable having the conversation," Guss adds. "It can be weird if the patient feels the doctor is uncomfortable having the conversation."

Mnemonics can help

One of the pioneering advocates of spiritual assessments, **Christine M. Puchalski**, MD, director of the George Washington Institute for Spirituality and Health (GWISH) at The George Washington University Medical Center, developed the FICA mnemonic to help guide the taking of a spiritual history or assessment, and it's the one Guss says he most often relies on.

There are others that can work as well, Guss says. The important thing is that the person taking an assessment use a mnemonic as a reminder of points to cover, not as a checklist that causes the assessment interviews to sound rote. **(See table, this page, for descriptions of mnemonics relating to patient spiritual assessment.)**

"When a checklist is used to take a spiritual history in an interrogatory manner, the pastoral care that the assessment is geared to help enhance in the first place is interrupted," Guss notes. "The

Mnemonic tools for use in making a spiritual assessment

The FICA tool:
F: Faith — Does the patient consider himself or herself spiritual? What gives his or her life meaning?
I: Importance — What importance does faith or belief have in the patient's life?
C: Community — Does the patient belong to a spiritual or religious community that is meaningful to him or her?
A: Address in care — How does the patient want his or her spirituality to be addressed by the health care team?

Puchalski CM, Romer AL. Taking a spiritual history allows clinicians to understand patients more fully. *J Pall Med* 2000;3:129-37.

The HOPE mnemonic:
H: Hope — Sources of meaning, comfort, strength, peace, love, and connection.
O: Organized religion.
P: Personal spirituality and practices.
E: Effects on medical care and end-of-life decisions.

Anandarajah G, Hight E. Spirituality and medical practice: Using the HOPE questions as a practical tool for spiritual assessment. *Am Fam Physician* 2001:63: 81-88.

The FAITH tool :
F: Faith — Do you have a faith or religion that is important to you?
A: Apply — Do your beliefs apply to your health?
I: Involved — Are you involved in a church or faith community?
T: Treatment — How do your spiritual views affect your views about treatment?
H: Help — How can I help you with any spiritual concerns?

King DE. Spirituality and Medicine, in Fundamentals of Clinical Practice. Mengel MB, Holleman WA, Fields SL, eds. New York: Plenum; 2002:651-669.

The SPIRIT mnemonic:
S — Spiritual belief system.
P — Personal spirituality.
I — Integration and Involvement in a spiritual community.
R — Ritualized practices and restrictions.
I — Implications for medical care.
T — Terminal events planning (advance directives).

Maugans TA. The SPIRITual history. *Arch Fam Med* 1996;5:11-16.

assessment can unfold gradually, and it's important to establish a rapport."

A 2007 study by Harvard medical researchers showed nearly three-quarters of advanced cancer patients surveyed felt their spiritual needs were not met by the medical system.[2] People who had spiritual support tended to have better quality of life, and people who described themselves as religious were twice as likely to want more aggressive treatment to extend their lives, the authors report.

The Joint Commission, the nation's leading provider of accreditation to health care facilities, says patients should receive a spiritual assessment that, at a minimum, determines their denomination, beliefs, and what spiritual practices are important to them. Topics to cover include sources of strength and hope, the use of prayer, the patient's philosophy of life, whether there is a clergy/minister/rabbi who the patient would like to be in contact with, and the role spirituality plays in the patient's view of health and medicine.

References

1. McCord G. Discussing spirituality with patients: A rational and ethical approach. *Ann Fam Med* 2004;2:356-361.
2. Balboni TA, Vanderwerker LC, Block SD, et al. Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *J Clin Oncol* 2007;25:555-560. ■

Are pacts linking pro sports teams and providers fair?

AMA ethicists question sponsorship deals

Is a sick person in Houston more likely to seek care at Methodist Hospital because that facility is the "official hospital" of the Houston Astros, a Major League Baseball team? Does a sponsorship deal between a medical group and a team that involves player care put physicians in an ethical bind between the interests of the team and the interests of injured players?

According to the American Medical Association (AMA), delegates of the AMA Council on Ethics and Judicial Affairs (CEJA) discussed the propriety of such arrangements, through which physicians, hospitals, or health systems pay for the exclusive right to bill themselves as official providers of care to athletes, or, more broadly, the "official hospital of" a particular team, during the AMA's interim meeting in November.

In some cases, practice groups or hospitals pay millions to a major league football, basketball, or baseball franchise in exchange for the right to provide care to the players, and to advertise that role — a far cry from the days when teams paid physicians, rather than the other way around.

Under other arrangements, usually involving hospitals or health systems, a team is paid a fee for the right for a hospital to bill itself as the "official hospital," giving the hospital a prestigious marketing platform, the opportunity for joint community benefit projects, and a presence at the sports venues; but players are not required to seek care at the sponsoring hospital.

For example, in the case of the Boston Red Sox, Beth Israel Deaconess Medical Center is the Red Sox organization's "official hospital," but does not actually provide care to players. Beth Israel provides first aid to fans and others attending Red Sox games at Fenway Park, sponsors scholarships, and conducts joint community projects with the team. The Red Sox and Beth Israel in October 2007 agreed to a second five-year relationship; the fee the medical center will pay the team was not disclosed.

CEJA delegates raised concerns that when a health system's paid sponsorship agreement with a sports organization does involve patient care, there could be conflicting interest between what is best for the team and what is best for the player/patient.

Beth Israel CEO Paul Levy says there is no such ethical conflict in his hospital's arrangement, since the hospital does not provide care to players as part of the agreement.

Additionally, Major League Baseball and the players' organization have policies that prohibit players' medical care from being tied to sponsorship contracts. The National Football League also has a policy that prohibits football teams from entering into marketing contracts with health providers that require players to use the sponsoring health systems' physicians.

CME answers

1. B; 2. C; 3. C; 4. D.

Some CEJA delegates suggested that the council declare the practice of marketing sponsorships unethical, but no action was taken on the issue. ■

Poor patients perceive discrimination in care

Poor, uninsured people report disrespect, racial discrimination, or other unfair treatment during health care visits, according to a recent study.

University of South Carolina sociology professor Irena Stepanikova, PhD, and a colleague evaluated data on 4,556 U.S. adults who participated in a telephone survey in which they reported whether they had experienced disrespect or unfair treatment during a health care visit because of their racial or ethnic background.

Responses by uninsured blacks, Hispanics, and poor whites indicate that "uninsurance and poverty are related to increased perceptions of racial and ethnic bias in health care," says Stepanikova. She and her co-author wrote that discrimination in health care poses a significant public health problem, because people who have experienced it are more likely to put off medical tests and procedures and less likely to receive preventive health care services, such as flu shots and cholesterol testing.

Overall, people without insurance had 2.39 times higher odds of perceiving racial and ethnic bias during health care visits, compared to people with private insurance. Those living below the poverty line also were more likely to report feeling discriminated against, the authors report.

Among the most common factors leading to the patients' perceptions of biased treatment include: clinical staff "talking down" to the patient, other patients seen ahead of the surveyed patient, clinician didn't pay enough attention or spend enough time, and health care providers didn't take time to clearly explain things.

"Unfortunately, stereotyping and bias are more likely in situations in which providers are stressed and under time pressure — attributes that may disproportionately afflict settings where minorities and the uninsured get care," reports Burgess.

(To read the full report, go to: Stepanikova I, Cook KS. The effects of poverty and lack of insurance on perceptions of racial and ethnic bias in health care. *Health Services Research* on-line, 2007; www.blackwell-synergy.com/loi/hesr.) ■

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

- Electronic informed consent
- Make sure patients understand you
- Effective ethics orientation
- 'Preferred patients' list

CME Questions

1. A drawback to induced pluripotent stem (iPS) cells converted from adult skin cells is that it is easier to generate patient-specific or disease-specific embryonic stem cells.
A. True
B. False

2. Researchers who successfully converted adult human skin cells to induced pluripotent stem (iDS) cells say iDS cells:
A. are identical to embryonic stem cells.
B. are more difficult to obtain than embryonic stem cells.
C. can be used to generate patient- and disease-specific cells.
D. None of the above

3. Which of the following is not a mnemonic designed to assist in performing a patient spiritual assessment?
A. FICA
B. FAITH
C. FOCUS
D. SPIRIT

4. Minnesota and Massachusetts hospitals recently adopted policies stating that patients won't be billed if they experience injury or death from which of the following adverse events?
A. wrong-site surgery
B. medication error
C. retention of foreign body
D. All of the above