CCH Health Care Compliance LETTER

Volume 8, Issue 18 health.cch.com September 6, 2005

Submission of Articles. Requests for information about article submission guidelines should be sent directly to Andra Popa at popaa@cch.com.

Comments? Please direct any questions or comments regarding articles appearing in the newsletter to the e-mail address above.

For more information about the CCH Health Care Compliance Portfolio, please visit our online store at http://health.cch.com.

Discount drug purchase exempt from antitrust requirements

by Andra Popa, J.D., LL.M

A non-profit hospital may provide pharmaceuticals to two unaffiliated entities entitled to protection under the Non-Profit Institutions Act of 1938 (NPIA) for their own pharmaceutical purchases, determined a recent Federal Trade Commission (FTC) advisory opinion. The NPIA exempts purchases of supplies by nonprofit institutions from the Robinson-Patman Price Discrimination Act, which prohibits price discrimination except in instances when cost savings are justified. The FTC advisory opinion cautioned that the transaction is permitted only if it is structured to meet the conditions established in NPIA:

- the clinic and hospice must be entitled to NPIA protection for their own purchases;
- the clinic and hospice must use the supplies for their "own use" as defined by NPIA;
- the hospital must charge a price that does not exceed its direct costs in purchasing and transferring the pharmaceuticals.

In this transaction, the FTC noted that both entities qualify for protection under NPIA. The first entity is a non-profit institution funded entirely by donations, grants, and unpaid services by volunteer physicians, nurses, and other health care workers. The second entity is a non-profit corporation formed to establish a Medicare-certified inpatient hospice facility.

Another condition to the advisory opinion is that the clinic and hospice may treat only their patients with the pharmaceuticals as required by NPIA. Since the patients of the hospital are neither patients of the clinic nor of the hospice, NPIA does not apply to pharmaceuticals dispensed directly by the hospital to clinic or hospice patients. Further, the clinic and hospice cannot use the pharmaceuticals to fill the prescriptions of walk-in customers.

The FTC further stated that the transaction would also lose its exemption under the Robinson-Patman Act if the hospital sold pharmaceuticals to the clinic or hospice at a profit. The hospital may charge the clinic and the hospice only its acquisition cost for the pharmaceuticals plus costs associated with the transfer. Overhead expenses that would occur regardless of the transfer cannot be added to the transfer fee.

The hospital paid a lower price for the pharmaceuticals than is currently available to the clinic and hospice and, therefore, the hospital's transfer of the pharmaceuticals at cost to the entities allows the clinic and hospice to purchase at a discount.

FTC Advisory Opinion, North Mississippi Health Services, August 16, 2005

Decline in survey frequency for nonaccredited hospitals by Andra Popa, J.D., LL.M

States will be unable to maintain a survey frequency that ensures that short-term acute care nonaccredited hospitals are surveyed once every three years unless the national annual survey rate for short term acute care nonaccredited hospitals increases, according to the findings of a report issued by the Office of Inspector General (OIG).

The OIG determined that to ensure that all short-term acute care nonaccredited hospitals are surveyed once every three years, at least 33 percent of hospitals should be surveyed each year over a three year period, assuming that the number of hospitals does not change and no hospital is surveyed more than once. A decline in the survey rate for these entities can be attributed to several factors: (1) conversions of nonaccredited hospitals to critical access hospitals add more cases to states' survey workload; (2) legislatively mandated survey cycles take priority over nonaccredited hospital surveys; and (3) the language of the budget call letter allows states to consistently meet the 33 percent annual survey rate for their nonaccredited hospitals while not surveying all nonaccredited hospitals within the same three year time frame.

The OIG expressed concern at CMS' response to its recommendations in which CMS proposed the following adjustments: (1) lower the priority level of surveys for nonaccredited hospitals to every 4.5 years on average; (2) require states to target hospitals that are more likely to have quality problems; and (3) add a performance standard so that the state survey agencies can verify that the top priority survey frequencies are met. The OIG is concerned that CMS' proposal to extend the length of time between surveys to an average of 4.5 years would create a gap between surveys at some nonaccredited hospitals that would exceed this amount of time. Certification and complaint surveys remain the principal way CMS and state agencies ascertain whether nonaccredited hospitals meet federal health, safety, and program standards.

OIG Report, OEI-01-04-00020, August 2005

CMS links cardiac DRGs to illness severity by Gene' Stephens, J.D., Contributing Editor

To better reflect the severity of patient illnesses and to provide more accurate care for patients, the Centers for Medicaid and Medicare (CMS) will implement a key recommendation from MedPac's 2006 Inpatient Prospective Payment System final rule. The recommendation suggested revisions to the cardiac diagnosis related groups (DRGs) for speciality hospitals that focus on cardiac, orthopedic or surgical cases to allow greater options for patients. As part of its extensive review, CMS found an analytical basis for revising nine cardiovascular DRGs that accounted for nearly 700,000 cases based on conditions called Major Cardiovascular Conditions or MCV. CMS plans to replace commonly used DRGs, and particularly those DRGs that are commonly billed by specialty hospitals, with twelve new DRGs that will more accurately reflect the resources necessary to care for patients, and that will recognize illness severity differences within cardiac speciality hospitals.

Cardiac Hospitals. In 2003, cardiac hospitals treated approximately 38,000 Medicare cases according to a CMS press release. The cases represent about 80 percent of patients treated by physician-owned specialty hospitals. Cardiac hospitals, similar to full-service hospitals, have emergency departments, community outreach programs, and can accommodate 50 to 80 beds with an average daily census of 40.4 beds for those hospitals that are open for more than a year. Cardiac hospitals also provide services to a high volume of Medicare patients, as inpatient stays by Medicare recipients averaged 67 percent nationwide. In addition, physicians reportedly own a 49 percent share in cardiac hospitals nationwide.

Future Activities. CMS expects to provide a more comprehensive analysis of the MedPac recommendations regarding DRGs in its proposed changes for fiscal year 2007. CMS also plans to complete a review of the list of complications and cormorbidities (CC) that are used to assign patients to a higher weighted DRG, which may lead to a revision of the DRG classification system to better reflect resource utilization. The revised DRG classification system also would remove conditions from the CC list that only have a marginal impact on hospital's costs.

CCH Health Care Compliance Letter

Portfolio Managing Editor
Pamela K. Carron, J.D., LL.M

Coordinating Editors
Susan Smith, J.D., M.A.
Andra Popa, J.D., LL.M

CCH Washington Bureau
Paula Cruickshank
DOJ, FTC–John Scorza
SEC–Peter Feltman
Health Law–Catherine Hubbard
Tax–Jeff Carlson, Steve Cooper

Designer
Kaveh D. Ryndak

Comments from readers are welcome and should be directed to Andra Popa at popaa@cch.com, Tel. 847-267-2476, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

CCH Health Care Compliance Letter is published 24 times a year by CCH INCORPORATED, 4025 W. Peterson Avenue, Chicago, IL, 60646. Subscription rate is $305 per year. First-class postage paid at Chicago, Illinois, and at additional mailing offices. POSTMASTER: SEND ADDRESS CHANGES TO *CCH Health Care Compliance Letter*, 4025 W. PETERSON AVENUE, CHICAGO, IL 60646. Printed in U.S.A.

Fraud & Abuse (cont.)

Finally, CMS plans to reform the ambulatory surgical centers (ASCs) payment system to diminish differences in payment rates among physician-owned specialty hospitals and rates for hospital outpatient services under the outpatient prospective payment system. CMS found that the payment rates for hospital outpatient services performing orthopedic and surgical services are often higher than the payment rates for the same procedures when performed in an ASC. The payment reforms are expected to be implemented by January 2008. Entities must also be primarily engaged in inpatient care to meet Medicare's definition of a hospital. Specialty hospitals that are not primarily engaged inpatient care will be denied new applications for hospital provider agreements, and may have their existing provider agreements terminated.

In its efforts to obtain as much as information as possible, CMS will seek input from the public on the standards that should apply to speciality hospitals in an "Open Door Forum" in September 2005. The forum will allow the public to participate in a live dialogue with CMS officials.

CMS Press Release, August 23, 2005.

Tax-Exempt

Nonprofit sector releases final report on charitable governance by Larry Perlman, J.D., LL.M, C.P.A.

The Panel on the Nonprofit Sector has released its final report on recommendations to improve nonprofit organizations, including several proposals addressing tax abuse and increased transparency of charitable organizations. The report provides more than 120 recommendations that call for action by charitable organizations, Congress, and the IRS to improve oversight and to ensure appropriate procedures are followed.

The report came at the behest of Senate Finance Committee Chairman Charles E. Grassley, R-Iowa, and ranking member Max Baucus, D-Mont., in order to assist the lawmakers in drafting legislation to improve charitable governance.

Grassley said that he is especially pleased with the panel's recommendation that there should be minimum payouts for donor-advised funds and supporting organizations. In addition, he said he is gratified to see the panel's comments about financial statements and audits and that the panel's proposals would not place undue burdens on small charities.

The chairman also acknowledged that his committee will rely on IRS Commissioner Mark W. Everson as well as the Treasury for their judgment on reforms, particularly in addressing abusive situations that the commissioner referred to in his testimony before the SFC on April 5.

Specifically, the report made recommendations for donor-advised funds, supporting organizations, gifts of appreciated property, compensation and administrative expenses. Included among the panel's proposals are:

- Improvement in annual information returns filed by charitable organizations (Forms 990, 990-EZ, and 990-PF) so they provide more accurate, complete, and timely information for federal and state regulators, managers of charitable organizations, and the public;
- Congress should not implement a new periodic review system to verify that a charitable organization continues to meet the qualifications for tax-exemption; instead, the IRS should focus its resources on review and investigation of the current returns filed by charitable organizations;
- Every charitable organization should provide more detailed information about its operations, including methods it uses to evaluate the outcomes of programs, to the public through its annual report, Web site, and other means; and
- Congress should require charitable organizations with $1 million or more in annual revenues to conduct an audit and attach audited financial statements to their Form 990 series returns, and those with annual revenues between $250,000 and $1 million to have their financial statements reviewed by an independent public accountant.

The report can be found on the Council on Foundations's Web site at www.nonprofitpanel.org/final/index_html.

CMS Press Release, July 1, 2005.

Right to refuse treatment vs. right to refuse duties: Honoring principles while providing care

by Judith A. Tichenor, J.D., L.C.S.W.

Like all matters of conscience, the controversy of when and how life ends has necessitated review as the issue re-emerged in the recent case of Terri Schiavo. The nation at once was both galvanized and polarized by the recent public conflict over Ms. Schiavo regarding her true medical condition, the artificial prolongation of her life, and what her true wishes would be if only she could express them herself. Ms. Schiavo, a 41-year-old woman, suffered heart failure at the age of 26, allegedly as a result of an eating disorder, and, once revived, lived the rest of her life in what was diagnosed as a "persistent vegetative state" or PVS. Her husband, Michael Schiavo, who was appointed her legal guardian when it became apparent that she could no longer take care of herself, maintained that his wife would not want to be kept alive on artificial nutrition and hydration.

Ms. Schiavo's parents and siblings vehemently disagreed and contended that she was still vital, that her condition could improve with therapy, and that she would never have violated her religious beliefs by saying she did not want to be kept alive through artificial means. After multiple court hearings stretching over nearly 15 years, the U.S. Supreme Court refused to hear the case. This was so even after President George W. Bush rallied Congress to pass "Terri's Law," an act that demanded the high Court review all the lower courts' decisions favoring Michael Schiavo's position. On March 17, 2005, Ms. Schiavo's feeding tube was removed for the last time (after two prior court-ordered removals and reinsertions), and on March 31, Ms. Schiavo died.

Several major principles and philosophies enter into the debate on such health care decisions, and people make these decisions for themselves and their family members all over the world, hundreds of times a day. The purpose of this comment is not to examine or take a side in the debate on the philosophical, psychological, or spiritual issues inherent in these cases. Rather, this comment presents the legal issues and, more briefly, the accreditation standards regarding the growing conflict between patients' right to refuse treatment and staff members' right to refuse to be involved in the withdrawal of life sustaining treatment. Additionally, considerations are offered on developing health care organization policies and procedures for managing a patients' right to refuse life-sustaining treatment and, simultaneously, to honor employees right to avoid involvement in such procedures that challenge certain personal and professional consciences.

Health care organizations, including hospitals, nursing homes, home health agencies and hospices face, and have always faced, these circumstances as an ongoing and inevitable consequence of caring for very ill patients. What once seemed like a settled practice in the early 20th century later became what appeared to be settled law by the early 1990s. The issue has now gone center-stage again with the right-to-life movement's growing interest and investment in the preservation of life regardless of any other considerations, and the equally strong convictions held by the proponents of "death with dignity." Health care organizations face new challenges as a result, especially with the appearance of patient care professionals in the workforce who hold strong and opposing opinions about the withdrawal of artificial sustenance to the irreversibly and/or terminally ill. The question in the health care employer's setting is: whose rights, if anyone's, should predominate? Moreover, how should a health care organization manage the conflict between patients' rights and health care employees' rights and therefore, still provide care in this shifting philosophical, legal and ethical landscape?

Medical background in the treatment vs. duties conflict

In short, there was a time as recent as the mid-1960s, where the United States, the most technologically advanced nation of that time, did not have the current miracles of medical technology that we hold as commonplace today. With the exception of I.V. transfusion of blood and fluids, such life-saving instruments as respirators or ventilators, feeding tubes, Stryker frames for paralyzed trauma victims, and morphine pumps (to name just a few) were either not yet invented or were hardly commonplace. As

our technology grew and improved, so did our ability to sustain ourselves through illnesses, accidents and disorders that, without these measures, otherwise would end our lives.

With these advancements came new challenges and dilemmas. Suddenly, determining when life ended, which was once a simple matter of checking for breath on a mirror, for a pulse, or for a heartbeat, became unclear and loaded with controversy. As medical research further developed ways to measure brain activity, we began to define when death occurred based on whether a person's EEG showed the presence of certain brain waves. Finally, with the creation of CT and MRI scans, we can now create images of the brain that inform us about whether the brain's larger structures, such as the cerebral cortex, are actually intact and capable of function.

In our ever-vigilant battle against death, certain acute life-threatening illnesses and diseases were apparently conquered, only to be replaced by new chronic, long-term life-threatening illnesses and disorders. Moreover, we learned how to pull brain- and spinal chord injured trauma victims out of the wreckage of their accidents, keep them breathing on the way to the ER and beyond, and rehabilitate some of them so that they might, if they chose to, lead productive lives from their wheel chairs.

We have gotten so good at prolonging life, that, to paraphrase a character on the perennially popular televised series ER, we have overridden the brain's messages that "tell the body to die." Apparent from this statement is the recognition that, in the past three decades, we have come to excel at overriding the body's natural end-of-life mechanisms. As we have, highly principled people have been moved to weigh in on the legal, ethical and moral debate of not only when life begins, as in the ongoing abortion controversies, but also when it ends; on what our rights are in calling the shots during the end-of-life treatment process; on whom the decision to sustain life should rest when a person can no longer speak for themselves; and on whom we can rely to deliver certain types of care.

Legal landscape of the right-to-die/ right-to-refuse-treatment cases

The first well publicized case involving the right-to-refuse treatment was the case of Karen Ann Quinlan. [1] Ms. Quinlan became comatose for reasons still undetermined and went into a PVS at the age of 22. It was evident that somehow her heart had stopped and the subsequent lack of oxygen to her brain resulted in severe and permanent brain damage. Her father became her appointed legal guardian and took on a protracted legal battle against her health care providers to have her ventilator turned off and to allow her to breathe on her own, or in other words, to "let nature take its course." Her health care providers argued that doing so would end her life and leave them in a legal and ethical predicament. The New Jersey Supreme Court upheld Quinlan's right to refuse life prolonging treatment, as attributed to her by her parents who claimed that, if Karen were able to decide for herself, she would not want to be kept artificially alive in her current brain-damaged state. Her ventilator was removed, she breathed on her own for a period of weeks but never recovered, and not long afterward, she died.

The second pivotal case went all the way to the U.S. Supreme Court. In that case, a car accident left 25-year-old Nancy Cruzan in a PVS.[2] Ms. Cruzan sustained severe and permanent brain damage after being resuscitated at the scene, where it was estimated that she had been deprived of oxygen for at least 12-14 minutes.[3] Ms. Cruzan had to be artificially sustained with a feeding tube and IV fluids for hydration. Her parents initiated a multi-year legal battle against the health care organization to end the artificial nutrition and hydration after her medical team, fearing liability, refused to remove her tubes without a court order. Her mother and father, who were also appointed as her legal guardians, ultimately met the legal burden of presenting adequate evidence that Nancy herself, if she could make her wishes known, would refuse the artificial maintenance of her life in the context of PVS she then endured. The Court upheld Nancy's right to refuse treatment as expressed through the voices of her parents/legal guardians. Her artificial sustenance was withdrawn and she died shortly thereafter.

The legal and medical communities initiated action around these and other lesser known state-level cases and developed documents such as living wills, health care powers-of-attorney, and Do-Not-Resuscitate (DNR) orders. These documents are now known as "advanced directives" and were initiated in major part to give expression to the wish not to be kept alive through artificial means should the circumstance arise where a person could not speak for themselves. They also were initiated to reduce legal liability on the part of health care professionals who could face both civil action and/or criminal prosecution by honoring a patient's wish to end life-sustaining treatment where other parties disagreed with that wish, or where such withdrawal might be deemed as tantamount to homicide.

However, it has become clear that these advanced directives tend not to be honored by emergency personnel. This is due to the presumption that when family members call paramedics, they want all efforts at resuscitation to occur. As a result, some states, such as Illinois, are now offering citizens an advanced directive in the form of orange DNR placards that can be placed on home refrigerators to notify paramedics and emergency personnel of a person's desire not to be resuscitated under certain conditions.

Federal codification of the requirements for advanced directives under state plans for medical assistance occurred in the Federal Patient Self Determination Act of 1990 (PSDA).[4] The act includes language requiring health care facilities to develop and maintain policies and procedures on advanced

directives for life sustaining treatment, including an individual's right to make decisions regarding the medical care performed and the right to refuse care. It further requires health care facilities to inform patients of those policies and procedures, including how they will be implemented, and prohibits discriminatory medical treatment of patients who do not have advanced directives.

Most recently, the U.S. Supreme Court has drawn the line at any attempts to create a right to physician assisted suicide, or euthanasia, by striking down state laws legalizing, and by affirming laws banning, physician assisted suicide.[5]

Legal refusal of health care duties

A growing minority of individuals, including some health care personnel, have become more vocal about their personal, moral, and/or religious rejection of the right-to-refuse treatment doctrine. Consequently, they express a need to avoid participation in the withdrawal of life-sustaining treatments to either terminally or chronically ill patients, regardless of statutes and case law supporting the right to self-determination in medical care.

This is not the first time in medical history that such a refusal to perform professional duties has occurred. In the 1950s, subsequent to the U.S. Supreme Court rulings finding that the fundamental right to privacy lives among the "penumbra of rights" [6]guaranteed to American citizens in the Ninth Amendment, and subsequent to the technical advancements of contraception, health care professionals refused to offer care where the physician or treater's religious beliefs forbade the dispensing of contraception. Those physicians who, out of their convictions, refused patients' requests for contraception, would, based on their ethics, refer those patients to other physicians who had no religious or moral prohibitions against providing such care.

However, this quiet practice does not seem to be the final answer for health care providers and institutions. Growing concerns from professionals who adhere to the "right-to-life" doctrine have prompted a more public examination of policies and procedures on a professional's right to refuse duties on the basis of conscience. Many health care professionals, including pharmacists, nurses, and doctors, have not only refused to provide certain types of health care and prescriptions, but now further refuse to provide patients with referrals to professionals who will provide such services. Some of these professionals are taking the additional step of obtaining employment in ob/gyn offices and abortion clinics as well as on medical-surgical units with the intent to refuse to perform duties such as dispensing contraception or withdrawing artificial nutrition and hydration as a form of protest. Health care organizations and accreditation bodies are faced with an ongoing shift in demands to reconfigure policies and procedures regarding the management of patients' rights not to be treated vs. employees' rights not to perform certain care tasks.

Furthermore, the U.S. government has enacted the Hyde-Weldon Amendment in 2004,[7] and 47 states have passed statutes, all of which include what are known as "conscience clauses," granting health care professionals the right to refuse to perform certain duties that they find abhorrent to their consciences. Some state statutes mandate that these professionals and providers offer referrals to patients for the services they have refused to provide and other state statutes make no such provision.

An attempt to extend one such clause to include artificial sustenance was vetoed by the governor of Wisconsin. The Death with Dignity National Center reported that on April 12, 2004, Gov. Jim Doyle vetoed legislation that "would have allowed healthcare professionals to decline to provide certain medical procedures, including in vitro fertilization, on religious or moral grounds without fear of disciplinary action."[8]

According to the report, the vetoed bill would have extended Wisconsin's existing "conscience clause" statute. Originally, the statute protected health care professionals right to refuse to perform abortions or sterilizations "for moral or religious reasons." The extension would have afforded Wisconsin health care workers the right to refuse the performance of more procedures than just abortions, including the withdrawal of feeding and hydration tubes. The bill, had it been enacted, would have also allowed health care providers the right to refuse to make referrals to other health care professionals willing to perform the listed procedures. The governor indicated that the legislation placed the ideological beliefs of scarce rural health care providers in already underserved populations above their patients' rights to access legitimate medical services, which the governor found to unfairly deny patients access to services.

A California trial court case illustrates the dilemma that health care organizations are at risk of encountering. While the topic involves a nurse's refusal to issue emergency contraception, the ruling could apply equally to an issue involving a nurse's refusal to remove a feeding tube or a respiratory therapist's refusal to turn off a ventilator on the basis of conscience and religious beliefs.

A jury in Southern California found that an employer, a women's healthcare center, had discriminated against a nurse's religious beliefs where the employer discharged her. When the nurse had originally refused to administer an emergency contraceptive drug on the basis of her religion, the center's management accommodated her religious beliefs by assigning her to a comparable position that did not require her to provide those services. However, when the nurse began telling other clinical staff that they were administering a chemical abortion by dispensing emergency contraception, the center discharged her. The jury found that, even though the center had initially accommodated nurse's beliefs with the job transfer, it still violated her rights by discharging her after she expressed those beliefs to other employees. The fired nurse was awarded $47,000 in damages. It was unknown at the time of publication whether the employer has appealed.[9]

Other cases have involved the legality of a healthcare employer's discharge of a nurse for distributing anti-abortion literature including one trial case in Kentucky. FN 2. Also, a case is making its way through federal courts regarding a challenge to the federal conscience protections for pro-life healthcare providers under the Hyde-Weldon Amendment. The Hyde-Weldon Amendment provides that no federal, state, or local government agency or program that receives federal health and human services funds may discriminate against a health care provider because the provider refuses to provide, pay for, provide coverage of, or refer for abortion.[10]

Actions for health care organizations to consider

Prior to the 2004 revision to its accreditation standard, the Joint Commission on the Accreditation of Health Care Organization (JCAHO) offered three standards covering the health care organization's responsibilities to employees who refuse duties as a result of a variety of conscience-based concerns and their patients. The HR.6 JCAHO standards covered a healthcare staff member's right not to participate in any aspect of patient care that causes him or her to suffer a moral, ethical, or cultural dilemma. Simultaneously, the standards maintained the position that such a refusal should not in any way be allowed to harm the provision of patient care. Under these old JCAHO standards, healthcare HR consultants often observed that the healthcare corporation would need to respect its staff members' religious beliefs, cultural values and ethical views when it comes to the right to refuse duties. However, consultants also emphasized that the facility must also ensure that patient care would not be compromised in the granting of a staff member's request to avoid participation in an aspect of patient care. In the era of growing health care staff shortages, this put health care organizations in a bit of a dilemma.

Refusal of duty issues tend to emerge in the provision of a variety of healthcare services, including:

- contraception and abortion;
- the removal of ventilation equipment where brain damage renders the patient incurable;
- the withholding of food and/or hydration for terminally ill patients; (emphasis added)
- research involving human embryonic tissues and stem cell research; and
- cloning.

Currently, the JCAHO standards have since been condensed into one standard, Standard Rl.1.10 which is generally drawn and simply reads: "The hospital follows ethical behavior in its care, treatment, and services and business practices." Under the section "Elements of Performance for Rl.1.10," Element 7 states:

> The leaders ensure that care, treatment, and services are not negatively affected when the hospital grants a staff member's request to be excused from participating in an aspect of the care, treatment, and services.

However, despite the consolidation of the HR 6 standards into one more general standard, health care organizations are still well-advised to ensure that patient care directives are met while ensuring, especially in the current legal climate, that staff rights to refuse morally objectionable duties are respected.

To help aid in the protection of the patient's right of treatment refusal, the objecting staff member's right to conscientiously object to certain duties, and the health care organization's need to conduct its business in a legally protected manner, a written HR policy and a corresponding written procedure should be created. Each should address the: (1) mandatory process through which a staff member may request to be excused from participation in a service or treatment process which he or she believes is a violation of his or her religious, cultural or ethical position; and (2) appropriate staffing response to the employee's request that removes the staff member from that specific duty but does not negatively affect patient care.

Possible solutions to the conflict include, but are not limited to:

- removal of the duty or duties the employee finds contraindicated by his or her beliefs, followed by:
- reassignment of those duties to a staff member who does not have such a conflict; and
- assignment of the requesting employee to other non-offensive duties; or
- transfer of the requesting employee to a different position that is comparable to his or her old position in title, duties, responsibilities, compensation and benefits.

It is further advisable that the health care organization create duty refusal request forms for staff to fill out in order to avoid morally objectionable duties. The hospital can opt for requests that are in either verbal or written form. Written forms that an employee can sign are strongly encouraged in order to reduce the risk of an employee engaging in successful litigation at a later date and these requests should be submitted through the typical chain of command. Documentation of all conversations and written records of decisions and solutions to the duty refusal should also be kept.

The HR policy should clarify for employees and management that the conflict between the request and the need for service delivery must be resolved, as well as the proper request procedure the facility uses and the permissible amount of time allowed for resolution of the conflict.

Finally, there are some pre-employment strategies regarding dealing with potential conflicts in the handling of staff rights to refuse duties. The pre-employment phase is an excellent point to begin addressing such concerns. However, an employer must avoid asking about a person's religious beliefs, cultural norms or ethnic heritage, even if the employee initiates such a discussion during any point of the interview process. Such communications from the interviewer could be construed as discriminatory reasons for failure to hire an applicant.

A sample of a good pre-employment practice that the health care employer may utilize is for the employer to prepare a written policy explaining:

- the services that the hospital offers;
- the circumstances under which an employee might be asked to offer such services;
- where the right to refuse duties emerges;
- the process by which a request to avoid duty must be handled; and
- the potential outcomes for such a request.

The employer is encouraged to then present the policy to the applicant and discuss it during the interview process, asking the job candidate if he or she has any objections or reservations about performing any of the services listed. The employer is strongly encouraged to document the prospective employee's response. The employee should then be asked to sign an acknowledgement of having read and understood the policy, procedures, and possible results of such a request. These practices are designed to avoid a conflict before one occurs, to assist in the most effective job assignment, and to aid the employer's defense in the event of an employee lawsuit. In listing the potential outcomes of a duty refusal, care should be taken to avoid any outcomes that suggest disciplinary actions, discriminatory actions or retaliatory motives under Title VII prohibitions against religious discrimination.

While no policies or procedures can guarantee that conflicts will not occur, or that conflicts will not escalate into full-blown court cases, health care HR departments and employers can take these and other steps to form policies and procedures that will ensure adequate patient care, reduce employee/employer difficulties, and hopefully relieve the consciences of valued, highly skilled professionals.

The key is to take the time to contemplate the potential problems inherent in right-to-refuse-treatment/right-to-refuse-duty conflicts, and then to originate, analyze, and develop those employment policies and procedures to appropriately serve the rights of each without sacrificing either group's values and needs in the process. An ounce of prevention in these emotionally turbulent and ever-changing legal seas is worth a veritable ton of unquantifiable damages in the form of patient and family suffering, the loss of valuable health care professionals, and a fortune in time and legal fees.

Judith A. Tichenor is the senior planned giving officer at the Children's Memorial Hospital Foundation in Chicago, Illinois. She is also an attorney writer/analyst who has served in both the health care and outpatient psychiatric fields as clinical social worker for over 23 years. She practiced as an attorney for seven years concentrating in employment law, workers' compensation, and mental health law. She also served as a medical social worker, volunteer coordinator, and bereavement program director for the first JCAHO-accredited, Medicare-certified home health hospice in the United States.

1 *In re the Matter of Quinlan*, 70 N.J. 10 (N.J. Sup. Ct. 1976.

2 *Cruzan v. Director*, Mo. Dept. of Health, 497 U.S. 261 (1990).

3 Lack of oxygen to the brain for more than six minutes initiates the process of damage to the brain.

4 42 U.S.C. 1395 cc(a).

5 *Quill v. Vacco*, 521 U.S. 793 (1997).

6 *Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678 (1965).*

7 Hyde-Weldon Amendment, 2004.

8 "Wisconsin governor vetoes bill protecting healthcare workers' conscience rights," Women's Health Law Weekly, May 16, 2004; republished by the Death With Dignity Nation Center website at www.deathwithdignity.org.

9 Manion, Francis J. and Surtees, Geoffrey. "Anatomy of a Case: From Contact to Settlement," Center for Law & Justice International, *available at* www.clji.org.

10 "Christian Lawyers Group Seeks to Defend Federal Conscience Protections for Pro-Life Healthcare Providers," Center for Law & Religious Freedom, *available at* www.clsnet.org.