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Patient Rejects Educational Experience for Resident

A nameless patient asked the *New York Times* "Ethicist" whether it was "her responsibility to provide training for medical students" during the course of a surgical examination. When she refused, the surgeon chastised her noting that she "was preventing the next generation of doctors from being trained."

"The Ethicist's" April 15, 2007, response was that while it was "reasonable" for the surgeon to make the request, her "brow-beating" of her patient was not.

All patients "rely on the skills of physicians" who receive clinical training in the fashion proposed by her surgeon and "have a general obligation … to assist the next generation of patients as the past generation of patients has assisted (us)," "The Ethicist" opined.

Because physician training does not require the participation of every single patient, allowances must be made, "The Ethicist" properly noted, for patients who are going to find that extra doctors in the room create discomfort for them.

> "She was...obliged to deliver care to her patient, not to provide education to residents."

The inquiring patient's surgeon should have accepted her position without intimidation or "eye-rolling." She was primarily obliged to deliver care to her patient, not to provide education to residents.

"The Ethicist" suggested that there might be other ways to contribute to the progress of medical education such as organ donation or philanthropy in lieu of providing a non-therapeutic clinical experience for physicians-in- training.

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New HIV Testing Guidelines

The Centers for Disease Control has issued revised recommendations for HIV testing of adults, adolescents and pregnant women in health care settings. These recommendations suggest routine HIV testing of all patients aged 13 to 64. Patients are to be notified that HIV testing is being performed, but are given the right to "opt out;" no longer will a separate HIV consent form be required.

According to a note by Dr. Alan R. Lifson and Dr. Sarah L. Rybicki of the University of Minnesota School of Public Health in the February 2007 issue of *The Lancet*, HIV testing had concentrated on patients presenting with specified clinical limitations or personal histories and, as a result, many patients who were infected with the virus were not being identified.

The authors expressed concern about the new CDC notification/opt-out recommendation, especially at sites involving patients with low literacy rates and in "busy clinical settings" where patients will not be sufficiently informed that they can decline the test. "(N)otification about testing," the authors stress, "should be direct, comprehensible and culturally appropriate."

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Most significantly, Drs. Lifson and Rybicki also stress that patients testing negatively must be advised "that they could still be infected if risk behaviors were engaged in recently and that unsafe behavior carries continued HIV risk."

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Garlic As More Than Seasoning

Dr. Christopher D. Gardener of the Stanford University Medical School and colleagues associated with other academic institutions investigated the efficacy of garlic as a cholesterol-lowering agent with 192 adult subjects. Both raw garlic and garlic supplements were employed.

> "...garlic supplements or dietary garlic in reasonable doses are not likely to produce lipid benefits."

In the report of their randomized clinical trial in the February 26, 2007, issue of *Archives of Internal Medicine*, the authors report, unhappily, that "garlic supplements or dietary garlic in reasonable doses are not likely to produce lipid benefits." As to the possibility that garlic may have other positive health related influences other than as a pleasant seasoning, the authors urge that "large, carefully designed trials" be conducted.

An editorial reviewing the study in the same issue of *Archives* by Dr. Mary Charlson of the Center for Complementary and Integrative Medicine at the Weill Cornell Medical College is not so quick to dismiss garlic's health potential. She refers to a pilot study published in the *Journal of Nutrition* last year attributing benefits to a therapy of "aged garlic" coupled with statins and aspirin as offering some hope.

After discussing the difficulty of conducting trials of nutritional supplements, Dr. Charlson argues that the potential positive impact of garlic should not be completely discounted. In her opinion, "(t)he jury is still out."

Hospitals' Obligation to Maintain Deceased's Remains

Health Care Insights most often addresses issues associated with the delivery of health care during life. Every so often, the courts have occasion to address the standard of care imposed on health care providers after death; a recent decision by a New York State Supreme Court (trial) justice is worth examination in this regard.

Ernst Moise was found dead in his Queens, New York, apartment. After his body was identified by his sister, it was removed to the local morgue where the city medical examiner completed an autopsy, certified the cause of death to be a heart attack and sent the remains to a hospital morgue refrigerator.

Unfortunately, the morgue's external thermometer was not functioning accurately and, as a result, the temperature within the morgue was allowed to reach 65 degrees, as opposed to the 38 degree temperature to which the thermometer was supposed to be set, thereby allowing the remains to decompose.

Under New York law, and, most likely, the applicable statutes and regulations of all jurisdictions, hospitals over a certain size are required to have a morgue with refrigeration capacity.

The improper storage and handling of the remains allowing them to decompose while in the hospital, amounted to "prima facie negligence," the court ruled. The court rejected the hospital's argument that it lacked notice of the malfunctioning refrigerator due to the fact that the thermometer was not functioning properly. "The hospital should have known, without being informed by anyone, that the freezer was not working. (The hospital) has a non-delegable duty to maintain the freezer."

In its gloomy dismissal of the hospital's arguments, the court noted chillingly that corpses cannot speak and the next of kin are not expected to visit. It is unlikely that anyone other than hospital employees would ever enter the morgue's freezer.

Wainwright v. N.Y.C. Health and Hospitals Corp., Supreme Court, Queens County, May 2007.

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The Internal Revenue Service and Electronic Health Records

The health care trade and industry press have been filled for years with articles about the failure of the health care world, particularly hospitals, to drop their reliance on paper records and to move to electronic formats. Many writers lament the backwardness of providers in adopting health care management information systems while at the same time recognizing the deterrent impact that the tremendous cost associated with this change would generate, primarily for smaller entities such as physician groups.

To facilitate adoption of electronic health records (EHR), hospitals have recently offered to subsidize physician acquisition of software and hardware, even at below fair market levels. The problem is that any subsidy of for-profit entities such as physicians by not-for-profits runs the risk of theoretical violations of both the anti-kickback laws and federal income tax limitations applicable to not-for-profit providers. Internal Revenue Code limitations prohibit private individuals from improperly benefiting from the income or assets of not-for-profit entities lest the not-for-profits face loss of the tax exemption or the imposition of financial sanctions on management and directors.

Against this complicated backdrop, the Internal Revenue Service published a memorandum on May 11, 2007, indicating that EHR subsidies to physicians are permitted subject to certain conditions, described in regulations issued by the Office of Inspector General of the Department of Human Services, among which are:

- Physicians must be members of the hospital's medical staff.
- No restrictions may be placed on the types of payors reimbursing the physicians' patients.
- A written agreement is required.
- Interactivity with non-hospital MIS systems is mandated.

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