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The Bronx County Medical Society wants to work with you to improve the care that we deliver to our Bronx patients. We recognize the important role you play in providing outstanding care. To that end, we want to meet with you to learn about your issues and successes so we can continue to attract intelligent, motivated physicians to our county and help retain the talented physicians who call the Bronx their professional home. Also, we want those same physicians to realize they have a dynamic physician organization committed to improving our profession through advocacy, networking, education and mutual support.

We recognize that our large diverse patient population provides great opportunity but also great challenges. All of us who love and care for our unique patient population have common issues we need to overcome: low socioeconomic status and low health knowledge, fragmented social and IT infrastructure, and sub-optimal communication and coordination between healthcare entities. The legal climate leave us with high malpractice and other general liability costs. Furthermore our aging infrastructure provides multiple challenges to care delivery. Finally, health insurance and hospital consolidation and payment reformation provide additional instability that requires continual readjustment.

By working together, we believe we can create a more satisfying environment for both physicians, patients, vendors, medical practices and hospitals. We will work tirelessly to reduce administrative cost and inefficiencies, improve communication, and advocate for legislation that improves the bottom line. Please let us know of any initiatives we can partner with you to achieve these desired outcomes. Encourage your physicians to join our society and lead us in initiatives that help you. This will lead to improved physician engagement and retention, reducing burnout, and ultimately healthier and happier patients.

MARK YOUR CALENDAR! Annual Membership Assembly, Expo & Dinner Sunday, September 11, 2016 – Marina Del Rey – please join us (See page 3)
Vision Rehabilitation: A neglected entity
By: Hamidreza Moein, MD & Shervin Mortazavi, MD

Rehabilitation is a general term refers to only services that improve physical and social function of disabled person. Disabled person is defined by the rehabilitation act of 1973 as, “any person who has physical or mental impairment which substantially limits one or more of such person’s major life activities, has a record of such impairment, or is regarded as having such impairment”. There are about 54 million disabled people in the USA. Rehabilitation services can include medical/surgical treatments, social/financial or environmental supports. Rehabilitation has been widely studied and applied for patients with traumatic brain injuries, myocardial infarction or stroke. Although vision impairment is one of the 10 leading causes of disability in the nation but vision rehabilitation has been neglected for many years. Vision impaired individuals are those who have difficulty with their daily activities even with glasses or different applied surgeries or medications.

The prevalence of low vision ranges from 3 million to 14 million people in the USA based on different definitions. People over 65 years old constitute majority of low vision population. These patients become more dependent in reading, self care, shopping, driving, and financial management. Major causes of vision impairment are diabetic retinopathy, age related macular degeneration (AMD), cataract and high intraocular pressure (glaucoma). Despite considerable improvements in development of new drugs and surgical treatments for these patients still many of them are not treatable or just partially treatable. Therefore, vision rehabilitation will play a significant role in low vision individual’s quality of life and will allow them to use their remaining sight in best way. Considering increasing age of the population this field will have a substantial growth potential. Vision rehabilitation includes medications/surgeries, optical/non-optical/electronic devices, skill training or any social support for visually impaired patients. It can be delivered by optometrists, ophthalmologists, occupational therapist, or any other low vision professional or specialist. The function of visually impaired patients is not necessary related to their best visual acuity. Socioeconomic and other co morbidities are also involved in function of these patients. In fact, some mild-moderate visually impaired individuals (best corrected visual acuity of <20/60 to 20/160) need as much care and services as legally blind individuals (best visual acuity of <20/200 or visual field of <=20 degrees). But unfortunately since some of these patients do not meet the criteria for legally blind they are not eligible for using special community services. Insurance coverage for vision rehabilitation costs is one of the barriers for these patients. Gradually with increasing demand for vision rehabilitation most health care plans are going towards covering the costs especially after the 1999 and 2001 Medicare acts.

According to a public survey in 2008, sponsored by National Eye Institute (division of National Institute of Health), 71% of Americans believed that loss of sight has the greatest impact in their daily life more than anything else. But only very few percentage of them were aware that most blinding diseases including glaucoma and diabetic retinopathy can develop without any alarming symptoms. This reveals the importance of public education to prevent blinding diseases and lower the burden of low vision. There are 285 million people with visual impairment all over the world. Vision 2020 is a joint program of World Health Organization (WHO) and International Agency for the Prevention of Blindness initiated in 2010 to reduce 25% of the avoidable causes of blindness by 2020. Vision 2020 involves public education to encourage population of over 40 years old for annual eye examinations, also to help low vision individuals by increasing the use of vision rehabilitation services and assistive devices. Following this initiative program, low vision studies and educational programs for impaired vision individuals start increasing all over the world. Large numbers of new soft wares, mobile applications, magnifying or adaptive devices, and navigation strategies have been developed in recent years to help low vision people. Improvements in teaching and training patients to use these devices and providing support have been also another step forward. Occupational therapists together with orientation and mobility specialists nowadays play an important role to improve reading, writing, and driving in low vision people. Studies showed increased reading accuracy after 4 hours of training. On the other hand, low vision individuals who do not receive training for assistive devices are more likely to discontinue using them. Magnifiers are among the first that came to help low vision people. Besides currently there is a long list of available smart phone applications, which basically can be applied as magnifiers, customized keyboards with ability of world prediction or correction, and sound detection. In addition, development of smart glasses such as Google glass and Orcam started a revolution in assisting low vision people. Moreover, the “open glass project” now aims to improve this technology towards identifying objects in the environment for the blind or low vision individuals. The smart glasses developed in Oxford University and eSight are examples of these glasses which record real time videos and relay that to a small computer processing unit. Then the device can send the interpreted information by sound through ears of these people so that can inform the visually impaired individual of his or her surroundings. Researchers are still trying to optimize these assistive devices and better understand the CNS structures involved in vision and visual pathways. Still more studies are needed to evaluate the effectiveness of different rehabilitative interventions not only on visual acuity but also in developing quality of life of visually impaired people.

References:

- [http://www.iapb.org](http://www.iapb.org)
- [https://nei.nih.gov-low vision and blindness rehabilitation- national plan for eye and vision research [NEI Strategic Planning](https://nei.nih.gov-lowvision-rehabilitation-section)]
- [www.visionaware.org/blog/visionware-blog/google glass](http://www.visionaware.org/blog/visionware-blog/google glass)
- [http://esighteyewear.com/eyewear](http://esighteyewear.com/eyewear)
The Bronx County Medical Society request the honor of your presence at the Annual Gala honoring our Immediate Past President, Shervin Mortazavi, MD  
Sunday, September 11, 2016 - Marina Del Rey One Marina Drive, Bronx, NY 10465  
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Considerations When Tampering Occurs

Patient safety should be a foremost diversion consideration

By Kim New, JD, BSN, RN

In every case of drug diversion at a healthcare facility, the possibility of patient harm exists. Patients may receive substandard care or a paucity of care from an impaired provider. They may have untreated or inadequately treated pain, or be exposed to bloodborne pathogens and other dangerous substances as a result of tampered injectable drugs. Because the risk of harm is measurable, performing a patient harm risk assessment should be a priority part of every diversion response plan.

There are scenarios in which patients are more likely to be negatively affected. Patient harm almost certainly occurs in cases where there is documented pain yet the ordered “prn” medication is diverted. Similarly, when the patient has scheduled pain medication that is ordered to be administered around the clock, diversion of doses is likely to result in harm. Tampering and substitution also result in patient harm should any of the altered drug reach the patient.

Several cases of tampering have been reported recently, including some that raise substantial concerns about the well-being of the patients affected. Tampering can be done artfully and it is not always readily apparent. Even tamper-resistant or tamper-evident safeguards can be bypassed by a savvy diverter.

Make diversion difficult

The best way to address tampering is to hinder the ability of staff to divert. Preventive measures that facilities can employ include requiring a witness for all inventory counts. This prevents a staff member from removing intact stock and substituting tampered stock during the count.

It is also important to limit the number of Patient-Controlled Analgesia (PCA) keys available to staff to the smallest number possible, given the needs of the patient population being served. PCA keys should be stored in a single access compartment in an automated drug cabinet if possible, so staff that are inclined to tamper will know their transactions will be apparent to auditors.

A requirement that returns be witnessed is another way to inhibit the ability to tamper, along with a requirement that all returns go into a designated return bin, versus being returned directly to patient stock.

Using locking cases and portless tubing for continuous controlled substance infusions will help deter tampering at the bedside.

The most basic preventive measure is of course ensuring medications are kept secure at all times from the moment they are removed from the source until they are administered. In clinical settings where opioids are commonly removed in advance of administration, such as procedural and surgical suites, the staff should understand that the risk of tampering increases every moment the medication is left unattended. Medication must be placed in secondary secure storage, such as a locked bedside safe or drawer, or kept in the visual custody of the staff member. Being aware that colleagues could potentially tamper with medication is critical.

Means of detection

There are ways to detect tampering at the drug storage location and remote locations throughout the facility. Regular physical counts of controlled substance stock are one of the best ways to quickly detect tampering. I have
Tampering can be done artfully and it is not always readily apparent. Even tamper-resistant or tamper-evident safeguards can be bypassed by a savvy diverter.

Some transaction patterns are known to be associated with tampering. They include:

- Repeated cancelled removals of a specific drug
- Repeated returns of a specific drug
- Frequent inventory counts (which allow access to drug supply without registering a transaction)
- Excessively frequent access to Patient-Controlled Analgesia (PCA) keys, or access to PCA keys for patients not under the care of the staff member

In one case in a cardiac catheterization lab, a dose of fentanyl seemed not to have any effect. The nurse retrieved another vial from the drug cabinet, also without apparent effect. It was only when a third vial was retrieved in an attempt to treat the patient's pain, that the nurse realized there were needle punctures in the rubber hubs of all the vials in the cabinet. A formal institutional policy should require fully documenting cases of suspected tampering, including photographing the medication in situ, securing it and having it analyzed.

**Conclusion**

When diversion by tampering and substitution is suspected, there should be a defined process for assessing for the likelihood that patients have been harmed. The process should include a realistic discussion of the risks. Cases have been reported in which an ER nurse tampered with morphine or hydromorphone stock in a busy ER setting for over a year, yet the institution somehow reached the conclusion that no patients could have been affected.

Facilities should strongly consider offering confidential bloodborne pathogen testing of the diverting staff member in all cases of diversion of injectable medications, to facilitate assessment of the risk of patient harm.

When tampering is confirmed, reporting should be robust, including reporting to the FDA Office of Criminal Investigations (18 U.S.C. § 1365 et seq.), the professional and pharmacy boards, law enforcement and local public health officials, where appropriate. NP

**Staff education**

Staff should be trained to report therapeutic failure immediately, when pain medication does not appear to have the desired effect. There should be a process in place to secure the medication in question and to inspect remaining stock for signs of tampering.

Kim New, JD, BSN, RN, is the principal at Diversion Specialists and is a specialist in controlled substance security and DEA regulatory compliance, and is a consultant to healthcare facilities across the country. She works with facilities to set up and expand their drug diversion programs with the goal of improving patient safety. She is a nurse and an attorney. You can reach her at Kim_New@zoho.com or (865) 456-1813.
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The 2016 legislative session concluded June 20th.

Legislature Does Not Pass Proposed Statute of Limitations Changes  The State Legislature left Albany without taking action on legislation (A.285-A and A.10719-A/S.6596-B) that would have substantially lengthened New York’s medical liability statute of limitations. We thank the thousands of physicians who contacted their legislators over the last several weeks to express their concerns regarding the adverse impact to patient access to care if this legislation were to be enacted without corresponding tort reforms to offset the huge premium increase this legislation would have required. Conversations will be continuing over the summer and fall regarding comprehensive changes that are necessary to correct our dysfunctional medical liability adjudication system.

Legislation Advanced By MSSNY to Rectify E-Prescribing Issues Encountered By Physicians Passes Both Houses MSSNY is pleased to report the passage of three bills by both Houses of the Legislature which, if enacted into law, would address many concerns which have arisen as a result of the e-prescribing law. The first bill, S. 6779, Hannon/A.9335-B, Gottfried would ease the onerous reporting burden on physicians every single time that they need to issue a paper prescription in lieu of e-prescribing. In March, the Bureau of Narcotics Enforcement announced that when a physician invokes one of the three statutory exceptions and writes/faxes or calls in a paper script because: their technology or power has failed; the prescription will be filled outside of New York; or it would be impractical for the patient to obtain medications in a timely manner, they must electronically submit to the department an onerous amount of information about the issuance of the paper prescription. DOH asks that each time a paper/fax/oral prescription is issued, the prescriber must electronically inform the DOH of their name, address, phone number, email address, license number, patient's initials and reason for the issuance of the paper prescription. This creates an onerous burden for all physicians, particularly in situations where there is a protracted technological failure, and the physician needs to report dozens upon dozens of paper prescriptions. In fact, Surescripts has stated publicly that there is a 3-6% e-prescription transmission failure rate. This means that in the state of New York anywhere between 7.6 million to 15 million e-prescriptions will fail every year and each prescriber involved with these failures who subsequently write a paper prescription will need to file this information with the state. In some small communities, even the patient's initials can convey information that will enable others who access this information to identify the patient who will receive the medication. The bill passed this week affords a much more preferable alternative by allowing physicians and other prescribers to make a notation in the patient's chart indicating that they have invoked one of the three statutory exceptions. The second bill, A.9837, Gottfried/S. 7334, Hannon, would allow for the transmissions of e-prescriptions to a secure centralized site from which they can be downloaded by a pharmacy when the patient presents. This would lessen the pressure on the patient to decide during the office visit which pharmacy he or she will use, enable a patient to shop around and change his or her mind for whatever reason. If a patient requests, the prescriber would print out a copy of the prescription to make it easier for the pharmacy, and be useful for the patient as a reminder.

The third bill, A.10448, Schimel/S. 7537, Martins would authorize a pharmacy which does not have a particular medication in stock to transfer the prescription to another pharmacy. Currently, e-prescriptions cannot be transferred by one pharmacy to another thereby requiring the patient to return to or call the prescriber's office to ask that he/she transmit the e-prescription to another pharmacy creating unnecessary burdens on the patient and delaying timely access to their medication.

Each of these measures will be sent to the Governor for his consideration. MSSNY will keep you apprised of the action taken on each of these very helpful proposals.

Legislative Package Approved to Address and Arrest Opioid Abuse in NYS Three measures were introduced and approved by the legislature to comprehensively address and arrest the opioid epidemic in NYS. While MSSNY expressed strong concerns regarding some aspects of these proposals, MSSNY was able to secure modifications that protect clinical discretion and allow for the recognition that every physician practice and the needs of our patients are unique. In addition, the Legislature places new requirements on insurers to provide coverage for needed treatment and on hospitals and pharmacists to disseminate information.

CME Mandate The legislation requires prescribers authorized to prescribe opioids by the U.S. Drug Enforcement Administration and every prescribing resident under a facility registration to complete three hours of coursework on pain management, palliative care, and addiction by July 1, 2017 and every three years thereafter. With regard to the course, the legislation recognizes that the course must be approved by commissioner who shall establish standards and review and approve course work; MSSNY this year with the OASAS medical director and representatives from the nurse practitioner and physician assistant associations developed and offered a course – already available through MSSNY’s website (mssny.org)– which MSSNY will seek to have approved in order to assure that its members may comply with July 1, 2017 deadline; establishes that the coursework may be taken online; requires that, upon completion of course, must document by attestation on a form prescribed by the commissioner that he/she has completed the course; and allows the department to allow for an exception process for those (1) who can demonstrate to the department's satisfaction that there would be no need to complete the course; or (2) that he/she has completed course work deemed by the department to be equivalent to the course work approved by the department.

While MSSNY was not able to secure a one-time course or sunset we were able to assure that the course can be completed online and that the department would allow for an exception process to be utilized to exempt those for whose practice such a course is not applicable and those who have already taken a course.
Opioids Limits The legislation would establish limits on the prescription of a seven-day supply of any schedule II, III, or IV opioid upon initial consultation or treatment of acute pain. The bill gives flexibility to the prescriber to, upon any subsequent consultations for the same pain, issue (up to a thirty day supply) by appropriate renewal, refill or new prescription for the opioid or any other drug. In addition, the legislation: defines “acute pain” to mean pain, whether resulting from disease, accidental or intentional trauma or other cause that the practitioner reasonably expects to last only a short period of time. Such term shall not include chronic pain, pain being treated as part of cancer care, hospice or other end-of-life care or pain being treated as part of palliative care practices; and limits application of co-pays for the limited initial prescription of an opioid to either (i) proportionate amount between the copayment for a thirty day supply and the amount of drugs the patient was prescribed or (ii) the equivalent to the copay for the full thirty-day supply provided that no additional copays may be charged for any additional prescriptions for the remainder of the thirty-day supply. MSSNY advocacy assured that the prescriber, upon any subsequent consultations, has flexibility in prescribing appropriate renewals, refills or new prescription beyond the initial period. Importantly, the term “consultation” is intended to not require in person examination but can include a phone conversation between prescriber and patient at the conclusion of the initial 7-day supply.

Insurance Coverage for Substance Abuse Treatment The legislation requires insurers to afford coverage currently not afforded for substance abuse and treatment services including provision to: require insurers to (i) provide insurance coverage, without prior authorization, for inpatient services for the diagnosis and treatment of a substance use disorder as long as needed; and (ii) only conduct a utilization review, including retrospective review, commencing on or after the fifteenth day; require insurers to use an objective diagnostic tool approved by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and consistent with the treatment service levels within the OASAS system (gives insurers until December 31, 2016 to ensure their review tools comply with OASAS standards); require insurers to provide at least five days of coverage, without prior authorization, for medications necessary for the treatment of a substance use disorder; eliminate prior authorization under Medicaid and by commercial carriers for access to buprenorphine or injectable naltrexone; require insurers to provide coverage for the prescription of opioid antagonists to any person (e.g. parent, guardian, sibling) under the same policy as the treated addicted individual; and extend the period individuals may be held at treatment facilities for drug treatment from 48 to 72 hours. During such time, patients must be reevaluated regularly. Under the bill, patients must also be given a discharge plan upon their discharge from the facility in order to ensure a continuum of care, including information on how to access additional treatment services. Generally speaking MSSNY policies support timely access to medical care and treatment. These provisions are consistent with the direction taken in those policies.

Information to Patients The legislation seeks to assure that patients are made aware of the risks associated with controlled substances and of addiction services that are available in their community. The bill would require the commissioner of the office of alcoholism and substance abuse services (OASAS) to create educational materials that would be disseminated by a pharmacist to a consumer at the time the consumer receives his or her prescription of controlled substances concerning the risks of using controlled substances, the warning signs of addiction and contact numbers for HOPELINE; and require hospitals to develop discharge protocol for services for individuals suffering from substance use disorder which include distribution of informational materials to patients upon their discharge and procedures for the identification, assessment, and referral of individuals with a substance use disorder. MSSNY was successful in eliminating a proposal that would have placed a duty on a prescriber to provide consultation regarding the addictive nature of opioids and eliminated the proposed requirement to have the patient sign a form attesting that they received such counseling from their prescriber.

Legislation to Enable Physician Override of Insurer “Step Therapy” Medication Protocols Passes Legislature Legislation (A.2834-D, Titone and S.3419-C, Young) passed the Assembly and Senate this week to articulate a process for physicians to request and be granted an override of an insurer medication step therapy protocol when it is in the best interest of their patients’ health. MSSNY strongly supported this bill, and worked with a wide array of patient advocacy organizations, specialty societies, hospitals, and pharmaceutical manufacturers to achieve passage of this legislation. The bill will must be approved by the Governor for it to become law. The bill would require a health insurer to grant a physician’s override request of an insurer step therapy protocol if one of the following factors are present: 1) the drug required by the insurer is contraindicated or could likely cause an adverse reaction; 2) the drug required by the insurer is likely to be ineffective based upon the patient’s clinical history; 3) the patient has already tried the required medication, and it was not effective or caused an adverse reaction; 4) the patient is stable on the medication requested by the physician; 5) the medication is not in the best interests of the patient’s health. While the legislation would generally require the health insurer to make its decision within 3 days of the override request of the physician, the insurer would be required to grant the override request within 24 hours of the request if the patient has a medical condition that places the health of such patient in serious jeopardy if they do not receive the requested medication. Perhaps most importantly, if the physician’s request for an override is denied, it would enable a physician to formally appeal the decision both within the plan’s existing appeal mechanism as well as taking an external appeal.
Legislative Session Produces Administrative Simplification Bills

In addition to passage of the “step therapy” bill, the Legislature also approved other bills prior to adjourning designed to reduce the administrative burden on physicians in their dealings with health insurers.

The Assembly and Senate passed legislation (A.501-E, Cusick/S.2545-D, Lanza) this week that would reduce from 90 to 60 days the time within which a health insurer must complete its review of the application of a physician to participate in the network of a health insurer, as well as reducing from 90 to 60 days the time within which a physician in some situations can become “provisionally credentialed” if the plan does not complete its review. The bill also would eliminate some ambiguous statutory language that currently gives discretion to a health insurer to delay a decision on a physician’s application after these deadlines have passed. The Assembly and Senate also recently passed legislation (A.6983-A, McDonald/S.4721-A, Hannon) that would direct the Commissioner of Health and Department of Financial Services to create standards to provide greater uniformity among health insurers when physicians request insurers to cover their patients’ needed prescription medications.

CVS Health’s Retail Clinic Bill Fails- Again

CVS HEALTH which operates CVS Pharmacies, a pharmacy benefit manager, mail order and specialty pharmacies, and retail-based health clinic subsidiary, MinuteClinic, attempted to secure passage of legislation (S. 5458, Hannon and a similar bill A. 1411, Paulin) which would allow the establishment of corporate owned retail clinics statewide without establishment of public need as is normally required under the certificate of need provisions of current law MSSNY had previously succeeded against an effort to defeat the retail clinic proposal that had advanced as part of the executive budget. Subsequently, a similar proposal (S. 5458, Hannon) was passed by the Senate in May. Just this week, a similar bill was considered by the Assembly but it failed to garner the necessary votes. MSSNY working closely with the Nurses Association and other specialty medical societies succeeded in beating back this additional effort defeating the bill for the second time this year.
ETHICAL DILEMMAS IN HEALTH CARE
Shideh Sherafat Kazem Zadeh

Background
An ethical dilemma by definition, is making decision based on two or more moral conflicts in such a way that any possible resolution is not tolerable, and is not necessarily right or wrong. Many factors including personal beliefs, religious beliefs, experience, knowledge, culture and values affect making decision. Dealing with ethical dilemma in health care system is a matter that occurs on a daily basis for providers, patients and health care leaders, and might impact the direction of the care. [1,2]

Discussion
When talking about a particular ethical dilemma, we should bring up relevant questions and then answer them. Some of the questions are as follows:
1. Who should make decision, and who will be affected by the decision?
2. What legal issues are required to be considered?
3. Which factors are involved in making decision?
4. What are the other options?
5. How will we deal with this ethical dilemma, and what is the possible resolution? [3,4,5]

Giving answers to these questions clarify that managing ethical issues are not as simple as it might be assumed. Since many health care ethical issues have been raised, the health care system has provided ethical protocols to give common answers to some of the major ethical issues that patients and providers are dealing with on a daily basis. However, some ethical dilemmas are required to be more clarified. It is the responsibility of hospital’s ethical committee to make the care providers aware of the principles of decision making. Here are some of the major ethical dilemmas and the ways that are being managed:

- Each patient and care provider has the right to protect himself / herself from transmissible diseases. Therefore, ethics committee of hospitals should educate nurses and physicians, provide protective equipment for them, and properly dispose biohazardous materials whereas patients do not feel uncomfortable.[7]
- Elderly individuals who are terminally ill but still are in good state of mind may make decision about their end of life care such as resuscitation, tube feeding, dialysis, palliative care and organ donation. In the situation that they could not make decision, living will and advance directives will speak instead of them. However, euthanasia is still controversial and requires more ethical assessment. [6]
- Confidentiality is the other important ethical issue that should be deeply cared in health care facilities. Patients’ records should not be released to third party without patient’s permission, and conversation between a patient and a doctor should be kept confidential. [7]
- Ethical committee of hospitals and medical clinics should rigorously care about sexual harassment. It could occur between a care provider and a patient or between a supervisor and a provider. In these circumstances ethics committee should take action to investigate the situation. Improving gender equality and professional manner minimize sexual harassment in health care facilities. [7,8,9]
- The other ethical issue which is highly debateful is abortion. Some who mostly are religious believers are against abortion. They suggest that people should not interfere in the fate of a human being. Others who are pro-abortion believe that a fetus is not a human being and early termination of a pregnancy is not a murder. Considering both clinical knowledge and ethical issues help to make a better decision. [10]

Conclusion / Suggestion:
Ethical dilemma in health care system is a challenge in making decision, and it is mainly because of the existence of ethical conflicts and legal issues. Although there have not been clear answers to many paradoxes yet, the health care system of the USA has prepared ethical protocols in order to provide rules for some common ethical dilemmas. Frequent reviewing of the current protocols and defining new resolutions for other controversial ethical issues will help to improve the quality of health care.

References:
5) Resolving Ethical Dilemmas. KE Murphy. Focus Newsletter, October 1997.
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