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Is medical ethics education reaching today's students?

Go beyond the theoretical: Offer case-based learning

Currently, the more than 140 medical schools in the U.S. teach ethics “in just about 140 different ways,” says **D. Micah Hester**, PhD, a professor at University of Arkansas for Medical Sciences in Little Rock. Hester is also a clinical ethicist at Arkansas Children's Hospital.

“My hope is that we do, in fact, begin to have a more robust and sustained national conversation about medical ethics education,” says Hester.

Janet Malek, PhD, associate professor at Baylor College of Medicine's

Center for Medical Ethics and Health Policy in Houston, names the following obstacles to improving ethics education: pressure to reduce classroom time, lack of dedicated resources, and resistance or mixed messages coming from institutional cultures.

Most attempts at improving medical ethics education occur at the local level, with individual schools making decisions about curriculum. “Some schools have integrated ethics into other courses, like ‘doctoring’ courses,” notes Hester.

EXECUTIVE SUMMARY

Lack of resources, pressure to reduce classroom time, and students' shorter attention spans are some current challenges to improving medical ethics education. Institutions are trying the following approaches:

- offering small-group teaching and case-based learning,
- having students shadow clinicians to see how ethical issues are handled in clinical practice, and
- using simulated patients for practice obtaining informed consent and giving bad news.

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EDITORIAL QUESTIONS

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Ethics education has made a great deal of progress in recent years, according to **Michael Green**, MD, MS, vice chair of the Department of Humanities and chair of the Hospital Ethics Committee at Milton S. Hershey (PA) Medical Center.

“Previously, some places taught ethics and some didn’t — it was optional,” he explains. “We had to fight hard to get it into the curriculum.”

While ethics is part of virtually every medical school curriculum, there is much variation in how it’s taught. A recent report evaluated the current state of medical ethics education in the U.S.¹ “We wanted to come up with a framework to build some consensus around that,” says Green, one of the report’s authors.

Malek, another of the report’s authors, says the goal was to offer an overview of the current landscape in ethics education and to identify issues that schools and educators should be thinking about. “We hope that readers might find some guidance about how to meet changing accreditation requirements and the types of problems they will need to find answers to,” she says.

One reason for inconsistencies in ethics education is that the resources available at institutions vary widely. “Some places have one part-time person, and others have robust ethics programs with a dozen people,” Green says. “So you can’t expect the same sort of curriculum.”

Malek sees many medical schools and residencies offering more curricular time and faculty support for education in medical ethics. This is in part because it supports the achievement of the Accreditation Council for Graduate Medical Education’s core competencies and related milestones.

“Ethics educators are working

to develop new approaches that fit within evolving paradigms of medical education,” says Malek.

Shorter attention spans

Green directed a course on medical ethics and professionalism for medical students at Penn State College of Medicine for more than two decades. In recent years, he’s noticed that students, while bright and motivated, seem less interested in reading materials and attending lectures. “Every year, we end up shortening the amount of readings we provide — and every year they say it’s still too much,” he says. “One of the biggest challenges for us is how to successfully engage the students.”

Instructors now emphasize small-group teaching and experiential learning. “Having students listen to lectures and read philosophical texts doesn’t work as well today,” says Green. “The students respond much better to case-based approaches.”

Using simulated patients, students practice eliciting informed consent, ensuring confidentiality, and giving bad news. “We are not only delivering information, which is important, but we are also helping them develop skills to act ethically,” Green says.

Hester says some institutions are making a concerted effort to infuse ethics into clerkship education. This allows students to see “real-life” examples of ethical challenges. “Others have attempted different modalities for imparting ethics education, from simulation to problem-based learning,” says Hester.

Loyola’s educators use a “Medical Ethics Bowl” competition as a curricular modality to both provide case content and evaluation. “It requires research, argument, and

teamwork to address ethically challenging issues in healthcare,” says Hester.

Looking forward, Malek expects to see ethics integrated throughout medical education, rather than separated into free-standing courses. “We may also see a movement toward the use of OSCEs [Objective Structured Clinical Exams] and virtual patients to teach and evaluate ethics and professionalism,” says Malek.

The following are some current concerns involving medical ethics education:

- **Students often receive very little ethics education during residency.**

Most institutions provide ethics education only during the first two years of medical school, strictly in a classroom setting. “During the clinical years when they really need ethics the most, there are fewer opportunities for such teaching,” explains Green.

Early on, ethical problems are just theoretical for students. “These problems aren’t real; they haven’t lived them,” says Green.

Only after students begin working in the hospital wards, or are residents working as doctors, do they really experience the dilemmas — yet there tends to be very little ethics education offered at that point, Green says.

“Ethics is not considered the most important topic for doctors to keep up with,” says Green. “But I think this just means we need to find more creative ways to reach these learners.”

- **Students often lack good role models in clinical practice settings.**

“Everything we do can be easily — and often is — undermined in a short amount of time by role models who don’t embody the things we’ve been telling them,” says Green.

For instance, ethicists teach

students to represent themselves accurately and honestly. “Then, in one brief moment, an attending physician introduces them as ‘Doctor X,’ and says that the young doctor will be getting informed consent for an upcoming procedure,” says Green. Now the student has to decide whether to contradict the attending who misrepresented them, and how to deal with the consent issue — which really is the responsibility of the attending physician and not the student. “It’s a powerful negation of what we teach,” says Green.

To really make a difference, Green says ethics education has to find a way to affect the culture of medicine more generally. “That means having a culture of respect. This is long, hard, challenging work,” says Green.

Green says ethicists need more engaging ways to reach broader audiences in the clinical practice setting. “Any experienced clinician will tell you that some of the most challenging cases they face are those that raise ethical dilemmas, rather than scientific challenges,” he says.

J.S. Blumenthal-Barby, PhD, Cullen Associate Professor of Medical Ethics and associate director of medical ethics at Baylor College of Medicine’s Center for Medical Ethics and Health Policy in Houston, says ethicists need to teach healthcare professionals more about how to behave ethically, rather than just ethical principles that identify the right thing to do.

“We know from the moral psychology literature that people are often prey to certain biases that impact their moral behavior in ways that are subtle and unconscious,” says Blumenthal-Barby. For example, putting eyes above the coffee donation box at work makes it more likely that people will do the right thing and pay for the coffee they are

using.

“Or, as the Zimbardo prison experiments demonstrated, people will hurt other people if an authority figure is doing so or is asking them to,” says Blumenthal-Barby. “In such cases, the moral agents know the right thing to do; they just don’t do it.”

Blumenthal-Barby says ethicists need to teach healthcare professionals how their behavior is shaped by their environment. “Only then will the principles that we teach have any utility in terms of translating into actual behavior,” she says.

- **There is lack of evidence on how different content, modalities, and materials achieve the stated aims of ethics education.**

Hester sees this as the primary challenge to improving ethics education. In general, medical ethics education aims at clarifying the nature of an ethical issue, developing sensitivity to the appearance of ethical concerns in medical situations, and providing tools for addressing ethical concerns once they are recognized.

“However, even after 40+ years of medical ethics teaching, what content, teaching modalities, and materials achieve these goals is an open question,” Hester says.

It’s very difficult to evaluate what kind of effect educational efforts have on learners. “Because medical ethics courses are often integrated with other courses and take place over a period of time, confounding factors make it nearly impossible to discern the impact of the course itself,” Malek says.

The goal of ethics education is to affect behavior that won’t take place for many years. “So the effectiveness of an intervention could only be measured by longitudinal studies that are difficult and expensive to run,” says Malek.

It is challenging to evaluate the

extent to which a student, resident, or physician is “ethical,” since there is no consensus definition of this and no established tool to assess this characteristic and its associated behaviors.

“Without the ability to determine which educational interventions are effective and which are not, it is hard to improve those approaches,” says Malek.

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Is hospital discharge unsafe? Ethical response is needed

Unsafe discharges are “serious issue,” experts say

It’s a difficult yet common scenario: A patient with complex care needs does not have a reliable caregiver at home to assist with implementing their post-discharge care needs.

In these cases, it’s necessary to determine if the patient has the capacity to make the decision, says **Erin Sarzynski**, MD, MS, an assistant professor of geriatric medicine at Michigan State University in East Lansing.

“If the patient does have capacity, then a clinician is challenged to facilitate the discharge against his or her better judgment,” Sarzynski says.

If Sarzynski is concerned about a patient’s welfare post-discharge, she works with case management to create a contingency plan. This could include having family or friends check on the patient and arranging home healthcare services or sub-acute rehabilitation care, which may be a viable option for up to 30 days post-discharge if the patient was admitted for at least three nights under

inpatient status.

“However, if the patient lacks capacity to make the decision to return home without a reliable caregiver, then the clinician must determine who is the proxy decision-maker,” says Sarzynski. If the patient has not previously appointed a durable power of attorney for healthcare, it is necessary to contact next of kin, or in some cases apply for a court-appointed guardian.

“Thereafter, clinicians must arrange post-discharge care with input from the proxy decision-maker,” says Sarzynski.

Ethical obligation for safe discharge

In some cases, an elderly, frail patient is determined to go home alone, “and nobody thinks it’s a good idea. That becomes a serious issue sometimes,” says **Wayne Shelton**, PhD, professor at the Alden March

Bioethics Institute at Albany (NY) Medical College.

Physicians and nurses have an ethical obligation to ensure that the discharge is safe, says Shelton. This includes the safety of the patient’s caregiver. “A spouse may have the best of intentions, but has health problems of his or her own,” he says. If the spouse is clearly unable to care for the patient, the bioethicist may need to become involved to discuss other options. “You may have to talk about sending the patient to a nursing home, which may be something they don’t want to talk about,” says Shelton.

Ethicists can begin the discussion by making sure that patients and family understand the risks involved. “Basically, we try to get them to reconsider their decision,” says Shelton. “We explain that they risk getting in worse shape medically.”

Shelton says it’s “virtually impossible” for ethicists to tell an elder person with capacity who has

made up his or her mind to go home that he or she can't do so, regardless of the risks. "We do have patients who leave against medical advice. Even if it entails some risk, we can't stop them," says Shelton.

The clinical team struggles with seeing a patient leave, knowing it's likely unsafe. "Sometimes the patient comes back with additional problems," Shelton says. "This is one of the prices we pay for autonomy."

"Safe discharge" laws preclude hospitals from discharging patients who don't have a safe plan for continued care after they leave a hospital. "This has become a real challenge with regard to uninsured patients," says **Janet L. Dolgin**, PhD, JD, co-director of the Hofstra University Bioethics Center in Hempstead, NY. Dolgin is also director of the Hofstra University's Gitenstein Institute for Health Law and Policy.

"Mostly, now, this is relevant to undocumented immigrants, who are not generally covered by Medicaid or state exchanges," notes Dolgin. Hospitals are required by the Emergency Medical Treatment and Labor Act (EMTALA) to accept all "emergency" patients, but nursing home facilities are not. In fact, nursing homes are typically reluctant to accept patients whose care costs will go uncovered.

"Thus, hospitals have sometimes kept patients long after the patients were not well-served by continued hospital care because no safe discharge options were available," says Dolgin.

Ethicists can offer valuable mediation if there's disagreement as to whether a particular patient should be discharged. "Sometimes meetings among clinicians, patients, patients' family members, social workers, or hospital administrators can shape options that seem acceptable to everyone involved," says Dolgin.

The following are other ethically challenging scenarios involving hospital discharges:

- **A patient is medically cleared for discharge, but refuses to leave the hospital.**

"There are a variety of reasons why patients stay in the hospital longer than they need to. This is a big problem in healthcare," says Shelton.

Several recent ethics consults at Albany Medical College have involved this very scenario. Sometimes it's a family member who objects to the discharge on the grounds that the receiving facility is too far away.

"This raises the question of how far is too far for the family, if there is no local place for the patient to go to," says Shelton. "There are limited options for other places patients can go."

If a patient or family strongly

objects to the discharge, ethicists sometimes work with clinicians to find a way to accommodate them to some extent. "We can usually work things out and negotiate an extra day. It's not a hard science — these things are negotiable in terms of decision-making," says Shelton. "But there are limits."

One reason is that keeping patients hospitalized who are medically ready for discharge is simply not in the patient's best interest. "The hospital is not a place to be, unless you really need to be there," says Shelton. "And it's certainly not in the best interest of the healthcare system, because it costs a whole lot of money."

Ethicists try to get across that the patient doesn't need the level of care he or she is receiving in the hospital, and that the patient is better off in a long-term care facility. "People can get quite comfortable having nurses and doctors taking care of them here," says Shelton. "It's a communication challenge."

- **Case managers and social workers can't find a facility willing to accept the patient.**

"Some patients have a reputation for being difficult, and nobody wants to take them," says Shelton. "Facilities sometimes push difficult patients on each other, protecting their own turf."

The next step may be unclear if one facility after another flatly refuses to accept a particular patient. "This has raised some questions about the role of the ethics consult," says Shelton. "It's not really our role to call nursing homes and talk about discharge planning." However, Shelton occasionally has stepped in to make such calls. "Strictly speaking, it's not something we should be doing," he says. "But it tends to get people's attention."

- **Clinicians are pressured**

EXECUTIVE SUMMARY

Ethically challenging hospital discharges include patients with inadequate at-home care and those who leave against medical advice. Ethicists recommend the following approaches:

- Determine if patients have capacity to make the decision to return home without a reliable caregiver.
- Work with case management to create a post-discharge contingency plan.
- Contact nursing homes on behalf of clinicians if placement is especially difficult.

by hospital administrators to discharge patients.

Hospital administration recently alerted Sarzynski of “high census,” with a request to discharge patients in the early morning. At the time, one of her patients was a homeless man medically ready for discharge, but a severe weather advisory had been issued. “These cases are difficult to navigate,” says Sarzynski.

The primary ethical issue is non-maleficence, says Sarzynski. The homeless patient is the clinician’s primary responsibility, she says — not patients waiting to be admitted to the hospital. “Even so, it’s best to negotiate a compromise that enables the largest number of patients to receive the medical care they need, thereby meeting the ethical principle of utilitarianism,” says Sarzynski.

Sarzynski chose to discharge the homeless patient in the evening, with explicit instructions to stay overnight in the hospital lobby — a warming center — before departing the next day. “Thankfully, the case manager was able to provide a meal voucher as well,” says Sarzynski.

While Sarzynski did feel pressure to proceed with a potentially unsafe discharge, in the end she felt that the hospital did support her contingency plan. “In the end, I believe we met both ethical principles: non-maleficence and utilitarianism,” says Sarzynski.

Such plans require a team effort, however. “It’s an excellent example of the role a bioethicist can play: offering nuanced solutions that enable members of the medical team to negotiate clinical

problems,” says Sarzynski.

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Study: Families perceive less aggressive end-of-life care as better quality

Among family members of older patients who died of advanced-stage cancer, earlier hospice enrollment, avoidance of ICU admissions within 30 days of death, and death occurring outside the hospital were associated with perceptions of better end-of-life care, according to a recent study.¹

Researchers used information obtained from interviews with family members of Medicare patients with advanced-stage lung or colorectal cancer in the Cancer Care Outcomes Research and Surveillance study who died by the end of 2011. Some key findings include the following:

- Of 1,146 patients with cancer, bereaved family members reported excellent end-of-life care for 51%.
- Family members reported excellent end-of-life care more

often for patients who received hospice care for longer than three days (59%) than those who did not receive hospice care or received three or fewer days (43%).

- In contrast, family members of patients admitted to an ICU within 30 days of death reported excellent end-of-life care less often (45%) than those who were not admitted to an ICU within 30 days of death (52%).

- Family members of patients who died in the hospital reported excellent end-of-life care less often (42%) than those who did not die in the hospital (57%).

- Family members of patients who did not receive hospice care or received three or fewer days were less likely to report that patients died in their preferred location (40%) than those who received hospice care for

longer than three days (73%).

“Patients with advanced-stage cancer are receiving increasingly aggressive medical care near death, despite growing evidence that high-intensity treatments may not be associated with better patient quality of life, outcomes, or caregiver bereavement,” says **Alexi Wright**, MD, the study’s lead author. Wright is an assistant professor of medical oncology at Dana-Farber Cancer Institute in Boston.

Several quality measures for end-of-life care have been endorsed by medical and policy groups, including the American Society for Clinical Oncology and the National Quality Forum. “But few studies have examined whether these measures reflect patients’

preferences or bereaved family member's perceptions of the quality of end-of-life care," says Wright.

Existing measures characterize the repeated use of emergency department visits near death as poor quality of care. "However, we did not observe a difference in family-reported ratings by this measure," says Wright. The lack of validation of this indicator suggests that some aggressive care measures may be less salient to patients and families, adds Wright.

"Our findings suggest that

efforts to increase earlier hospice enrollment and avoidance of ICU admissions and hospital deaths might improve the quality of end-of-life care," says Wright.

Possible approaches include enhanced counseling of patients and families, early palliative care referrals, and an audit system to monitor physicians' use of aggressive end-of-life care.

"These might result in the provision of more preference-sensitive care for patients, and overall improved quality of end-of-

life care," says Wright.

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Chaplain visits in ICU uncommon, study finds

Misunderstanding of role is one reason for underutilization

[Editor's Note: This is the second of a two-part series on the role of chaplains in the hospital setting. In this story, we report on how chaplains and ethicists can work together to ensure ethical care. Last month, we explored how chaplains can help to resolve conflicts over whether to withdraw life-sustaining interventions.]

Chaplain visits in the ICU are uncommon at Duke University Medical Center, usually occur just before the patient dies, and communication between the chaplain and the physician about the visit is rare, a recent study found.¹

Researchers in the Division of Pulmonary and Critical Care Medicine at Duke University Medical Center conducted a retrospective chart review of 4,169 adult admissions during a six-month period to five ICUs. Key findings include the following:

- Two hundred forty-eight patients were visited by a chaplain (5.9%).

- Chaplain visits were most frequently requested in the medical ICU (13%) and least frequently requested in the cardiothoracic ICU (2%).

- Of the 246 patients who died in the ICU, 81% were seen by a chaplain. These visits occurred a median of one day prior to death.

- Families were most likely to request a chaplain visit (19%), followed by chaplain-initiated visits (17%), visits requested by nurses (15%), and visits requested by physicians (4%).

- In only 6% of visits did the chaplain speak with the physician about the encounter. More often, the discussion was with the nurse (57%).

Chaplains are often underutilized in the hospital setting because they are not seen as a part of the healthcare team, says **Robyn M. Axel-Adams**, MDiv, BCC, program manager and senior affiliate faculty at the Charles Warren Fairbanks Center for Medical Ethics in Indianapolis.

"People too often think that you

call the chaplain when someone is about to die or needs prayers," says Axel-Adams. "We are skillfully trained to be with people of all religions or no religion."

Board-certified chaplains have master's degrees, are endorsed by their own faith community, receive at least a year of additional training in the clinical setting, and are certified by the Associate of Professional Chaplains after meeting 29 competencies.

William Nelson, PhD, director of the Rural Ethics Initiatives at the Dartmouth Institute for Health Policy and Clinical Practice at Lebanon, NH, notes that the forerunner of the American Society for Bioethics and Humanities was a group called Ministers in Education. The earliest ethics committees at faith-based institutions were called Medical and Morality committees.

"The earliest ethicists really were clergy and chaplains," he says. "I find it interesting that, for some people, chaplains have sort of lost their place

as very vital colleagues in addressing ethical issues.”

The clinical team sometimes feels that involving the chaplain will result in “too many hands in the pot.” “Having multiple people communicating with the patient or family can result in confusion or even mixed messages,” says **Jennifer Cobb**, M.Div., BCC, director of Mission and Spiritual Care at Mercy St. Louis Missouri, Chesterfield.

Clinicians sometimes misunderstand the chaplain’s role. “Some people might think they are just trying to impose religious beliefs,” says Nelson.

Vance Goodman, MDiv, a chaplain in the cardiac ICU at Dallas-based Children’s Health, sometimes contends with an outdated belief that chaplains only function as religious or faith-based guides. “This antiquated idea posits that chaplains are relegated to the world of religious rituals, prayers, or sacred readings,” says Goodman.

If chaplains round with the clinical team, and attend patient care meetings, they’re more likely to be viewed as part of the healthcare team, says Nelson.

“Chaplains can help the healthcare team understand the role of beliefs, religion, and cultural values in patient care,” he explains.

Some physicians shy away from asking patients if they’d like to see a chaplain. “I’ve had some physicians say, ‘That’s getting too personal.’ Some think of it as a taboo subject,” Nelson says. “It’s an area they just don’t feel comfortable with.”

Spiritual and religious concerns and perspectives are often tied to how patients experience illness, notes Nelson. “Certainly the patient’s concepts of spirituality influence end-of-life decision-making,” he says. “Chaplains can help patients sort

through their own story, if you will, of what they want or don’t want.”

Chaplains listen to patients and families’ stories, and translate medical terminology into “regular people talk,” says Axel-Adams. “So many ethics consultations happen due to communication breakdown. Chaplains are able to help bridge between the two worlds.”

Many medical and nursing students have little exposure to chaplains, however. “We have medical students shadow chaplains to better understand what they are all about,” says Nelson. This promotes the view of chaplains as part of the interdisciplinary team that provides ethically grounded care.

The patient’s spiritual, emotional, and moral point of view becomes important as ethical dilemmas arise, says Goodman.

“Chaplains can be helpful where a person’s belief system or religious tradition offers differing views about treatment than what is suggested by the medical team,” Goodman says. One example of such a conflict is when a person needs a blood transfusion, and the Jehovah’s Witness tradition condemns the exchange of blood.

“A chaplain can assist the person, their family, and the staff to navigate conversations around the theological tenets espoused and the reasonable treatment options available,” says Goodman.

Ideally, chaplains are represented on every hospital’s ethics committee to serve as a resource for committee members and during ethics consults. “But like other members of the ethics committee, the chaplain needs to be ethically competent,” Nelson says. “Just because you are an ordained clergy person doesn’t mean inherently you have had lots of bioethics training.”

Nelson says chaplains need to go beyond just using their pastoral care skills and develop a level of expertise in applied healthcare ethics.

“The chaplain may have only had one course in ethics in theology school, and it may have been a course from a religious perspective. They need to go beyond that,” says Nelson.

A basic understanding of how healthcare systems work is also helpful to chaplains. If the root of an ethical dilemma is allocation of resources, for instance, the ethicist needs some understanding of how healthcare is paid for. “Like other committee members, chaplains need to have at least a basic understanding of the types of problems they’re encountering,” says Nelson.

Mercy St. Louis Missouri’s chaplains and ethicists have embarked on a unique education collaborative. “We are building a stronger sense of team between the disciplines and educating both disciplines on the roles, gifts, and challenges of each other,” says Cobb.

Training provided to chaplains includes knowledge of their own role in ethics, and the ethicist’s role. “This careful preparation results in a strong collaborative spirit between the disciplines,” says Cobb. “It helps the chaplain understand what the ethicist is working toward.”

Chaplains at Mercy are involved in complex care, palliative care, and cancer care teams. “Our patients are more than physical beings; they are also emotional and spiritual beings who need care for the whole person,” says Cobb. “As such, we continue to integrate chaplains into the care of patients who are most in need.”

Mercy’s chaplains serve patients beyond the traditional hospital setting. This includes telephone chaplaincy for patients referred from physician clinics, and for patients

at high risk for readmission. “We also have virtual chaplaincy for patients who are being treated by our outpatient virtual team,” says Cobb.

Chaplains are encouraged to attend and participate in Ethics Grand Rounds as often as possible. Occasionally, chaplains in a specialty area, such as palliative care, have co-facilitated Ethics Grand Rounds. “Through this process, our chaplains and ethicists continue to become more appreciative and supportive of the different roles,” says Cobb.

Chaplains often educate front-line clinicians about the many positive ways ethicists can help with difficult situations. “Likewise, our

ethicists are embracing the role of the chaplain, and encourage clinicians to involve pastoral care as part of the interdisciplinary team,” says Cobb.

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Dying in America recommendations not reality in most hospital settings, experts say

Change is underway, but barriers exist

The Institute of Medicine (IOM)’s landmark September 2014 report, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, identified serious deficiencies in end-of-life care in the U.S. Institutions reacted to the report’s recommendations in various ways.

“The *Dying in America* report generated a great deal of momentum across organizations and stakeholders,” says **Salimah H. Meghani**, PhD, MBE, RN, FAAN, an associate professor at University of Pennsylvania’s School of Nursing in Philadelphia. Meghani served on the IOM’s Dying in America committee.

During a recent IOM National Action Conference on policies and payment systems to improve end-of-life care, 40 organizations shared

specific plans and organizational commitment to convert the report’s recommendations to action. These included leading medical and nursing bodies, specialty organizations, insurers, health systems, charitable organizations, and public grassroots initiatives.

“It is difficult to take stock of the activities underway,” says Meghani. “They are broad-ranging, and the outcomes will become evident in time.”

There are multiple barriers to implementing the IOM’s recommendations, both at provider and system levels. “At the system level, incentives remain misaligned with what patients and families need and want during an advanced serious illness,” says Meghani.

The health system is gradually shifting away from a fee-for-service

delivery model toward value-based models. However, palliative care is not always included.

“From a clinician’s perspective, we need both more training in end-of-life communication, but also more research to generate evidence-based models to improving these communications,” says Meghani. The Centers for Medicare & Medicaid Services (CMS) recently approved advance care planning codes. “Hopefully, this will generate a tide in this direction,” says Meghani.

Matthew R. Kenney, PhD, vice president of mission and ethics at Saint Francis Hospital and Medical Center in Hartford, CT, says there is often a disconnect between treatments or interventions provided for patients and their families, and what is actually needed. “There is also a lack of effective utilization

of existing resources,” he says. The following are some underlying reasons for this, according to Kenney:

- **Providers often refer patients to hospice too late.**

In Connecticut, patients are referred to hospice with an average of two weeks to live, says Kenney. “This does not provide adequate time for the multidisciplinary care team — which should include the physician, nurse, social worker, chaplain, and family — to do the difficult but necessary grief work constitutive of end-of-life care,” he says.

- **Some providers lack understanding of what palliative care is and how it can be utilized effectively.**

“There is often a misunderstanding that palliative care and hospice are the same thing,” says Kenney. Providers don’t always recognize that palliative care and curative interventions are not incompatible, and can coexist.

“A referral to palliative care is not a sign of failure on the part of the attending physician,” says Kenney.

“Rather, it is a recognition that we have an obligation to provide the best possible care for patients and their families.”

- **Providers often have end-of-life conversations only after the person is seriously ill.**

“The ICU is not the best place to have these conversations, since this is often too late,” Kenney says.

Ideally, end-of-life and advance directive conversations are part of a larger ongoing dialogue between care providers and patients about values, beliefs, and goals of care. Kenney often gives presentations or grand rounds on this topic. He recommends that the conversations occur during a non-clinical office visit with a primary care physician, with a loved one, or other surrogate decision-maker present.

“Of course, for this to be a reality, we need to reimburse physicians for these conversations and give them more than 15 minutes to have them,” he says.

- **Providers need better education and training on**

- **discussing goals of care with patients.**

“Meaningful end-of-life conversations should not be outsourced to the palliative care team because other clinicians are uncomfortable with such conversations,” Kenney says.

Palliative care colleagues, social workers, and chaplains can serve as models of how to conduct these discussions effectively. “But they cannot be expected to shoulder the weight of these conversations alone,” says Kenney.

SOURCES

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Autonomy, consent are key ethical concerns with egg freezing

Growing numbers of women are choosing to freeze their eggs in order to delay childbearing until later in life. Some ethicists, however, worry that the existence of oocyte cryopreservation technology places responsibility for juggling career, education, and family-making on women alone.

“I think it is all too easy for this technology to become the ‘solution’ to the ‘problem’ of women’s fertility declining with age,” says **Josephine Johnston**, director of research and research scholar at The Hastings

Center in Garrison, NY.

Another way of viewing the problem, she says, is that there is a lack of economic, cultural, and structural support for women having babies during their peak fertility.

Cryopreservation does very little to change “the work/life system” that most women find themselves in, says **Erin Heidt-Forsythe**, PhD, assistant professor in women’s, gender, and sexuality studies and political science at The Pennsylvania State University in University Park.

“There is an economic system that

enforces a ‘fertility penalty’ on women who have children,” she notes. This system doesn’t ensure paid family leave, convenient and high-quality child care, or flexible work schedules for parents.

Karey A. Harwood, PhD, associate professor in the Department of Philosophy and Religious Studies at North Carolina State University, says it is worth considering whether egg freezing is a “technological fix” for a social problem that ultimately sells women short.

“Some ethicists raise the concern that oocyte cryopreservation works

at cross purposes with efforts to reform the workplace to make it more equitable and family-friendly,” says Harwood.

Inmaculada de Melo-Martín, PhD, MS, professor of medical ethics in medicine at New York City-based Weill Cornell Medical College, says it is ethically problematic to talk about women “wishing” to defer childbearing. “This presents the problem as one that results primarily from women’s free choices,” she says.

Arguably, she says, such “choice” results from social conditions that make it difficult for many women to both have jobs or pursue an education and have children at a younger age.

“Oocyte cryopreservation for healthy women thus medicalizes what is essentially a social problem, reinforces norms about women’s responsibility for their reproductive health, and extends concerns about infertility to healthy women,” says de Melo-Martín. Some other ethical concerns include the following:

- **Oocyte cryopreservation is costly, and thus unavailable to many individuals.**

While there are higher rates of infertility and impaired fecundity for women and men of lower socioeconomic status, says Heidt-Forsythe, cryopreservation is beyond their financial reach. She argues that this reinforces, rather than alleviates, equal access to medical care around infertility. “Reproductive autonomy thus comes at a price — for those that are willing and able to pay huge sums to freeze their eggs,” says Heidt-Forsythe.

- **The benefits of cryopreservation may be exaggerated, and the risks minimized.**

Oocyte cryopreservation protocols are quite new, and large safety and efficacy studies are lacking, notes de Melo-Martín. Therefore, the long-term

safety and efficacy evidence is non-existent.

“Given this state of affairs, offering this new technology to young healthy women under the guise of ensuring their future fertility is certainly ethically problematic,” de Melo-Martín says.

Many women believe that oocyte cryopreservation ensures a reproductive future by which women can carry pregnancies to term even if they are infertile. “However, in reality, this future is far from secure,” says Heidt-Forsythe. Studies have shown that the use of frozen eggs lowers the success rate for pregnancies brought to term with live births.

“There are currently few guidelines — beyond the American Society for Reproductive Medicine’s professional guidelines — that mandate truthfulness or accuracy in reporting the likelihood of pregnancy for those women that cryopreserve their eggs,” says Heidt-Forsythe.

Johnston fears that prospective users of elective cryopreservation might not be adequately informed about risks. “I have these concerns based on some of the advertising and marketing strategies I have seen,” she says.

Women pay a considerable amount of money to have their oocytes extracted, cryopreserved, and then stored for what might be years, even when they will never come to use the cryopreserved eggs. “Conflicts of interest can thus play a role in recommendations for these

procedures,” says de Melo-Martín.

Success rates with egg freezing decline significantly with a woman’s age. “If women are provided with good information, the weighing of risks and benefits ought to be left to them, out of respect for patient autonomy,” says Harwood, adding that potential users of this technology have to be savvy and discerning consumers.

“The caveat emptor approach, with the burden on the buyer to become better informed, seems to be the model governing expectations about oocyte cryopreservation,” Harwood says.

SOURCES

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COMING IN FUTURE MONTHS

- Update on ethical considerations of residency work hour limits
- Why “big data” in healthcare has some ethicists concerned
- How providers’ bias against obese patients affects their care
- Ethical challenges of informed consent for psychiatric patients

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CME/CE QUESTIONS

1. Which is an effective approach to

**providing medical ethics education
to medical students, according to
Michael Green, MD, MS?**

- A. Minimize the use of case-based learning and small-group teaching.
- B. Restrict ethics education to the first year of medical school.
- C. Have students practice eliciting informed consent, ensuring confidentiality, and giving bad news, using simulated patients.
- D. Increase the amount of time students spend reading philosophical texts.

2. Which is true regarding hospital

**discharges, according to Erin
Sarzynski, MD, MS?**

- A. If a patient insists on leaving the hospital but clinicians believe this is unsafe, it is unethical to allow the discharge even if the patient has decision-making capacity.
- B. Providers encouraged to discharge patients by administrators due to high census should place a higher value on the ethical principle of utilitarianism, as opposed to non-maleficence.
- C. If the patient lacks capacity to make the decision to return home without a reliable caregiver but has a proxy decision-maker, clinicians must arrange post-discharge care with input from the proxy decision-maker.
- D. If patients leave against medical advice, clinicians no longer have an ethical obligation to come up with a

post-discharge contingency plan.

**3. Which is true regarding end-of-life care
for patients who died of advanced-
stage cancer, according to a recent
study?**

- A. Duration of hospice care had no measurable effect on the percentages of family members who reported excellent end-of-life care.
- B. Earlier hospice enrollment, avoidance of ICU admissions within 30 days of death, and death occurring outside the hospital were associated with perceptions of better end-of-life care.
- C. Family members reported excellent end-of-life care more often for patients who did not receive hospice care at all.
- D. Family members of patients who died in the hospital reported excellent end-of-life care more often than those who did not die in the hospital.

**4. Which is true regarding chaplain visits
in the intensive care unit, according to
a recent study?**

- A. Visits usually occurred well before the patient was near death.
- B. Communication typically occurred on an ongoing basis between the chaplain and the physician about the visit, resulting in improved end-of-life care.
- C. Most patients, or their family members, interacted with a chaplain at some point during the ICU stay.
- D. Chaplains who visited a patient rarely spoke with the physician about the encounter.

Medical Ethics Advisor

2016 Reader Survey

In an effort to learn more about the professionals who read *Medical Ethics Advisor*, we are conducting this reader survey. The results will be used to enhance the content and format of this publication.

Instructions: Please fill in the appropriate answers and answer open-ended questions in the space provided. Fax the completed questionnaire to 678-974-5419, return it in the enclosed postage-paid envelope, or complete online at https://www.surveymonkey.com/r/MEA_2016_survey. The deadline is July 1, 2016.

1. How would you describe your satisfaction with your subscription of *Medical Ethics Advisor*?

- A. very satisfied B. somewhat satisfied C. somewhat dissatisfied D. very dissatisfied

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- A. always B. most of the time C. some of the time D. rarely E. never

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In future issues of *Medical Ethics Advisor*, would you like to see more or less coverage of the following topics?

- | | A. more coverage | B. less coverage | C. about the same amount |
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15. On average, how much time do you spend reading each issue of *Medical Ethics Advisor*?

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