MEDICAL ETHICS ADVISOR®

FOR OVER 25 YEARS, YOUR PRACTICAL GUIDE TO ETHICS DECISION MAKING

AUGUST 2016 Vol. 32, No. 8; p. 85-96

INSIDE

AHC Media

Updated Code of Medical Ethics Arrives: What Changes Mean

Code "not something to be overturned lightly"

If a particularly thorny ethical issue presents itself, generations of clinicians have turned to the American Medical Association (AMA)'s Code of Medical Ethics for guidance. After an eight-year project, the code has been modernized.

"It is important that it is updated on a regular basis. As science evolves and societal views change, the code can develop certain inconsistencies," says **Audiey C. Kao**, MD, PhD, an internist and the AMA's vice president of ethics.

A decade ago, it first became clear that a comprehensive review was needed. "We took on this project with great urgency, even though it took longer than we expected," says Kao.

First, the council did a preliminary review of everything in the code. "The council looked at particular areas that seemed distinctly dated, such as technology that had been superseded by multiple other scientific developments, or where opinions related to an outdated structure of healthcare delivery," says **BJ Crigger**, PhD, the AMA's director of ethics policy and secretary for the AMA's Council on Ethical and Judicial Affairs (CEJA).

The council then divided itself into teams, and solicited input from the

EXECUTIVE SUMMARY

The American Medical Association's Code of Medical Ethics has been newly modernized, with hope that increasing numbers of practicing physicians, residents, and medical students will turn to it for guidance. Changes include the following:

- Opinions were consolidated and terminology was made consistent.
- Explanations of the ethical principles involved were added.
- Plain prose replaced terminology that could become outdated.

Financial Disclosure: Consulting Editor **Arthur R. Derse**, MD, JD, Nurse Planner **Susan Solverson** BSN, RN, CMSRN, Managing Editor **Jill Drachenberg,** Associate Managing Editor **Dana Spector,** and Contributing Editor **Stacey Kusterbeck** report no consultant, stockholder, speakers' bureau, research, or other financial relationships with companies having ties to this field of study.

MEDICAL ETHICS ADVISOR®

Medical Ethics Advisor®,
ISSN 0886-0653, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.

Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.
GST Registration Number: R128870672.

POSTMASTER: Send address changes to:
Medical Ethics Advisor
P.O. Box 550669
Atlanta, GA 30355.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
Customer.Service@AHCMedia.com.
AHCMedia.com
Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.- 4:30 p.m. Friday.

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year (12 issues) with free CE nursing contact hours, $519. Add $19.99 for shipping & handling. Online only, single user: 1 year with free CE nursing contact hours, $469. Outside U.S., add $30 per year, total prepaid in U.S. funds.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site-licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at Groups@AHCMedia.com or 866-213-0844.

ACCREDITATION: AHC Media, LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media, LLC designates this enduring material for a maximum of ***1.5 AMA PRA Category 1 Credits™***. Physicians should only claim credit commensurate with the extent of their participation in the activity.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. This activity has been approved for 1.5 nursing contact hours using a 60-minute contact hour.

This activity is intended for acute care physicians, chiefs of medicine, hospital administrators, nurse managers, physician assistants, nurse practitioners, social workers, and chaplains. It is in effect for 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

CONTRIBUTING EDITOR: Stacey Kusterbeck
MANAGING EDITOR: Jill Drachenberg (Jill.Drachenberg@AHCMedia.com)
ASSOCIATE MANAGING EDITOR: Dana Spector
DIRECTOR OF CONTINUING EDUCATION AND EDITORIAL: Lee Landenberger.

EDITORIAL QUESTIONS
Questions or comments?
Call **Jill Drachenberg** at
(404) 262-5508

entire Federation of Medicine — all the state, county, and specialty medical societies represented in the AMA's House of Delegates. Various organizations pointed out parts of the guidance that they viewed as outdated, unclear, or where there was tension between the guidance and state medical policy or state law.

After reviewing all the feedback, CEJA started drafting updated opinions, using a newly adopted format. Crigger describes it as a "two-stranded effort." The council was looking at the content of the guidance, and at the same time, it was looking at the way the guidance was presented.

In early 2014, a revised draft of the modernized code was posted to an AMA member's forum for review and feedback. Finally, the council took to it to the House of Delegates formally for the first time for House action at the 2014 interim meeting, making still further adjustments at the annual and interim meetings in June and November 2015. The final code was approved in April 2016.

The multiyear project became so all-encompassing that the council added a minimum of one day to each of its four yearly meetings. "For three years, the council convened for five-day meetings, four times a year," says Crigger. "That is a huge commitment on the part of practicing physicians."

Feedback Broad in Scope

Reports by the Council on Ethical and Judicial Affairs deal with controversial issues and often prompt significant debate in the House of Delegates. Surprisingly, the project to modernize the code spurred less controversy than might have been expected. "Certain individuals or groups felt concern about various items, but nothing that rose to the level of debate that we see in some issues, such as aid in dying," says Crigger.

Some groups or individuals objected to guidance in the existing code that the council had not changed. "Addressing guidance about which some individuals continue to disagree was not part of the modernization process," explains Crigger. "There are other channels in the AMA to address that."

The level of scrutiny given to all the feedback received took time. Since the code provides guidance for all physicians, irrespective of specialty, the council had to consider implications of all key stakeholders. They did not want to rush the process.

"This was an important work," says Crigger. "The council wanted to take the time they thought was necessary to come to a consensus themselves."

The AMA's House of Delegates is comprised of 192 organizations, including every state specialty society and medical association. It was important to give them all a say. "This is a process that gave grassroots physicians a chance to voice their opinion," Kao says. "We needed to make sure everybody had an opportunity to offer their opinion."

Physicians from every geographic area, practice setting, and specialty weighed in. "We got a rich array of feedback," says Crigger. "I am confident we heard from every perspective out there."

For some physicians, being asked to give feedback on the code presented them with an opportunity to study it closely for the first time. "This offered a forum for them to understand what really is

in the code," says Kao. "That was an unexpected silver lining of this process."

Some delegates suggested the work be done chapter by chapter, covering one subject area at a time, such as genetics or end-of-life care. The council disagreed, arguing that the approach needed to be comprehensive. "There's no one chapter that will cover everything you need in a given situation," Crigger says. "They all intertwine in interesting ways."

Conservative Approach

The council very deliberately reflected on whether they believed the code had intended guidance to be obligatory, ethically permissible, and open to some form of physician discussion or and discretion, or absolutely prohibited.

"To capture all of those meanings, we very consistently used the modal verbs 'must,' 'should,' and 'may,'" says Crigger. A preface was added to the code, explaining how these terms should be interpreted.

From the start, the council made a conscious decision to take a very conservative approach. Changes to the guidance were made very sparingly, and focused mainly on updating "egregiously outdated scientific terminology," says Crigger. "This is the consensus that has emerged from the council and the House after 50 years. It is not something to be overturned lightly."

The following are some changes that were made:

• Opinions were consolidated.

"For example, we ended up consolidating six separate opinions on fees for medical services into a single coherent opinion," says Crigger.

• Elements were identified that were considered obsolete, inappropriately stated, or unclear.

• Consistent terminology is used.

Some sections of the code referred to "proxies," while other sections used the terms "surrogates" or "authorized decision-makers."

Containing the range of plausible interpretations was one of the council's concerns. "We use similar terminology, so we are talking about confidentiality in the same way everywhere it occurs," says Crigger.

• Where an opinion didn't already include a brief opening paragraph highlighting the ethical principles involved, one was added.

"Before, there was a presumption that 'everybody knows what the underlying values are, so let's just give the guidance,'" says Crigger. The code now spells out the ethical foundation for the opinion that follows.

• For the most part, the council tried to avoid using terms of art that could become outdated, or be subject to evolving interpretation.

The council proposed at one point to introduce the term "right to an open future" in guidance on decision-making involving pediatric patients, for instance.

"A couple of members of the House of Delegates said, 'What the heck does that mean?' says Crigger. The language was revised to set out the concept that decisions not be made in such a way that you foreclose the pediatric patient's own opportunity to make that decision at a later date, when he or she has the capacity to do so.

"Except for terms of art that have been in the literature for decades and will be very familiar to readers, the council decided that if you can say it more clearly in one or two sentences, it was preferable to use the plain prose," says Crigger.

Use the Code

The ultimate goal is for every physician to understand what is in the code, and what is expected of them, ethically speaking. "Some, but not all, medical schools and residency training programs use the code when teaching future generations of physicians," notes Kao. "The new format will serve that 'textbook' purpose better in the past."

It's equally important for practicing physicians to utilize the code. "We need to develop professional educational modules based on various opinions in the code, so physicians use it as part of their lifelong learning," says Kao.

Crigger notes that the code has traditionally been viewed as "rules for acting," with clinicians consulting it to determine what should be done, or not done.

"We wanted to make it clear that the code is a resource for thinking through situations a physician may encounter," says Crigger. In some cases, physicians might even disagree with the guidance that the code gives because they come up with compelling reasons to do things differently.

"In that sense, I can see it being as much a tool for ethics consultants who are not physicians, as for physicians themselves," says Crigger. ■

SOURCE

• BJ Crigger, PhD, Director, Ethics Policy, Secretary, Council on Ethical and Judicial Affairs, American Medical Association, Chicago. Phone: (312) 464-5223. Fax: (312) 224-6911. Email: bette.crigger@ama-assn.org.

Surprising Data on Hospice in Nursing Homes: It Doesn't Increase Care Costs

Recent research debunks the myth that providing hospice services in the nursing home setting increases healthcare costs. In fact, use of hospice services does not increase care costs in the last six months of life for nursing home residents, found a study of 2,510 long-stay nursing home decedents, a third of whom received hospice services.[1]

The study's finding suggests that costs are offset by the avoidance of costly hospitalization and subsequent post-acute care in the nursing home.

"The findings add to a growing body of research demonstrating the value of hospice care in providing both high-quality care and cost savings," says **David A. Fleming**, MD, MA, MACP, director of University of Missouri's Center for Health Ethics in Columbia.

A 2013 study linked hospice care to a reduction in hospital admissions and days, ICU admissions and days, 30-day hospital readmissions, and in-hospital deaths.[2] Earlier research found that hospice reduced Medicare expenditures by an average of $2,309 per hospice user.[3]

Niharika Ganta, MD, MPH, assistant professor of clinical medicine at the hospital of the University of Pennsylvania Palliative Care Service in Philadelphia, says, "When hospice services are not offered, both patients and families are missing an opportunity to get valuable support during an often difficult and trying time."

Delayed Referrals

Various factors prevent or delay referral to hospice. "Psychologically, death remains an avoidable reality for physicians and patients alike," says Fleming. "With the amazing technologies and treatment options now available, hope for cure remains strong."

Starting the conversation can often be difficult. Also, patients, families, and healthcare professionals are often unclear about eligibility for hospice care and the benefits it offers.

"Enrollment policies may restrict access to hospice," says Fleming. Some patients are not eligible for hospice because they are receiving chemotherapy or blood transfusions.

Cultural and ethnic barriers, ranging from language differences to religious beliefs, can prevent substantive and effective communication about end-of-life issues. "For some historically underserved populations, there is often mistrust of the healthcare system," adds Fleming. "There may be resistance to any suggestion of limiting what is felt to be potentially curative treatment, regardless of its futility."

Ganta was surprised that only about a third of nursing home residents in the study received hospice care. "I would imagine that a larger portion of residents would qualify for hospice services," she says.

In Ganta's experience, the most common reason patients and families do not access hospice services is because they are not aware of the services provided. Many worry about extra out-of-pocket costs associated with more services.

Many people, including providers, feel nursing homes can adequately address and care for patients at end of life. "On the contrary, end-of-life care is a specialized field that requires a trained multidisciplinary team approach to provide holistic care for the patient," says Ganta. "Nursing homes are not equipped to deliver such care."

Fleming says the following things are needed:

- development of clear, rational, and equitable enrollment policies,
- effective education materials for patients and families,
- outreach guides for ethnic groups and underserved populations, and
- enhanced education and training curricula for healthcare professionals.

Clinical ethics consultants typically have specialized training and experience, making them well-positioned to mediate responses to the conflicts or concerns that often arise near the end of life, says Fleming.

"They offer important insights and guidance in decisions about

EXECUTIVE SUMMARY

Providing hospice services in the last six months of life for nursing home residents does not increase costs, found a recent study. Some factors that can prevent or delay referrals include the following:

- Starting the conversation is often difficult for providers.
- There is often lack of clarity as to eligibility for hospice care.
- Some enrollment policies restrict access to hospice.

hospice and end-of-life care, as well as in the development of policies and educational materials for patients, their families, and the healthcare team," Fleming adds.

Not Fully Informed

If eligible patients are not offered hospice, whether intentionally or unintentionally, then by definition they are not being fully informed about the full complement of evidence-based options available to them, says Fleming.

"Withholding such information thwarts the notion of shared trust in decision-making," says Fleming. This can result in decisions that are not fully informed, that are potentially coercive, and that disrespect the patient's dignity and autonomy.

"To not offer comfort and care through hospice services and other means, while continuing aggressive and medically futile treatment when the patient is overmastered by their disease, is both unethical and unprofessional, knowing the harm to patients that may be inflicted," says Fleming.

Support services offered by hospice range from support for spiritual distress to assistance with getting financial affairs in order. When hospice is not involved, "families are not able to easily access grief and bereavement counselors," says Ganta. "Providers may feel burdened that they are not able to fully support patients at the end of life."

Rosemarie Tong, PhD, emeritus professor of healthcare ethics at the University of North Carolina at Charlotte, says it's important for patients to be aware that they have the option of comfort treatment only.

"The part of informed consent that currently speaks to patients' 'right' to select no aggressive treatment is to be rephrased as a 'right' to select palliative care only," she says.

Tong says hospice is not so much about dying as it is about living one's life in the fullest way possible for whatever time one has left. "Not providing people information about hospice care deprives them of the time they need to repair human relationships," says Tong. "It also deprives people of a meaningful opportunity to make sense of their life in view of death." ■

REFERENCES

1. Unroe KT, Sachs GA, Dennis ME, et al. Effect of hospice use on costs of care for long-stay nursing home decedents. *J Am Geriatr Soc* 2016; 64(4):723-730.
2. Kelley AS, Deb P, Du Q, et al. Hospice enrollment saves money for Medicare and improves care quality across a number of different lengths-of-stay. *Health Aff* 2013; 32(3):552–561.
3. Taylor DH, Ostermann J, Van Houtven CH, et al. What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program? *Soc Sci Med* 2007; 65(7):1466-1478.

SOURCES

- **David A. Fleming**, MD, MA, MACP, Director, Center for Health Ethics, School of Medicine, University of Missouri, Columbia. Phone: (573) 884-2013. Fax: (573) 884-1996. Email: flemingd@health.missouri.edu.
- **Niharika Ganta**, MD, MPH, Assistant Professor of Clinical Medicine, Palliative Care Service, Hospital at the University of Pennsylvania, Philadelphia. Phone: (215) 478-2250. Email: Niharika.Ganta@uphs.upenn.edu.
- **Rosemarie Tong**, PhD, Emeritus Professor of Healthcare Ethics, University of North Carolina at Charlotte. Phone: (704) 687-2850. Email: rotong@uncc.edu.

Increase in Industry-Funded Trials Raises Concerns

More clinical trials are being funded by industry, with fewer funded by the National Institutes of Health (NIH), found a recent study. From 2006 to 2014, the number of industry-funded clinical trials increased by 1,965 (43%), while NIH-funded trials decreased by 328 (24%).[1]

"The decline in NIH-funded clinical trials is, without doubt, a result of the decrease in congressional budget allocations for the NIH from 2010 through 2013," says **Ruth Macklin**, PhD, professor in the Department of Epidemiology and Population Health at Albert Einstein College of Medicine in Bronx, NY.

Still, the NIH remains the largest funder of biomedical research in the world. "The pharmaceutical and biotech industries are profit-making entities, and their chief goal is to increase their revenue," says Macklin. The more clinical trials they fund, the greater the opportunity to bring new products to market.

Andrew Childress, PhD, assistant professor at Baylor College of Medicine's Center for Medical Ethics and Health Policy in Houston, agrees that the stagnation of government-sponsored research funding caused

investigators to look elsewhere to fund their labs. "Within the last decade or so, there has been a concomitant rise in the number of academic-industry partnerships," he adds.

The following are some concerns from ethicists involving industry-funded clinical trials:

• The fact that investigators are typically reimbursed by the pharmaceutical industry to conduct these studies creates a potential financial conflict of interest.

Investigators are sometimes paid based on enrollment, or may receive incentives or bonuses related to protocol completion.

"In these cases, investigators would have a financial incentive to keep a participant in the study for as long as possible, even in light of adverse events," explains Childress.

Some investigators also have a financial interest in the company. "While conflicts of interest are not inherently problematic, when they compromise or appear to compromise the scientific integrity of the study, then public trust in research is diminished. Patient safety may also be compromised," says Childress.

When the sponsor is financially vested in the outcome, it calls the objectivity of the science into question, he says. Data manipulation, falsification, and ghostwriting are particular concerns. "Investigators or sponsors may be tempted to resort to these strategies to make the results appear more positive than warranted by the evidence," says Childress.

• Fairness in the allocation of resources is a concern when clinical trials are conducted for pharmaceutical interventions that are profitable, but don't address pressing health concerns.

"This means that resources are not being spent on more pressing public health problems," says Childress.

• There may be a tendency to medicalize aspects of human growth and development that are not necessarily pathological in order to profit from treatments for these maladies.

Childress says industry sponsors are generally less interested in funding research on lifestyle modifications. These require longitudinal studies to show an effect, and resources to monitor outcomes — but likely will not translate into products that a company can sell.

"The profit motive begins to determine the research agenda," says Childress. "This will likely lead to research that benefits only those who can afford the resulting intervention."

Over the past couple of decades, there has been a great increase in the number of industry-sponsored trials in developing countries, notes Macklin.

"This increase has been because it is cheaper and, until recently, there has been inadequate ethical oversight over research conducted in these countries," says Macklin. Ethical questions remain about the process of obtaining informed consent, the qualifications of contract research organizations that implement industry-funded trials, and the quality of ethical review by local institutional review boards (IRBs).

"Possible safeguards include better training for local research ethics committees, and improved scrutiny by the FDA of ethical aspects of clinical trials sponsored by industry," says Macklin.

Childress believes rigorous standards of peer review and reproducibility can weed out bad science. Ultimately, the IRB and the academic institution are responsible for enforcing conflict-of-interest disclosure policies.

"Meta-analyses can point to trends in research that might indicate a skewing of the data toward more positive outcomes for industry vs. government-sponsored trials," suggests Childress. ■

EXECUTIVE SUMMARY

More clinical trials are industry-funded, with fewer funded by the National Institutes of Health, raising concerns about the potential for conflicts of interest. Some safeguards include the following:

- better training for local research ethics committees,
- improved scrutiny by the FDA of ethical aspects of clinical trials sponsored by industry,
- rigorous standards of peer review and reproducibility, and
- meta analyses on trends that might indicate a skewing of the data.

REFERENCE

1. Ehrhardt S, Appel LJ, Meinert CL. Trends in National Institutes of Health funding for clinical trials registered in ClinicalTrials.gov. *JAMA* 2015; 314(23):2566-2567.

SOURCES

• **Andrew Childress**, PhD, Assistant Professor, Center for Medical Ethics and Health Policy, Baylor College of Medicine, Houston. Phone: (713) 798-8164. Email: Andrew.Childress@bcm.edu.

• **Ruth Macklin**, PhD, Professor, Department of Epidemiology & Population Health, Albert Einstein College of Medicine, Bronx, NY. Phone: (718) 430-3574. Fax: (718) 430-3076. Email: ruth.macklin@einstein.yu.edu.

Study: Most Physicians Reported for Sexual Misconduct Aren't Disciplined by Medical Boards

Most physicians reported by hospitals, medical societies, and malpractice insurers to the National Practitioner Data Bank (NPDB) for sexual misconduct have never been disciplined by their state medical board for that behavior, a recent study found.[1]

Some key findings of the study, which looked at physicians reported to the NPDB for all causes from 2003 to 2013, include the following:

• During the study's time frame, 1,039 physicians, or roughly 1% of all physicians, had at least one NPDB report of sexual misconduct.

• Of this group, 76% were reported by a state medical board because they either had a disciplinary action occurring at their hospital or because they were sued.

• The remaining 253 physicians were reported for either clinical privileges sanctions or malpractice payments related to sexual misconduct — but only 30% of them had a medical board license action in their file.

"As is true in the general population regarding the reporting of sexual misconduct, such behavior by physicians is significantly underreported to state medical boards," says **Paul Hofmann**, DrPH, FACHE, president of Hofmann Healthcare Group, a Moraga, CA-based consulting firm specializing in healthcare ethics, and a former hospital CEO.

Hofmann says the ethical issue is far greater than simply the failure of state medical boards to discipline physicians for sexual misconduct. "Most often, these victims are staff members and patients, who are particularly vulnerable because they are reluctant to report inappropriate behavior, knowing the uneven power relationship puts them at a severe disadvantage," he explains.

Julie M. Aultman, PhD, director of the Bioethics Graduate Program at Northeast Ohio Medical University in Rootstown, sees the following ethical concerns when a state medical board fails to take appropriate actions and impose necessary sanctions consistent with the severity of the misconduct:

• The state medical board fails in its duties to prevent unnecessary harms and ultimately protect the public.

This includes current and future patients, healthcare professional colleagues, students, and others who are in contact with the physician. "Unfortunately, these incidents, as well as sexual boundary violations with patients, do occur and continue to go either unreported or, if reported, improperly and inconsistently investigated," says Aultman.

• State medical boards that fail to investigate reports of sexual misconduct or fail to appropriately discipline physicians perpetuate the injustice that has occurred.

• By failing to discipline physicians when there is clear and convincing evidence that sexual impropriety or a violation has occurred, the state medical board's integrity and the overall integrity of medicine is compromised.

Once the board receives a complaint, it needs to determine how much time and resources to allocate to investigating it. "Just because a complaint is brought doesn't mean it's true. The doctor is entitled to due process," says **John D. Banja**, PhD, a medical ethicist at the Center for Ethics at Emory University in Atlanta.

It can take months, and tens of thousands of dollars, to perform a proper investigation and ultimately make a determination. The facts of such cases vary widely, with complaints ranging from off-color jokes being made to sexual assault. "The devil is in the details, and every case is different," says Banja.

There have been notorious, well-publicized cases of multiple women reporting being sexually assaulted by a doctor who is still practicing medicine. "Those are the kind of cases that really make our blood boil when we come across them," says Banja. "So you look at the board and say, 'How could you have allowed this physician to continue to practice?'"

One question is whether there is enough evidence to revoke or suspend the physician's medical license, or

EXECUTIVE SUMMARY

Most physicians reported by hospitals, medical societies, and malpractice insurers to the National Practitioner Data Bank for sexual misconduct have never been disciplined by their state medical board for that behavior, a recent study found. Ethical concerns from experts include the following:

• The state medical board is failing to protect the public.

• Lack of disciplinary action perpetuates the injustice that has occurred.

• The overall integrity of medicine is compromised.

limit the physician's privileges. Only 11 states require state medical boards to report cases of sexual misconduct.

"Where there is good evidence that there is a sexual predator, I think they should all be required to do that," says Banja. Even if the victim doesn't want to press charges, the police now have a record of the incident. Depending on the evidence, they may choose to set up a sting operation with a female police officer impersonating a patient.

"The point is we need expert strategies to either help these doctors change their behaviors, or else, to sanction their licenses in ways that stop them from preying on patients," says Banja.

Hofmann says that hospitals are implicitly condoning the behavior if they have not done the following:

- developed and implemented a comprehensive code of conduct and a policy pertaining to sexual harassment,
- educated physicians, employees, and volunteers about their content,
- monitored compliance through informal and formal assessments,
- addressed incidents of noncompliance quickly and effectively,
- prohibited retribution against anyone who has observed and reported, or been compromised by, sexual harassment or other forms of sexual misconduct, and
- reviewed these documents on a regular basis and revised them when necessary.

"It is ethically imperative that board, senior management, and medical staff leaders must, by their own behavior and actions, demonstrate zero tolerance for unacceptable sexual statements and behavior by anyone, regardless of organizational status and influence," says Hofmann. The importance of discouraging all forms of sexual misconduct should be emphasized by including this issue in the medical staff bylaws or the medical staff rules and regulations.

"Bioethicists should be outspoken, persuasive advocates to ensure hospital staff and patients are in a safe environment," says Hofmann.

Aultman has served in the capacity as an educator for those professionals who have crossed or violated sexual and nonsexual boundaries, and whose medical licenses have been suspended through the state medical board.

> "MAYBE THE VALUE OF THE BIOETHICIST IS TO REMIND THE HOSPITAL OF ITS NEED TO BE MORALLY COURAGEOUS IN THE FACE OF THESE INCIDENTS."

"Unfortunately, oftentimes such reports at the institutional level are not thoroughly investigated, or are simply dismissed by authority figures and administration," says Aultman. She sees a role for bioethicists as consultants for the general counsel at healthcare institutions.

"However, bioethicists who tackle these types of issues should be well-educated in both the ethical and legal issues surrounding sexual misconduct," says Aultman. To improve this situation at the institutional level, she says, bioethicists should educate healthcare professionals and empower professionals to report.

Banja sees an ethical issue in the fact that most complaints come from patients and family members. Few come from healthcare providers or hospitals, who likely fear retaliation or bad publicity.

"I suspect that a lot of hospitals are guilty of too much leniency, and too willing to give physicians the benefit of the doubt even when the evidence is persuasive," Banja says. He adds that hospitals need to have risk managers, legal, and mental health experts involved when addressing such cases. While bioethicists probably lack this expertise, they serve an important role as the "conscience of the hospital," says Banja.

"Maybe the value of the bioethicist is to remind the hospital of its need to be morally courageous in the face of these incidents," says Banja. "We are in the business of protecting all the patients who come in through our doors." ■

REFERENCE

1. AbuDagga A, Wolfe SM, Carome M, et al. Cross-sectional analysis of the 1039 U.S. physicians reported to the National Practitioner Data Bank for sexual misconduct, 2003–2013. *PLoS ONE* 2016; 11(2): e0147800.

SOURCES

- **Julie M. Aultman,** PhD, Director, Bioethics Graduate Program, Northeast Ohio Medical University, Rootstown. Phone: (330) 325-6113. Fax: (330) 325-5911. Email: jmaultma@neomed.edu.
- **John D. Banja,** PhD, Center for Ethics, Emory University, Atlanta. Phone: (404) 712-4804. Fax: (404) 727-7399. Email: jbanja@emory.edu.
- **Paul B. Hofmann**, DrPH, FACHE, President, Hofmann Healthcare Group, Moraga, CA. Phone: (925) 247-9700. Email: hofmann@hofmannhealth.com.

Ethical Concerns if Patients are Abusive to Providers

Healthcare providers in the hospital setting are encountering increasing incidents of rude — and sometimes violent — patients and family.

"Hospitals are struggling with really demanding — even threatening — patients. We get people coming in saying, 'You will do it. I'm a taxpayer and you work for me,'" says **Richard C. Boothman**, JD, executive director of clinical safety and chief risk officer at University of Michigan Health System in Ann Arbor.

The breakdown of paternalism and rise in patient autonomy is one contributing factor. "The old deference to doctors is breaking down, maybe for good reasons. But there is now a breakdown of respect," says Boothman. "The incidence of threats is skyrocketing, and it's truly disturbing."

The problem is worst in the ED, due in part to escalating tensions amid crowding and lengthy waits. "We have preached to the general public that they need to be advocates for their own care," says Boothman. "Sometimes we have 20 patients waiting for a bed — all of them thinking they need to advocate for themselves." Some people do so in an inappropriate manner, with raised voices and threatening tones, he says.

"Now layer onto that a culture that is steadily getting more insistent, more violent, and less deferential to physicians," says Boothman. The hospital recently held a grand rounds for the obstetrics/gynecology department on how clinicians can teach patients what their expectations are for their behavior.

At Springfield-based PeaceHealth Oregon, an Action Response Team (ART) was created in response to increasing concerns about patients who appear capable of violence. "The frequency is pretty surprising. We have at least one case a week," says **John Holmes**, PhD, director of mission and ethics.

Clinicians call ART meetings, which include risk management, ethics, spiritual care, and nursing, if they have concerns about their safety for any reason. Common examples are verbally abusive patients with a documented history of violence, or patients who angrily demand a particular narcotic.

"Providers are under a lot of pressure to cut back on prescribing narcotics," explains Holmes. "If a patient doesn't get the answer they want, sometimes they decide to take matters in their own hands."

Complex family dynamics sometimes escalate out of control. "People have different ideas about what's best for the patient, and who should and shouldn't be there when decisions have to be made," says Holmes.

The team then comes up with a plan for that particular patient. "Security is involved, if necessary," says Holmes. "Sometimes it's just a matter of coming up with calming techniques to communicate with the patient."

Address Root Cause

Autumn Fiester, PhD, executive director of the Penn Program for Clinical Conflict Management, says the key to managing verbally abusive patients or families is to "find the root cause and work to address it." Fiester is director of education and faculty in the Department of Medical Ethics & Health Policy at Perelman School of Medicine at the University of Pennsylvania in Philadelphia.

"Verbal abuse and other types of challenging behavior should be seen as symptoms of a problem, not viewed as a problem in itself," says Fiester. She says providers need the following two things:

- a robust skill set in conflict resolution, and
- dedicated personnel in the institution who can be brought in to help navigate situations that have turned into heated conflicts.

Philip M. Rosoff, MD, MA, professor of pediatrics and medicine at Duke University's Trent Center for Bioethics, Humanities & History of Medicine in Durham, NC, says this is a complex issue that touches on many different aspects of medical care, in both the inpatient and outpatient arenas.

"Disruptive patients and families can be barred from the premises if their presence and behavior is believed to be threatening, or is otherwise disruptive," says Rosoff. In his experience, hospital administrators sometimes go too far in their tolerance for bad behavior. "They give too much leeway, frequently in the name of good 'customer relations,'" says Rosoff.

There can sometimes be a tension between the well-founded desire for hospitals to be welcoming places to patients and their families, and tolerating behavior that could prove to be threatening and dangerous.

"The most appropriate way to approach this challenge is to attempt to negotiate and compromise to

accommodate the large variety of people who come to hospitals, but not lose sight of our duty to maintain a safe environment for all," says Rosoff.

Clinical ethicists trained in conflict mediation can play crucial roles in addressing these issues, says Rosoff, "both in the moment and from an organizational perspective."

Blair Henry, BSc, MTS, a senior ethicist at Sunnybrook Health Sciences Centre and assistant professor at the University of Toronto, Ontario, points to increasing incidents of healthcare providers being injured by violent patients. "The ethical quandary is a conflict between a duty to care vs. self-protection," he says.

He recommends the following approaches:

• ensure that policies address preventive strategies such as de-escalation and other violent behavior management techniques,

• ensure signage is visible in common areas and treatment rooms outlining the need for respectful engagement between a patient and the staff, and

• ensure that the causes of violent behaviors are considered.

"A policy needs to be careful about labelling people vs. behaviors," says Henry. Underlying causes of violence may be related to alcohol or drugs, diseases, or mental health disorders.

"We need to balance the rights of a staff person to a safe work environment against the rights of the individual exhibiting the behaviors to receive care," says Henry. ■

SOURCES

• **Richard C. Boothman,** Executive Director of Clinical Safety/Chief Risk Officer, University of Michigan Health System, Ann Arbor. Phone: (734) 764-4188 ext. 44188. Email: boothman@med.umich.edu.

• **Autumn Fiester,** PhD, Director, Penn Clinical Ethics Mediation Program/ Faculty, Department of Medical Ethics & Health Policy, Perelman School of Medicine at the University of Pennsylvania, Philadelphia. Phone: (215) 573-2602. Email: fiester@mail.med.upenn.edu.

• **Blair Henry,** BSc, MTS, Senior Ethicist, Sunnybrook Health Sciences Centre, Assistant Professor, Department of Family and Community Medicine, University of Toronto, Ontario, Canada. Phone: (416) 480-6100 ext. 7178. Email: Blair.henry@sunnybrook.ca.

• **Philip M. Rosoff**, MD, MA, Professor of Pediatrics & Medicine, Trent Center for Bioethics, Humanities & History of Medicine, Duke University, Durham, NC. Phone: (919) 668-9025. Fax: (919) 668-1789. Email: philip.rosoff@dm.duke.edu.

Only Half of Veterans with Advanced Cancer Receive Palliative Care, Says Study

Patients with advanced cancer should receive palliative care soon after diagnosis, according to the American Society of Clinical Oncology — but a recent study shows this is true for only half of veterans.[1]

Researchers analyzed care received by all veterans over 65 with cancer who died in 2012. Of these 11,896 individuals, 52% received palliative care. Of this group, many received it late in the disease's progression instead of immediately after diagnosis.

The study found that 71% of patients received hospice care. However, Veterans Administration (VA) patients were less likely to receive hospice care for the minimum recommended three days compared with those in Medicare or in other contracted care paid for by VA. VA patients also first received hospice care a median of 14 days before death, compared with patients in VA-contracted care, who entered hospice a median of 28 days before death.

Sally Welsh, MSN, RN, NEA-BC, chief executive officer of the Pittsburgh-based Hospice and Palliative Nurses Association, says three primary components of palliative are the following:

• to provide "person-centered" care that is based on the values and beliefs of the individual,

• to utilize expert communication skills, especially related to advance care planning and goals of care, and

• to promote comfort through the provision of expert pain and symptom management.

"The ethical principles of autonomy, beneficence, nonmaleficence, and veracity are all key ethical principles embedded in the provision of quality palliative care," says Welsh.[2]

Welsh says ethicists can advocate for early palliative care by championing the integration of advance care planning and goals of care discussions for all patients.

"Ethicists can help promote care discussions that include the benefits and burdens of care and which encompass the values and beliefs of the patient," says Welsh. ■

REFERENCES

1. Gidwani R, Joyce N, Kinosian B, et al. Gap between recommendations and practice of palliative care and hospice in cancer patients. *Journal of Palliative Medicine* 2016. Online ahead of print. doi:10.1089/jpm.2015.0514.
2. Coyle, Nessa and Ferrell, Betty R. HPNA Palliative Nursing Manuals: Legal and Ethical Aspects of Care. Ed. Oxford University Press, New York. (2016).

SOURCE

- **Sally Welsh,** MSN, RN, NEA-BC, Chief Executive Officer, Hospice and Palliative Nurses Association, Pittsburgh. Phone: (412) 787-9301. Fax: (412) 787-9305. Email: SallyW@hpna.org.

Ethics of Televised Prescription Drug Ads

There is widespread public support for removing televised prescription drug ads, says a 2016 telephone survey of 1,006 U.S. adults.[1]

In November 2015, the American Medical Association (AMA) called for a ban on direct-to-consumer advertising of prescription drugs and medical devices, including television advertisements.[2] According to the AMA, member physicians are concerned that a growing proliferation of ads is driving demand for expensive treatments, despite the clinical effectiveness of less costly alternatives.

'Paltry and Potentially Misleading'

A sea change in medicine emphasizes shared decision-making, notes **Adrienne Faerber**, PhD, instructor at The Dartmouth Institute for Health Policy & Clinical Practice in Hanover, NH.

"The old argument that drugs are complicated — and that patients can't understand them and must rely on the advice of their doctors — doesn't work in this new environment," she says.

Patients clearly want information about the drugs they're taking, she says. While some consumers are using other sources of high-quality drug information, many get their information solely from televised ads. "Advertising is, unfortunately, a common way that patients are connecting with the brands of drugs they're taking," says Faerber.

For the small number of viewers who might actually need the drug, the information in the advertisement is "paltry and potentially misleading," she says. "Unfortunately, I don't expect prescription drug ads to leave television any time soon."

Previous research has shown that shown that drug advertising poorly informs patients, and uses sophisticated techniques to persuade patients to take drugs they may not need.[2]

Faerber expects consumers to become increasingly dissatisfied with drug advertising. "My hope is there will be increasing skepticism about the advertised claims and resources where consumers can fact-check drug ads," she says. ■

REFERENCES

1. Harvard T.H. Chan School of Public Health. Americans' attitudes about changing current prescription drug & medical device regulation citation.May 2016. http://bit.ly/1TVZyOL.
2. American Medical Association. AMA Calls for Ban on Direct to Consumer Advertising of Prescription Drugs and Medical Devices. November 17, 2015, http://bit.ly/1MT7KZJ.
3. Faerber AE, Kreling DH. Content analysis of false and misleading claims in television advertising for prescription and nonprescription drugs. *J Gen Intern Med 2014*; 29(1):110–118.

SOURCE

- Adrienne Faerber, PhD, Instructor, The Dartmouth Institute, Hanover, NH. Email: adrienne.e.faerber@dartmouth.edu.

COMING IN FUTURE MONTHS

- Ethics of meeting hospitalized patients' spiritual needs
- How to utilize peer-based healthcare ethics education
- Underlying causes of spike in research misconduct cases
- Ethical challenges of caring for children with autism

MEDICAL ETHICS ADVISOR®

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log on to AHCMedia.com, then select "MyAHC" to take a post-test.
3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, a credit letter will be emailed to you instantly.
5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CME/CE QUESTIONS

1. Which is true regarding hospice services and nursing homes, according to a recent study?

A. The majority of nursing home patients received hospice care in their last six months of life.
B. Providing hospice services in the last six months of life for nursing home residents does not increase costs.
C. Hospice use increased 30-day hospital readmissions from nursing homes.
D. In-hospital deaths usually increased if hospice was provided in the nursing home setting.

2. Which is true regarding industry-funded clinical trials, according to Ruth Macklin, PhD?

A. Industry sponsors are generally more interested in funding research on lifestyle modifications, which require longitudinal studies to show an effect.
B. The potential for financial conflict of interest has in large part been eliminated, since investigators are no longer reimbursed by the pharmaceutical industry.
C. Improved scrutiny by the FDA of the ethics involving such trials is needed.
D. It is permissible for investigators to be paid based on enrollment, and to receive incentives related to protocol completion.

3. Which is true regarding physicians reported for sexual misconduct, according to recent research?

A. State medical boards fail to discipline most physicians reported for sexual misconduct.
B. State medical boards are disciplining physicians without thorough investigations.
C. State medical boards are seeing a growing trend of physicians reporting colleagues for unsubstantiated sexual misconduct.
D. The majority of complaints come from colleagues or hospital administrators, as opposed to patients.

4. Which of the following did a recent study find regarding veterans with advanced cancer?

A. Of veterans with advanced cancer who received palliative care, most received it soon after diagnosis.
B. VA patients were more likely to receive hospice care for the minimum recommended three days, compared to Medicare patients.
C. Veterans received hospice care earlier in their end-of-life care than those in VA-contracted care.
D. Only half of veterans received palliative care.