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## Advance Care Planning Often 'Useless': Providers Can't Always Access in EHRs

*Clinicians can't always find patients' documented wishes*

**W**ith electronic health records (EHRs), patients' advance care planning (ACP) should be only a mouse click away. Too often, this isn't reality.

"Until the EHR, advance directives have been readily lost pieces of paper that have not accompanied patients across settings," says **Daniel P. Sulmasy, MD, PhD, MACP**, André Hellegers professor of biomedical ethics at Georgetown University's Edmund D. Pellegrino Center for Clinical Bioethics in Washington, DC.

Many clinicians can recall instances when a patient's advance directive was

left at home or at a skilled nursing facility, and wasn't available when it was needed in the hospital setting. It was hoped that EHRs would solve

this problem, but, unfortunately, most systems are not set up with advance directives in mind.

"They are often tucked away in an unorganized mass of scanned documents under a 'miscellaneous' tab, or are never scanned in the first place," says Sulmasy.

Physicians report problems with interoperability between outpatient and inpatient EHR

systems, found a recent study.<sup>1</sup> There also is a lack of consensus about who

**ADVANCE DIRECTIVES "ARE OFTEN TUCKED AWAY IN AN UNORGANIZED MASS OF SCANNED DOCUMENTS UNDER A 'MISCELLANEOUS' TAB, OR ARE NEVER SCANNED IN THE FIRST PLACE."**



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**EDITORIAL QUESTIONS**

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should document advance care planning.

“We knew from prior research that health systems face challenges documenting advance care planning in the EHR,” says **Ellis Dillon**, PhD, the study’s lead author. Dillon is a research sociologist at Sutter Health-Palo Alto Medical Foundation Research Institute in Mountain View, CA.

The study focused on documentation of advance healthcare directives (AHCD) and Physician Orders for Life-Sustaining Treatment (POLST). “We wanted to better understand what providers think about ACP documentation in the EHR,” says Dillon.

Researchers examined data on seriously ill patients 65 years or older with no pre-existing ACP documentation. The patients were seen during 2013 and 2014 by 358 primary care providers and 79 specialists at a large multispecialty group practice. The group also conducted interviews with 13 providers with high and low rates of ACP documentation in primary care, oncology, pulmonology, and cardiology. “We were surprised to see a trend toward primary care providers documenting ACP more than oncologists, pulmonologists, and cardiologists,” Dillon says. Two key

findings of the study are as follows:

- Of the 79 specialists, 11.4% documented at least one AHCD and 8.9% documented at least one POLST.
- Of 358 primary care physicians (PCPs), 70.9% documented at least one AHCD and 37.7% documented at least one POLST.

“Interviewed primary care physicians often believed ACP documentation was beneficial and accessible, while specialists more often did not,” notes Dillon.

Specialists reported more confusion about how to document in the outpatient system. Some expressed concerns that ACP documented in the outpatient EHR would be inaccessible in the inpatient system when it was needed. In contrast, PCPs reported having standard clinic workflows in place for ACP documentation.

“Ethically, in order for patients to have the opportunity to guide their future care, they must be given the opportunity to participate in ACP conversations with physicians in the outpatient setting — before a crisis occurs,” says Dillon. There was a lack of consensus about who should document ACP.

“Our research indicates that ACP is often not documented in accessible areas of the EHR,”

## EXECUTIVE SUMMARY

Physicians report problems with interoperability between outpatient and inpatient electronic health record (EHR) systems, found a recent study. Other findings include the following:

- There is a lack of consensus on who should document advance care planning.
- Primary care providers documented advance care planning more than specialists.
- Specialists worry that advance care planning documented in the outpatient EHR will be inaccessible in the inpatient system.

adds Dillon. Problems with interoperability between outpatient and inpatient EHR systems raise an important ethical concern, says Dillon: “It compromises the ability of both outpatient and inpatient care teams to access the most up-to-date information on patient preferences for life-sustaining treatment and other aspects of care.”

## Barrier to Communication

Inefficient EHRs prevent effective communication between patients, care teams, and healthcare systems on end-of-life wishes. “Finding advance care directives and other documentation that pertain to knowing and understanding patient treatment preferences remains a problem,” says **David A. Fleming**, MD, MA, MACP, co-director and scholar at University of Missouri’s Center for Health Ethics in Columbia.

Care teams often are blind to documentation that reflect the patient’s previously expressed preferences. This opens the door to mismatches between the treatment provided and the patient’s wishes.

“New Medicare rules allowing payment for advance care planning

may encourage physicians to be more diligent about such documentation,” says Fleming.

However, EHR systems tend to be difficult to navigate and noninteroperable between healthcare systems. “Even the most well-crafted documentation is often useless, because it is inaccessible at the time needed,” says Fleming.

EHRs still don’t “talk” to each other across care settings. Thus, they have yet to deliver on the promise of making advance directives available wherever the patient goes.

“Medicare payments for advance care planning won’t help this. It is a problem with systems that have not given advance directives the clinical priority they need,” Sulmasy says. Hospital ethicists who identify this problem should work with IT to ensure EHRs facilitate the work of advance care planning, he adds.

Another concern is that increasing the number of quality metrics required for advance care planning will only serve to improve compliance behavior. This could mean that the emphasis will be on meeting regulatory goals, as opposed to patient-centered ones.

“Quality of care does not necessarily improve by increasing the reporting burden for physicians and healthcare systems,” says Fleming.

“In fact, it may achieve just the opposite.” ■

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# Ethical Debate Continues Over Genetically Modified Human Embryos

The first-known experiment to create genetically modified human embryos in the U.S., using a gene-editing tool called CRISPR, has reignited the ethical debate on this type of research.<sup>1</sup>

“Science and technology usually, and often correctly, hate ‘no’ for

an answer. But the modification of human embryos is special and worrisome,” says **Kenneth W. Goodman**, PhD, FACMI, director of University of Miami (FL)’s Institute for Bioethics and Health Policy.

There are unknown and potentially unacceptable risks to

individuals modified in this way, says Goodman. “There are no clear review criteria for separating traits from maladies, or human enhancement from disease prevention.”

Clinical trials on genome editing of the human germline might be ethically permissible, but only for

serious conditions under stringent oversight, concluded a recent report from the National Academies of Sciences, Engineering, and Medicine.<sup>2</sup> Goodman says a “time out” is needed to gain insight into the complex ethical, legal, and social issues at play: “That is not a ‘no.’ It’s a plea for caution.”

**Charis Eng**, MD, PhD, FACP, chair of the Genomic Medicine Institute and director of the Center for Personalized Genetic Healthcare at Cleveland (OH) Clinic, says, “CRISPR/CAS9 gene editing has captured the imagination of clinicians and the public alike, for its promise in editing gene mutations that cause fatal diseases.” Ethical concerns center on off-target effects, which can introduce mutations in other genes, and the potential of using gene editing for trivial reasons, such as good looks.

“A recent paper from a multinational collaboration might address the early generation CRISPR/CAS9 off-targeting effects,” says Eng.<sup>3</sup> In this paper, the investigators were able to show minimal to trivial off-target effects by introducing the enzyme and guide RNA at the gamete stage. “I suspect that as this technology, and even next generation CRISPR/CAS9, is developed, the off-target effects will become nonexistent,” says Eng.

Eng sees a parallel with the way in

vitro fertilization (IVF) was initially viewed as shocking and controversial, but now is commonplace.

“When they announced the first IVF baby born, cries of ethics, ‘test tube baby,’ and ‘designer babies’ were heard around the world,” says Eng.

**“SHOULD SAFETY BE SHOWN, AND INVESTIGATORS AND CLINICIANS DEMONSTRATE THAT THEY FOLLOW AGREED-UPON ETHICAL GUIDELINES, THEN ONE DAY SUCH GENE EDITING COULD BECOME STANDARD OF CARE.”**

Over time, IVF was shown to be safe, successful, and performed within accepted guidelines. “The accusatory cries died down quickly, and an obstetrical standard of care was born,” says Eng.

As more research is conducted, concerns about clinical trials for gene editing for devastating diseases

may be similarly alleviated. “When a disruptive new technology emerges in clinical care, skepticism and controversy often greet it,” says Eng.

The U.S. has currently barred clinical usage or clinical trials for CRISPR/CAS9 editing of embryos.

“Should safety be shown, and investigators and clinicians demonstrate that they follow agreed-upon ethical guidelines, then one day such gene editing could become standard of care,” says Eng.

Eng says the technology should be thought of for somatic, not just germline, gene editing. “Imagine being able to take out malignant stem cells and editing the driver somatic mutations to the normal gene sequence,” she says. “We might be curing cancer without any chemotherapy or targeted therapy.” ■

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## EXECUTIVE SUMMARY

The first-known experiment creating genetically modified human embryos in the U.S. using a gene-editing tool called CRISPR reignited ethical debate on this type of research. Some ethicists voice concerns about the following:

- unknown and potentially unacceptable risks to individuals modified in this way;
- off-target effects, which can introduce mutations in other genes;
- the potential to use gene editing for trivial reasons.

# Study: Surrogates Sometimes Place Own Wishes Over Patient's

*Some misunderstand their decision-making role*

Surrogate decision-makers are valuing what they think is best for the patient more than they value patient preferences in the process of making medical decisions for them, found a recent study.<sup>1</sup>

"This was the opposite of what we expected to find. It controverts the currently accepted ethical standard of surrogate decision-making," says **Rohit Devnani**, MD, the study's lead author. Devnani is a physician in the department of pulmonary and critical care medicine at Community Health Network in Indianapolis.

As a resident, Devnani became interested in the ethics of surrogate decision-making. The current ethical norm is based on the principle of "substituted judgment" — making decisions that reflect what patients would have decided.

"I wondered if surrogate decision-makers are making decisions according to substituted judgment, or if there are other driving forces that play a more prominent role in their decision-making," says Devnani.

The discrepancy between ethical theory and reality raised another ethical question. "It provides an opportunity to examine whether

our current ethical standard of surrogate decision-making may be revised to incorporate making decisions according to the best interest principle over substituted judgment in a way that is ethically permissible," says Devnani.

**"THE SURROGATES ARE RELUCTANT OR UNWILLING TO 'LET GO' AND ALLOW THE PATIENT TO HAVE A NATURAL DEATH DUE TO INJURY OR DISEASE."**

Surrogates don't necessarily consciously intend to impose their preferences on the patient. "The principal reason is surrogates simply assume their wishes are the same as the patient's," 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.

## Reluctant to 'Let Go'

However, some surrogates clearly want to trump the patient's preferences. This typically occurs when the patient wants treatment withheld or withdrawn. "The surrogates are reluctant or unwilling to 'let go' and allow the patient to have a natural death due to injury or disease," says Hofmann. Self-serving intentions, though rarer, sometimes come into play. "Unfortunately, on some occasions, the surrogates could have a financial incentive to delay a patient's death," notes Hofmann. He says the following four questions should be raised:

1. Does the patient still have decision-making capacity, and, if so, what is his or her preference?
2. In the absence of decision-making capacity, is there a valid advance directive available?
3. If there is a negative response to the first two questions, are there one or more credible surrogates who can provide a compelling statement regarding what the patient would want based on previous conversations?
4. If the answer to the last question is no, ask the surrogates the following question: "If your mother/father/sister/brother/other relative/friend could wake up and cogently state his or her preference under these circumstances, what would you hear?"

"Too many physicians begin a

## EXECUTIVE SUMMARY

Surrogate decision-makers may value what they think is best for the patient more than they value patient preferences, found a recent study. Some reasons for this include the following:

- Surrogates may need education on their role in decision-making.
- Surrogates may be unwilling to allow the patient a natural death.
- Some surrogates simply assume their wishes are the same as the patient's.

family conference by describing the patient's condition and prognosis, listing the available options and asking for the family or surrogate decision-maker to indicate a preference," says Hofmann. Instead, a physician can first ask what the participants understand about the patient's condition and prognosis.

"We know the continuum of understanding is highly variable from one family to another," says Hofmann. Then, physicians can ask what the patient would choose if he or she could communicate effectively. "It could be continued aggressive therapy, or a shift to pain and symptom management," says Hofmann.

Is the clinical team convinced a surrogate isn't acting in the patient's best interest? **Blair Henry**, BSc, MTS, a senior ethicist at Sunnybrook Health Sciences Centre and assistant professor at the University of Toronto in Ontario, says it is important to assess the following:

- **Why the clinical team disagrees with the surrogate.**

"Are we evaluating the quality of choice they are making, or the process they are using to base the choice on?" asks Henry.

- **Collateral information and other sources.**

"If the patient has been followed by a specialist affiliated with your center, be sure to have them involved in the goals of care conversation," says Henry. For instance, an oncologist can be invited to a meeting in the ICU if aggressive therapy is being discussed. He or she may be able to share comments made by the patient in the past that could be helpful in the current context.

- **Unspoken factors that might be at play.**

For example, some surrogates push for aggressive care because they don't want to be responsible for the patient's death.

- **What the surrogate understands about their role.**

Surrogates may have no idea as to the rules they need to follow as a decision-maker. "When left to their own devices, surrogates tend to focus on what they perceive to be in the

patient's well-being, and not the patient's preference," says Henry. ■

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# Patients More Likely to Choose Do Not Resuscitate After Educational Video

*Many receive information on CPR from TV shows*

**H**ospitalized patients who watched a video about code status choices were less likely to choose full code, and more likely to choose do not resuscitate (DNR) or do not intubate, found a study of 119 patients hospitalized on the general medicine service at Minneapolis Veterans Affairs Health Care System in Minnesota.<sup>1</sup>

"We were not surprised that fewer patients chose CPR and intubation

after being presented with the facts about the likelihood of survival after these interventions," says **Aimee Merino**, MD, the study's lead author. Merino is a fellow in the department of hematology, oncology, and transplant at University of Minnesota in Minneapolis.

What was surprising was the reaction of other professionals to the idea of using a video to educate patients about resuscitation, she says.

The institutional review board voiced concerns that viewing the video could be psychologically stressful for patients.

"This seems to suggest, at least amongst some medical professionals, that patients are not seen to have either the right to know, or the ability to understand, the risks and benefits of resuscitation," says Merino.

Many participants who watched the video expressed gratitude for the

information. “A few requested that we allow their family members to view it,” says Merino.

Many patients hear information on CPR and intubation from television shows. “This often distorts the risks and benefits of undergoing these interventions, as well as outcomes for survival and functionality if successfully resuscitated,” says Merino.

Most physicians are not trained to hold these discussions. “Put together, these factors bring into question the effectiveness of the current approach to informed consent for resuscitation efforts,” says Merino.

Anecdotal accounts and research on resource utilization suggest that implementation of futile care is widespread at the end of life.<sup>2,3</sup>

Standardization of certain aspects of the code status conversation could prevent this, suggests Merino. “Ultimately, improved decision-making should better align patient choices with their true intention around code status,” she says.

Tools to standardize conversations regarding informed consent for end-of-life care must never be used as the sole source of information for decision-making, cautions Merino.

“Healthcare providers must still have a deep understanding of how to guide a patient through the process of making decisions about code status, provide recommendations, and support the decision in times of uncertainty,” she says.

There is no “one size fits all” approach to complex medical decision-making. “Cultural diversity and demographic differences often necessitate an individualized approach to these discussions,” says **Ryan Greiner**, MD, another of the study’s authors and the producer of the video.

Decision aids raise an ethical question as to whether it’s appropriate for providers to use the tool to support a specific recommendation, or if the tool should be neutral and objective. “We need to answer the question of whether decision aids, like videos, should or shouldn’t be persuasive in their intent,” says Greiner, an internist at North Memorial Health in Robbinsdale, MN.

Music, visuals, and the commentator’s tone all have the potential to subconsciously influence the patient’s decision. “As a professional body, we will have to

decide if it is okay to manipulate these variables to get a desired outcome,” says Greiner. ■

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# Radiation Oncologists Want, but Often Lack, Palliative Care Training

*Skills ‘are not just innate’*

**A**lthough 96% of radiation oncology residents see palliative care as an important competency, most feel their training is inadequate, found a recent study.<sup>1</sup>

“Palliative care is an important part of an oncologist’s practice and, specifically, a radiation oncologist’s

practice, where 30% to 40% of the patients are seen for a palliative radiation consult,” says **Monica S. Krishnan**, MD, the study’s lead author. Krishnan is an assistant professor of radiation oncology at Harvard Medical School in Boston.

Researchers surveyed 404

radiation oncology residents. Most (81%) wanted more palliative care education. “We were surprised to note that, on average, 79% of residents rated their training in palliative care as ‘not/minimally/somewhat’ adequate across all palliative care domains,” says

Krishnan. These include symptom management; communication on goals of care; advance care planning; care coordination; and psychosocial, cultural, spiritual, legal, and ethical issues. “These findings highlighted the need to improve palliative care education during training,” concludes Krishnan.

## Need Support From Colleagues

With so much clinical content to learn in the highly technical field of radiation oncology, “the curriculum becomes very full,” says **F. Amos Bailey**, MD, FACP, FAAHPM, professor of palliative medicine at University of Colorado Anschutz Medical Campus in Aurora.

Radiation oncologists need support from colleagues with expertise in palliative care, says Bailey. “Providers can learn these skills. They are not just innate.” He recommends making the following changes:

- making members of the palliative care team available to support radiation oncologists;
- having radiation oncology trainees spend clinical time with palliative care providers to better understand the experiences of the patients and families they are caring

for in the last months and weeks of life;

- ensuring appropriate use of single or limited fraction treatment plans for patients needing palliative radiation;
- developing standards and requirements for palliative care in radiation oncology training and in postgraduate training.

## Little Structured Training

A growing body of research points to radiation oncologists’ need for palliative care training. A recent study assessed 162 consults for palliative radiation therapy in 2014 at three Boston-area hospitals. Researchers found that clinicians encountered multiple palliative care issues, including physical symptoms and goals of care.<sup>2</sup>

Ninety-one percent of radiation oncologists believe palliative and supportive care is an important competency for their specialty, found a recent survey of 4,093 radiation oncologists.<sup>3</sup> While most are moderately confident in their ability to assess and manage pain and gastrointestinal symptoms, the same isn’t true for their ability to manage anorexia, anxiety, and depression. Despite these areas of

decreased confidence, 42% do not receive any additional palliative and supportive care education beyond their residency training.

Another study surveyed 87 program directors of radiation oncology residency programs. While 93% agreed or strongly agreed that palliative and supportive care are important competencies for radiation oncology residents and fellows, only 67% of residency programs had formal educational activities in principles and practice of palliative supportive care.<sup>4</sup>

The researchers, a group of radiation oncologists, suspected their specialty was not providing enough structured education to provide good palliative care. “And sure enough, even though the programs did provide quite good radiation oncology-specific palliative education, the survey showed they provided little structured training in the broader field of palliative care,” says **Gabrielle Kane**, MD, another of the study’s authors. Kane is medical director of radiation oncology at Seattle-based UW Medical Center. However, program directors did have an interest in expanding and improving palliative care education.

**Kavita Dharmarajan**, MD, another of the study’s authors, concurs. “The findings confirmed our hypothesis — that most directors believed palliative care was an important competency for trainees to develop, but that there were certain ‘holes’ in the training,” says Dharmarajan, assistant professor of radiation oncology and palliative medicine at the Icahn School of Medicine at Mount Sinai in New York City.

Before the study, little was known about whether and how radiation oncology training

### EXECUTIVE SUMMARY

Residents, practicing radiation oncologists, and program directors believe palliative care training is important, but education is lacking in some areas, according to multiple recent studies. Some possible solutions include the following:

- Make the palliative care team available to support radiation oncologists.
- Ensure radiation oncology trainees spend clinical time with palliative care providers.
- Develop national standards for palliative care training in radiation oncology.

programs incorporated palliative care training. “Now that we know the areas where teaching is insufficient, we can focus on creating education tools to address those particular concepts,” says Dharmarajan.

The researchers hope that a national curriculum and clear guidelines will be developed. “We have now raised awareness,” says Kane. “There is a motivated and active group within the specialty who are focused on helping improve this educational need.”

## Decision-making Is Complex

The need for good communication on advance care planning is a key issue uncovered in the studies. This includes considering not offering radiation to patients who are unlikely to see a timely benefit from the treatment.

“It is unethical for us to give a treatment that, in all likelihood, would be futile,” says Dharmarajan. Radiation oncologists should not routinely give 10 fraction treatments to patients whose prognosis is limited to weeks, for instance. “And if it’s limited to days — or if treatment is likely to be more burdensome than helpful — we probably shouldn’t be giving any radiation at all,” says Dharmarajan.

Kane says palliative radiotherapy is a “large and important component” of radiation oncology. “Trainees learn a lot about this aspect of palliation, but very little about the more holistic approach of palliative care — controlling all symptoms with multiple modalities — and the sometimes terrifying emotional aspects of end-of-life issues,” she says.

Though the technical aspects of palliative radiation are straightforward, decision-making often is more complex. “Radiation oncologists are somewhat more isolated in their practice, living down in the basement with their big machines instead of in the hub of inpatient units,” explains Kane. Other specialists’ ways of

“EVEN THOUGH THE PROGRAMS DID PROVIDE QUITE GOOD RADIATION ONCOLOGY-SPECIFIC PALLIATIVE EDUCATION, THE SURVEY SHOWED THEY PROVIDED LITTLE STRUCTURED TRAINING IN THE BROADER FIELD OF PALLIATIVE CARE.”

palliating cancer patients’ symptoms also come into play. For instance, side effects of certain medications can hinder the ability to deliver palliative radiation therapy.

Patients are typically referred back to their primary oncologist to address issues such as side effects of radiation. This is especially likely if patients are no longer under the direct care of the radiation oncologist. However, says Dharmarajan, “Ethically, we as radiation oncologists have a responsibility to see patients through

the course of radiation treatment and the immediate period after it.” ■

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# Early Error Disclosure Training Prepares Residents to Provide Ethical Care

*Multidisciplinary training fosters team approach*

Nursing, medical, pharmacy, and dental students at Seattle-based UW Medical Center learn about error disclosure as a group.

“They can appreciate the need for effective teamwork in the planning phase, before initiating error disclosure,” says **Andrew A. White, MD**, an associate professor in UW’s department of medicine.

Feedback from students indicates that they learned not only about disclosing medical errors, but also about other professionals’ roles and perspectives, found a recent study.<sup>1</sup>

“Part of our premise is that we typically make mistakes as a team, and should disclose and accept accountability together. That happens best if all of the students are training together,” says White, one of the study’s authors.

Simulation with standardized patients allows residents to comprehend the dynamics of these difficult conversations in a risk-free setting. “We want the students to wrestle with some real-life emotions, without being traumatized by the simulation,” explains White.

To effectively prepare healthcare professionals for effective and ethical medical error disclosure, says White, “educational leaders should introduce the topic early, utilize simulation, apply current theory about how adults learn, and make the training interprofessional.”

Previous research has shown that medical, nursing, and pharmacy students witness errors and adverse events early in their clinical training.<sup>2</sup> “Healthcare professional schools should provide robust training in the preclinical years, to anticipate the need for guidance,” advises White.

## Patients Want Transparency

Case-based teaching pushes learners at all stages to contemplate how they and their institution should uphold multiple ethical principles during disclosure, says White. “Patients expect us to be transparent and truthful with the facts, and to be accountable for the harm we have caused,” he adds. This means

acknowledging their distress, and providing an appropriate apology and emotional support.

However, trainees grapple with competing desires. They want to meet the patients’ needs, but worry about their own self-preservation, fearing consequences from their supervisors in addition to the patients.

“Educational leaders can minimize the ethical dilemma for trainees by upholding a just culture, and an emotionally supportive due process after trainees are involved in errors,” says White. He suggests ethicists facilitate ethical error disclosure in the following ways:

- **Be alert for instances where care teams have not shared all available information with the patient and family.**

“Those are times to probe the team’s assumptions and motivations,” says White.

- **Be familiar with research showing that patients want transparency about adverse events.**

This can help ethicists to refute groundless assertions that being truthful about errors will needlessly upset patients, says White.

- **Encourage the robust development of emotional support systems for healthcare workers involved in errors.**

“Virtually all healthcare workers intend to provide safe care, and are emotionally devastated when they make harmful mistakes,” says White.

Effective error reporting and disclosure programs go hand-in-hand with ethical responses toward the healthcare workers involved. “It

## EXECUTIVE SUMMARY

Role-modeling, a strong patient safety culture, and simulation training provided to interdisciplinary groups facilitate error disclosure, found several recent studies. Ethicists can be aware of the following:

- Be alert for instances where care teams have not shared all available information with the patient and family.
- Be familiar with research showing patients want transparency on adverse events.
- Help to develop emotional support systems for healthcare workers involved in errors.

can be frustrating to train students and residents on the ideal ethical handling of mistakes, knowing that they may enter healthcare systems that do not support those behaviors,” notes White.

A recent study’s findings underscore this difficulty. Researchers assessed 49 residents’ error disclosure skills using structured role play with a standardized patient in 2012-2013.<sup>3</sup> Residents identified these two factors as key facilitators for disclosure:

- role modeling;
- a strong local patient safety culture.

“Significant further change should occur in the systems and culture of healthcare institutions, in order for graduating trainees to find that their skills match the reality of their practice environment,” concludes White. ■

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## SOURCE

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## CME/CE QUESTIONS

1. **Which is true regarding documentation of advance care planning in EHRs, according to a recent study?**
  - a. Physicians report problems with interoperability between outpatient and inpatient EHR systems.
  - b. Physicians agree that specialists, not primary care physicians, should document advance care planning.
  - c. Oncologists documented advance care planning far more often than primary care physicians.
  - d. Most primary care physicians lacked standard clinic workflows for advance care planning documentation.
2. **Which is recommended to reduce conflict with surrogate decision-makers, according to Blair Henry?**
  - a. Instructing surrogates to use the “best interest” principle over substituted judgment in nearly all situations.
  - b. Informing family members that their role as a surrogate decision-maker requires them to follow specific rules for treatment decisions.
  - c. Bearing in mind that financial incentives are the primary reason surrogates impose their preferences on the patient.
  - d. Asking surrogates which clinical option they would prefer, instead of asking what the patient would choose.
3. **Which is true regarding education on code status choices, according to a recent study?**
  - a. Hospitalized patients who watched a video about code status choices were more likely to choose do not resuscitate or do not intubate.
  - b. Most patients reported psychological stress after viewing an informational video.
  - c. Patients were already well-informed about the risks and benefits of CPR and intubation.
  - d. Most patients believed outcomes after CPR and intubation to be poorer than they actually are.
4. **Which is true regarding ethical error disclosure, according to Andrew A. White, MD?**
  - a. The risk of harm from transparency on adverse events is generally greater than any potential benefit.
  - b. Providing emotional support to healthcare workers involved in adverse events is in conflict with patient-centered care.
  - c. Ethicists should look for instances where care teams have not shared all available information with the patient and family.
  - d. Training on adverse events disclosure in residency is ineffective because residents are unlikely to have been responsible for errors prior to entering clinical practice.



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