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INSIDE

RELIAS
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Misconceptions on Meaning of DNR Status Surprisingly Common Among Clinical Team

Potentially beneficial care is sometimes withheld

An urgent request for an ethics consult recently came in from a nurse manager, who was distressed because an attending physician ordered continuous positive airway pressure (CPAP) for a do not resuscitate (DNR) patient.

"The patient received the CPAP per the physician order. There was a need to have a conversation with the nurse and team that 'DNR' does not mean 'do not treat,'" says **Mathew David Pauley**, JD, MA, MDR, a regional ethicist at Kaiser Permanente Northern California in Oakland.

The nurse believed the patient's DNR status indicated the patient did not wish to receive any treatments, but this was not the case. "Often, attitudes and approaches toward patients with DNR lean toward 'this person is comfort measures only,' when the person is not," says Pauley.

> "OFTEN, ATTITUDES AND APPROACHES TOWARD PATIENTS WITH DNR LEAN TOWARD 'THIS PERSON IS COMFORT MEASURES ONLY,' WHEN THE PERSON IS NOT."

Providers often tell patients or surrogates, "DNR does not mean 'do not treat'" to allay concerns that DNR will result in someone getting no further treatment. "That said, often from the healthcare provider side, DNR does mean do not treat," says Pauley.

When DNR patients are going into surgery, many clinicians assert that patients must be full code throughout

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AUTHOR: Stacey Kusterbeck
EDITOR: Jill Drachenberg
EDITOR: Jesse Saffron
EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

EDITORIAL QUESTIONS
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the perioperative process. "This can create a number of issues and problems," says Pauley. "Every institution I have worked at allowed patients to remain DNR for procedures."

Helping both clinicians and patients understand the person's code status is helpful. "The 92-year-old man who we emphatically educated to be DNR because of how frail he is, remains as frail, and at the same risk of harm, when he goes in for his ortho procedure," says Pauley.

DNR also does not mean airway issues should not be addressed, adds Pauley: "If one is DNR and is also choking on a peach slice, the medical team should be actively trying to clear that person's airway."

Residents appear to assume that patients who would refuse CPR would prefer not to receive other interventions, found a recent study.[1] Researchers surveyed 533 internal medicine residents, asking what interventions they would pursue for various clinical scenarios. Key findings include the following:

• decisions to intubate or perform CPR were largely dictated by patient code status;

• decisions to deliver noninvasive interventions such as medications, blood cultures, or imaging were largely unaffected by code status;

• decisions to pursue aggressive or invasive options (dialysis, bronchoscopy, surgical consultation, or transfer to the ICU) differed significantly based on code status.

Without explicit clarification of the patient's goals of care, potentially beneficial care may be withheld against the patient's wishes, the researchers concluded.

"A patient preference against CPR does not entail a preference against other invasive treatments. It requires a conversation," says **Paul Hutchison**, MD, MA, assistant professor in the division of pulmonary and critical care medicine at Loyola University Chicago's Stritch School of Medicine in Maywood, IL.

A patient with a DNR order who goes into shock may still want a central line and vasopressors, necessitating ICU care. Under the mistaken belief that a DNR order means a preference for comfort measures only, some clinicians won't admit a DNR patient presenting to the ED to the ICU. "The patient shouldn't necessarily be denied treatment in the ICU merely because of these orders," says Hutchison.

All the do not intubate (DNI) or DNR order indicates is that the patient does not favor receiving those particular medical treatments in the case of either a cardiac arrest or respiratory failure.

EXECUTIVE SUMMARY

Clinicians sometimes assume DNR status means a preference for comfort measures only, but this is not necessarily the case.

- Such orders indicate only that the patient does not wish to receive CPR in the event of cardiac arrest.
- How code status is addressed for hospitalized patients is patient-specific.
- Healthcare providers can discover patient preferences only with a shared decision-making process.

"The ICU offers opportunities for various other forms of treatment that still may benefit the patient," explains Hutchison.

When hospitalized patients are asked about their code status, typically the question focuses on intubation and CPR. In contrast, Physician Orders for Life-sustaining Treatment (POLST) forms typically specify whether the patient wants full treatment, selected treatments, or comfort measures only.

"The Patient Self-Determination Act says only that patients need to be asked if they have an advance directive and are to be provided one if they wish," notes Hutchison. There is no requirement to obtain a code status.

"For a lot of admitted patients, asking about code status may actually have some detrimental effects," says Hutchison. For instance, a conversation about code status with a young, healthy person coming in for an elective procedure could negatively affect trust between the patient and the hospital.

On the other hand, for patients at high risk for decompensation and death, there's an opportunity to increase the number of advance directives completed for inpatients. "It should be a patient-by-patient determination," says Hutchison. A one-size-fits-all approach is not feasible for hospital patients of varying ages, with varying levels of illness and varying preferences.

"How we address code status and advance directives with any given patient is completely dependent upon who the patient is and the clinical context," says Hutchison.

Healthcare providers are "called upon, ethically and clinically, to get it right for our patients — especially in writing orders with high-stakes implications," says **Kathy Johnson Neely**, MD, MA, medical director of the medical ethics program at Northwestern Memorial Hospital in Chicago.

DNR orders should be written only as the outcome of a shared decision-making process, says Neely: "The patient or surrogate brings to the table their values, goals, and limitations." Healthcare providers bring expertise regarding the patient's medical condition and options for care. This includes risk, benefit, burden, and anticipated outcomes as they would play out in various clinical contexts.

"THE ONLY WAY TO ELICIT WHETHER THERE ARE OTHER INTERVENTIONS THE PATIENT WOULD NOT WANT UNDER ANY CIRCUMSTANCES IS TO CONTINUE THE SHARED DECISION-MAKING CONVERSATION."

When healthcare providers engage in a shared decision-making discussion concerning cardiopulmonary arrest, says Neely, "we present them with a fork in the road." There are only two options with very different treatment plans and hoped-for outcomes: attempting resuscitation, or allowing natural death with palliative interventions only.

"Healthcare providers must clearly recognize that a DNR order addresses only the pathophysiologic condition of cardiopulmonary arrest, and that a DNR order takes off the table only the package deal of interventions we know as CPR," says Neely, adding that a DNR order does not preclude intubation for reasons other than cardiopulmonary arrest. Appending a DNI order in a unilateral fashion presents "a serious clinical and ethical breech of shared decision-making," says Neely. Similarly, a DNR decision of itself does not preclude cardioversion for arrhythmia (other than ventricular fibrillation or pulseless ventricular tachycardia) or noninvasive positive pressure ventilation.

"The only way to elicit whether there are other interventions the patient would not want under any circumstances is to continue the shared decision-making conversation," says Neely.

Thoughtful, thorough discussions are especially important when completing a POLST document with a patient, as these travel with the patient to any future healthcare setting. "We need to get it right for the long-term plan our colleagues may implement in the future, as well as our immediate care of the patient," says Neely.

A patient with metastatic cancer with a DNR order might wish to eliminate any burdensome, life-prolonging interventions, taking intubation, ICU-level of care, and electrocardioversion entirely off the table. Alternatively, that same patient might want a time-limited trial of intubation; for example, if somnolent after a seizure for airway support, or in the context of exacerbation of COPD.

On the other hand, a frail, elderly patient living alone might have a DNR order, wanting no resuscitation

attempted if she is found down at home — but falls and fractures her femur. "In this unanticipated context, she might or might not agree with rescinding her DNR," says Neely.

Continued treatment of a patient with a DNR order should be the default, says **Kathy Kinlaw**, associate director of the Emory University Center for Ethics in Atlanta. This is the case whether the patient enters the hospital with a pre-existing DNR order from a long-term care facility, or a DNR order is entered during the hospitalization.

"The organizational culture of care needs to educate and reinforce these distinctions with multidisciplinary team members involved with resuscitation decisions and caring for patients dealing with serious or critical illness," says Kinlaw.

In academic settings, team rounds should not be omitted for patients with DNR orders, adds Kinlaw: "There is much to learn from these patients and families." Patient monitoring should also continue; medications, central lines, specialty consultation, transfer to intensive care, and surgery may all be appropriate for DNR patients.

"Provision of indicated treatment for the patient should be assumed, unless an explicit conversation addresses the question of forgoing of other treatments," says Kinlaw. Clinical ethicists can play an important part in clarifying this point. This can be done with conversations on the floor to educate and reinforce what DNR decisions entail — and what they don't entail.

"This is true in ethics consultations with particular patients and families, but also proactively, in shifting the practice in units where DNR decisions are frequent," says Kinlaw.

Such early ethics intervention can even change the way in which initial resuscitation conversations proceed. "This enhances understanding for clinical team members, patients, and families from the start," says Kinlaw. ■

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- **Paul Hutchison**, MD, MA, Assistant Professor, Division of Pulmonary and Critical Care Medicine, Loyola University Chicago, Stritch School of Medicine, Maywood, IL. Phone: (708) 216-0461. Email: Paul.Hutchison@lumc.edu.
- **Kathy Kinlaw**, Associate Director, Center for Ethics, Emory University, Atlanta. Email: kkinlaw@emory.edu.
- **Kathy Johnson Neely**, MD, MA, Medical Director, Medical Ethics Program, Northwestern Memorial Hospital, Chicago. Phone: (312) 694-2578. Email: k-neely@northwestern.edu.
- **Mathew David Pauley**, JD, MA, MDR, Regional Ethicist, Kaiser Permanente Northern California, Oakland. Phone: (510) 987-4608. Email: mathew.d.pauley@kp.org.

Residents Reporting More Moral Distress

Complaints should come as no surprise, experts say

"Medicine is changing me into a doctor I am not proud to be." Unfortunately, residents are voicing such sentiments more frequently to **Julie M. Aultman**, PhD, director of the medical ethics and humanities program at Northeast Ohio Medical University in Rootstown.

"Having the privilege to follow trainees from undergraduate premedical education through their residency reveals the genuine struggles they face," says Aultman.

Many residents are disheartened by lack of time to build relationships with patients. Sometimes, the inability to resolve serious ethical infractions is the problem. Residents occasionally report witnessing forced resuscitation of patients with DNR status, or withholding of medical mistakes from patients.

"Trainees often feel as though they lack the moral courage to report unethical behaviors," says Aultman. During small group discussions, medical students and residents admit that they fear being viewed as a "whistleblower" and losing respect of peers and colleagues.

Fostering a "culture of ethics" is what's needed, says Aultman: "Open and honest communication that is welcomed, rather than ignored or ridiculed, decreases the frequency and intensity of moral distress."

Teaching the foundations of ethical theories and principles also is important. This allows trainees to justify their opinions, and prompts them to look at multiple perspectives before making a moral judgment.

"Patient autonomy, for example, when better understood, can guide trainees to understand the importance of patient decisions," says Aultman.

Before trainees actually report moral distress to their supervisors, Aultman advises them to collect relevant facts, ask questions, and seek the advice of peers and mentors. "For trainees that take on leadership roles, I advise them to bring morally distressing situations to open forums for discussion," says Aultman.

Medical educators are hearing from students about moral distress more frequently, reports **M. Sara Rosenthal**, PhD, professor and founding director of University of Kentucky's program for bioethics and chair of the hospital ethics committee.

In a review of past resident case conference presentations, the issue of moral distress emerged as a recurring theme.

"We need to treat moral distress like an occupational hazard that is to be expected, and not something that happens out of the blue," says Rosenthal. A recent paper reviewed the literature on best practices for reducing moral distress of trainees exposed to end-of-life cases, focusing on medical education and organizational ethics programs.[1]

Provider burnout has been a recent focus for bioethicists at East Carolina University in Greenville, NC, including its prevalence and causes. In conversations with providers, **Maria Clay**, PhD, realized that many symptoms of burnout were similar to the residual effects of moral distress. These include anger, lack of empathy, and moral and physical fatigue.

"Several experts expressed the concern that provider burnout could not be addressed without first addressing the lingering effects of moral distress," says Clay, chair of the department of bioethics and interdisciplinary studies at East Carolina University in Greenville, NC.

Addressing medical trainees' moral distress can provide insights for how to address moral distress experienced by attendings, adds Rosenthal: "We need to pay greater attention to mentors and medical educators."

Efforts to address moral distress should not be isolated by discipline, says Clay: "Moral distress is a team phenomenon. Programs must include all members of the healthcare teams."

Supervisors' Obligations

Moral distress and what it means is "a very important early discussion that needs to be had" between trainees and supervisors, according to **Celia B. Fisher**, PhD, director of the Center for Ethics Education and professor of psychology at Fordham University in Bronx, NY.

Trainees may believe that they are prevented from doing what is morally right by limitations in their institutional setting. This sometimes stems from simple misunderstandings.

"Various rules and procedures in the hospital setting are based on ethical values. But these are typically not articulated to the trainee," says Fisher.

For example, trainees may openly discuss a patient's condition with colleagues, unaware that hospitals must adhere to very specific procedures for protecting the confidentiality of medical records — including which hospital staff should have access to patient information.

"These may differ from the trainee's personal values. Some things we might do as a person for a loved one might be professionally unacceptable from a physician," notes Fisher. To relieve patient distress, trainees may disclose their own personal medical history, inadvertently committing professional boundary violations that can cause patient harm.

If the distinction between personal and professional values is not made clear to trainees, moral distress is more likely to be reported. Another obligation for supervisors: Be clear that the topic of moral distress is open for discussion.

"When you are meeting every week, or whatever the supervisory situation is, you should be asking questions about moral distress," says Fisher.

The professional appropriateness of discussing such issues should be made clear at the beginning of the supervisory relationship. The trainee understands that addressing moral quandaries is a part of his or her professional development.

EXECUTIVE SUMMARY

Trainees are reporting moral distress more frequently, according to bioethicists interviewed by *Medical Ethics Advisor*. Some approaches include the following:

- provide education on ethical principles behind hospital practices;
- routinely ask about moral distress during supervisory meetings;
- be open to the possibility that unethical practices are occurring.

If moral distress isn't aired and addressed, it puts trainees at risk for unethical practices themselves. "They may do what they believe is a moral action that may actually be harmful to the patient," says Fisher. Some examples include the following:

• overprescribing pain medication because they believe it's a beneficent way to act;

• underestimating the level of disease to alleviate distress;

• disclosing information to a patient about his or her medical condition prematurely. "It may be perceived as a definitive diagnosis, but it's just speculation until it's confirmed," says Fisher.

On the other hand, trainees sometimes have valid ethical concerns about hospital policies and procedures, or clinical practices. "There may be something going on that is not consistent with the ethical values of the field, but supervisors just weren't aware of it," says Fisher.

For instance, trainees may observe that the initial intake conducted by other staff did not include appropriate informed consent, or that a medical history was not adequately completed to ensure appropriate follow-up care. Trainees may also discover that a staff member is responding to patients in a manner that reflects harmful stereotyping or biases. "Those kinds of behaviors are very important to discuss with supervisors to help rectify patient care," says Fisher. ■

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- **Maria Clay**, PhD, Chair, Department of Bioethics and Interdisciplinary Studies, East Carolina University, Greenville, NC. Phone: (252) 744-1290. Email: clayma@ecu.edu.
- **Celia B. Fisher**, PhD, Director, Center for Ethics Education/Professor of Psychology, Fordham University, Bronx, NY. Phone: (718) 817-0926. Email: fisher@fordham.edu.
- **M. Sara Rosenthal**, PhD, Professor and Founding Director, Program for Bioethics/Chair, Hospital Ethics Committee, University of Kentucky, Lexington. Phone: (859) 257-9474. Email: m.sararosenthal@uky.edu.

Nonessential Meds, Including Vitamins, Often Continued in Dying Patients

Nonessential medications, such as vitamins, often are continued in actively dying, hospitalized patients, concluded a recent study.[1]

"Quite frankly, it seems to be a lack of common sense," says lead author **F. Amos Bailey,** MD, FACP, FAAHPM.

The research was a secondary analysis of data from the Best Practices for End-of-Life Care for Our Nation's Veterans (BEACON) trial, an intervention to align care for the imminently dying in inpatient settings with care patients would receive in a hospice setting.[2]

"It has been noted that most people say that they would want hospice care at the end of life," says Bailey, a professor of palliative medicine at the University of Colorado Anschutz Medical Campus in Aurora.

For a variety of reasons, many still die in inpatient settings such as acute care hospitals or nursing homes. A minority die in hospice or palliative care settings. Some hospital and nursing homes have addressed this by designating hospice and palliative care sections or beds.

"Our goal was to support primary palliative care and comfort care for the imminently dying in any location in the hospital or nursing home," says Bailey.

The BEACON researchers implemented a Comfort Care Order Set to ensure that:

• patients had orders for comfort-focused medications (opioids for pain and dyspnea; antipsychotics for delirium and nausea/vomiting; benzodiazepines for anxiety, agitation, and seizures; and medications for death rattle);

• low, frequent dosing was used as needed;

• alternative routes such as sublingual or subcutaneous were used instead of oral or IV routes if necessary;

• a comfortable environment was provided with fewer restraints, fewer IVs, fewer feeding tubes, and fans for shortness of breath.

"We noted anecdotally that many patients we consulted on were still taking medications that we would consider nonessential," says Bailey. Often, the researchers would find

cups of these medications at the bedside because the patient was unable to take them.

"We suggested to teams and nurses that this may be a sign of imminent dying," says Bailey.

The researchers did not require providers to stop any specific treatment before switching to comfort care. However, they did instruct providers that all interventions should be reviewed. "We thought it was more important to try to make sure comfort measures were available and used," explains Bailey.

Data on medication use was analyzed from electronic medical records of 5,476 deceased veterans. Some key findings include the following:

• five nonessential medications (clopidogrel, donepezil, glyburide, metformin, and propoxyphene) were ordered rarely (less than 5% of cases);

• simvastatin, calcium tablets, multivitamins, ferrous sulfate, diphenhydramine, and subcutaneous heparin were ordered commonly.

"We were surprised that these medications were continued at such high rates," says Bailey.

One-third of dying patients received heparin injections, which are costly and painful to inject; one-sixth received cholesterol medications. About 10% of patients were given iron, calcium, and/or multivitamins on the day they died. "These are huge pills that even people in good health sometimes have trouble swallowing," says Bailey.

Patients who died in an ICU were more likely to receive a nonessential medication, as were older patients. Patients who received a palliative care consult, had a DNR order placed, or were given medications for death rattle were less likely to receive a nonessential medication.

"Healthcare providers recognized these patients to be imminently dying, which prompted them to de-prescribe some of these medications," says Bailey.

The study's findings were not surprising to **Bryan Pilkington**, PhD, director of academic programs at Fordham University's Center for Ethics Education in Bronx, NY: "There remains disagreement over what constitutes appropriate care as a patient approaches the final stages of dying."

Giving truly unnecessary medications that could be used for other patients is an ethical concern. However, says Pilkington, if the medications do aid the dying patient, then administration should be continued: "Providing substandard treatment, even with the good aim of providing scarce resources to other patients, is not morally acceptable."

Bailey sees these additional ethical concerns if nonessential medications are continued for imminently dying patients:

• It exposes the patient to discomfort from injections and pill burden, particularly with hard-to-swallow medications, when there can be no possible benefit.

"These are examples where there is only burden without potential positive gain," says Bailey. "This is clearly not beneficence in action."

• Cost of the medications, and for nursing staff, pharmacy, and others involved in their administration, is significant.

"This is not trivial," says Bailey. "It is easier to calculate the cost of medications than the cost of the effort to continue to administer."

• The practice distracts healthcare providers and family from truly helpful and supportive care for the patient and family.

"The hour spent crushing and trying to coax a dying patient to swallow a calcium pill in pudding is an hour not available to attend to the true care needs of patients," says Bailey. ■

EXECUTIVE SUMMARY

Nonessential medications often are continued in actively dying hospitalized patients, found a recent study. Some ethical concerns include the following:

• patients experience discomfort with no possible benefit;

• high-cost medications are administered, with no benefit;

• clinicians are taking time that could be used for patient care.

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- Bryan Pilkington, PhD, Director of Academic Programs at Fordham University's Center for Ethics Education, Fordham University, Bronx, NY. Phone: (718) 817-0926. Email: bpilkington1@fordham.edu.

Physicians Rely on Device Reps, but Have Ethical Concerns

Being locked into single relationship can adversely affect patients

Surgeons are concerned about conflicts of interest and patient safety due to the increasing presence of device representatives in operating rooms. However, the surgeons also rely on those reps, found a recent study.[1]

"This is certainly a topic that is fraught with ethical issues," says **Sue Ross**, PhD, one of the study's authors. "I suppose this will always be the case at the interface of medicine and industry."

Researchers surveyed 22 physicians about their relationships with device industry representatives. "We chose to interview cardiovascular and orthopedic surgeons, because the devices they use tend to be in the higher-risk category," says Ross, professor and Cavarzan chair of mature women's health research at the University of Alberta in Canada.

Participants described:

• a tension between physicians and representatives that required physicians to be vigilant about conflicts of interest and patient safety;

• representatives varying regarding disclosure of device defects;

• tension between hospitals, whose policies and business practices were focused on cost control, and physicians who were required to use particular devices despite concerns about their safety and effectiveness.

"We were surprised that the role of device industry representatives was deemed to be crucial by many of the surgeons in assisting with their surgical practice," says Ross. The reps were not involved with the actual surgery. Rather, they used their knowledge about their own specific products, and their skill in assembling devices, to advise surgeons on practical aspects of their use.

"The devices are now so complex and may involve a number of interchangeable parts, and the choice of individual components is patient-specific," notes Ross.

Safer, Quicker Surgery

As employees of the device companies, the reps are obliged to represent that company. "The surgeons are, in a sense, their clients," says Ross. Additionally, the reps have specific technical skills that can assist with patients' surgical care.

"The surgeons need those skills," says Ross. "Some surgeons believe that the reps make the surgery safer and quicker in most instances."

The problem is that the reps can have conflicts of interest in terms of selling more product versus making the best choice for an individual patient, says Ross. Some ethical concerns include:

• Hospitals may be conflicted by making decisions based on financial considerations instead of purchasing the ideal devices for individual patients.

"Surgeons and hospitals may have a goal of quick surgery, so that more cases can be treated," adds Ross.

• The relationship between rep and surgeon gives the company a competitive advantage to maintain the hospital's business.

"Where the conflicts of interest come into play are when device manufacturers are in competition with each other — which is often the case," says Ross.

• Physicians and surgeons may choose products that are not the best match for their patients' needs.

If they rely on only one firm's representatives, doctors can typically only choose from among the range of products offered by that firm.

"What the firm is good at manufacturing may not be optimal for any one particular patient," says **Genevieve P. Kanter**, PhD, assistant professor in the division of general internal medicine and division of medical ethics and health policy at the University of Pennsylvania Perelman School of Medicine in Philadelphia.

EXECUTIVE SUMMARY

Surgeons rely on device representatives' presence, yet are concerned about conflicts of interest and patient safety. Some possible solutions include:

• hospitals, rather than surgeons, determining which companies get their business;

• physicians being informed of competitors' products;

• surgeons actively seeking alternatives to the device they're currently using.

• Physicians may value whatever perks they get from their relationship with the device firm.

These aren't necessarily financial perks. "It may be social connection or friendship with a particular rep with whom they work closely — or with the goodies that the firm can offer," says Kanter. Either way, it can lead physicians to favor one firm or device over another, separate from the device's merits.

Having comfortable relationships with specific reps can cause conflicts by limiting the surgeon's choices, says Ross: "The company may or may not have the best device for a particular patient."

Open to Alternatives

Surgeons interviewed by the researchers offered various solutions to reduce conflicts. For example, some hospitals determined which companies would have their business, reducing surgeons' choice in the matter.

To minimize conflicts of interest, physicians must be open to the products offered by firms other than the firm producing the device they're currently using, says Kanter. Doctors often get used to working with a particular device or firm, so seeking out competitors doesn't come naturally.

"But doctors periodically seeking out alternatives is the best way to not get locked in to a single relationship that may or may not be in the best interest of all their patients," says Kanter.

The drive toward precision medicine is likely to affect the situation one way or another. Medical device companies may respond by developing more versatile products — or by driving up prices. "Doctors should keep their eyes open for these developments," says Kanter. ■

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- **Sue Ross**, PhD, Professor and Cavarzan Chair in Mature Women's Health Research, Department of Obstetrics and Gynecology, University of Alberta, Canada. Phone: (780) 735-6490. Email: sjross@ualberta.ca.

Ethics of Withholding Fertility Services From Prospective Parents

Decisions balance reproductive rights against potential harm

Fertility programs may withhold services from prospective parents due to valid concerns that they'll be unable to care adequately for offspring, according to an updated position statement from the American Society of Reproductive Medicine (ASRM).[1]

"The provision of fertility services necessarily inserts a medical professional into a patient's reproductive plan," notes **Judith Daar**, JD, chair of ASRM's ethics committee and visiting professor at UCLA School of Law and clinical professor of medicine at University of California, Irvine School of Medicine. This distinguishes this method of family formation from natural conception, in which the parties' actions and decision-making occur in a private setting.

"Given this unique role, reproductive medicine specialists have an opportunity to observe and learn about their patients' medical, social, and psychological histories," says Daar, clinical professor of medicine at University of California, Irvine School of Medicine.

In rare cases, a provider becomes concerned that prospective parents are unable to provide minimally adequate or safe care for any resulting child. ASRM's Ethics Committee supports a provider's decision to withhold fertility treatment in an effort to avoid significant harm to a future child.

"Such decisions are ethically difficult," says Daar. "They require balancing of a person's right to reproduce against an unknown but likely risk that a child will suffer significant harm."

In order to maximize the possibility

this balance is correctly struck, the Ethics Committee recommends that any program's assessment of a patient's ability to care for a child or potential to cause harm to a child be made jointly among members of the healthcare team. If indicated, consultation with appropriate other professionals — including mental health specialists — also should occur.

The position statement also recommends that fertility clinics draft written procedures for making a determination to withhold services when there are concerns about the child-rearing capacities of prospective parents. "Such policies should be made available to patients," says Daar. "Any determination to withhold treatment should be documented."

Lisa Campo-Engelstein, PhD, associate professor at the Alden March Bioethics Institute at Albany (NY) Medical College, says it's important to bear in mind that people who conceive naturally are not subject to anyone's judgment as to whether they would be fit parents.

"Yet, providers of fertility services turn people away for all kinds of reasons. Some are well-grounded, and others not. We have different standards for people who are infertile," says Campo-Engelstein.

Some argue that it's inappropriate for healthcare providers to decide whether individuals will be competent parents or not, as the individuals are seeking a medical service. "If they oppose the patient's lifestyle, that doesn't seem like a well-grounded reason to turn someone away," says Campo-Engelstein.

At the same time, healthcare providers have no ethical obligation to provide care they believe is inappropriate, unless it's a life-threatening situation. "If they are concerned that the parent is not going to be able to care for the child, they might feel causally — and morally — responsible for any offspring that result," says Campo-Engelstein.

While the patient's right to refuse treatment is almost absolute in medicine, rights to receive treatment are more limited. "Doctors have autonomy, too, and can decide they are not going to treat you," notes Campo-Engelstein.

Providers do have an obligation to refer patients elsewhere if the treatment is medically indicated but they are refusing the patient for religious or philosophical reasons. Depending on what these reasons are, it could raise ethical concerns. For instance, the provider's view on which individuals make good parents might be biased or discriminatory. "I worry that this will reinforce the dominant cultural narrative of who makes good parents, which tend to be white, heterosexual, middle- or upper-class, able-bodied folks," says Campo-Engelstein. "And that's excluding a lot of other people." Lesbian couples have reported being refused fertility services.[2] Another well-known case involved two deaf women who wanted a deaf sperm donor, but were refused.[3]

If providers really believe their patient is incompetent to be a parent or could harm a future child, says Campo-Engelstein, one option might be to have patients undergo psychological counseling, so it's not only the physician's judgment involved.

An overarching ethical consideration, says Campo-Engelstein, is that providers don't make this determination in other areas of medicine. For instance, some providers allow parents not to vaccinate their children or to refuse certain treatments. "But we draw the line with life-threatening conditions," says Campo-Engelstein. "Where to draw the line [with fertility services] is a tough question." ■

EXECUTIVE SUMMARY

Fertility programs occasionally withhold services from prospective parents due to concerns about their child-rearing capacities. An updated position statement says that assessment should be:

- made jointly among members of the healthcare team;
- involve consultation with appropriate other professionals, including mental health specialists if indicated;
- based on clinics' written procedures.

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- **Lisa Campo-Engelstein**, PhD, Associate Professor, Alden March Bioethics Institute, Department of Obstetrics & Gynecology, Albany (NY) Medical College. Phone: (518) 262-0239. Email: campoel@amc.edu.
- **Judith Daar**, JD, Visiting Professor, UCLA School of Law/Clinical Professor of Medicine, School of Medicine, University of California Irvine. Email: jdaar@law.whittier.edu.

Caregiver Knowledge Affects Mortality of Patients With Left Ventricular Assist Devices

Psychosocial factors affect patient outcomes

How well caregivers understand the patient's illness affects mortality rates of patients with left ventricular assist devices (LVADs), found a study.[1]

"There is a tendency on the part of providers to just look at the medical and surgical factors and not give psychosocial factors much weight, or give them weight arbitrarily," says **Courtenay R. Bruce**, JD, MA, assistant professor of medicine and medical ethics at the Center for Medical Ethics and Health Policy at Baylor College of Medicine in Houston.

Researchers reviewed social workers' clinical assessments of 96 adult patients implanted with LVADs from 2010-2014. Having a caregiver who understands the severity of the illness and options available to the patient, who has identified a backup plan, and who is able to provide logistical support significantly mitigated risk of death.

"We need to determine which psychosocial factors actually impact outcomes, and how much weight to give them," says Bruce. "Otherwise, we are making decisions in a very unfair and biased way."

Fairer Decisions Made

Patients with LVADs require significant support from caregivers. This goes beyond someone who can be reached in the case of an emergency. "You need someone by your side who can be depended on for a while — for a good year — before you can do it on your own," says Bruce.

This raises the question of how this kind of sustained support can be provided to patients who lack it. Hired caregivers or support groups are possibilities, but the main thing is that it is something providers should carefully consider, says Bruce.

> "WE NEED TO MAKE MORE CONSISTENT, FAIRER DECISIONS. IT'S A ROLE FOR AN ETHICIST, TO BE PRESENT AND TRY TO MITIGATE THE CHANCES OF THOSE THINGS IMPACTING THE GROUP'S DECISIONS."

"It impacts mortality and morbidity and it should count, and we need to figure out how to strengthen people's networks to make it happen," she says. Bruce suggests the following:

• Social workers or psychiatrists who perform assessments for LVAD programs must consider the right psychosocial factors and weigh them appropriately. "We need to know what actually impacts morbidity and mortality, and what we can do to make outcomes as good as they can be," says Bruce.

• Ethicists should attend patient selection committees to minimize bias or arbitrary decision-making.

"We need to make more consistent, fairer decisions," Bruce says. Medical patient selection committees aren't immune to bias, power differentials, and group dynamics, adds Bruce: "It's a role for an ethicist, to be present and try to mitigate the chances of those things impacting the group's decisions." ■

REFERENCE

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SOURCE

- **Courtenay R. Bruce**, JD, MA, Center for Medical Ethics and Health Policy, Baylor College of Medicine, Houston. Phone: (713) 798-4929. Email: crbruce@bcm.edu.

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CME QUESTIONS

1. **Which is true regarding DNI/DNR status?**

   a. DNR status means a preference for comfort measures only.
   b. DNI or DNR orders indicate only that the patient does not wish to receive these particular medical treatments in the event of cardiac arrest or respiratory failure.
   c. Patients should be full code throughout the perioperative process.
   d. Medications, central lines, ICU transfer, and surgery are not appropriate for patients with DNR status.

2. **Which did a recent study find regarding residents and DNR status?**

   a. Residents appear to assume that patients who would refuse CPR would prefer not to receive other interventions.
   b. Code status did not affect decisions to intubate or perform CPR in most cases.
   c. Decisions to deliver noninvasive interventions such as medications, blood cultures, or imaging were largely dictated by code status.
   d. Code status played no role in decisions to transfer patients to the ICU.

3. **Which is true regarding nonessential medications and actively dying hospitalized patients, according to a recent study?**

   a. Multivitamins and calcium tablets were commonly continued in actively dying hospitalized patients.
   b. Older patients were less likely to receive nonessential medications.
   c. Patients who had a palliative care consult were more likely to receive a nonessential medication.
   d. Patients who had a DNR order placed were less likely to receive a nonessential medication.

4. **Which is true regarding surgeons and device reps, according to a recent study?**

   a. Surgeons strongly objected to device representatives' presence during surgery.
   b. Surgeons had no concerns about conflicts of interest.
   c. There was consistency regarding the way vendors disclosed device defects.
   d. Surgeons reported tension due to hospitals' focus on cost control, which required use of devices despite safety concerns.