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Ethics Services Report Unprecedented Surge in Demand for Consultations

At the same time ethics consultation services are seeing a surge in demand, cases are increasing in complexity.

“There has been a real growth in ethics consult numbers. We are not the only system experiencing this,” reports **Ryan R. Nash, MD, MA, FACP, FAAHPM**, director of the division of bioethics at the Ohio State University College of Medicine in Columbus.

“There is a desire to have someone who is a bit removed, and not part of the other services, who can just focus on the ethics question and not something else,” says Nash.

At Milton S. Hershey Medical Center in Hershey, PA, there has been an increase in demand every year since

the clinical ethics consultation service was established in 2005. Currently, the 550-bed Level I trauma center performs about 65 consults a year. “The peer-reviewed literature supports this anecdote of increasing demand,” says **Rebecca**

Volpe, PhD, director of the clinical ethics consultation service. One 500-bed facility reported an increase in ethics consultation requests from 19 in 1990 to 551 in 2013.¹

To manage demand, Milton S. Hershey’s ethics service is continuing to build a strong cohort of consultants. “We

inevitably get consults that are borderline ethics,” notes Volpe. If a request is really about a legal concern, ethicists explain, “We’re not the right resource for you. It sounds like you are calling mostly with a question about

“THERE IS A
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EDITORIAL QUESTIONS
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legal risk. If that's the case, we suggest
calling risk management at this
number."

This helps ethicists manage their
workload. "Also, as ethicists we have a
specific skill set and we ought not to
be practicing outside our scope," says
Volpe.

Historically, ethics consultation
services were used less frequently after
palliative medicine programs were
implemented. "But now growth in
ethics demand is happening even in
systems with thriving palliative care
programs," says Nash.

As systems grow their clinical
ethics services, utilization and case
complexity increase. "The degree
of difficulty of the consultations
is higher," says Nash. Clinicians
sometimes need help identifying
the appropriate decision-maker,
or resolving conflicts with medical
mediation work.

"Clinical bioethics services can
do a great deal of good in preventing
things from escalating," says Nash.

Ethics resources vary widely.
Organizations may use full commit-
tees, subcommittees, independent
consultation models, or small teams of
several ethicists. "Being nimble is the
key to being helpful," says Nash.

Some systems use nonphysician
ethicists, others use only physician
ethicists, and some use both. "I think
all three models can be successful,"
says Nash. Large systems seeing more
than 500 consults a year may have

four or five full-time ethicists on staff,
while others have just one or two.
Some work with a strictly volunteer
staff. "But if you are getting consults
daily, it will make you lose volunteers
quickly," says Nash. "When you
have 300 or more consults a year, a
volunteer group is not going to work."

Even if there are several dozen
consults a year, volunteer ethicists
will feel the strain. "You grow only
when there is buy-in, and not
just philosophical buy-in, but a
commitment of funding and time,"
says Nash.

Of Milton S. Hershey's seven-
member ethics consult service, four
members take primary call, and three
serve as backup. Each person who
takes call receives a portion of the .5
full-time equivalents (FTEs) allotted
to the service. This covers a small
percentage of their salary. "In this way,
we demonstrate to both the individual
taking call and their division chief
that clinical ethics is an activity that is
valuable and valued," says Volpe.

Each of the ethicists is a full-
time faculty member with research,
teaching, and clinical care obligations.
"When the ethics pager goes off, we
are without exception in the middle
of something else," says Volpe.

Ethicists may be working on a lecture,
a research proposal, or facilitating a
small group of medical students.

Some institutions use a full-time
clinical ethicist model. A single
individual takes all calls and does little

EXECUTIVE SUMMARY

Ethics consultation requests and case complexity are increasing significantly, ethicists report. Some responses to meet surging demand include the following:

- acknowledging the increasing demands on ethicists;
- sharing recurrent themes with leadership;
- establishing weekly unit-based rounds.

else in terms of teaching or research. “While I do see the advantages of this system, for me the interplay between teaching, research, and clinical ethics is one of the biggest advantages — and joys — of my job,” says Volpe. The following are some examples:

- clinical cases encountered during ethics consults are used for small group teaching;
- experience in teaching complex ethics topics to students improves ethics consultants’ communication skills;
- research skills improve with exposure to frontline educational and clinical realities.

“Having committed individuals who receive some kind of acknowledgement — for us, in the form of FTE — for their work is important for retaining good people,” says Volpe.

An increasingly pluralistic society is likely a contributing factor to ethics demand. “If you see culture wars among society, there’s going to be culture wars at the bedside,” says Nash. Sometimes cases are so difficult that a subspecialist is needed who has experienced the scenario previously, or is familiar with the relevant literature. “All health professions should have some competence in communication. But they may have gaps and may need assistance,” says Nash.

In Volpe’s experience, institutions without palliative care or psychiatric consult services see higher numbers of ethics consultations. “Our psychiatry consult service performs the vast majority of capacity evaluations that are necessary for patient care,” says Volpe. The hospital also has a strong palliative care service, which conducts most consults involving end-of-life goals of care.

“If neither of these services existed — or they were weak — ethics would be conducting many more consults

each year,” says Volpe. “Capacity evaluations and goals of care discussions would likely be under our purview.”

Another institution-specific variable is the degree of investment in ethics. “When institutional culture or leadership does not overtly support ethics, it can be difficult for an ethics consult service to see sustained growth,” says Volpe.

With care becoming more complex, a team approach is used for patient care. As a result, says Volpe, “Institutions as well as individual providers are taking an increasingly inclusive view of services such as clinical ethics.”

For some ethicists, a surge in demand for ethics mirrors the surrounding culture. “In the same way in which our society is struggling with ‘What is the right thing to do?’ we see that same struggle blossoming in the hospital,” says **Martha Jurchak**, PhD, RN, executive director of the ethics service at Brigham and Women’s Hospital in Boston.

Jurchak says that previously held societal agreements on morality have been “shredded.” “The previous standard of some objective truth is replaced by ‘the truth is what I say it is,’” she explains. “I find we struggle with how to do clinical ethics consultation in a post-moral world.”

Meeting surging demand for ethics consultations, says Volpe, “is no small feat, even for services such as ours that enjoy strong institutional support.”

At the end of an ethics rounds discussion or consultation of a particularly difficult case, Jurchak often says, “OK, this is a really emotionally draining case. An important part of the work is how you take care of yourself after you leave here. You need to pay attention to this to be able to continue to do this hard work.”

Keeping hospital leaders informed on ethics consultation volume also is important. Ethicists at Brigham and Women’s report this information at quarterly meetings with the chief nursing officer and chief medical officer. They make a point of including some compelling stories along with their data. “It’s important that there be some narratives to help the numbers come alive,” says Jurchak.

Establishing proactive interventions, such as weekly unit-based rounds, can help. Jurchak often begins by saying “Who are the patients on the unit this week that you are worried about?”

Talking about an “ethics worry” builds moral community in the organization. “Everyone is sensitive to the ethical aspects of their work, and feels the moral agency to address them,” says Jurchak. ■

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Proposed Model Ethics Curriculum Developed for Dermatology Residency

Standardized methods to teach ethics skills in dermatology residencies are currently unavailable. A recent paper offers a model curriculum.¹

“We hope that our proposed ethics curriculum will be adopted by other programs across the U.S.,” says **Jane M. Grant-Kels**, MD, one of the paper’s authors. Grant-Kels is professor of dermatology, pathology, and pediatrics and vice chair of the department of dermatology at UConn Health in Farmington, CT.

Robert T. Brodell, MD, FAAD, another of the paper’s authors, notes that dermatologists in clinical practice encounter ethical issues every day. “Traditionally, physicians would have tried to follow the Hippocratic Oath or asked themselves, ‘What would my gray-haired professor have done?’” says Brodell, professor and chair in the department of dermatology at University of Mississippi Medical Center in Jackson.

Case-based discussions with residents and experienced faculty can be “stimulating, fun, and educational for all concerned,” says Brodell. “We wanted to present an option, rather than have every dermatology residency program reinvent the wheel.”

The model curriculum is designed to impart the knowledge and skills to meet the Accreditation Council for Graduate Medical Education (ACGME) Dermatology Milestones for Professionalism over a three-year cycle.

Enough material is included for a three-year program of monthly topics. These range from academic honesty in preparing for the certifying examination, to business conflicts

and self-promotion. The goal of the curriculum is to provide a framework of topics and resources that all programs, even those without access to faculty trained in ethics, can use.

“It is widely accepted that ethics training should be integral to both undergraduate and graduate medical education,” notes co-author **Lionel Bercovitch**, MD, a professor of dermatology at Warren Alpert Medical School of Brown University in Providence, RI.

Topics change and evolve over the years. Ethical issues around acquisition of practices by private equity are one example. “What might be accepted as the norm in one decade may be considered unethical, or even unlawful, in another,” says Bercovitch. “There is never a shortage of topics to discuss.”

Ethics training has become a major goal of residency programs and the Norcross, GA-based Association of Professors of Dermatology. “All of the bureaucratic demands on doctors results in their having less time to consider these issues,” says Grant-Kels.

The vast amount of knowledge covered in residency programs leaves little time for ethics. “But one of the features of the curriculum is its elective nature, allowing individual programs to tailor it to their needs and time availability,” Bercovitch says.

Individual topics can be chosen from the list based on resident and faculty interest level. “It is meant primarily as a guideline for ensuring that trainees receive exposure and a level of competence in the ACGME ethics and professionalism milestone,” says Bercovitch.

Each of the authors has

implemented a version of the curriculum. “We have found that case-based discussions serve to cement information about the science of dermatology while considering the care options through an ethical lens,” says Brodell.

Twelve hours of ethics education is performed each year at the University of Mississippi. At Uconn Health, a 24-hour series is conducted over three years, using case-based PowerPoint presentations to generate a lot of group discussion. “The feedback from the residents is very positive,” reports Grant-Kels.

For Brodell, the biggest challenge is doing “one more thing” when the didactic curriculum of residency programs already is chock-full.

“Ultimately, we need to continue having open, honest point/counterpoint discussions about issues of the day,” says Brodell.

Knowing the answer to an ethical question isn’t always enough in a complex care environment. “This is why guidelines should be developed to codify ethical performance, when possible, in areas such as the ethics of genetic testing,” says Brodell. Dermatologists won’t necessarily agree on a single “right” answer.

“But if a significant majority can come to agreement, guidelines of care could be developed around ethical issues, just as they have been developed around scientific issues,” says Brodell. ■

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Novel Training Program Pairs Clinicians With Chaplains

It's critical that all clinicians routinely assess patients for spiritual distress, identify appropriate treatment strategies, and work closely with trained spiritual care professionals, according to a recent paper.¹

"It's as essential that we care for spiritual needs as it is to care for physical, psychological, and social needs," says **Betty Ferrell, RN, PhD**, one of the paper's authors. Ferrell is director of the division of nursing research and education at City of Hope National Medical Center in Duarte, CA.

Ignoring patients' spiritual needs is "unacceptable and unethical care," adds Ferrell. "For virtually every ethical dilemma you can name, there is an underlying spiritual issue."

This is most apparent when decisions are made on life-sustaining treatments, says Ferrell. "Those decisions are influenced by what we believe about life. We can't

really say we practice healthcare in an ethical way if we ignore spirituality."

Least Comfortable Topic

The End-of-Life Nursing Education Consortium gathered data on training programs in all 50 states and 96 countries.² Clinicians named spirituality as the topic they were least comfortable discussing with patients. "We laughingly say it's a bad sign when clinicians are more comfortable talking about sexuality than spirituality," says Ferrell, the paper's lead author.

Ferrell says that in the past, physicians rarely talked with patients about sexuality. "But we learned that we had to. And if we ignore it and don't do a good assessment, then patient care will suffer."

She says the same is true of spirituality. "A classic case would be an ICU patient who comes to us in

a state of crisis, whatever the crisis may be," Ferrell explains. The initial effort is focused on a rush to diagnose the problem, perform the necessary laboratory tests, and stabilize the patient. "But if we continue to focus only on the physical without asking, 'Who is this person and who is their family?' we are setting ourselves up for disaster," she says.

Ferrell offers this alternative: That on the first day of care, someone on the team, whether the physician, nurse, or social worker, as part of routine practice, asks the family these questions:

- Are you part of a faith community?
- Is religion or spirituality important in your healthcare? Does it influence the way you make decisions?
- What will be important as we care for your loved one in the ICU?

"We need to be aware of spiritual issues in the same way we are aware of what drugs the patient is taking," says Ferrell. The clinician may learn that the family is part of a congregation that believes in miracles. "That should be a huge flag, because this is the exact patient and family that we are going to have a standoff with," says Ferrell. Such a family is likely to insist a patient is full code even as all clinical team members recognize that the patient is terminally ill.

"Unless we ask about religion, we

EXECUTIVE SUMMARY

Patients' spiritual needs often go unaddressed due to providers' lack of prioritization, time, and training. A novel training program pairs clinicians and chaplains, with the goal of:

- assessing patients' spiritual needs;
- knowing how to give referrals;
- understanding how to work with spiritual care professionals.

don't know. And if we don't know, we are setting ourselves up for ethical crisis," says Ferrell.

For a Muslim family, says Ferrell, this may mean the family won't make any important decisions without consulting their imam, or won't want family conferences scheduled during prayer time. The clinical team may learn that a patient hasn't been to church in years, and now feels that God is punishing him, indicating a need for chaplain involvement.

Ferrell says that in healthcare settings, there is increased awareness of the importance of assessing patients' cultural needs. But sometimes it turns out that issues are more spiritual than cultural, she says: "With our Latino population, we often find that the ethical dilemmas we are facing are really about being Catholic."

'Spiritual Distress Is Pandemic'

Spiritual care is lacking, primarily due to staff members' deprioritization and lack of time, according to a recent study that explored patient's spiritual care needs, experiences, preferences, and research priorities.³ Patient and caregiver focus groups were conducted at 11 countries, with the goal of developing standards.

"One of the questions that came up was, 'What is the evidence on what people want in their care?'" says **Christina M. Puchalski**, MD, OCDS, FACP, FAAHPM, director of the George Washington Institute for Spirituality and Health in Washington, DC.

The fact that spirituality was important wasn't surprising, "although they expanded the disease trajectory," says Puchalski. One

patient shared that when the doctor asked about spirituality, it was the first time she had ever thought about it in the context of her health. "I share that story when I talk to my physician colleagues. This is why we need to do a spiritual history," says Puchalski. Clinicians described distress over being so rushed that they can't listen to the patient's whole story.

"WHAT'S DRIVING THIS IS THAT SPIRITUAL DISTRESS IS PANDEMIC. WE NEED TO BE ABLE TO ATTEND TO THAT."

A newly implemented training program at the George Washington Institute, called the Interprofessional Spiritual Care Education Curriculum, pairs clinicians with chaplains. The goal is to give physicians, nurses, social workers, and psychologists practical skills in how to assess patients' spiritual needs. This includes how to give referrals and how to work with chaplains.

There already is great demand for the program, reports Puchalski: "What's driving this is that spiritual distress is pandemic. We need to be able to attend to that." It's not only individual physicians, but also health systems, that have an ethical obligation to address spiritual suffering, she stresses.

Intense interest in spirituality on the clinical front is now being mirrored in the research arena, she says. "It's phenomenal how

much research is being done in this area. People are recognizing how important spirituality is in addressing the totality of the suffering of patients."

Puchalski notes that the traditional approach is for the clinical team to take care of the patient's physical health, while psychologists take care of emotional health, and chaplains take care of spiritual health. "But we can't parse it out that way. More people are moving away from that medical model," she says.

The chaplain can care for spiritual pain as an expert. But others on the clinical team can do it as generalists, says Puchalski: "All of us on the team need to address the whole person." ■

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Education Needs Still Unmet for Family Presence During Resuscitation

Critical care nurses' needs for education on family presence during resuscitation are not being met, found a recent survey of 395 critical care nurses.¹

"As this topic was first reported in the literature three decades ago and has been repeatedly recommended in practice guidelines, it is surprising that nurses' needs for education are still not being met," says study author **Kelly Powers**, PhD, MSN, RN, an assistant professor in the school of nursing at the University of North Carolina at Charlotte.

Guidelines recommend critically ill patients' family members be offered the option to be present during resuscitation, yet the practice remains controversial.² "It is important to determine the reasons for this controversy and interventions that may improve guideline implementation," says Powers.

The study specifically focused on education as a possible intervention. "It has been shown to improve nurses' perceptions and self-confidence in prior studies," notes Powers. Some key findings include the following:

- Only one-third of nurses received education on family presence during resuscitation.
- Eighty-three percent indicated they wanted such training. "So although some may have received

education, they still desired more information," says Powers.

- Sixty-one percent of nurses received requests from family members to be at the bedside during resuscitation. Qualitative data revealed that nurses wanted help with these requests. "Specifically, they wanted to be educated on how to communicate with and support family members, and how to handle difficult situations should they arise," says Powers.

- Nurses wanted information on team training and how to implement family presence during resuscitation.

"As the focus on providing family-centered care continues to gain momentum, it is essential to educate nurses and other providers so they are more likely to honor family members' wishes," says Powers.

It is important to recognize that the critical care experience affects the family, too. "While our primary focus during resuscitation must be on the patient, we cannot forget our duty to care for their family as well," says Powers.

An umbrella term used for negative psychological symptoms that can result is "Post-intensive Care Syndrome-Family," or "PICS-F." "Offering family the option to remain at the bedside during resuscitation has been shown to significantly reduce

the frequency of the psychological symptoms that characterize PICS-F," says Powers.

Patient survival rates following CPR are low. "Anyone who has witnessed a 'code' knows that they can be brutal and often do not end well," says **Wayne Shelton**, PhD, a professor at Albany (NY) Medical College's Alden March Bioethics Institute.

Most patients who arrest and receive CPR in a hospital do not survive resuscitation. Even more do not survive to discharge. "The benefits of CPR, especially outside the ICU setting, are often assumed to be greater than the data actually indicate," says Shelton.

When families are invited to witness the team perform CPR, they may feel they are participating in the care of the patient, as opposed to just playing a passive role waiting in the hallway for the latest news. Nevertheless, many physicians are not entirely comfortable allowing families in the space where a code is being performed.

"If the family is not allowed to witness the code, a good care team will make sure the family is kept updated on what is happening," says Shelton. Someone, perhaps a nurse or chaplain, remains with them to provide support.

"My sense is whether or not to allow families to witness a code should be decided on a case-by-case basis," says Shelton.

Clinical ethics consultants often get involved in cases when the patient is very sick or dying, and CPR is not medically indicated or is medically inappropriate. "Based on the patient's medical condition, the physicians in

EXECUTIVE SUMMARY

Critical care nurses reported unmet need for education on family presence during resuscitation. Nurses wanted information on:

- team training;
- implementation;
- communicating with families.

charge have determined that CPR would not provide a benefit, add to suffering, and prolong the dying process,” says Shelton. Yet some families want “everything done,” including CPR.

“It is interesting that CPR, within the culture of medicine, is most often not viewed like other medical procedures,” says Shelton.

Surgery, for example, is routinely withheld if the patient is not clinically a candidate for the procedure. “There is no obligation to take a dying patient into the OR if, in the judgment of the surgeon, the patient would in all likelihood die due to the procedure,” notes Shelton.

Though the same determination can be made at times about CPR on certain patients, physicians are required to ask family surrogates for consent to make the Do Not Resuscitate (DNR) order.

“Most family surrogates are reasonable and do not want their loved ones to experience unnecessary suffering before they pass,” says Shelton.

But some families will not give consent to a DNR order, and demand CPR for a patient who is actively dying. “In an effort to get their consent, at times some physicians may invite the family into the room to witness the code so they will see just how brutal the procedure is on this very sick patient,” says Shelton.

The physician’s hope is that the family will change their minds. “From an ethical point of view, this is untenable,” says Shelton. To ethically justify such a strategy, one would have to believe that CPR is obligatory and should be performed in all cases where the family did not give consent to a DNR.

“At some point, as determined clinically by expert physicians, because of the patient’s medical

condition, to perform CPR would be a violation of the obligation to do no harm,” says Shelton. This logic holds for all other medical procedures. “But in the culture of medicine, strongly influenced by a certain interpretation of the law, CPR is sometimes viewed differently,” says Shelton.

Clinical ethics consultants often are brought in to help resolve these conflicts. “Often, families, with time to vent their concerns and fears, are able to shift their thinking about goals of care from recovery to comfort,” says Shelton.

“IT IS INTERESTING THAT CPR, WITHIN THE CULTURE OF MEDICINE, IS MOST OFTEN NOT VIEWED LIKE OTHER MEDICAL PROCEDURES.”

At other times, it is necessary to state clearly the limits of the physician’s obligation. This includes not only respecting patient and surrogate autonomy, but also beneficence and nonmaleficence, notes Shelton.

“One option that clinical ethics consultants make clear to the physician is not acceptable is what is referred to as a ‘slow code,’” says Shelton. That is when the care team asks the family to leave the room, and then goes through the motions of doing CPR, but in a way that doesn’t injure the patient.

“The benefit of this strategy is that it reduces harm to the patient. But the ethical downside is that it is

deceptive,” says Shelton. It gives the false impression to the family that everything was done when that was not the case.

“From an ethical perspective, providing full disclosure to the family about the limits of the physician’s obligation to provide CPR is essential,” says Shelton.

Effective communication and trust should be the underpinnings of any situation involving the possibility of CPR, says Shelton.

Families want to be kept informed and be respected, Shelton says, regardless of whether they are allowed in the room during CPR or are given limits about the physician’s obligations.

“The issues under consideration will have greater chance of being resolved to everyone’s satisfaction if there is a sound relationship between the care team and family,” says Shelton.

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Nurses Report Barriers to Involving Family Caregivers

Patient care demands, the professional practice environment, and lack of resources hindered nursing family caregiver involvement, found a recent survey of 374 critical care nurses.¹

“In the ICU, critical care nurses are key staff in promoting and supporting caregiver engagement in patient care,” says **Breanna Hetland**, PhD, RN, CCRN-K, the study’s lead author. Hetland is an assistant professor at the University of Nebraska Medical Center’s College of Nursing in Omaha.

Yet nurses’ individual perceptions and personal beliefs greatly influence their attitude toward engaging family caregivers in patient care. Ideally, interventions encourage collaborative partnerships between patients, families, and critical care nurses.

“It is imperative to understand the perceived barriers that critical care nurses face in regards to involving family caregivers in the patient’s care in the ICU,” says Hetland.

Approaches Linked to Many Factors

Researchers found that nurses’ approaches to family involvement were not only dependent on their personal beliefs. They also were linked to other factors related to the family, the patient, the professional practice environment, and available resources.

“The results of our study indicate a need to further examine factors such as staffing, space, and resources for families, and unit culture,” says Hetland. Establishing policies and

procedures that outline the role of family caregivers also is important, she adds.

Nurses reported these obstacles to involving families:

- workload burden associated with the care of critically ill patients;
- an ICU culture that is unsupportive of family involvement;
- lack of policies and guidelines to enhance the practice;
- inadequate interprofessional and nursing leadership support.

“In addition, nurses had concerns about patient and family safety and legal repercussions,” says Hetland. “These were their rationales for limiting family involvement.”

Hetland says that some nurses did not know how to involve families. They posed questions about who should be involved and how they should be involved.

If nurses are expected to engage caregivers, says Hetland, “there must be readily available, evidence-driven policies and procedures, supported by current practice guidelines, to help standardize patient care.”

Conflicting Interests

Ethicists can create opportunities for goals of treatment discussions and advance care planning across the continuum of care. “This is one of the best ways to facilitate family-centered care,” says **Tyler S. Gibb**, JD, PhD, a clinical ethicist and co-chief in the program in medical ethics, humanities, and law at Western Michigan University Homer Stryker MD School of Medicine in Kalamazoo.

One of the primary concerns,

from an ethical perspective, is balancing the disparate interests of the various stakeholders. Sometimes, these are in direct conflict.

“Particularly when establishing a goal of treatment, the team is forced to make value judgments about which interests to prioritize,” says Gibb.

Incomplete information is one of the biggest barriers to family involvement, says Gibb. This includes clearly articulated preferences or goals, diagnostic information, prognoses, and treatment efficacy.

All of these “are each unknowable to a greater or lesser degree in certain circumstances,” says Gibb. “Making ethically justifiable decisions without perfect information is always a challenge.” ■

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Study: Less Money Spent on End-of-Life Care for Rural Medicare Patients

Medicare expenditures are lower for rural beneficiaries with cancer than urban beneficiaries, found a recent study.¹

“Cancer is a significant cost-driver for insurers. Cancer patients are often a larger proportion of high-cost recipients,” notes **Elizabeth Crouch**, PhD, the study’s lead author.

Researchers analyzed utilization and expenditures for Medicare beneficiaries with breast, lung, or colorectal cancer in the last six months of life. For each type of cancer, total expenditures were lower for rural decedents compared to their urban counterparts.

“Increasing incidence and prevalence rates of cancer, combined with new and costlier cancer treatments, have patients, insurers, and policymakers alike concerned with the availability and provision of affordable, high-quality care for cancer patients,” says Crouch, an assistant professor in the department of health services policy and

management at the University of South Carolina in Columbia.

Rural cancer patients face limited access to most healthcare services — especially palliative care — compared to urban cancer patients. “Hospice services, for example, are predominantly located in urban areas,” says Crouch.

She says that this means that rural beneficiaries, particularly those with lung or colorectal cancer, are less likely to enroll in hospice than urban beneficiaries. “If they do enroll, they often enroll much later,” says Crouch. Similarly, rural patients have less access to oncology specialists and palliative care providers.

There has been limited research focusing on the last six months of life — the costliest time — for beneficiaries with cancer, she says. “In particular, little was known about rural-urban differences in end-of-life care for cancer patients,” she adds.

Even after adjusting for sociodemographic characteristics, chronic conditions, and region, the

researchers still found that rural beneficiaries had lower expenditures. “This suggests disparities in access to end-of-life care,” says Crouch. The researchers suggest that programs linking patients with the specialty care they need virtually is one approach to mitigating these disparities.

“Rural patients have a right to high-quality care at the end of life,” says Crouch. ■

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SOURCE

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Shared Decision-making Is ‘Moral Imperative’ Despite Challenges in ED

Shared decision-making is an important concept for patient autonomy, but how does it play out in the unique ED setting?

“There is a moral imperative to perform shared decision-making in the ED setting when the appropriate preconditions are met,” according to **Marc Probst**, MD, MS, an assistant professor of emergency medicine in the Icahn School of Medicine

at Mount Sinai in New York City. Probst is the primary author of a recent paper on this topic.¹

Shared decision-making should be the default approach to decision-making in the ED — except in clinical situations lacking clinical uncertainty or equipoise, patient decision-making ability, and time, the authors wrote.

For example, a patient who

presents to the ED under the influence of drugs or alcohol would generally not be eligible for shared decision-making, and nor would a patient suffering from acute psychosis.

“The emergency physician has medical expertise in diagnostic testing and therapeutic interventions. Patients know their goals and values best,” says Probst. Shared decision-

making uses these two perspectives to arrive at a mutually agreed-upon plan of care.

“Important information, education, and perspectives, based on physician assessment, should be balanced with patient preferences,” says **Catherine A. Marco**, MD, FACEP, a professor in the department of emergency medicine at Wright State University in Dayton, OH.

Unique Challenges of ED

Shared decision-making in the ED setting is difficult due to time constraints, lack of previous physician-patient relationship, and lack of privacy, Marco says.

“Despite these challenges, it is crucial to undertake shared decision-making whenever possible to agree on the best possible course of action,” says Marco. Clinicians must take into account patient preferences, goals of treatment, recommended therapeutic interventions, and expected outcomes. Marco offers the following two examples of shared decision-making in the ED:

- A 55-year-old woman presents with chest pain, with risk factors of diabetes mellitus and hypertension. The initial cardiac troponin and EKG both are normal. Her heart score is

EXECUTIVE SUMMARY

Clinicians face unique challenges to shared decision-making in the ED setting. These include:

- time constraints;
- lack of previous physician-patient relationship;
- lack of privacy.

calculated at three, placing her at low risk of an adverse cardiac event. Through shared decision-making, the physician and patient agree that she can be safely discharged home with outpatient follow-up with her primary care physician, who will see her within 24 hours.

“This case illustrates the importance of shared decision-making as a route to consider treatment recommendations and expected outcome, in conjunction with patient preferences and goals of therapy,” says Marco.

- An 88-year-old man presents with shortness of breath. He has known metastatic lung cancer and currently is undergoing chemotherapy. He is experiencing significant nausea, vomiting, and chest pain. He states his doctors have not discussed his prognosis or expected disease course. Through shared decision-making with the patient, emergency physician, and oncologist, the patient is informed of his diagnosis and treatment options. These include hospital admission,

discharge to home, or discharge to hospice. The patient and family agree that he does not wish any further chemotherapy or hospitalizations. He is agreeable to hospice care, and is discharged to hospice from the ED.

“This case illustrates the importance of multidisciplinary care, and consideration of patient goals of therapy,” says Marco. ■

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CME/CE QUESTIONS

- 1. Which is true regarding demand for ethics services, according to Ryan R. Nash, MD, MA, FACP, FAAHPM?**
 - a. Organizations should cut ethics staffing if palliative care programs are introduced.
 - b. Ethics services are seeing less complex cases.
 - c. Utilization and case complexity increase as systems grow their clinical ethics services.
 - d. Physician ethicists are less successful than nonphysicians at resolving conflicts between families and clinicians.
- 2. Which is recommended regarding patients' spiritual needs, according to a recent paper?**
 - a. Clinicians should not assess spiritual needs unless patients request it.
 - b. Clinicians should routinely assess patients for spiritual distress.
 - c. Physicians have no ethical obligation to address patient's spiritual needs.
 - d. Clinicians in the hospital setting have an obligation to leave the patient's spiritual health to chaplains who have the appropriate expertise.
- 3. Which is an ethical obligation of clinicians, according to Wayne Shelton, PhD?**
 - a. Invite the family to witness a code specifically to obtain consent to a DNR
 - b. State clearly the limits of the physician's obligation
 - c. Meet the family's demands to provide CPR with a "slow code."
 - d. Give the inaccurate impression to the family that everything was done if necessary to avoid harming the patient.
- 4. Which is true regarding involvement of family caregivers, according to a recent study?**
 - a. Patient care demands hinder family caregiver involvement.
 - b. Policies outlining the role of family caregivers are detrimental to patient care, even if they are evidence-based.
 - c. ICU culture has no effect on nurses' ability to involve families.
 - d. Increased workload burden associated with the care of critically ill patients makes nurses more determined to involve families.