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Ethics Involvement Needed With Complex Discharges

Moral distress is issue

Ethicists are seeing increasing numbers of consults involving concerns with discharge planning. “This is an even more common ethical issue than end-of-life issues. Those happen regularly, but not hourly as with discharges,” says **Bob Parke**, BA, BSW, MSW, RSW, MHSc, a former clinical ethicist at Humber River Hospital in Toronto.

Discharge planning encompasses multiple ethical issues, including consent, capacity, and autonomy. “The pressure for expedient discharges can risk less-than-thorough assessments and referrals for follow-up care,” says Parke, who worked as a discharge planner in the hospital setting early in his career.

Moral distress stemming from discharge planning needs to be “on the radar screen of ethics,” says Parke.

If patient preferences conflict with clinical recommendations, or needed resources are unavailable, it can be a cause of significant moral distress for clinicians. “Not uncommonly,

“THE PRESSURE FOR EXPEDIENT DISCHARGES CAN RISK LESS-THAN-THOROUGH ASSESSMENTS AND REFERRALS FOR FOLLOW-UP CARE.”

patients would likely benefit from additional support — for example, a home health aide — but don't qualify for funding,” says **Maralyssa Bann**, MD, director of hospital medicine at Seattle-based Harborview Medical Center.

Hospital policies regarding potentially unsafe discharges, says Bann, “should take into account an ethical framework for how to frame the discussion, as well as how to support the clinician and patient.”

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EDITORIAL QUESTIONS
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The following are common scenarios that trigger ethics consults:

• **Utilization managers are pressuring family to arrange nursing home admission prematurely.**

Because an elderly patient's cognitive function decreased during hospitalization, a utilization manager pressured the family to start the process of arranging nursing home admission. "Fortunately, there was a good history of the person's preadmission cognitive and physical function," says Parke. Clinicians advocated for more time to assess the patient. This included referrals to a geriatric specialist.

"This was met with anger for delaying a discharge plan," says Parke. A thorough assessment revealed that the patient was experiencing delirium, not dementia. After some additional time and treatment, the patient was discharged home. "If the healthcare team had yielded to expediency, the patient would have been wrongfully discharged to an inappropriate setting," says Parke.

A good social work assessment and a collective advocacy on behalf of the patient contributed to a positive outcome. "Doing the ethically correct discharge required courage and knowledge of the patient," says Parke.

• **The patient wants to go home, but clinicians think it is unsafe.**

"While we accept that a capable person has the right to live at risk, we feel moral distress about whether we are doing the right thing discharging the person," says Parke. This is true for suicidal patients, persons living with substance abuse, frail seniors who live alone, or vulnerable people returning to possibly abusive situations.

A recent ethics consult involved an elderly woman who lived alone with minimal social support, who was hospitalized after a fall. The patient wanted to go home, but the physiotherapist and occupational therapist were concerned about fall risk. In such cases, says Parke, "there is tension between our desire to avoid harm and also respect our patient's autonomy."

The ethicist's first question was, "Is the patient competent to make decisions?" The staff acknowledged that the patient clearly understood that a fall could lead to a serious injury and limit her ability to care for herself. The patient was discharged home, despite staff's concerns about a serious injury that might be avoidable in a supervised care setting. The clinical team's ethical obligations included:

- performing a quality assessment, which revealed the patient's need to get home to care for pets who were unattended;
- making referrals to social workers who identified financial resources to supplement home care.

EXECUTIVE SUMMARY

Multiple ethical issues arise during discharge planning, including consent, capacity, and autonomy. The team's ethical obligation includes:

- performing a thorough assessment to discover any undetected issues;
- involving others to identify resources to supplement care;
- facilitating any home care services patients are eligible for.

“We cannot always assume that the optimal discharge plan is being made,” says Parke. Consequently, all team members — including the bioethicist — may need to recommend necessary follow-up care.

Patients don’t always agree to the treatment plan. “In these situations, the clinician may be tasked with creating a plan in line with the patient’s desire to maintain independence that feels unsafe,” says Bann.

The ethical dilemma then becomes a debate between respect for autonomy and the principle of beneficence. “Clinicians have a duty to provide appropriate care and benefit to a patient, while the patient has the right to choose an alternative,” Bann says.

• **The patient wants to go home and is cleared for discharge, but the family thinks it is unsafe.**

After a patient’s recent displays of uncharacteristic anger and forgetfulness, the family requested admission to a long-term care facility. After treatment, both cognitive and physical function improved.

“The patient and staff both started to ask about going home,” says Parke. The family objected. In this case, the team’s ethical obligation included conducting a thorough assessment to determine whether the patient needed assistance with basic activities of daily living.

It turned out that the patient had difficulty hearing. If this communication barrier went undetected, says Parke, “we might have created a discharge plan that did not engage the patient in the decision-making process.”

The ethicist informed the patient’s surrogate decision-maker, who

was very reluctant to accept the discharge, that:

- the law allows only the capable person to make their own healthcare decisions;

- the role of the surrogate only comes into effect when an individual is found incapable.

The patient was ultimately discharged home over the surrogate’s objections. The team’s ethical obligation at that point, says Parke, was “to ensure that the optimal level of support was planned for when the patient was discharged home, where the patient wanted to be.” ■

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‘Uh-oh, the Ethics Police Are Here!’ Address Misconceptions Head-on

Constant education on role is needed

“Someone must have done something wrong.” Whether they admit it, that is the first thought some clinicians have when they catch sight of an ethicist in the department.

“Sometimes there is an assumption that when you call ethics, you couldn’t figure it out on your own, so you had to call these other people in,” says **Anita J. Tarzian**, PhD, RN, program coordinator of the Maryland Healthcare Ethics Committee Network in Baltimore.

Heading off such concerns, which are sometimes unspoken, is ideal. Tarzian begins consults by stating: “These days, we are working at a faster pace, and decision-making

is more complex. We view ethics consults as a kind of moral timeout. We carve out space to reflect with someone who has a neutral perspective.”

Regardless of how much an institution values ethics, “ethicists are still faced with continually educating others about their role,” says **Paula Goodman-Crews**, MSW, LCSW, bioethics director at Kaiser Permanente San Diego, and Kaiser Permanente Southern California bioethics program director.

The following are some scenarios involving misconceptions of the ethics role:

• **Clinicians sometimes call**

ethicists because of ongoing communication problems.

A revolving door of ethics consults for the exact same issues does everyone a disservice. “You are enabling the continuation of substandard clinical practice,” Tarzian explains.

A better approach: Address the root of the problem by helping clinicians communicate about a particular issue. “Ethics has to figure out how to be a benefit not just for that individual encounter, but at the institutional level,” says Tarzian.

For instance, a physician’s strong moral distress might be the underlying reason for an ethics

consult. “The skilled ethicist will be able to discern the contributing factors and work with the team,” says Goodman-Crews.

Recently, a nurse reported that a physician had not obtained appropriate informed consent from a patient. The nurse wanted the ethicist to talk to the physician about it. “It was with good intent. But she was trying to use ethics as a buffer,” says **Steven Squires**, MEd, MA, PhD, vice president of mission and ethics at Cincinnati-based Mercy Health. It soon became apparent that the nurse had never spoken directly to her colleague about the concern. “Everybody tries to avoid difficult conversations. But that’s not a reason to call ethics,” says Squires.

• **Clinicians ask for help with something outside the purview of ethics.**

Squires finds that a “warm handoff” to the appropriate hospital department is best. A curt response, like “That’s not ethics. That’s legal,” comes off as dismissive. Instead, the ethicist can respond: “I understand how needing interpretation of how the law applies to this situation would be troubling. I wonder if our colleagues in legal could help with this?”

• **A clinician wants the ethicist to get the patient or family on board with a treatment plan.**

“This is a dynamic that sometimes happens, which is a

misunderstanding of ethics,” says Tarzian.

Recently, a surgeon asked an ethicist to convince an elderly patient to undergo a procedure that the surgeon thought beneficial. Goodman-Crews explained that the role of the ethicist is not to convince, but to help facilitate meaningful conversation based on established ethical norms.

Some ethics consults are called because the team believes the family’s decision on treatment is harming the patient. Demands for aggressive care for a patient who is not expected to survive discharge from the ICU or regain enough neurological function to ever be conscious again are common examples. It is not necessarily a reason to involve ethics, says Tarzian. The clinical team refers to a multisociety consensus statement for guidance.¹

“If the team still gets pushback, you go through the conflict resolution process,” says Tarzian.

This requires the clinical team to concur with the prognosis and appropriate treatment. This way, everyone is on the same page when it is time to communicate with the family. “A lot of time, there is lack of consensus among the team itself as to what options should be on the table and off the table,” says Tarzian.

Ethicists should not merely persuade families to do what the clinicians want. However, they should

be of help in conveying that the team is in agreement that a particular treatment should not be offered. “If the team has tried their best and hasn’t succeeded, then the ethicist — who presumably has excellent communication and mediation skills — can give it a try,” says Tarzian.

• **Clinicians believe the ethicist is there just to criticize.**

“In reality, it’s about how to bring together the different interests that people think are important, and making them jell as much as possible,” Squires says.

Squires invites people to think of him as a member of the team. He then explains that ethics is not out to take over, but simply to offer the best ethics knowledge possible after asking the right questions and getting the right information.

Tarzian offers this explanation: “It’s not our job to tell you what to do. If it’s an issue of medicine, the medical team makes those decisions. What we are doing is facilitating a conversation to figure out what’s the right thing to do, using shared decision-making standards.”

• **People are unclear if the ethicist is leading or participating.**

“You have to establish the ground rules,” says Tarzian. This means clarifying whether the ethicist is being asked to lead a meeting, or simply be present as a participant.

“The question is, ‘How can I be of service to the team?’ Ethicists need to clarify what their role is,” says Tarzian. “I don’t see that happening all the time.”

• **The team thinks the ethicist did a poor job because some of the involved parties are still unhappy.**

“There is a perception that if everyone is not happy at the end of the consult, the ethicist hasn’t done a good job,” says Squires.

Many consults are called due to

EXECUTIVE SUMMARY

Clinicians sometimes wrongly assume the ethics role is to reprimand, criticize, or convince. To avoid misunderstandings, ethicists can clarify:

- whether they are leading a meeting or participating in one;
- that the root causes of poor communication should be identified;
- that they can help convey the team’s agreement that a particular treatment should not be offered.

an intractable conflict that's gone on for days or weeks. "I don't know of anybody, irrespective of their skill, who can erase all the negative feelings that have been harbored," says Squires. A more realistic goal is to come to a resolution that everyone can agree to. ■

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Online Comments Allow Greater Input on Ethics Consults

A close inspection of the medical record revealed conflicting information regarding a particular patient's code status at University of Michigan Health System. The issue was identified and addressed due to an online comment system allowing for broad committee participation in ethics consultations.

The system was designed to "promote consistency and achieve consensus in services rendered, as well as to enable quality assurance," says **Andrew Shuman**, MD, service chief of the clinical ethics service at University of Michigan's Center for Bioethics and Social Sciences.¹

Researchers analyzed 159 adult ethics consults recorded between January 2011 and May 2015. The most common comments were:

- requests for additional information;
- recommendations for additional services;
- references to formal policies or standards.

"The electronic venue created a meaningful and substantive discussion," says Shuman. "The process appears to improve the overall quality of clinical ethics consultation."

Recommendations now reflect the input of diverse committee members.

"There is a focus on ensuring that case summaries, ethical analyses, and recommendations are accessible, clear, and specific," says Shuman.

More Expertise Available

Input on ethics consults was previously limited to whoever happened to be on call when a request came in. The online system means more people can share insights on ethical dilemmas.

"It allows the considerable and varied expertise of the members of our ethics committee to be brought to bear on the dilemmas that arise in our clinic," says **Raymond De Vries**, PhD, the center's associate director.

Medical students are able to see how cases were debated and ultimately resolved. "This provides them with firsthand experience in ethics consultation that normally would be impossible," says De Vries.

Most members of the ethics committee have full-time obligations elsewhere. They were typically unable

to give feedback on consults, except post-hoc during monthly meetings. The online comment system has changed this.

"The folks doing the consult can get real-time, useful opinions of the nurses, philosophers, social scientists, and chaplains who are committee members, but are not right there in the midst of the consult," says De Vries. ■

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Ethics of Exception From Informed Consent in Emergency Research

Obtaining informed consent isn't possible for patients with life-threatening conditions such as cardiac arrest, hemorrhagic shock, or traumatic brain injury. Thus, these patients often have been excluded from clinical research.

To mitigate this, regulations allowing Exception From Informed Consent (EFIC) or Waiver of Informed Consent (WIC) were developed in 1996.

But how are these actually being used in emergency research? To answer this question, researchers analyzed 28 studies using EFIC or WIC.

"The motivation for this study was to determine how often and how well EFIC has been used since its availability. 2016 marked the 20th anniversary," says **Michelle H. Biros**, MD, MS, professor of emergency medicine and interim chair in the department of emergency medicine at University of Minnesota Medical School in Minneapolis.

The researchers wanted to see if investigators explained why EFIC is justified to answer the study questions. "Research without prospective consent is a sensitive issue," says Biros. "It is important for investigators to show that

EFIC was carefully considered and appropriately applied."

Not all studies reported completion of prestudy regulatory requirements. Only half of studies reported the FDA investigational new drug/investigational device exemption application. Less than half reported community consultation (46%) and public disclosure (36%). Justification of the need for the use of EFIC and WIC was described in only 46% of publications.

"Although logistical aspects of the EFIC requirements are frequently discussed in primary research papers, the justification for its use is not so well-described," concludes Biros.

Research using EFIC needs to balance competing ethical principles.

"Two alternative safeguards were created to substitute for prospective informed consent: public notification and community consultation," says **Terri Schmidt**, MD, MS, professor emeritus in the department of emergency medicine at Oregon Health & Science University in Portland. The intent was to balance protection of potential subjects with the greater public good of improving care.

"The devil is in the details," says Schmidt. "We still struggle with

the best ways to do community consultation and public notification to meet the intent." As both an emergency researcher and a healthcare ethicist, Schmidt attended a community consultation meeting for the first study performed at OHSU using EFIC.

"Despite our best efforts, only four people attended the meeting," says Schmidt. The IRB head indicated that he planned to approve the study, but that better ways to engage the community were needed. "I agreed, and have done a few studies looking at other ways of doing it," says Schmidt.^{2,3}

Impossible to Attain

Ideally, research participants receive a thorough explanation of risks and benefits, have adequate time to consider these in light of their own personal values and goals, and have any questions answered in a respectful and thoughtful manner.

"There are multiple issues facing the patient and the researcher in the emergency medicine setting that make that ideal impossible to attain," says **Roger J. Lewis**, MD, PhD, FACER, a professor and chair in the department of emergency medicine at Harbor-UCLA Medical Center in Torrance, CA.

The ethical challenge for researchers working in this area is to balance the goals of providing information and fostering patient autonomy, yet still allow important research to be conducted.

"It's an inconvenient truth that in order to improve the care of patients with acute medical conditions, you

EXECUTIVE SUMMARY

Researchers do not always justify use of exception from informed consent, found a recent study. Other findings include:

- not all studies reported completion of the prestudy regulatory requirements;
- only half of studies reported the FDA investigational new drug/investigational device exemption application;
- less than half reported community consultation and public disclosure.

have to do research on patients with acute medical conditions,” says Lewis.

Both the patient, who is a prospective research participant, and the population that in the future suffers from the acute condition, have the potential for improved care. “Failing to do the research simply means we are condemning all future generations to receiving the same unproven therapies that we often use today,” says Lewis.

Other ethical issues include the following:

- The patient’s condition may be distracting, anxiety-provoking, or otherwise affect the ability to think clearly.

This is true even for medical conditions that do not directly affect cognition. “This makes it difficult even for the patient to apply their own values to the decision,” says Lewis.

- The dual role of the clinician/investigator in providing care and conducting research makes it difficult to maintain the clear boundaries between clinical care and research that ideally would exist.

- The time frame for treatment may be relatively short.

“This makes it necessary to make a decision quickly about participation, versus receiving standard care for their condition,” says Lewis.

Gaps in Regulations

The regulations specifically state that they are intended for the investigation of therapies for diseases without effective treatments, or where treatments are unproven. “That language, while I believe intentionally vague, has been interpreted by many as not allowing

this provision of the regulations to be used when a treatment is often successful, but we are trying to make more modest improvements in outcomes,” says Lewis.

The ethical question: Should regulations apply if effective treatment does exist, but researchers want to further improve outcomes? An example would be a traumatic injury with an 80% survival rate with current treatment. The way the regulations are written, it is unclear whether the EFIC can be used to evaluate a therapy intended to improve the survival rate to 90%.

“There is a tremendous need for clarity in determining the types of therapies for which the exception can be used,” says Lewis. This would allow researchers to broaden its use, to evaluate therapies that are potentially more effective than current treatment.

Whether EFIC can be applied in settings where patients are at substantial risk of poor outcome or death, but most do well, currently is unclear.

“It’s up to the IRB, informed by the processes of community consultation, to determine when the risk/benefit ratio of subjects is sufficiently neutral or positive so it makes sense,” says Lewis.

In some cases, the FDA decided that EFIC could not be used because the majority of people do well with existing therapy, even though there was significant room for improvement in outcomes. “That has made proposed trials infeasible using consent limited to legally authorized representatives,” says Lewis.

At the time the regulations were being drafted, there was a general consensus that it was very important that their use be restricted to the most dire situations. “Researchers

now have over two decades of experience with the application of the regulations,” notes Lewis.

A relatively small number of subjects enrolled under the exceptions withdraw or are dissatisfied with their participation. In light of this, argues Lewis, “It’s time to consider broadening the scope of therapies that can be evaluated under the exceptions.” ■

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Religion, Sense of Calling Linked to Caring for Medically Underserved

A recent survey of third- and fourth-year medical students revealed that their intention to practice in underserved areas is influenced by factors such as growing up in medically underserved settings, previous work experience in religiously affiliated organizations, a very strong sense of calling, and high medical school social mission scores.¹

“Caring for the medically underserved remains a pressing need in our shifting healthcare environment,” says **John D. Yoon, MD**, one of the study’s authors. Yoon is associate program director of the internal medicine residency program at Mercy Hospital and Medical Center in Chicago, and associate faculty of the MacLean Center for Clinical Medical Ethics at the University of Chicago.

Of the 474 students who responded to a follow-up survey, 34% had an intention to practice among the underserved.

“The ability of physicians to derive intrinsic meaning from their work may be an important factor influencing long-term workforce retention when caring for the underserved,” says Yoon.

Physicians will encounter challenges that test their commitment. These include high educational debt, lack

of positive role models, and exposure during training to the often chaotic work environments of underresourced clinics and hospitals.

“When push comes to shove, physicians will by default rely on their deepest commitments and their inner resources,” says Yoon.

The study is part of the University of Chicago’s Project on the Good Physician, a research initiative on the ethical and professional development of physicians in training.

“A growing number of critics argue that conventional, didactic approaches fall far short of helping physicians develop the moral characteristics essential for good medical practice,” says Yoon.

In this particular study, the researchers wanted to learn more about how a medical student becomes a physician “who finds enduring meaning and intrinsic reward in the sort of clinical practice that meets the pressing needs of the United States public,” says Yoon.

The researchers noticed a “glaring gap” in the medical literature on the role of religion and spirituality. “We did find that more religious medical students were more likely to report intentions to enter primary care in underserved settings,” says Yoon.

However, the majority of medical students have no intentions of practicing among the underserved. This is the case despite a physician shortage that disproportionately affects this population.

“Our study highlights the important role that institutional cultures of academic medical centers might have in training the kind of physicians who are committed to caring for the underserved,” concludes Yoon.

Physicians strongly committed to caring for the underserved act as role models for trainees. “I suspect that these cultures will have an immense long-term influence on whether trainees choose careers that care for the underserved,” says Yoon. ■

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Ethics of Informed Consent for Opioid Discontinuation

Patients addicted to opioids often find themselves with nowhere to turn when they try to discontinue the medication.

“Unfortunately, for most of the past three decades, prescribers have not been providing this information to patients,” says **Anna Lembke**, MD, program director of Stanford (CA) University’s addiction medicine fellowship.

Physicians themselves were unaware of the risks. “They were taught that as long as the patient was being prescribed an opioid for a medical condition, their risk of addiction and adverse consequences was less than 1%,” says Lembke.

About a quarter of patients receiving opioids from a doctor will begin to misuse them, and approximately 10% will become addicted.¹ Sixty percent of 809 long-term opioid users said doctors offered no advice on how or when to stop taking the drugs, found a 2016 survey conducted by *The Washington Post* and the Kaiser Family Foundation.²

On the local, state, and federal levels, says Lembke, “we are not doing an adequate job helping patients who have already become dependent on opioids through a doctor’s prescription.”

Many individuals on high-dose, long-term opioid therapy experience co-occurring psychiatric disorders. “The process of the opioid taper destabilizes not only their pain condition, but also their mental health,” says Lembke.

Opioid tapering must occur in a “humane and safe way,” says Lembke.

This is a slow process — months to years, in some cases — including

mental health support and alternative pain therapies. “Not just prescribers, but also third-party payers, have an ethical obligation to conduct safe and humane opioid tapers,” says Lembke.

Any person who takes an opioid medication for an extended period of time can be expected to develop a physiological dependence on it, says **Ben A. Rich**, JD, MA, PhD, emeritus professor of medicine (bioethics) and school of medicine alumni association endowed chair of bioethics at UC Davis School of Medicine in Sacramento.

“This is not a pathological condition. It is the reason why patients who are discontinuing such medications must be weaned from them slowly,” says Rich.

The addiction potential of opioids, based on inadequate and flawed data, was seriously underestimated during the 1990s and early 2000s. “This misinformation was exacerbated by promotional undertakings by the pharmaceutical companies that manufactured these medications,” Rich says.

Physicians were strongly urged to consider prescribing strong opioids for chronic pain patients, even before less risky nonopioid medications and physical therapy were given a reasonable chance. “Physicians were admonished by national professional organizations, as well as the pharmaceutical industry, to recognize their ethical obligation to promptly and effectively address their patients’ complaints of pain,” adds Rich.

Rich says physicians have ethical and professional obligations to:

- provide patients with safe and effective strategies for withdrawing from opioids;

- monitor how well patients understand their role in the withdrawal process;

- meet regularly with patients to review progress toward successful withdrawal.

“If the opioid epidemic has any silver lining, it’s that it has forced medical schools to take the problem of addiction seriously,” says Lembke. Many medical schools are currently revamping curricula to teach addiction medicine, with a particular focus on safe opioid prescribing.

“Without the knowledge and skills, doctors will not be able to help, even when ethically mandated to do so,” says Lembke. ■

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New Data Support Family Participation in ICU Rounds

When family members of critically ill patients attend rounds in the ICU, enhancing communication and satisfaction may improve healthcare quality, a Canadian study suggests.¹ Researchers observed 302 rounds on 210 patients in seven hospitals. They found that family members attended 68 rounds, were present in the ICU but didn't attend 59 of the rounds, and were not present during the majority of rounds. Some key findings include:

- rounds took about four minutes longer when families were present;
- there were no significant differences in the discussions doctors had about patient prognosis;
- family attendance might improve information-gathering, team dynamics, doctor-patient-family relationship-building, workflow, and shared clinical decision-making.

Family participation during ICU rounds has been recommended for more than a decade.² “But most of the literature examining outcomes of this practice are forms of satisfaction and experience reports,” says **Selena Au**, MD, the study's lead author and a critical care physician at University

of Calgary's department of critical care medicine in Alberta.

Family members and providers share some perspectives on family participation in ICU rounds, but there also is some discordance, found another recent study.³ “It gives us a calling to find out the source of this discrepancy, and find and measure appropriate objective outcomes,” says Au, the study's lead author.

The researchers surveyed 63 family members and 258 providers. About 38% of providers estimated only moderate family member interest in participating in rounds. Yet 97% of family members expressed high interest. “It's not a surprise to me that families describe themselves as finding benefit from rounds,” says Au.

Family members and providers both said that listening and sharing information about the patient were appropriate roles for family members. Compared with family members, providers were more likely to perceive family participation as causing stress and confusion. “Role clarity, and its importance to communication, is a recurring theme within many ethical dilemmas that arise,” says Au.

Notably, families saw their role as largely passive. “Proper education on families' role as an active co-decision-maker during rounds is needed, on both the family and provider fronts,” concludes Au. ■

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- **Selena Au**, MD, Department of Critical Care Medicine, University of Calgary, Alberta. Email: selena.au@albertahealthservices.ca.

Identify What Kind of Ethics Help Nurses Need

Most ethicists are keenly aware nurses want more ethics education, but are uncertain as to the specific scenarios they find most troubling.

“What are nurses asking for? It may be how to communicate their concerns, tools for ethical analysis, coaching, or support,” says **Cynda Hylton Rushton**, PhD,

RN, FAAN, Anne and George L. Bunting professor of clinical ethics at Johns Hopkins University's Berman Institute of Bioethics in Baltimore. She suggests these approaches:

- hold focus groups to better understand the nuances of nursing requests;
- develop interprofessional ethics rounds;

- engage frontline nurses to understand their concerns;
- provide additional training for a group of nurses who then serve as “ethics champions” on their units.

Ethicists at Johns Hopkins implemented a monthly “ethics for lunch” series attended by about 50 physicians, nurses, chaplains, and students.

Recent topics included disagreements between surrogates and clinicians over pain management, assessment of decision-making capacity, and patients making racist remarks about healthcare professionals. “They are case-based, and reflect themes from our ethics consults,” says Rushton. “They are a forum for community dialogue and education.”

These are some common ethical challenges reported by nurses:

- **End-of-life care conflicts between team members, patients, or surrogates.**

“Often there are conflicts around patients’ goals of care and the boundaries of ethical permissibility in aspects of end-of-life care,” says Rushton.

Ethicists can be proactive in helping nurses explore the ethical boundaries at the end of life and the ethical tensions that accompany decisions that may cause suffering or moral distress. “Identifying ethically troubling cases before the situation has deteriorated can help bring concerns into dialogue,” says Rushton.

- **Adequacy of informed consent.**

Nurses sometimes are concerned that the patient’s decision-making capacity has not been appropriately assessed, says Rushton.

But another ethical concern is whether all options, including no treatment, have been disclosed to the patient. Several nurses at West Virginia University Hospitals voiced concerns that oncologists were focusing mainly on the potential benefits of certain treatment options, and downplaying burdens and side effects.

“The patient is not really participating in full shared decision-making if they haven’t been given all the facts,” says **Alvin Moss**, MD, a professor at West Virginia University’s

Center for Health Ethics and Law in Morgantown.

- **Refusal of nurse care, particularly when it results in harm to the patient that reflects poorly on the institution or is not reimbursable.**

A patient who refuses to allow a nurse to change a central line dressing may end up with a bloodstream infection. Likewise, a patient who refuses to be turned can end up with a pressure ulcer. “Both of these are potentially reportable harm events, and the associated care is not reimbursable,” notes **Lucia D. Wocial**, PhD, RN, FAAN, a nurse ethicist at Fairbanks Center for Medical Ethics at Indiana University Health in Indianapolis.

It is a delicate balance for nurses who are in a position of trying to help a patient who is refusing nursing care. “Nurses should neither quickly accept the refusal nor override it. These situations can be nuanced,” says Wocial. Nurses need to use excellent communication skills to connect with the patient emotionally and cognitively and persuade him or her to accept the nursing care. “Persuasion is okay. Coercion — ‘Do it or I won’t give you your pain medication’ — is not,” says Wocial.

- **Potentially inappropriate treatment is being given, such as aggressive life-sustaining treatments for patients with terminal illness.**

“This is particularly concerning when a patient is actively dying, is a full code, and the nurses are responsible for initiating the resuscitation attempts,” says Wocial. If a nurse feels a patient is at risk of dying, the nurse should initiate conversations with the medical providers about planning for the code before it happens. “There are also times when a code will happen, even if a patient is not going to survive

it,” says Wocial. “The nurse can have conversations with the team about how to navigate that.”

Bioethicists can help clinical team members sort through their values and what it means to respect others’ values. “Bioethics can also help nurses think through why a short code is ethically defensible and a ‘slow code’ or ‘show code’ are not,” says Wocial.

- **Understaffing with potential to harm patients.**

“This often shows up as concerns about not being able to fulfill their image of being a good nurse because they don’t have the time to spend with their patients to deliver quality nurse care,” says Rushton. How nurses balance competing obligations raises the ethical issue of justice.

“Nurses may need coaching to be able to articulate the nature of their concern with leaders,” says Rushton.

For example, nurses can reframe concerns about staffing to reflect legitimate concerns about patient safety. “Helping nurses unpack their ethical concerns assists them in communicating more effectively to engage others in addressing the root causes,” says Rushton. ■

SOURCES

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CME/CE QUESTIONS

- 1. Which is true regarding discharge planning, according to Bob Parke?**
 - a. The team has no ethical obligation to involve others to identify resources to supplement care.
 - b. Pressure on the family exerted by utilization managers falls outside the purview of ethics.
 - c. Patient safety always supersedes patient autonomy if a patient wants to be discharged home but clinicians believe a skilled nursing facility is needed.
 - d. The team's ethical obligation includes facilitating any home care services for which patients are eligible.
- 2. Which did a recent study find regarding caring for the medically underserved?**
 - a. Growing up in medically underserved settings was associated with intention to practice in underserved areas.
 - b. Most medical students reported an intention to practice in underserved areas.
 - c. Religious medical students were less likely to report intending to practice in underserved settings.
 - d. Exposure to physicians committing to caring for the underserved had no influence on trainees' choosing to practice in this area.
- 3. Which did a recent study find regarding family participation in ICU rounds?**
 - a. Rounds were quicker when families were present.
 - b. Doctors had higher-quality discussions on patient prognosis when families were present.
 - c. Compared with family members, providers were more likely to perceive family participation as causing stress and confusion.
 - d. Most family members had only moderate interest in participating in rounds.
- 4. Which is an appropriate role for a clinical ethicist, according to Anita J. Tarzian, PhD, RN?**
 - a. To persuade families to do what the clinicians want.
 - b. To convey to the family reasons a particular treatment is considered inappropriate.
 - c. To ensure that all stakeholders come to a consensus.
 - d. To make a decision about what is the right thing to do.