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RELIAS
MEDIA

More Data on Moral Distress: It Harms Nurses, Physicians, Hospitals — and Patients

Ethics availability 'vitaly important'

A group of researchers set out to learn the most effective ways to decrease moral distress in healthcare. In the process, they discovered the toll it was taking was greater than expected.

"I was stunned to discover that a significant number of ICU nurses have considered leaving their positions because of moral distress," says **Marianne C. Chiafery**, DNP, PNP-BC, a clinical ethicist at University of Rochester (NY) Medical Center and an assistant professor of clinical nursing at University of Rochester.

Over a two-month period, 32 nurses from three ICU settings in an 800-bed tertiary academic medical center

participated in six "ethics huddles."¹ A nurse ethicist led the discussions. Nurses appreciated the chance to analyze situations that troubled them deeply, says Chiafery, the study's lead author. "The depth of moral distress ran deeper than I expected."

The nursing ethics huddles were associated with higher quality of work life, improved patient care, and increased clinical ethics knowledge. Many nurses reported improved communication skills as well. "This was not an intentional goal, but

"IT IS VITALLY IMPORTANT THAT ETHICISTS, OR FACILITATORS WITH A STRONG BACKGROUND IN ETHICS AND ETHICAL REASONING, MEET WITH STAFF ON A ROUTINE BASIS."

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AUTHOR: Stacey Kusterbeck

EDITOR: Jill Drachenberg

EDITOR: Jonathan Springston

EDITORIAL GROUP MANAGER: Terrey L. Hatcher

SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

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EDITORIAL QUESTIONS

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(404) 262-5508

a nice bonus for all involved,” says Chiafery.

Developing solutions to address ethical dilemmas was helpful in decreasing distress. Especially important, says Chiafery, is that someone with ethics expertise is available to:

- help nurses work through difficult situations;
- listen with an empathic ear;
- facilitate conversation and discussion;
- provide ethics education.

“It is vitally important that ethicists, or facilitators with a strong background in ethics and ethical reasoning, meet with staff on a routine basis,” says Chiafery.

Moral distress is nothing new, although there’s much greater awareness of it. “It has been around for a long time,” says **Lucia D. Wocial**, PhD, RN, FAAN, a nurse ethicist at Fairbanks Center for Medical Ethics at Indiana University Health in Indianapolis.

The fact that people are recognizing that moral distress is a significant concern for all clinical care providers is a “hopeful sign,” says Wocial. “Individual providers as well as organizations are beginning to recognize that it is not just an issue for nurses.”

The National Academy of Medicine’s Action Collaborative on Clinician Well-Being and Resilience, launched in 2017, is one example.

It is not enough, though, says Wocial: “Addressing moral distress also depends on a recognition that the culture of healthcare at the unit, organization, and industry level must change.”

Nurse-Physician Communication

As an ICU nurse, **Natalie S. McAndrew**, PhD, RN, ACNS-BC, CCRN, experienced moral distress many times. Mostly, it involved decisions made by family or providers about life-sustaining interventions at the end of a patient’s life. “Healthcare organizations have to start taking this issue seriously. Otherwise, we will continue to keep losing nurses,” says McAndrew, an assistant professor in the College of Nursing at University of Wisconsin-Milwaukee.

McAndrew conducted several recent studies on moral distress. One explored the relationship between moral distress and the professional practice environment. That study identified communication between nurses and physicians as an important factor.² “The more we have a good relationship, the more moral distress is going to tend to go down,” says McAndrew.

For example, simply understanding why a provider wants to try one more intervention can

EXECUTIVE SUMMARY

Moral distress causes some ICU nurses to consider leaving their positions — and negatively affects patient care. To mitigate this, organizations can:

- improve communication between nurses and physicians;
- track well-being of healthcare providers;
- address systemic issues causing moral distress

decrease moral distress. “That is how you grow as a clinician and do the kind of self-reflective practice that can help you with the next moral distress and the next one after that,” says McAndrew.

Another study explored the differing perspectives of nurses and physicians on end-of-life decision-making in the ICU.³ “Nurses and physicians experience moral distress,” says McAndrew. “The ability to resolve the distress is closely tied to one’s ability to share their moral perspective.”

When team members feel their perspectives about care are not heard, says McAndrew, “it becomes difficult to provide support to patients and families.”

The overall impact of moral distress and effective interventions remained unclear. “We needed a good idea of, ‘What is the state of the science?’” says McAndrew. This led to an analysis of 42 studies from 2009 to 2015 that suggested that moral distress has negative effects on the quality of care.⁴

“More data on how ethical conflicts and moral distress affects patients and families is needed,” says McAndrew. However, few effective approaches were identified in the literature. “We need to develop more effective interventions to improve patient, family, and provider outcomes,” says McAndrew. Putting metrics in place to assess the well-being of healthcare providers is an important step.

The growing focus on burnout among healthcare professionals has called attention to the problem of moral distress. “I think the burnout that we are experiencing is a manifestation of the ethical conflict that we feel, typically with end-of-life decisions,” says McAndrew.

Unresolved moral distress may be

an antecedent to burnout. “Many health professionals will share that they get to a point where they have simply had enough and leave their clinical practice setting, or even the profession,” says McAndrew. Working with symptoms of burnout is a concern too, says McAndrew: “This can negatively impact patient and family care.”

“I THINK THE BURNOUT THAT WE ARE EXPERIENCING IS A MANIFESTATION OF THE ETHICAL CONFLICT THAT WE FEEL, TYPICALLY WITH END-OF-LIFE DECISIONS.”

While there’s greater awareness of moral distress, hospital administrators tend to see it as something an individual nurse experiences. Too much emphasis on coping skills can obscure the fact that systemic problems are involved, says McAndrew.

For instance, there may be a policy in place that prevents a family member from remaining at the bedside continuously, for instance. “We want to be careful that we don’t just say, ‘It’s just your problem as an individual and you need to go fix yourself,’” says McAndrew.

Also largely unrecognized: that physicians and other disciplines are adversely affected by moral distress. Often, it’s viewed as purely a nursing issue.

“Physicians’ voices are heard over the nurses’ voices, and the nurse gets caught up in the middle of the physician and family,” says McAndrew. “We need to work together in this.” ■

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- **Marianne C. Chiafery**, DNP, PNP-BC, Assistant Professor of Clinical Nursing, School of Nursing, University of Rochester (NY). Phone: (585) 276-5184. Email: Marianne_Chiafery@URMC.Rochester.edu.
- **Natalie S. McAndrew**, PhD, RN, ACNS-BC, CCRN, Assistant Professor, College of Nursing, University of Wisconsin-Milwaukee. Phone: (414) 229-5701. Email: mcandre3@uwm.edu.
- **Lucia D. Wocial**, PhD, RN, FAAN, Nurse Ethicist, Fairbanks Center for Medical Ethics, Indiana University Health, Indianapolis. Phone: (317) 962-2161. Email: lwocial@iuhealth.org.

Data on Hospital Use at End of Life Suggest Less Burdensome Care

Fewer people are dying in hospitals — and while ICU use in the last 30 days of life remains high, it is not increasing, according to a recent study.¹

“There is striking reduction in patterns of transitions that we believe are burdensome to the dying persons and their family,” adds **Joan Teno**, MD, MS, the study’s lead author.

Transfers to different healthcare facilities during the last three days of life decreased from 14% in 2009 to less than 11% in 2015. “We have been doing this research for the past decade. We were surprised to see changes in the burdensome patterns of care,” says Teno.

Increased Hospice Use

The study was a follow-up to previous research published in 2013 that documented trends in end-of-life care.² The previous study examined Medicare patient data between 2000 and 2009. Researchers found that during that time, more people were dying shortly after ICU stays, repeated hospitalizations, and experiencing burdensome transitions of care. The 2018 study examined a data set through 2015.

The Affordable Care Act (ACA) was enacted in between the two

studies. One notable change is that Medicare Advantage now is caring for significant proportion of decedents. “With the passing of time and implementation of the ACA, we were interested in the secular trends,” says Teno, a professor of medicine at Oregon Health and Science University (OHSU) School of Medicine and a senior scholar at the OHSU Center for Ethics in Health Care in Portland.

Other key findings of the study, which compared Medicare fee-for-service beneficiaries who died in 2015 compared with 2000, include the following:

- Hospice use continued to increase, with a reduction in late referrals.
- Spending more than three days on hospice means that you can do more than just treat symptoms,” says Teno.²
- About one-third of individuals died in hospitals in 2000, but this decreased to 20% in 2015.
- ICU stays in the last month of life stabilized at 29% of patients since 2009.

Further research is needed to examine whether the changes in patterns of care reflect patients’ goals and values. “What is important is that care is consistent with patient-informed preferences,” says Teno.

Default: High-intensity Care

Hospital admissions decreased across all age groups, and ICU admissions decreased for patients over 65, found a recent analysis of 22,068 patients with chronic illnesses who died between 2010 and 2015.³

“We were interested in understanding the intensity of care at the end of life for patients with chronic, serious illness within our healthcare system,” says **J. Randall Curtis**, MD, MPH, one of the study’s authors.

Hospitalizations and ICU stays may be entirely appropriate at the end of life for some patients with chronic serious illness. “But we know that our healthcare system often defaults to high-intensity care at the end of life,” says Curtis. This is the case even when that care is not consistent with patients’ informed wishes.

The researchers developed a system within the electronic medical record to track these metrics over time. Less use of the hospital and the ICU in the last 30 days of life for patients with chronic serious illness was an encouraging sign. “The decrease is occurring over a time when our system has been focusing on improving palliative care and palliative care education throughout the system,” says Curtis, a professor of medicine and director of the Cambia Palliative Care Center of Excellence at UW Medicine in Seattle.

The study’s findings suggest that efforts to improve palliative care may reduce burdensome care at the end of life. “There is an ethical imperative to continue our work in this area,” says Curtis. ■

EXECUTIVE SUMMARY

ICU use in the last 30 days of life remains high, but is not increasing, according to a recent study. Other findings:

- Fewer people died in hospitals.
- There were fewer burdensome transitions of care.
- Hospice use increased, with a reduction in late referrals.

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- **J. Randall Curtis**, MD, MPH, Professor of Medicine/Director, Cambia Palliative Care Center of Excellence at UW Medicine, Seattle. Phone: (206) 744-3356. Email: jrc@u.washington.edu.
- **Joan Teno**, MD, MS, Professor of Medicine, OHSU School of Medicine, Portland. Email: teno@ohsu.edu.

Long-term Opioid Use in Palliative Care: 'Much Concern and Consternation'

'Very complex zone,' ethically speaking

Palliative care specialists once became involved only at the very end of a patient's life, but many referrals now occur much earlier. The American Society of Clinical Oncology's recently updated guidelines recommend that patients suffering from advanced cancer receive dedicated palliative care services with eight weeks of diagnosis.¹

This change has resulted in many benefits for patients. It also means that opioids are being given for longer time frames, raising some ethical concerns. "This is a very complex zone that has gotten more complex in the context of the opioid epidemic," says **Timothy E. Quill**, MD, a professor of medicine, psychiatry,

and medical humanities at University of Rochester (NY)'s Palliative Care Program and co-author of a recent paper on this topic.²

For years, palliative care providers believed, based on claims of pharmaceutical companies and medical societies, that the risk of addiction was very low. "The thinking was that opioids could safely be given at high doses as long as they were given under medical supervision," explains **Jessica S. Merlin**, MD, PhD, MBA, another co-author of the paper. Merlin is a visiting associate professor of medicine at the University of Pittsburgh.

Opioids were initially used only to keep hospitalized patients comfortable in advanced stages of cancer. "The field of palliative care fought so hard

to get opioids seen as something that were not given only at the patient's dying breath," says Merlin.

Unrelieved suffering was the ethical concern then — and now, Quill explains. "The pendulum has swung so far in the direction of fear of prescribing opioids, such that many patients who have very serious, potentially terminal illness that is very painful now have a hard time finding a clinician willing to treat their pain."

Culture Shift Needed

There are not enough palliative care providers to evaluate and see all such patients. Yet, many providers in other specialties refuse to prescribe opioids under any circumstance. "Clinically, this is a problem that occurs a lot. And it is a topic of much concern and consternation among palliative care providers," says Merlin. Palliative care providers treating patients with a heavy burden of pain symptoms are torn between their calling to relieve suffering and the risk of opioid addiction.

"We wanted to start a national dialogue about it, and hopefully

EXECUTIVE SUMMARY

Palliative care providers caring for patients suffering a heavy pain burden are torn between their calling to relieve suffering and the risk of opioid addiction.

- Most use urine drug-testing, treatment agreements, and practitioner database monitoring programs.
- Many palliative care providers lack training in caring for patients with addiction.
- There is a shortage of addiction specialists to treat patients.

encourage people to do educational research and policy work around this topic,” says Merlin.

Another recent study looked at 157 palliative care providers’ experiences with managing chronic pain in cancer survivors prescribed long-term opioid therapy.³ Key findings include the following:

- most reported using tools such as urine drug-testing (71%), treatment agreements (85%), and practitioner database monitoring programs (94%);
- only 27% of providers reported having training or systems in place to address addiction.

“This verified what we had hypothesized about addiction treatment resources,” says Merlin, the study’s lead author.

What should palliative care providers do if the patient develops an opioid use disorder? “Ideally, their role should be to treat that opioid use disorder, just as the palliative care provider would treat any other complication of the opioids they’re prescribing,” says Merlin. There are multiple barriers to ethical care if patients develop an opioid use disorder, including:

- some institutions do not have a culture of identifying and treating addiction;
- many palliative care providers lack training in how to care for patients with addiction;
- treating addiction takes time and resources, and providers may lack both;

- there is a shortage of addiction specialists to treat patients.

“Integrating addiction treatment into the palliative care setting is one solution,” says Merlin. In this model, palliative care providers give basic addiction care and call a specialist only if necessary, similar to a primary care physician providing basic diabetes care and involving an endocrinologist as needed.

“Embedding addiction specialists within clinics encountering significant numbers of patients with opioid use disorder is another possibility,” says Merlin. This mirrors the integration of addiction specialists in some primary care clinics.

There is no reason why palliative care providers can’t treat an opioid use disorder, argues Merlin: “Treatment may depend on the patient’s prognosis, but it doesn’t require a whole lot of specialized knowledge. We don’t need to reinvent the wheel.”

There is always the risk that someone will misuse and divert opioids to the general population. “This must be balanced against the risk of undertreating seriously ill patients who may die in pain because we are afraid of overtreatment,” says Quill.

Known best practices include prescribing contracts and clear policies of how best to prescribe and monitor. More research is needed, says Quill, “to learn the specifics about what works and what does not since, there is so little data.”

At the institutional level, Merlin wants to see frontline palliative care providers become more vocal: “A culture shift is needed around this issue.” ■

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- **Jessica S. Merlin, MD, PhD, MBA**, Visiting Associate Professor of Medicine, University of Pittsburgh. Email: merlinjs@upmc.edu.
- **Timothy E. Quill, MD**, Professor of Medicine, Psychiatry and Medical Humanities, Center for Ethics, Humanities and Palliative Care, University of Rochester (NY) School of Medicine. Phone: (585) 273-1154. Email: timothy_quill@urmc.rochester.edu.

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'Can You Get the Patient to Consent?'

Ethics Role Misunderstood

A decisionally capable patient is diagnosed with a curable form of cancer, but refuses the recommended surgery. In frustration, the clinical team calls in ethics — to convince the patient to consent.

“This, of course, is not in line with how ethicists practice,” says **Andria Bianchi**, PhD, a bioethicist at University Health Network in Toronto. This common scenario stems from a mistaken belief: That the primary role of ethicists is to convince patients, families, or surrogates to follow a recommendation. Bianchi suggests ethicists respond to such requests by explaining how they can be of help in the situation:

- **Act as a mediator between the two parties.**

“One of the roles of an ethicist is to offer clinical ethics consultation and mediation when ethical dilemmas arise, while remaining as neutral as possible,” notes Bianchi.

- **Learn more about the patient’s perspective.**

“An ethicist may help to unpack the patient’s decision,” says Bianchi. This gives the patient the opportunity to ask questions and explore alternative options, all with the goal of making a truly informed decision.

- **Find out why clinicians want to pressure the patient.**

A surgeon may not comprehend why the patient is refusing surgery, believing it is highly likely to be curative. “Understanding and validating their distress is often an important first step,” says Bianchi.

- **Educate clinicians on the patient’s right to make an informed decision.**

“The ethicist can help maintain an

environment conducive to informed decision-making,” says Bianchi.

- **Participate in any debriefs that occur.**

This can help regardless of whether the patient decides to consent. “It provides a forum for the clinical team and any other parties to express their feelings about the case and explore any lessons learned,” says Bianchi.

“ONE OF THE ROLES OF AN ETHICIST IS TO OFFER CLINICAL ETHICS CONSULTATION AND MEDIATION WHEN ETHICAL DILEMMAS ARISE, WHILE REMAINING AS NEUTRAL AS POSSIBLE.”

This is the perfect time to offer an ethics education session. “The clinical team will know what to expect when they decide to involve ethics in the future,” says Bianchi. For ethicists, it’s an opportunity to explain their role.

Clinicians often are surprised to learn that, in fact, ethicists are not the ones who make the final decisions on ethically complex situations. Bianchi explains it to clinicians this way: “While ethicists do contribute to decision-making processes, they do not make decisions on behalf of patients, families, organizations, or clinical teams.”

For example, the clinical team might be trying to figure out if they should implement an opt-out policy to specify staff who do not want to participate in medical assistance in dying. “In this scenario, the ethicist would probably clarify that the decision is ultimately up to the person in charge of the clinical team,” says Bianchi. The ethicist is not the one making the decision, but can still offer insights on possible approaches. “This enables the decision-maker to make an informed choice about how to proceed, based on their specific circumstance,” says Bianchi.

Time for Self-reflection

Has an ethicist ever tried to convince a patient to follow clinical recommendations in the past? If so, it’s no surprise that clinicians expect it.

“The first thing to consider is whether the ethics consultants might possibly have contributed to that misconception,” says **Charity Scott**, JD, MSCM, Catherine C. Henson professor of law at Georgia State University College of Law in Atlanta.

If asked to convince a patient to consent to surgery, ethicists should “engage in thoughtful self-reflection on its possible contribution to those misunderstandings,” says Scott.

The way ethicists approach consults varies. “Some ethicists believe their role is to make ethical recommendations and are willing to take positions,” says Scott. These ethicists willingly take sides on the rightness or wrongness of a particular course of action. Other

ethicists remain neutral, with a focus on conflict resolution. Given these differences, says Scott, “it’s no surprise if there is misunderstanding about the ethics role.”

Is there more than one ethically acceptable option? If so, ethicists should avoid making a specific recommendation, says Scott.

“One key reason to avoid taking sides is to avoid usurping the decision-making power of the legally appropriate decision-maker,” says Scott.

Finding out how previous

consults contributed to misunderstandings on the ethics role can shed light on inconsistent approaches. “This investigation will take diplomatic questioning of clinicians, patients, and families,” says Scott.

There may be a discrepancy between the ethics service’s philosophical views of its role and what people are actually experiencing. If so, says Scott, it should be acknowledged openly.

“Formal education may be needed to ensure members of the

ethics service are all on the same philosophical and operational page going forward,” says Scott. ■

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- **Andria Bianchi**, PhD, Clinician-Scientist/Bioethicist, University Health Network, Toronto. Phone: (416) 597-3422 ext. 7611. Email: andria.bianchi@uhn.ca
- **Charity Scott**, JD, MSCM, Catherine C. Henson Professor of Law, Georgia State University College of Law, Atlanta. Phone: (404) 413-9183. Email: cscott@gsu.edu.

Advance Care Planning Video Feasible for Safety-net Settings

Using a video on advance care planning for diverse adults in safety-net, primary care settings is feasible, a recent study concluded.¹

“While we know advance care planning can help patients receive medical care aligned with their wishes, there are numerous barriers to discussing and documenting this information,” says **Rebecca Sudore**, MD, one of the study’s authors. Obstacles to good advance care planning include the following:

- limited time during provider visits;
- providers’ discomfort with the subject matter;
- patients’ limited health literacy.

“The motivation for this study was to improve accessibility to advance care planning for disenfranchised patients,” explains Sudore, a professor of medicine at University of California, San Francisco.

Researchers conducted two 90-minute group visits one week apart at Northern California safety-net primary care clinics. Of the 22 participants, 73% were people of racial

or ethnic minorities. Forty-six percent showed limited health literacy. “We were surprised by the effectiveness of this delivery model,” says Sudore.

Video Increases Knowledge

Participants watched a video covering surrogates, values for medical care, and discussing wishes. Two clinician facilitators encouraged discussion among the participants, but all educational content came from the video.

At the end of the group visit, facilitators asked participants to discuss their wishes with family and friends and to complete an advance directive. No assistance with advance care planning documentation was provided.

“We were surprised that the group participants were able to obtain all of the key information directly, and how little facilitation was required,” says Sudore.

Knowledge about surrogate designation improved. “Advance care

planning discussions with others and surrogate designation increased significantly,” says Sudore.

Historically, advance care planning rates among disenfranchised, safety-net patient populations have been low. The study’s findings suggest that simply watching a video can help with this.

“This group visit model could address some of the barriers to advance care planning in routine office visits and in resource-poor, safety-net settings,” concludes Sudore. ■

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- **Rebecca Sudore**, MD, Professor of Medicine, University of California, San Francisco. Phone: (415) 221-4810 ext. 23475. Email: Rebecca.Sudore@ucsf.edu.

Students Unable to Identify Ethical Dilemmas

Faculty members in the Doctor of Nursing Practice (DNP) program at the University of Portland noticed a concerning pattern. Graduate students were not able to identify ethical dilemmas. “This was despite the inclusion of an ethics thread in our curriculum,” notes **Amber Vermeesch**, PhD, MSN, FNP-C, RN, CNE, the study’s lead author and associate professor at University of Portland’s School of Nursing.

The faculty members were former fellows in the university’s Dundon-Berchtold Applied Ethics Faculty Fellowship program. “We had experience in identifying and applying an ethical framework in practice,” says Vermeesch.

Concerned about their students’ apparent inability to identify ethical issues, they decided to explore further.¹

“We proposed the inclusion of focused ethics education into all of our clinical courses for the DNP program,” says **Patricia H. Cox**, DNP, MPH, FNP-BC, director of the DNP program and an assistant professor at University of Portland School of Nursing.

The collaboration of PhD and DNP faculty members changed the way ethics is taught. Ethical dilemma case studies are now integrated into course outcomes for clinical courses.

“Understanding ethical frameworks and the process required

for critical decision-making allows for the highest provision of patient care,” the researchers concluded. ■

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- **Amber Vermeesch**, PhD, MSN, FNP-C, RN, CNE, School of Nursing, University of Portland (OR). Phone: (503) 943-7357. Email: vermeesch@up.edu.

Conflicts on Discharge Decision: Home or Skilled Nursing Facility?

Discharge to a skilled nursing facility is sometimes recommended in order to ensure continued independent community living for frail patients. Conflicting views as to what’s best for the patient sometimes raise ethical concerns.

To learn more about the disposition decision-making process, researchers looked at the factors associated with the surrogate’s decision to discharge to a skilled nursing facility instead of home.¹ Of the 182 community-dwelling patients in the study, 133 were discharged to a skilled nursing facility and 49 went home.

“The most interesting ethics issue from our study centers around the outcomes when family members and hospital staff expressed

different opinions,” says **Jennifer L. Carnahan**, MD, MPH, MA, the study’s lead author and a scientist at Indiana University’s Center for Aging Research, focusing on care transitions, especially from the skilled nursing facility setting to home.

Even when physical therapy recommended a skilled nursing facility placement, the family sometimes disagreed. “The way this typically comes up is when there is disagreement between the medical team and the caregivers about the optimal discharge destination for patients with impaired decision-making,” says Carnahan.

If the family member objected to a skilled nursing facility placement, the patient often would be discharged home. “This suggests that there is

disagreement about whether a skilled nursing facility or going home with family is in the best interests of the patient,” says Carnahan.

Is It ‘Safe Enough?’

For the clinical team, the question frequently becomes what is “safe enough,” says **Laura K. Guidry-Grimes**, PhD, a clinical ethicist at the University of Arkansas for Medical Sciences in Little Rock. The patient’s decision-making abilities, their level of social and financial support, and the severity of their medical condition all should be considered. The following are some common scenarios:

- patients without decision-making capacity are unable to

identify worsening symptoms, understand the need for treatment or monitoring, or know when to reach out for medical help;

- the patient's home presents safety concerns, such as a gas stove that the patient tends to leave on, unhygienic spaces, or a heater that does not work;
- family members want to take an incapacitated patient home, but there is no one available to monitor the patient.

"We see cases where families dismiss healthcare aides, which makes the patient especially dependent on the diligence and competence of family," says Guidry-Grimes. Many patients need extensive rehabilitation or skilled nursing help, but lack insurance or financial resources to cover the cost. Facilities also can deny patients if they are too full or if the patient presents psychiatric complexities. "Some facilities are much better run than others," adds Guidry-Grimes. "For clinicians who have these insights, even discharge to a facility can seem far from ideal."

Capacity Is Issue

If the patient is his or her own decision-maker, these questions are important from an ethics standpoint, says Guidry-Grimes:

- Does the patient adequately understand that the discharge is considered unsafe and what other options are available?
- What additional barriers might be affecting the patient's decision?
- Are there any ways to further enable the patient's autonomy interests?

"The patient might feel coerced by family not to accept placement into a facility," says Guidry-Grimes. Institutional pressures to discharge

patients when they are medically ready are another complicating factor. "It can be ethically reasonable to allow the patient a little more time to think through the options, perhaps with support from pastoral care or a loved one," says Guidry-Grimes.

For patients who lack decision-making capacity, "the ethical issues become mountainous," says Guidry-Grimes. "We see many cases where these patients are incapable of caring for themselves in the most basic sense."

A congestive heart failure patient could start out with a manageable disease that becomes increasingly dire because of failure to take medications. Unhygienic environments and exposure to the elements can further exacerbate medical problems.

"What can be particularly tricky, ethically speaking, is when these patients still express clear preferences for unsafe discharge," says Guidry-Grimes. Patients' preferences carry ethical weight, even if they are not authorized as their own decision-makers.

"Some negotiation on discharge might be possible based on what the patient expressly prefers," says Guidry-Grimes. When incapacitated patients do not have a surrogate decision-maker, there are additional obstacles to getting them into any facility. For one thing, no one is available to sign consents.

"These situations are ethically challenging," says Guidry-Grimes. Staff often feel uncomfortable restraining the patient or coercing them to stay in the hospital until adult protective services or a public guardian takes responsibility. The alternative also is ethically problematic. "Giving in to the patient means that healthcare staff

are knowingly allowing a vulnerable patient to go to an unsafe situation," says Guidry-Grimes.

For incapacitated patients who have surrogate decision-makers, request for an unsafe discharge raises questions about the ethical appropriateness of the surrogate.

"A surrogate should have a demonstrated interest in the patient's welfare and make decisions that are reasonably consistent with the patient's known values and interests," says Guidry-Grimes. She recommends that ethicists facilitate safe discharges by:

- helping staff think through these issues proactively before a distressing case occurs;
- working with healthcare teams to address common questions that arise when a patient or surrogate requests something that appears unsafe;
- providing training on capacity evaluations, criteria for surrogate decision-makers, institutional policy, and local law.

"The more we can help healthcare teams think through these issues as a team, the better," says Guidry-Grimes. ■

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- Jennifer L. Carnahan, MD, MPH, MA, Center for Aging Research, Indiana University, Indianapolis. Email: jenncarn@iupui.edu.
- Laura K. Guidry-Grimes, PhD, Assistant Professor/Clinical Ethicist, University of Arkansas for Medical Sciences, Little Rock. Email: LGuidryGrimes@uams.edu.

Code Status Conversations Often Lacking: Ethics 'Great Resource'

Patients routinely are asked about code status upon admission, yet communication breakdowns too often occur. Expecting ethicists to sort out this important issue with every patient is, of course, unrealistic.

“But they may have an important role in the education and support of clinicians,” says **Paul J. Hutchison**, MD, MA, assistant professor of medicine and bioethics at Stritch School of Medicine at Loyola University Chicago in Maywood.

Ethics can accomplish this by presenting at departmental grand rounds or lunch workshops. “And for difficult conversations with patients who require additional time and attention, an ethicist is a great resource in a consultative capacity,” says Hutchison.

Of patients wanting to be full code, 10% had no orders for resuscitation, found one study.¹ “The discordance signals a failure somewhere in the communication between clinicians and patients regarding code status,”

says Hutchison. The finding suggests one of two things is occurring, says Hutchison:

- that conversations between clinicians and patients are not accurately captured in the medical record;
- that patient wishes are not being correctly interpreted by clinicians.

“If the latter, there is a risk that some patients’ autonomy is being compromised,” says Hutchison. These patients may not receive appropriate treatments in a life-threatening emergency.

“Ultimately, improved communication, possibly through better clinician training, could limit the amount of discordance in the future,” says Hutchison.

The communication chain, ideally, includes these steps:

1. the clinician explaining code status in lay language to the patient;
2. the patient expressing understanding of code status;
3. the patient appreciating how the

information applies to his or her own situation;

4. the patient making a rational decision.

“How the patient communicates the decision is essential to the clinician’s code status order,” says Hutchison. ■

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1. Young KA, Wordingham SE, Strand JJ, et al. Discordance of patient-reported and clinician-ordered resuscitation status in patients hospitalized with acute decompensated heart failure. *J Pain Symptom Manage* 2017; 53(4):745-750.

SOURCE

- **Paul J. Hutchison**, MD, MA, Assistant Professor of Medicine and Bioethics, Stritch School of Medicine, Loyola University Chicago, Maywood. Phone: (708) 216-9215. Email: Paul.Hutchison@LUMC.edu.

Values-based Advance Care Planning in Outpatient Oncology

Values-based advance care planning paradigm was acceptable to the vast majority of cancer outpatients, but may increase distress, found a recent study.¹

“The motivation was to see if asking people about their values was tolerable and helpful, in addition to watching video decision aids,” says **Andrew S. Epstein**, MD, the study’s lead author and assistant attending on the Gastrointestinal Medical Oncology Service in the Department of Medicine at Memorial Sloan-

Kettering Cancer Center in New York City.

The researchers previously developed the Person-Centered Oncologic Care and Choices (P-COCC), an advance care planning intervention combining a patient values interview with an informational care goals video. The P-COCC tool was acceptable to 97% of the 33 participants. However, the researchers were somewhat surprised to find that it was associated with slightly worse distress.

“All patients deserve to know what

is going on with an illness, and to have their values elicited during their care so they can receive care most in line with their values,” says Epstein. ■

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1. Epstein AS, O’Reilly EM, Shuk E, et al. A randomized trial of acceptability and effects of values-based advance care planning in outpatient oncology: Person-Centered Oncologic Care and Choices. *J Pain Symptom Manage* 2018; 56(2):169-177.

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CME/CE QUESTIONS

1. Which did a recent study find regarding moral distress in ICU nurses?

- a. Ethics huddles were helpful only if conducted by physicians.
- b. Discussing ethical dilemmas markedly increased moral distress.
- c. High-quality communication between nurses and physicians can decrease moral distress.
- d. The most ethical approaches narrowly focus on coping skills of individual nurses as opposed to systemic solutions.

2. Which did a recent study find regarding end-of-life care?

- a. ICU utilization in the last 30 days of life is continuing to increase.
- b. Higher percentages of people are dying in hospitals.
- c. Hospice use continued to grow, with a reduction in late referrals.
- d. There is an increase of care that is inconsistent with patient preferences.

3. Which is true regarding neurosurgeons' financial ties with industry?

- a. Comprehensiveness of disclosure policies in neurosurgical journals' disclosure policies varied substantially.
- b. Most neurosurgical journals did not have any publicly available conflicts of interest disclosure policies.
- c. Most neurosurgeons have financial relationships with industry involving substantial amounts of money.
- d. The overall value of neurological surgery industry payment is very small compared to other specialties.

4. After viewing a video on advance care planning in a primary care setting, participants:

- a. showed greater confusion over surrogate designation.
- b. significantly increased their advance planning discussions.
- c. were less likely to complete advance directives.
- d. needed more detailed instructions from group facilitators.