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RELIAS
MEDIA

Updated Ethics Manual Addresses Many New Realities in Clinical Practice

'Moral compass' in face of new challenges

There was no shortage of new ground to cover when the American College of Physicians (ACP) set out to revise its *Ethics Manual*. Genetic testing, the protection of human subjects, social media professionalism, precision medicine and genetics, telemedicine, and physician volunteerism are just some of the ethical challenges clinicians now face.

“It is critical for physicians to reflect on long-held ethical tenets and principles, applying them to new circumstances on an ongoing basis,” says ACP president **Ana Maria Lopez**, MD, MPH, FACP.

The manual emphasizes the centrality of the patient-physician relationship and the need for physicians to put patients’ interests first. These ethical obligations, says Lopez, “are fundamental, timeless, and need to be continually reaffirmed in the face of technological and other challenges.”

The *Ethics Manual* was last updated in 2012. The seventh edition includes a six-step approach to ethical decision-making, which “could very well help physicians make ethical decisions on their own,” says **Matthew DeCamp**, MD, PhD.

DeCamp, an associate professor at University of Colorado’s Center for

THE MANUAL EMPHASIZES THE CENTRALITY OF THE PATIENT-PHYSICIAN RELATIONSHIP AND THE NEED FOR PHYSICIANS TO PUT PATIENTS’ INTERESTS FIRST.

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EDITORIAL QUESTIONS

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Bioethics & Humanities, says the manual “can be seen as a moral compass that will help physicians act rightly in the face of new challenges.”

New forms of electronic communication and questions about the fundamental role of medicine in society are two examples. “The fact that the manual was revised is an indication of how important it is for ethicists to continually re-examine the challenges physicians and patients are actually experiencing in the real world,” says DeCamp.

ACP includes more than 150,000 members. Thus, says DeCamp, “the manual can be seen as taking the pulse of a large and important part of the medical profession regarding its current thinking on contemporary ethical issues.”

Rapidly Evolving Changes

Particularly helpful to review, says **J.S. Blumenthal-Barby**, PhD, are “issues that practicing physicians encounter frequently but where there is rapid change and evolution.” Several areas covered in the manual are controversial. These include care of unauthorized immigrants, brain death, and potentially inappropriate treatments. “The manual could have acknowledged more explicitly that there is considerable disagreement

among thoughtful positions on these issues, as well as analyze the reasons for such disagreement,” says Blumenthal-Barby, who co-authored a recent editorial on this topic.²

Recognition that these issues are deeply contested is an important step in respecting patients and colleagues with different views, says Blumenthal-Barby, an associate director of medical ethics at Baylor College of Medicine’s Center for Medical Ethics and Health Policy in Houston.

“Thus, ethicists looking to the manual for direction might draw a distinction between areas of consensus and areas of controversy, and tread more carefully in areas of controversy,” says Blumenthal-Barby.

DeCamp anticipates that these two parts of the manual may garner particular attention:

- The very clear statement opposing legalization of physician-assisted suicide or euthanasia, despite what appears to be an increasing trend toward legalization in the United States.

“The uncertain legal and moral status of the practice can be difficult to manage institutionally and individually,” says DeCamp.

- The absence of drawing clear lines around what truly constitutes “futile” or “ineffective” medical care.

This reflects both the difficulty of defining terms like “ineffective” and

EXECUTIVE SUMMARY

Clinicians and ethicists can use a newly revised *Ethics Manual* from the American College of Physicians as a resource. Included are:

- a six-step problem-solving approach to ethical decision-making;
- positions on controversial areas such as care of unauthorized immigrants, brain death, and potentially inappropriate treatments;
- a statement opposing legalization of physician-assisted suicide or euthanasia.

the lack of consensus on what those terms mean, says DeCamp. Patients, physicians, and institutions may have different ideas about what constitutes effectiveness — is it survival alone, or survival with some quality of life? What chance of benefit is meaningful (1 in 100? 1 in 1,000? 1 in 10,000?) also is subjective. Thus, says DeCamp, “there can be challenges in interpreting physicians’ obligations to provide or not provide a particular intervention.”

Patients’ Obligations at Issue

Rosamond Rhodes, PhD, director of bioethics education at Icahn School of Medicine at Mount Sinai in New York City, describes the revised manual as “a cautious document.”

“For the most part, it is in line with other statements on medical and research ethics. It also shares a number of conceptual problems that pop up in similar ethics statements,” says Rhodes.

Regarding the patient-physician relationship, the manual refers to “mutual obligations, but does not specify why patients have obligations,

or what they are. Can that be true of children, the unconscious, or the demented?” asks Rhodes. “This is a feature of the document that I find troubling.”

Physicians take an oath and explicitly undertake obligations, but patients do not, says Rhodes. The manual also states that physicians’ ethical obligation to the welfare of patients is fundamental. “At the same time, they maintain that a physician need not accept a patient and may dismiss a patient. That apparent contradiction is not explained,” says Rhodes.

The manual includes a section on “futile treatment” and claims that the physician is not ethically obliged to provide it if ineffective or harmful. Rhodes sees the term “futile treatment” as a misnomer: “Interventions that provide no benefit and only inflict harm should not be offered and should not be called ‘treatment.’” Conversely, says Rhodes, interventions that are likely to sustain life should not be considered “futile.” They do offer the benefit of prolonged life, even when they are not likely to cure the underlying condition. “Readers would be better served by an unequivocal and clear account of the justification for refusing to

provide interventions that provide no benefits,” concludes Rhodes. ■

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‘Tremendous Need’ for Research on EMRs and Advance Care Plans

Effect still is unclear

Many patients have not completed advance directives. “Even when completed, these documents may not be available to the healthcare teams,” notes **Michael Huber**, MD, MS, the lead author of a recent study on this

issue. Electronic medical records (EMRs) may help with this, but the extent is unclear, according to recent research.¹

EMRs can prompt patients and clinicians to complete directives and make them easier to locate.

“We aimed to review the current evidence of using the electronic medical record to improve advance directives,” says Huber, an assistant professor of clinical medicine and palliative care physician at University of Illinois at Chicago.

The researchers analyzed 16 studies that included an EMR intervention to improve advance care plans. These were the most common tools reported:

- documentation templates;
- automated prompts;
- electronic order sets.

The two most common reported outcomes were documentation of an advance care planning conversation and placement of code status orders.

All patients should be offered the opportunity to complete advance directives, says Huber. These should be readily available to the healthcare team.

“The electronic medical record offers tools to assist in this. However, the efficacy of these tools remains unclear,” says Huber.

Few Studies Exist

Despite the proliferation of EMRs, there is little evidence of how useful they are in improving advance care planning. “We had suspected that the literature in this area was limited. But we were still surprised by how few studies have been done in this area,” says **Joyce W. Tang**, MD, MPH, co-author of the study and a comprehensive care physician at University of Chicago Medicine.

Existing research primarily used low-quality study designs. “There is tremendous need for high-quality study designs to build the evidence base in this area,” says Tang.

Some EMRs offer new capabilities for patient risk stratification and documentation. “These may allow for improved identification of patients for advance directive discussions; and more thorough, timely, and easily located advance directive documents,” says Huber.

Tools within EMS “will be most

effectively harnessed if paired with a larger suite of interventions,” says Tang. These include educational sessions, materials, and dedicated staff and workflows.

“Further studies will more clearly delineate the components which are most integral, and the types of supporting environments needed to maximize their effectiveness,” says Tang.

Greater Attention Needed

Some institutions have created advance care planning tabs for easier access. “This allows anyone who has access to the EMR to more easily find these kinds of notes instead of having to sift through days and weeks of progress notes,” says **Stuart G. FINDER**, PhD, director of the Center for Healthcare Ethics at Cedars-Sinai Medical Center in Los Angeles.

Providers also should be able to perform easy searches, says FINDER: “The idea is to utilize the capacity of the EMR to help make the information more readily available.”

A more out-of-the-box approach: Rethink what is included in the history and physical and progress notes. FINDER recently authored a paper suggesting that greater attention should be placed on what makes patients’ lives worthwhile to them.³ Information on goals, values, and preferences can then be incorporated when developing a medical plan of care. The point would not be to specifically document whether the patient wants specific interventions such as CPR, but rather to explore the goal of a current hospitalization.

“Or, for patients who are dying, to convey what kind of care makes

sense given the kind of life they’ve lived up until this point — and hence, what fits with the remainder of the patient’s life,” says FINDER.

If this information is routinely incorporated in medical records, providers will not have to resort to painstaking searches to find pertinent information. “This highlights something that was possibly lost in the shift to EMRs: narrative accounts of who our patients are,” says FINDER.

This was not necessarily evident in paper charts, either. “But with the switch to the EMR, quantifiable data is emphasized over documentation in narrative form,” says FINDER. This creates the need for a designated space within the EMR for advance care planning documentation.

For patients approaching the end of life, says FINDER, “this means being more explicit in uncovering what may be the minimal acceptable outcome or quality of life such that, if not achievable, the patient would rather accept death than go through medical intervention.” ■

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Providers Experience Moral Distress in Pediatric Mental Healthcare

Of 23 reported occurrences of moral distress, 61% involved pediatric mental health cases, found a recent study.¹ “Concerns stemmed from an influx of mental health patients and lack of training and experience by staff,” says **April Kam**, MD, MScPH, FRCPC, the study’s lead author.

Additional resources have since been made available to the pediatric ED. These include social workers and a mental health assessment unit. Better communication is evident between psychiatrists and ED clinicians.

“There still is moral distress around cases where there is little either team can do,” notes Kam, an associate professor of pediatric emergency medicine at McMaster University in Canada.

Limited community resources, such as lack of available inpatient beds, are disheartening to everyone involved. “Often, ED staff bear the brunt of the frustrations of exhausted family members who are finding it challenging to cope,” says Kam.

Douglas S. Diekema, MD, MPH, has seen these three pediatric mental health ethical issues lead to provider distress:

- **There is a lack of resources, both in terms of mental health providers and inpatient beds.**

“The number of patients presenting with mental health concerns has really taxed the resources that exist,” says Diekema, director of education at Treuman Katz Center for Pediatric Bioethics at Seattle Children’s Research Institute.

Many patients could benefit from an inpatient admission, but limited beds allow only those who represent a threat to themselves or others to be admitted. Outpatient therapy is similarly difficult to access. “This makes it difficult for kids to get the kind of counseling and care they need during times of personal crisis,” says Diekema.

- **Many states passed laws that permit teens to access mental health services without the consent of a parent.**

“This is a good thing,” Diekema says. The problem is that the laws require confidentiality and disallow an admission or required mental healthcare without the adolescent’s consent. Some explicitly state this, while other laws are interpreted as such. Regardless, providers may feel restricted in their ability to notify a parent even when it is in the teen’s best interest. In some cases, the adolescent clearly would benefit from treatment or admission. “Laws that require the teen’s consent may hamper a parent’s ability to get the

help they need for their child,” says Diekema.

- **Patients with eating disorders, particularly anorexia nervosa, may refuse help.**

The patients may not realize their behaviors represent a grave danger to themselves. How best to care for these patients is a source of great concern among healthcare providers.

“It is difficult to treat without patient cooperation,” says Diekema. “Forced treatment rarely improves long-term outcomes.” ■

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Clinicians Believe Chaplains Helpful — But Call on Them Infrequently

Clinicians are not regularly reading chaplain notes

Communication between clinicians and chaplains remains infrequent, found a recent survey of 219 ICU clinicians.¹

“Patients and families in the ICU often look to their faith not only to cope with their illness, but also as a framework for their decision-making,” says **Philip Jaekyung Choi**, MD, the study’s lead author. Choi is an assistant professor in the division of pulmonary and critical care medicine at the University of Michigan in Ann Arbor.

These clinical observations led to a project that studied chaplain involvement in the ICU at Duke University Hospital where Choi was a medical instructor in the department of medicine at the time.² That study found that chaplain consults were rare, mainly reserved for dying patients, and usually occurred in the last 24 hours of life or even after death.

The next step was for the researchers to learn how clinicians themselves viewed chaplain involvement.

“The main surprising finding was that all clinicians believed that chaplains would be helpful in most clinical scenarios — even when patients survive critical illness,” says Choi. This was true of physicians, nurses, and advance practice providers.

Consistent with the previous study’s findings, all the clinicians regularly consulted chaplains when patients were dying. They were less likely to do so when patients were recovering from critical illness —

even though the clinicians said they thought chaplains would be helpful in this circumstance. “It’s unclear exactly why there is this disconnect. But it’s certainly something to explore in the future,” says Choi.

“CHAPLAINS SHOULD BE CARING FOR THE PATIENT AND FAMILY WITHOUT ANY SPECIFIC AGENDA TO CHANGE THE COURSE OF CARE.”

The study confirmed that there is not much direct communication with chaplains. “Even through the medical record, clinicians are not regularly reading chaplain notes,” says Choi.

Unbiased Advocates

Many ethical dilemmas revolve around issues of faith. Patients’ or families’ interpretation of their faith sometimes leads to decision-making that conflicts with what the medical team deems as appropriate.

In these ethically challenging cases, chaplains can bridge communication gaps, says Choi: “Chaplains can serve as unbiased advocates for patients without any specific agenda.”

During any tense encounters between patients and clinicians, particularly when ethical issues come up, there may be potential bias on the clinician side. “Chaplains are trained to help bridge that gap,” says Choi. They do this by understanding the patient and family’s perspective and by communicating with the medical team.

Occasionally, care may seem medically futile, but the family wants to continue aggressive measures because their religion says they are not allowed to withdraw support. The goal is not simply to bring the family into alignment with the medical team’s wishes. That is not the chaplain’s role.

“Chaplains should be brought in so that they can help provide spiritual support through this distressing time and also to understand their beliefs and values,” says Choi.

It is possible that a consensus is reached on the best course of action. “But chaplains should be caring for the patient and family without any specific agenda to change the course of care,” notes Choi. ■

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Study: Many POLST Forms Completed by Surrogates

Surrogate preferences on Physician Orders for Life-Sustaining Treatment (POLST) forms were 60% less likely to choose “all treatment” than patients who made their own decisions, found a new study.¹

“We thought it was a good tool for some of our inpatients, and wanted to see how it was really being used,” says **Rachelle Bernacki**, MD, MS, one of the study’s authors and associate director of the Serious Illness Care Program at Ariadne Labs in Boston.

Researchers compared treatment preferences of patients to those of surrogates on the POLST forms. They reviewed 606 Massachusetts POLST forms at three hospitals and the corresponding patient electronic medical records (EMRs). Surrogates signed 253 of the forms.

The fact that such a high percentage of forms were signed by surrogates instead of patients wasn’t too surprising. The researchers expected this was the case: Hospitalized patients are often too sick to discuss and sign themselves the forms that signify agreement with the clinicians’ POLST orders. It also offers an explanation for surrogates’ tendency to limit life-sustaining care.

“It’s not uncommon, as patients get sicker, to have less aggressive care,” says Bernacki.

The timing of completion of

POLST forms is the real concern, says Bernacki. The hope is that more patients will discuss and complete them with their clinicians earlier.

The hospital’s Serious Illness Care Program has been in place for five years. Clinicians are asked: “Would you be surprised if this patient died in the next year?” If the answer is no, data are collected on whether anyone on the clinical team has had a serious illness conversation with the patient. Of the patients identified in the Integrated Care Management Program at Brigham and Women’s Hospital in Boston, 73% held conversations. Hopefully, this results in completed POLST forms, ideally with surrogates present.

“Our care management nurses have done a phenomenal job of that. We’ve had very good success,” says Bernacki.

POLST form completion requires more than just asking the patient, “Do you want to be DNR [do not resuscitate] or not?” A more in-depth discussion is necessary. “Best practice is to assess the patient’s understanding of the illness,” says Bernacki.

Next, clinicians explore what the patient wants to know regarding his or her prognosis. Finally, the discussion turns to what is most important to the patient. Clinicians ask open-ended questions such as “What are you worried about?” They also ask, “How

much are you willing to go through for the possibility of gaining more time?”

“This question is fairly well understood by patients,” says Bernacki. Some state they will go through anything to stay alive one more day, while others are unsure if they want to endure hospitalization again.

“We can then translate that to an order on the form,” says Bernacki.

Specific guidance makes clinicians noticeably less anxious about the tough conversations. At first, many fear it will take too much time. A previous study determined the median time was 21.8 minutes for physicians and 26 minutes for nurses.²

“It’s not a short conversation. But it’s also not so long that it’s not feasible to fit into your work day,” says Bernacki. ■

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Patients With LVADs More Likely to Die in Hospitals

Most patients with a left ventricular assist device (LVAD) died in the hospital, found a recent study of 18,733 patients.¹ From 2008 to 2016, 4,916 patients were known to have died. Of this group, 76.9% died in the hospital.

LVADs are becoming increasingly common, and researchers say they expect to see more patients with LVADs dying at home.

“There has been significant effort placed on developing LVAD technology and expanding access, with relatively little inquiry into the inevitable end-of-life process awaiting many patients living with an LVAD,” wrote **Colleen McIlvannan**, DNP, MS, BSN, the study’s lead author and an assistant professor at the University of Colorado Anschutz Medical Campus in Aurora.

Trial and registry data reported on causes and timing of death of patients with LVADs. “The main motivation

for this study was to provide a more granular view of the process of death with an LVAD,” says McIlvannan.

The researchers found variability in patients’ causes of death over time, as well as their health-related quality of life. They did expect to find that most died in the hospital, but were surprised that the percentage has not decreased over time.

“It begs the question of why we have not been able to facilitate deaths outside the hospital for these patients, despite the technology becoming more mainstream,” says McIlvannan.

It is well-established in the literature that most patients prefer to die outside the hospital. “The reasons for patients with LVADs dying in the hospital are likely multifactorial,” says McIlvannan.

There is a low threshold for admission, due to known complications associated with LVAD therapy. Lack of understanding

of patient preferences for end-of-life care is another reason. “We, as a community, need to focus on bolstering education and systems of care that address end-of-life needs in this population,” concludes McIlvannan. ■

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Much Common Ground Between Ethics and Hospital Leadership

Search for legitimacy continues at many institutions

Many healthcare providers rely on trade organizations to convey the value of their professions. “Bioethics has let itself get behind other fields. It has construed itself as clinical, but apart; clinical, but different,” says **Paul L. Schneider**, MD, FACP, chair of the bioethics committee at the Veterans’ Administration Greater Los Angeles Healthcare System.

Ethics professional societies

tend to focus more on content, and pay less attention to how the field itself is perceived. “There’s only been preliminary effort to help ethicists trying to do a better job at representing ourselves in that way,” says Schneider.

Last year, the American Society for Bioethics & Humanities’ Healthcare Ethics Consultant-Certified program became the first such initiative to identify and assess a national standard

for the clinical healthcare ethics consulting. Schneider says this is an important step, but “the tip of the iceberg. One of the challenges facing us in the field is a search for legitimacy. That’s what everything is about right now.”

The value of the work of ethicists is lost on some hospital leaders. “Hospitals are happy to defer issues to us in clinical ethics when we’re talking about low-risk cases that

tend to resolve themselves well,” says Schneider. The legitimacy of ethics comes into question if cases are higher risk, with more potential for court involvement and lots of conflict.

“We are seeing increasing demand for accountability and exactly how we do our work and under what rules and policies,” reports Schneider. At the same time, many ethics services struggle to meet surging demand for consults. “The fire has been turned up, but with no increased resources,” says Schneider.

Ethics Resources May Be Sparse

Some private-sector hospitals have seen modest increases in ethics resources in recent years, notes Schneider. However, ethics resources are generally sparse in U.S. hospitals, except at major academic medical centers. As an ethicist, says Schneider, “I am expected to do my work out of my back pocket. I am given 25% time, but it’s not enough to do all the work that I do.”

This often leads to conflicting obligations on the part of a “volunteer army” of ethicists. “It’s almost like there are two colliding forces,” says Schneider.

The push for more accountability and a higher-quality work product is stymied by insufficient resources. “With the few exceptions of the places that are well-resourced, most are not,” says Schneider. “Ethics tends to happen due to extra effort of the people involved.”

Justifying ethics resources often is complicated by the field’s unique mindset and terminology. “There are ‘translation’ problems between ethicists and administrators,” notes Schneider.

Resource allocation decisions are based on data, outcomes, and return on investment, not ethical principles.

“The problem is that most of us as ethicists are not innately businesspeople,” says Schneider. “It’s not really our strength.”

Still, there is much common ground between the goals of administrators and ethics. For administrators, resource use always is top of mind. For ethicists, the principle of stewardship comes into play.

“We are doing ourselves a disservice if we run away from that. Ethics should be part of those decisions,” says Schneider.

Ethical and cost-effective care are not necessarily mutually exclusive. “You are not doing it to save money, but it does save money in the long run,” says Schneider. “The bottom line is that doing the right thing is also cost-effective.”

Pragmatic Approach

Increasingly, hospital leaders are recognizing that ethics expertise “can help in the boardroom as well as at the bedside,” says **Tim Lahey**, MD MMSc, director of clinical ethics at the University of Vermont Medical Center in Burlington.

Lahey says ethics input can help institutions:

- make challenging decisions about whether to notify patients about an error;
- address unprofessional behavior;
- determine how to satisfy the organization’s promise to serve the community — even if a clinic that serves vulnerable populations is not performing well financially.

Ethicists can do more than just help organizational leaders make wise decisions. “They can help

organizational leaders show that their decision-making process was inclusive, well-considered, and wise,” says Lahey.

To benefit from ethics expertise at an organizational level, hospital leaders need to figure out these two things, says Lahey:

- how to adequately support individuals with ethics expertise;
- how to embed them in decision-making processes.

“It doesn’t help the organization to have ethics expertise if the ethicist is never in the room when major decisions are made,” says Lahey.

When decisions are made about conflicts of interest or the care of vulnerable populations, ethicists need to be there. Some hospital leaders already understand this. If so, ethicists can garner even more support, says Lahey, “by being pragmatic instead of overly academic and willing to roll up their sleeves.”

Some hospital leaders, less attuned to the need for embedded ethics expertise, are focused only on the short-term bottom line. To face this uphill battle, Lahey says to look for a crisis that allows the ethicist to help in a concrete way. The ethicist can then offer continued help, says Lahey, by making a comment such as, “That was fun helping out. In the future, if you’d like me to help prevent that from happening, please let me know how I can help.” ■

SOURCES

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- **Paul L. Schneider**, MD, FACP, Chair, Bioethics Committee, Veterans’ Administration Greater Los Angeles Healthcare System. Email: Paul.Schneider@va.gov.

How Effective Is Ethics? Ask Clinicians, Examine Processes

'The stakes of a consultation can be high'

At Cedars-Sinai Medical Center in Los Angeles, ethics consult requests come from all units and disciplines across the health system. This was considered when evaluations of the service were collected as part of a quality assessment effort.

"We began with a recognition that both the reasons for why clinicians request consultation, and what they find valuable in the ethics consultation, may vary widely," says **Virginia L. Bartlett**, PhD, assistant director of the health system's Center for Healthcare Ethics.

Ethicists really wanted to find out what mattered most to the people who asked for their help. They found some unexpected variations between the requests for ethics consults and the retrospective reports from the clinicians who made the request. Some said they called ethics because of a conflict with a physician. As the situation progressed, it became apparent that there were broader communication issues within the team.

"What was most surprising was that clinicians found the support of the consultation valuable, regardless of outcome," says Bartlett.

Next, ethicists considered how they will evaluate ethics consults going forward. A recent paper describes their efforts to solicit, analyze, and understand retrospective evaluations of the service.¹ "We continue to explore and evaluate how we seek feedback from our colleagues, and how that shapes our practice, education, and outreach," says Bartlett.

Differing Perspectives

Cheyn Onarecker, MD, MA, says one important question needs to be answered before setting out to assess ethics consults: "What does it mean to have an effective consultation?" Possible responses to this question vary depending on who is answering, and include:

- the medical team was satisfied the consultant (or committee) helped move the family or patient in a certain direction;
- the hospital is satisfied because expensive treatments could be stopped, or length of stay was shortened;
- the family was satisfied because they felt heard, and the consultant agreed with them on how to proceed.

Each of these measures shows how effective ethics was in the eyes of various parties. "But I think most of us in clinical ethics are also thinking more about the quality of the consultation itself," says Onarecker, chair of the healthcare ethics council at Trinity International University's Center for Bioethics & Human Dignity in Deerfield, IL.

The process, the personnel, and the actual content of the report probably are not considered by people who ask for help from ethics; however, these things are very important to ethicists themselves. "The stakes of a consultation can be high. We are often making recommendations regarding life and death," says Onarecker.

A poorly performed consultation presents significant negative

consequences for patients, families, the medical team, support staff, and the institution. Onarecker says the following are important questions to ask about the process of performing the ethics consultation:

- Was the consultation conducted in a timely manner?
- Was the process fair and inclusive of input from all interested parties?
- Did it result in a useful entry in the medical record?
- Have the personnel involved been trained adequately? Are they supported by the institution? Are they given sufficient time to provide consults?
- Are recommendations consistent with recognized ethical standards?
- Is there a review process to continuously improve the effectiveness of the consultation service?

Multiple tools are available for ethics committees to evaluate their services. Still, the issue of evaluating the effectiveness of consults continues to be a source of ongoing discussion at conferences and in the ethics literature.

"Hospitals were given the mandate to create ethics committees before we had any guidance," says Onarecker. The training necessary to be a consultant, instructions regarding the process of conducting an ethics consultation or managing a consultation service, and who should be on the ethics committee, all were unclear.

"Fortunately, we are making up some ground in these areas," says

Onarecker. “But we still have a lot of work to do to ensure consistent high-quality ethics consultations are being performed.” ■

REFERENCE

1. Finder SG, Bartlett VL. Discovering what matters: Interrogating clinician

responses to ethics consultation. *Bioethics* 2017; 31:267-276.

SOURCES

- Virginia L. Bartlett, PhD, Assistant Director, Center for Healthcare Ethics, Cedars-Sinai Medical Center, Los Angeles. Phone: (310) 248-8199.

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- Cheyn Onarecker, MD, MA, Chair, Healthcare Ethics Council, The Center for Bioethics & Human Dignity, Trinity International University, Deerfield, IL. Phone: (405) 272-7494. Email: cheyn.onarecker@ssmhealth.com.

Policies Can Set Boundaries, Ensure Ethical Discharges

Ethicists at University Health Network’s Toronto Rehabilitation Institute have seen multiple recent cases involving hospital discharges. All involved patients who wished to return home despite known safety risks and clinicians who were uncomfortable discharging the patient to a setting they viewed as unsafe.

Some recent cases involved a decisionally capable patient wanting to live at risk. Others involved patients who lacked decision-making capacity and failed to comprehend risks. In still other cases, an appropriate discharge location did not exist for a patient due to lack of caregivers or affordable housing in the community.

“At the heart of all of these potentially unsafe discharge situations is a conflict between differing values and principles,” says **Kevin Rodrigues**, BA, MTS, PhD(c), a clinical ethicist at the health system. These involve the ethical principles of beneficence, nonmaleficence, patient autonomy, and justice.

Discharge policies can be of great help in these cases, says Rodrigues, by providing:

- clear delineation of the obligations for clinicians and the institution at the time of discharge;

- clarity on the roles of various clinicians involved in the discharge, including physicians, social workers, and pharmacists;

- a conflict resolution process with clear guidance around escalation;

- contact information for various in-hospital and community resources;

- an ethical decision-making framework that is tailored to discharge planning. “This would be a helpful tool for clinicians as they attempt to balance stewardship of resources and obligations, both ethical and legal, to patients,” says Rodrigues.

Often, clinicians perceive the discharge plan is focused on the question of “What are we obliged to do?” instead of “What should we do?” “If a patient is capable of making a choice to live in unsafe conditions, for instance, to what extent should clinicians advocate for them to consider alternatives?” asks Rodrigues.

System pressures can lead to discharges that are less than optimal. There may be need to open beds for ED patients during volume surges. Funding models compensating patient flow also come into play. Rodrigues says policies should address these questions:

- What are obligations to the system and to the patient, and which takes precedence?

- How can discharge practices be made more equitable to avoid perceptions of bias?

- What obligation does the hospital have to ensure that a discharge is safe and sustainable?

“Policies can set appropriate boundaries and the foundations for a more robust and better structured discharge discussion,” says Rodrigues. ■

SOURCE

- Kevin Rodrigues, BA, MTS, PhD(c), Toronto Rehabilitation Institute, University Health Network, Canada. Email: kevin.rodrigues@uhn.ca.

COMING IN FUTURE MONTHS

- How virtual visits change patient/physician relationships
- Clinicians are turning to tele-ethics consults

- Educate clinicians on common ethical dilemmas
- Steps to take if legal requirements conflict with ethics

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CME/CE QUESTIONS

- 1. Which is true regarding EMRs and advance care plans, according to a recent study?**
 - a. There is now a strong body of evidence showing that EMRs facilitate placement of code status orders.
 - b. Despite the proliferation of EMRs, there's little evidence of how useful they are in improving advance care planning.
 - c. High-quality studies have demonstrated greatly improved access to advance directive documents.
 - d. EMRs have made it so difficult to access advance directive documents that they should not be used for this purpose.
- 2. Which is a current ethical concern involving pediatric mental health, according to Douglas S. Diekema, MD, MPH?**
 - a. Most patients who could benefit from inpatient admission refuse help despite available beds.
 - b. Providers would like to provide access to outpatient therapy, but patients are resistant.
 - c. State laws generally require a parent's consent for teens to access mental health services.
 - d. Providers may feel restricted in their ability to notify a parent even when it is in a teen's best interest due to existing laws.
- 3. Which is true regarding clinician/chaplain relationships, according to recent research?**
 - a. Most chaplain consults involve dying patients, usually in the last 24 hours of life.
 - b. ICU clinicians believe chaplains are most helpful during difficult family meetings.
 - c. ICU nurses rarely consult chaplains even when patients were dying.
 - d. Bringing the family into alignment with the medical team's wishes should be part of the chaplain's role.
- 4. Which did a recent study find regarding completed POLST forms?**
 - a. Most were signed by surrogates.
 - b. Surrogates were less likely to choose "all treatment" than patients.
 - c. Surrogates frequently chose aggressive care, but only based on patients' previously expressed wishes.
 - d. Hospitalized patients chose more aggressive care than outpatients.