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RELIAS
MEDIA

Analysis of Serious Ethical Violations Uncovered Failure to Identify Egregious Wrongdoing

Bad actors in medicine went undetected

Often, training is viewed as a way to stop ethical violations. But a recent analysis of 280 cases suggests this is not the answer. Nearly all cases of serious ethical violations involved repeated instances of intentional wrongdoing that went undetected.¹

“We were surprised at how ineffective systems are at identifying wrongdoing, tracking it, and preventing repeat occurrences,” says **James M. DuBois**, PhD, DSc, the study’s lead author. Key findings include:

- Ninety-seven percent of cases involved repeat offenses;

- Ninety-nine percent were intentional violations;
- Selfish motives, such as financial gain, drove 90% of cases;

- Ninety-five percent occurred in nonacademic medical settings, with 89% experiencing oversight issues;

- Personality disorder or substance use disorder are suspected in 51% of violators.

It is unrealistic to think that ethicists can prevent all first occurrences of wrongdoing. “But something has gone terribly wrong

when someone like Larry Nassar [former medical staff for USA Gymnastics and Michigan State University athletic teams] can abuse more than

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EDITORIAL QUESTIONS

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250 young women and girls before he is stopped,” says DuBois.

The researchers found that despite clear patterns, no factors provide readily observable red flags. This makes prevention difficult. In any field, there will be bad actors, says DuBois: “But in medicine, bad actors are able to do surgery, perform intimate exams, and prescribe opioids. The stakes are higher, and oversight is needed.”

The Federation of State Medical Boards has observed that hospitals and health organizations regularly ignore reporting requirements.²

“Hospitals need to investigate whether reports of professional misconduct are credible and to fulfill their reporting requirements,” says DuBois, the Steven J. Bander professor of medical ethics and professionalism in the School of Medicine at Washington University School of Medicine in St. Louis.

Hospital-based ethicists often receive informal complaints against healthcare providers. “It’s important that they not keep this information to themselves,” says DuBois. “Bring it to the attention of the appropriate leaders.” Follow-up is important to ensure that allegations are investigated.

“For more mild behaviors, it may be appropriate to speak with

clinicians directly, particularly if you have an existing relationship,” says DuBois. For more egregious behaviors such as sexual assault, it is best to work through formal channels. In some cases, it might make sense for the ethicist to contact the state medical board, or to encourage complainants to do so. “Hospitals frequently have anonymous compliance hotlines that might also be used in difficult cases,” suggests DuBois.

Burden of Responsibility

As an ethics educator, **Rebecca Volpe**, PhD, would love to believe that the courses she teaches actually change students’ behavior. “But there is very little evidence for that, unfortunately,” says Volpe, vice chair for education in the department of humanities at Penn State College of Medicine and director of the clinical ethics consultation at Milton S. Hershey Medical Center.

This is particularly true for shorter course curricula. The ethics course at Penn State College of Medicine is 24 contact hours. “If we are not going to stop wrongdoing or change trainees’ behavior, the question then becomes, ‘Why are we doing it?’” asks Volpe. Ethical sensitivity is one obvious answer. “An individual then knows he

EXECUTIVE SUMMARY

Of 280 serious ethical violations, almost all cases involved repeated intentional wrongdoing that went undetected, researchers found. Other key findings:

- systems were ineffective at identifying, tracking, and preventing repeat occurrences;
- nearly all cases involved males in nonacademic medical settings and a selfish motive;
- more than half of cases involved a person with a suspected personality disorder or substance use disorder.

or she is standing toe-to-toe with an ethical dilemma,” says Volpe. But that does not mean the individual knows what to do about it.

The timing of ethics education is another potential barrier to action. “As far as the type of physicians they become, their professional identity, that doesn’t really happen when they’re in the classroom. That happens during clerkships and residency,” says Volpe.

Penn State’s ethics course occurs in the second year of medical school. “We have been working so hard to get ethics education into residencies. But there are a lot of logistical barriers,” says Volpe. One possible solution may be embedded ethics rounds for residents. “But that requires a significant time investment for the ethicist — and assumes the institution even has an ethicist,” says Volpe.

It is easy to imagine trainees struggling with how to raise ethical

concerns. One reason is fear of retribution. “Students’ perception is that they are graded in large part on how well they get along with the team,” says Volpe. Speaking up is difficult if students fear their future hangs on good evaluations. “It’s important to teach physicians in training to report wrongdoing when they witness it,” says Volpe. “But there are a lot of reasons for them to stay silent.”

Even clinicians struggle with reporting their peers, regardless of whether the concern is cognitive impairment or unethical conduct. “But clinicians have significant power and authority in society,” says Volpe. “And because of that, we have a big burden of responsibility for policing our peers.” ■

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Almost One-Third of Proxies Do Not Know Patient’s Current Code Status

Is a person’s goal to be cured, to live long enough to see a particular event, to be comfortable, or something else? Researchers wanted to know how many ICU proxies believed they knew the answer.¹ They also wondered how many proxies felt confident that they knew what limits their loved one would place on pursuing that goal — would the patient choose not to resuscitate?

Initially, researchers asked these questions of proxies:

- “In your opinion, which would of the following options best describes [patient’s name] goal right now?”
- “In your opinion, how does [name] want doctors and nurses in the ICU to treat him or her?

- “Which of the following statements sounds most like what [name] would say?”

“But very quickly, we realized that proxies were giving answers that did not line up with the code status order active in the patient’s medical record at the time of the interview,” says **Alison E. Turnbull**, DVM, MPH, PhD, the study’s lead author and an assistant professor in the division of pulmonary and critical care medicine at Johns Hopkins University in Baltimore. Almost one-third of proxy answers about preferred code status conflicted with the code status in the chart at the time.

In most of these discordant cases, proxies reported that their loved ones would want their health to improve,

but would not be willing to start life support or receive CPR. The question then became: Are these families aware of the disconnect between what they are stating and what is in the EMR and are choosing not to say anything? Or, is the issue that the families really do not even know the clinical team’s current approach to the patient’s care?

“To try and answer that, we went back to the IRB and got permission to add a new question to the survey,” says Turnbull. The researchers then asked the proxies: Which of the following best describes how doctors and nurses in the ICU are treating [name] right now?

“That turned out to be a really important question,” says Turnbull.

Among 111 proxies, 29% did not know which of the multiple choice options represented their loved one's current code status. "We identified 15 proxies who correctly identified their loved one's current code status, reported it did not reflect the patient's values, but had not notified the clinical team," notes Turnbull.

Interestingly, findings were consistent regardless of a proxy's formal education. College graduates did not fare any better than families with less education when asked to identify the team's approach to care. When comparing proxies by race, researchers noticed that the proportion of black families who were correct about code status was greater than among white families. One hypothesis is that black families may have been more likely to ask clinicians questions and verify that their loved one was actually getting the kind of care preferred.

"We have a long, painful history of racial discrimination in Baltimore. As a result, black proxies may have been less trusting," says Turnbull.

The study was not designed to

identify differences between proxies who did or did not know their loved one's code status. "While it was interesting to look at these patterns and think about what might be generating them, we aren't able to say anything definitive," says Turnbull.

Wayne Shelton, PhD, says it is not too surprising that so many proxies do not know their loved ones' current code status. "Patients and their proxies come to the hospital often, and understandably, with a low level of medical literacy," notes Shelton, a professor at Albany (NY) Medical College's Alden March Bioethics Institute.

Of course, proxies should know the patient's code status and be able to reflect on whether to consent to a do not resuscitate (DNR) order. "But they cannot be expected to do so without a considerable amount of support from their care providers," says Shelton. Clinicians are obligated to provide comprehensible information and emotional support for what are often difficult decisions, he adds.

For proxies to be in the dark on

their loved one's code status "is not a reflection of their shortcoming, but that of the care team's," adds Shelton.

This is especially important when patients are frail and given a poor prognosis — and particularly when the patient is dying. "Care providers have a responsibility to discuss DNR status with proxies," says Shelton. ■

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Ethics of Virtual Visits: In-Person Visits Declined 33% in First Year

Some accountable care organizations (ACOs) are replacing in-person visits with lower-cost virtual visits. Using data from more than 35,000 patients from 2014 to 2017 within a Massachusetts-based ACO, researchers found that the use of virtual visits reduced in-person visits by 33%.¹

"The ethical implications of telehealth go well beyond the healthcare team's obligation to ensure privacy and confidentiality,"

says **David A. Fleming**, MD, MA, MACP, professor emeritus of medicine and senior scholar at the University of Missouri Center for Health Ethics in Columbia.

Providers and systems using telehealth also should consider how it influences the following:

- relationships with patients;
- access to healthcare;
- capacity for equitable treatment;
- cost;
- quality of life.

"Use of virtual technologies,

such as telehealth, have the potential of both enhancing and being detrimental to relationships between patients and their healthcare providers," says Fleming, who co-authored a paper on this topic.²

First-time visits tend to be more problematic. "My research indicates that physicians are more concerned about doing first-time visits virtually when clinical circumstances are complex and an in-depth physical exam is needed," says Fleming.

Virtual encounters make more

sense when the patient/physician relationship is well-established and the interaction is more routine in nature.

“However, for established relationships solidly grounded in trust, evidence indicates that virtual visits are often enthusiastically embraced,” says Fleming. In fact, they are even preferred by both patients and providers due to convenience and ease of access.

“There are clearly benefits to using telehealth where access can be improved and care provided where otherwise not available,” says Fleming.

Improvement in both clinical outcomes and patient satisfaction have occurred in underserved areas where specialty care is nonexistent, except for virtual visits, notes Fleming.

However, as with any new and innovative technology, expanded

use of telehealth may be at least partially driven by the desire for profit. “Healthcare systems should continuously check in with themselves to ensure that motives for innovation are ethically sound,” says Fleming.

Innovative efforts to improve delivery of high-value care are “laudable,” says **Timothy P. Lahey**, MD, MMSc, director of clinical ethics at University of Vermont Medical Center in Burlington.

For such approaches to work, incentives have to be properly aligned. It remains unclear how clinicians will be incentivized to provide high-value virtual care.

“We need to know if virtual visits achieve the goals we want,” says Lahey. It is not enough just to determine if patients are diagnosed and treated properly — it is also important that patients feel well-cared-for and heard. “I can imagine

a combination of quick virtual visits with real in-person contact could be the ideal approach,” says Lahey. ■

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New Guidance on Ethics of Providers' Internet Searches on Patients

Despite multiple ethical concerns raised regarding providers searching for online information about their patients, specific recommendations have been lacking. On behalf of the American Psychiatric Association's Ethics Committee, a group of authors developed a guidance on this practice.¹

“Growing concerns about the potential for problematic physician interactions with patients in the relatively new platform of social media was the motivation for the guidance,” says **Charles C. Dike**, MD, MPH, the paper's lead author. Dike is an associate professor of psychiatry and associate program

director of Yale University's law and psychiatry fellowship program. The recommendations include the following:

- Except in emergencies, it is advisable to obtain a patient's informed consent before performing such a search;
- Psychiatrists should be aware of their motivations for performing a search and should avoid doing so unless it serves the patient's best interests;
- Information obtained through such searches should be handled with sensitivity regarding the patient's privacy;
- The psychiatrist should consider how the search might

influence the clinician-patient relationship;

- When interpreted with caution, internet- and social media-based information may be appropriate to consider in forensic evaluations. “It is important for physicians to respect patients' autonomy in deciding what information about themselves to release,” says Dike.

It is highly possible the physician could learn negative, or even positive, information before the patient is ready to disclose it. “This could damage trust and ultimately cause harm to the patient-physician relationship,” says Dike.

Online information also could cause the physician to respond,

consciously or unconsciously, in ways that could be detrimental to the patient. “These observations are compounded by the fact that the information obtained online could be inaccurate,” says Dike.

There is the added question of the ethical obligation of the physician who finds information that suggests the patient or someone else is in danger. Even when conducted with the patient’s consent, findings could be unearthed that end up complicating the patient-physician relationship.

“This highlights the need for caution,” says Dike.

Ethics committees should discuss the circumstances under which it would be appropriate to search a patient’s information online, according to Dike. A targeted internet search could be appropriate if a patient is mentally compromised and needs urgent intervention. Institutions should consider developing policies addressing these issues, says Dike:

- circumstances under which to conduct an internet search;

- where to house information obtained (in patient’s chart or not);
- if (or when) to disclose findings to the patient or patient’s family.

“This would likely require discussions with the hospital leadership and attorney,” says Dike. ■

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Study Sheds Light on How Clinical Ethics Consults Are Categorized

Lack of standardization makes comparisons difficult

Ethics consultations are categorized in a surprisingly heterogeneous way, found a recent analysis of 30 articles.¹ The researchers identified 27 unique typologies, each containing five to 47 categories. The most common categories were do not resuscitate orders, capacity, withholding, withdrawing, and surrogate or proxy. Only 26% of the typologies (seven of 27 unique typologies) contained the five most common categories.

“We were very surprised by how heterogeneous the typologies

are,” says **Armand H. Matheny Antommara**, MD, PhD, one of the study’s authors.

Around the same time, the hospital’s clinical ethics consultation service at Cincinnati Children’s Hospital Medical Center had begun systematically documenting its own consultations. “Conducting a systematic review to see how other services had approached the problem of characterizing their consultations seemed the next logical step,” says Antommara, director of the ethics center.

There is a pressing need for the field of ethics to develop a standardized typology that a wide variety of consultation services can use, according to Antommara. “This will allow scholarship within the field to advance. In particular, it will facilitate comparisons between services and institutions,” he explains.

Cincinnati Children’s has yet to adopt a typology to characterize ethics consultations. These are characterized in terms of demographics, such as the patient’s age, the primary service, and the requestor’s credentials, role, and group. “We summarize the ethical issues with a brief narrative description,” adds Antommara.

This is currently feasible at a children’s hospital that performs about 60 consultations a year. “We are approaching the point of having sufficient documentation to qualitatively analyze the ethical issues on which we have been consulted,” reports Antommara.

EXECUTIVE SUMMARY

Ethics consultations are categorized by institutions in a surprisingly heterogeneous way, found a recent study. Standardizing this could:

- help people determine what kind of cases ethics should be routinely called for;
- compare how often consults are called at different institutions;
- identify specific areas for which clinicians need education;
- facilitate research on ethics consult services.

Ethicists already demonstrate the value of ethics to administrators, based on consultation volume and diversity of groups requesting consultations. “Describing the impact of several different consultations on patients, families, and providers has been valuable,” says Antommara.

Identify Ethics Value

Clinical ethics consultation services have become commonplace in the hospital setting. Yet empirical research on the effect of such services on patients, healthcare workers, and hospital systems remains limited, notes **Elizabeth Chuang**, MD, MPH, FAAHPM. There is significant variation in how ethics services are organized and how consults are requested. “There are many important empirical questions to ask about this variation,” says Chuang, clinical ethics research faculty at the Montefiore Einstein Center for Bioethics in Bronx, NY.

What is the “right” amount of ethics consultation remains an open question. The same is true as to which cases ethics should — or should not — be routinely called. “Studying variations between institutions can help us start to think about how to standardize ethics consultation,” says Chuang. However, a common language is needed. This would allow ethicists to

compare consultation services across institutions and allow similar types of consults to be grouped together.

“It would be interesting to see if different institutions routinely request a certain category of consults while others do not,” says Chuang.

This could inform outreach efforts to expand ethics consults. It also could reveal a pressing need to educate clinicians on ethical issues. For instance, clinicians might routinely call ethics for help identifying the most appropriate surrogate, determining capacity, or decision-making for patients who lack capacity and do not have a surrogate.

“In addition, looking at trends over time in categories of ethics consultation might identify emerging issues with new medical technology or new clinical challenges,” says Chuang.

Paving the Way for Ethics Data

The focus of Chuang’s research is healthcare disparities — particularly, differences in how clinicians communicate with patients of different ethnic, racial, and cultural groups from their own.

“If we could systematically categorize ethics consultation types, we could look at whether clinicians are more likely to request particular

types of consults for different ethnic, racial, and cultural groups,” says Chuang. This could pinpoint areas where better training in cross-cultural care could improve care and reduce conflict.

Standardizing how ethics consults are categorized would pave the way to making data on ethics consultations available for health services researchers. Some are developing sophisticated methods to examine the effects of changes in healthcare delivery. “It would be beneficial for clinical ethics to be a part of this trend as it may help identify the value of clinical ethics consultation services for health systems and patient outcomes,” says Chuang. ■

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Call for Uniform Brain Death Standard: Opponents ‘Increasingly Vocal and Influential’

Currently, Nevada is the only state with legislation requiring adherence to the American Academy of Neurology (AAN)’s evidence-based guidelines on brain death in adults. Now, the AAN is calling on U.S. legislators to require a uniform definition of brain death.¹

James A. Russell, DO, FAAN, says the new position statement was “prompted by concerns that misperceptions originating from a number of high-profile cases might serve to undermine the public trust in brain death and in the accuracy of its determination.” The AAN addressed this concern by endorsing:

- uniformity in brain death determination training, institutional policies, and the Uniform Determination of Death Act position on brain death;
- the accuracy of existing adult and pediatric guidelines for determining brain death;
- the need for uniform legal recognition of current adult and pediatric guidelines as the accepted medical standards for the determination of brain death;
- providing guidance and support for AAN members when facing requests for accommodation.

“It is the hope of the AAN and the authors of this position statement that the content of the position will be considered valid and acceptable to

all,” says Russell, lead author of the position statement and chair of the AAN’s ethics, law, and humanities committee. Looking forward, Russell says future developments may include:

- uniform brain death determination training programs, institutional policies, and practices;
- legal recognition of existing adult and pediatric guidelines for the determination.

“The hope is that the public trust in brain death and the accuracy of determination will be bolstered,” says Russell.

A Fundamental Question

While laws on many subjects diverge across jurisdictions, the question of who is alive and who is dead is too fundamental a question on which to permit inconsistency and uncertainty, according to **Thaddeus Mason Pope**, JD, PhD, director of the Health Law Institute and professor of law at Mitchell Hamline School of Law in St. Paul, MN.

“Nonuniformity reduces credibility and trust because it makes the determination of death seem more uncertain and fallible,” says Pope. Moreover, inconsistencies in the determination of death

may increase public suspicion and negatively affect organ donation.

In several recent cases, people have challenged the determination of death. “As the issue gets more coverage in the media, public misunderstanding and mistrust grows,” says Pope. Meanwhile, the number of court cases and hospital-based conflicts continue to increase. “Some advocacy organizations are actively promoting and even funding challenges to the determination of death by neurological criteria,” says Pope.

Pope expects that other state legislatures will follow Nevada’s lead and amend their determination of death acts. “It may even be necessary to enact a federal statute to assure nationwide uniformity,” he says.

Care Quality Is Issue

The AAN recently published consensus statements endorsing the validity of brain death and their best practice standard of brain death in adults.²

“Yet opponents to brain death are becoming increasingly vocal and influential,” says **James L. Bernat**, MD, one of the paper’s authors. Bernat is an active emeritus professor of neurology and medicine at Geisel School of Medicine at Dartmouth and former director of the program in clinical ethics at the Dartmouth-Hitchcock Medical Center in Hanover, NH.

Bernat says the best defense of brain death is to “rigorously show why brain death is equivalent to human death using conceptual and scientific arguments.”

EXECUTIVE SUMMARY

There are growing calls for a uniform brain death standard, but court cases and in-hospital conflicts continue to increase. Variation in practices can:

- lead to loss of confidence in physicians’ ability to determine death;
- negatively affect organ donation;
- open the door to legal challenges.

Despite best practice standards, there are still significant practice variations among U.S. physicians in how they determine brain death. Some of these variations are due to educational deficiencies, says Bernat. Some reflect personal or institutional practice preferences.

“This variation produces several problems,” says Bernat. “First, it is a problem in quality of care when physician practices vary significantly from best practice standards.”

Continued variation can cause observers — including judges — to question if the best practice standards are meaningful if they are not followed assiduously. Variation can also lead to the loss of confidence by the public in physicians’ ability to determine death.

“Opponents to the concept and practice of brain death can use the variation data to challenge the validity of brain death as a determination for human death,” notes Bernat.

Limited Accommodation

William D. Graf, MD, a pediatric neurologist at Connecticut Children’s Medical Center and the University of Connecticut in Farmington, says the two major ethical concerns in brain death determination relate to potential errors in diagnosis and unjustified medical treatment after death. Substantial progress has been made in unifying brain death determination guidelines since the Uniform Determination of Death Act was published, adds Graf.

“But because of some remaining inconsistencies among institutional brain death protocols in various states and hospitals, more needs to be done to assure the public about the validity and high reliability of brain death as

a medical and legal diagnosis,” says Graf.

There are no known cases in which compliant application of the current adult and pediatric brain death guidelines led to inaccurate determination of death with return of any brain function, including consciousness, brain stem reflexes, or ventilatory effort. “After brain death, there is no ethical obligation to provide further medical treatment,” says Graf.

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Currently, brain death is defined as the loss of all function in the entire brain and determined by qualified medical professionals using accepted medical standards for adult and pediatric patients. It is accepted as legal death in all U.S. jurisdictions. “These standards are currently widely accepted by the medical profession,” says **Leon G. Epstein, MD**, a pediatric neurologist at Northwestern University’s Feinberg School of Medicine in Chicago.

Regardless of legalities or scientific evidence, some will continue to be resistant to the concept of brain death or the method of its determination.

“After brain death determination, the medical profession needs to be respectful of requests for limited accommodation based on reasonable

social, moral, cultural, and religious considerations,” says Epstein. Such requests must be based on the values of the patient, not those of family members or other surrogate decision-makers.

“Pluralism has its limits,” says Epstein. “The definition of those limits are determined by social, cultural, religious, political, and legal consensus.” ■

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Study: Advance Care Plans Lacking When Serious Complications Occur

When patients with significant underlying comorbidities suffer life-threatening or serious complications at Indiana University Health, the palliative team is consulted. All too often, they find there is no advance directive in place.

“Patients undergo a thorough preoperative evaluation. But there is no process to counsel them on advance care plans,” says palliative care physician **Shilpee Sinha**, MD, FACP. Thus, difficult decisions often fall in the surrogate’s lap — or there is no named surrogate. “This causes significant distress and sometimes prolonged suffering,” says Sinha. “The family considers a comfort approach akin to ‘giving up’ on loved ones.”

To identify gaps in advance care planning, researchers retrospectively reviewed 400 charts of patients who had undergone an evaluation in a

preoperative clinic in 2017 at two high-volume hospitals. “My clinical experience was validated by the study’s findings,” says Sinha. Just 16% of patients had an advance directive scanned into the EMR. Some patients reported completing an advance directive, but it was not available in the EMR.

“My motivation is to help bring advance care planning more upstream and avoid such decision-making in a critical setting,” says Sinha. This would allow patients to exercise autonomy in the form of a written advance directive. “Without adequate counselling and assistance in preparing advance directives, this may be compromised when they lose capacity,” says Sinha.

To bring advance care planning “upstream,” Sinha says the clinical team must allocate time and resources to it. This must be done before

any major intervention (surgical or otherwise). These steps are needed:

- A trained facilitator should ask patients about their understanding of what an advance directive is, and whether they have created one;
- A designated member of the healthcare team should be made responsible for ensuring that existing or completed documents are scanned to the EMR in a well-identified location.

“Education is certainly a big part of this, as are developing policies after appropriate buy-in and understanding by all parties,” says Sinha. ■

REFERENCE

1. Sinha S, Gruber RN, Cottingham AH, et al. Advance care planning in a preoperative clinic: A retrospective chart review. *Gen Intern Med* 2019; Jan 2. doi: 10.1007/s11606-018-4744-8 [Epub ahead of print].

Spiritual Care in ICU: Persistent Unmet Needs

The authors of a recent literature review looked at the current state of spiritual care in the ICU setting.¹ The findings reveal both the benefits of spiritual care services and the persistent unmet needs.

“There is a growing body of evidence that patients experience significant spiritual stress when confronted with advanced illness,” says **Ware Kushner**, MD, chief of the pulmonary section at Veterans Affairs Palo Alto (CA) Health Care System.

Patients often want these spiritual needs addressed by physicians and other healthcare professionals. Clinical practice guidelines also recommend the spiritual support of critically ill

patients. Despite this, says Kushner, “there are few published reports addressing spiritual needs of patients and families in the critical care setting compared with other patient care settings.”

Most U.S. hospitals offer chaplaincy services. But ICU clinicians also have an important role in providing spiritual care to patients, says Kushner.

“Ethicists in the ICU setting must recognize that emphasizing biomedical facts and dismissing spiritual beliefs to advance a clinical argument may provoke distrust,” says Kushner.

Ethicists should try to explore and understand patients’ and family members’ spiritual views, if any.

“Once the patient’s or family’s views have been clarified, the ethicist can often then find common ground, achieve improved communication, and realize good outcomes,” says Kushner.

This commonly requires referral to a chaplain. Regardless of whether pastoral care is available, says Kushner, “the ethicist should remain mindful of the spiritual needs, beliefs, and practices of patients and family members.” ■

REFERENCE

1. Ho JQ, Nguyen CD, Lopes R, et al. Spiritual care in the intensive care unit: A narrative review. *J Intensive Care Med* 2018; 33:279-287.

Mindfulness Intervention Well-Received by Palliative Care Providers

During the first session of a newly implemented mindfulness-based self-care series, **Lisa Podgurski, MD**, jokingly assured palliative care providers she would not be asking anyone to levitate. Later, she learned that at least one participant was reassured to know that things were not going to get too “touchy-feely.”

“One colleague told me she had been dreading coming the first time because she thought it would be ‘too kumbaya.’ But she found that she looked forward to it each month,” says Podgurski.

The intervention stemmed from strong interest in addressing providers’ well-being. “Burnout is a serious problem among healthcare providers in all fields, and palliative care is not spared from these concerns,” says Podgurski, medical director of palliative care services at UPMC Magee-Womens Hospital in Pittsburgh.

Some existing interventions, such as eight-week formal courses held in the evenings, were too time-intensive. “They are wonderful, but that just isn’t accessible to some of the people that might really benefit from this,” says Podgurski.

Podgurski condensed the more time-consuming approaches into five one-hour sessions, and invited palliative care providers to participate. Many reported increased mindfulness practices.¹ “I was pleased to see that mindfulness levels improved and were sustained even after the session was completed,” says Podgurski.

Participants were made aware of a recommendation for 45 minutes of “meditation homework” each day. They were asked to begin very simply, with two minutes of meditation

twice a day. Podgurski attributes high turnout to the fact that the sessions were held at a time and place when providers would normally gather for activities such as grand rounds or journal club.

A particularly encouraging sign: All but one participant indicated a desire to continue working on mindfulness as a group. The group continues to meet for one hour a month. To involve other areas, additional sessions are offered to oncology nurses and internal medicine residents.

The intervention was not linked to lower burnout rates. No statistically significant change was seen over the study period. However, the burnout levels of the group were much lower than reported national rates.

“Perhaps a more multipronged approach could have resulted in a statistically significant change in our group’s burnout levels, despite our low rates to begin with,” suggests Podgurski.

The study supports the idea that content from formal, time-intensive

training programs can be condensed, and applied within a regular workday.

“This is part of the growing body of literature supporting institutional approaches to support providers’ well-being, rather than leaving the issue up to individual efforts only,” adds Podgurski.

The most important message, she says, is that providers’ paying attention to their own well-being “is not icing. It’s an important part of our role.” ■

REFERENCE

1. Podgurski L, Greco C, Croom A, et al. A brief mindfulness-based self-care curriculum for an interprofessional group of palliative care providers. *J Palliat Med* 2019; doi: 10.1089/jpm.2018.0550 [Epub ahead of print].

SOURCE

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CME/CE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Discuss new developments in regulation and health care system approaches to bioethical issues applicable to specific health care systems;
2. Explain the implications for new developments in bioethics as it relates to all aspects of patient care and health care delivery in institutional settings;
3. Discuss the effect of bioethics on patients, their families, physicians, and society.

COMING IN FUTURE MONTHS

- New data fuel ethical worries on conflicts of interest
- Many ethics consults involve correct surrogate identification
- Chaplains can help mediate ethical conflicts
- Ethical concerns on psychiatric patients in ED setting

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CME/CE QUESTIONS

- 1. Which did a recent study find regarding proxies of ICU patients?**
 - a. College-educated proxies were more likely to be able to identify the team's approach to care, than proxies with less education.
 - b. About one-third of proxies reported the patient had a code status that differed from the documented code status in the chart.
 - c. Most proxies were unaware of whether their loved one would choose not to be intubated.
 - d. Proxies often disagreed with the clinical team's approach to patient care specifically because it conflicted with their loved one's wishes.
- 2. Which is true regarding virtual visits, says David A. Fleming, MD, MA, MACP?**
 - a. Providers find virtual visits are most appropriate when clinical circumstances are complex and an in-depth physical exam is needed.
 - b. Patients find in-person visits necessary even for routine interactions.
 - c. There is evidence of better clinical outcomes in underserved areas without access to specialty care when virtual visits are made available.
 - d. Patients are clear that they reject virtual visits even after trusting relationships are solidly established.
- 3. Which does a new guidance say regarding providers searching for patient information via social media?**
 - a. Except in emergencies, it is advisable to obtain a patient's informed consent before performing a search.
 - b. Whether patients' informed consent is needed depends wholly on whether the provider is acting in the patient's best interest.
 - c. There is no potential downside to internet searches performed with the patient's full consent.
 - d. It is inappropriate to consider social media-based information even in forensic evaluations.
- 4. Which does a new American Academy of Neurology position statement call for?**
 - a. Allow for variation in practices in order to facilitate organ donation.
 - b. U.S. legislators should require a uniform definition of brain death.
 - c. Recognize that court cases challenging the determination of death by neurological criteria increase public awareness.
 - d. Provide for greater acceptance of requests for accommodation that are based on surrogate decision-makers' values.