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INSIDE

RELIAS MEDIA

Remote Ethics Consults Help With Growing Demand for Onsite Ethics

Goal is to reach more people with fewer resources

"You should always see the patient."

"This is one of the first lessons I was taught in ethics consultation," says **Craig M. Klugman**, PhD, a professor in the department of health sciences at DePaul University in Chicago.

Face-to-face contact allows ethicists to gauge body language and facial expressions of patients, families, and clinicians. "Often, words alone do not convey the entire story of the case," says Klugman.

Despite inherent limitations when the ethicist's input comes instead from a screen or phone, some hospitals are moving toward remote ethics consults. Lack of robust ethics expertise onsite and a surge in demand are contributing factors.

"We are seeing 250 to 300 consults per year and other major medical centers are seeing 300 to 1,000. I wouldn't have predicted that 20 years ago," says **Ryan R. Nash**, MD, MA, FACP, FAAHPM, director of the division of bioethics at The Ohio State University College of Medicine.

> "FINDING ENOUGH PEOPLE WITH THE TIME, TRAINING, AND INCLINATION TO SERVE ON AN ETHICS COMMITTEE, NEVER MIND CONDUCT ETHICS CONSULTS, CAN BE NEARLY IMPOSSIBLE."

Rural or critical access hospitals may lack any ethics expertise. "Finding enough people with the time, training, and inclination to serve on an ethics committee, never mind conduct ethics consults, can be nearly impossible," says Klugman.

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Volume of ethics demand at remote hospitals that are part of newly merged health systems sometimes is too low to warrant onsite ethicists. Some systems employ ethicists to cover a group of hospitals in fairly close proximity.

"But that still leaves a gap between the hospitals that are too far to drive to," says Nash.

Tele-ethics consults are a possible answer for all these scenarios. "As with all telemedicine, ultimately the program may help reach more patients and clinicians with fewer resources," says **Laura S. Johnson**, MD, FACS, an assistant professor of surgery at Georgetown University School of Medicine in Washington, DC.

Meaningful Reflection Needed

Some states have created ethics networks to provide ethics services to rural hospitals, including consultation. "The usefulness of these networks can be expanded through the use of tele-ethics," says Klugman.

In some ways, tele-ethics is really no different than other types of telemedicine, says Nash. For instance, once a stroke is diagnosed onsite, a remote neurologist can guide the clinical team on the next steps. "The same kind of thing can happen for clinical ethics," says Nash.

Bioethicists at the Cleveland Clinic occasionally offer input by phone when contacted by ethicists at partner or affiliated hospitals. Ethicists intend to work with other interested hospitals in the system to expand this approach by offering tele-ethics consults.

"We would like to not only provide the service, but also to study the interaction with some meaningful reflection on whether it's a helpful service," says Nash.

The following are some potential challenges of tele-ethics:

• The tele-ethicist needs to be able to access the patient's chart to read and write a consult note.

Many hospitals use different and incompatible EHRs. "This can be a particular challenge," says Klugman.

Nash sees tele-ethics as superior in some ways to the current peer-to-peer process that sometimes is used at Cleveland Clinic. This is because peer-to-peer consults rely on information gathered by ethicists at the hospital requesting the consult.

"We are often given advance on starting, stopping, or changing medical treatment. We are rendering what some would consider a medical opinion," says Nash.

If the recommendation is documented sparsely, as in "Dr. Nash from Ohio State says it's OK to stop treatment," the nuances of the discussion and thought process are lost. "The danger is that the

EXECUTIVE SUMMARY

Teleconsultations can help hospitals meet growing demand for ethics expertise, but also has limitations. Downsides to remote ethics consults include:

- Lack of face-to-face contact with patients and family;
- Inability to follow up with distressed clinicians afterward;
- Technical glitches such as audio problems.

ethics guidance could be taken out of its original complexity," says Nash.

It may later turn out that the ethicist was working with incorrect or insufficient information. In this case, says Nash, "the danger is that the ethics opinion may be misused, misperceived, or may be in error." But tele-ethics consults would require ethicists to gather information on their own and write their own note.

• It is sometimes unclear how tele-ethicists would be compensated.

Many ethics consults are performed on a volunteer basis with no reimbursement, raising the question of how teleconsults would be compensated. "There would need to be a way for a payment of services to make sure that the ethicist is not doing extra work for free," says Klugman.

• Tele-ethics may not cover informal consults.

Many ethics consults are "curbside" — a clinician spots the ethicist in the hallway and asks a quick question. "These are not formal consults, but are important. Tele-ethics has the disadvantage of not permitting curbside consults," says Klugman.

It also does not allow for the ethics expert to round with the team. "One solution might be to hold ethics office hours, where the ethicist is available via teleconferencing and people can come in and discuss cases," suggests Klugman.

In Kaiser Permanente's Northern California region, regional ethicists sometimes do receive quick calls from clinicians just to clarify policy or legal requirements. "It's almost the tele-ethics version of a curbside consult," says **Mathew David Pauley**, JD, MA, MDR.

• There always will be technical issues.

"Anyone who has tried to do WebEx knows there are technical difficulties," says Nash. Clumsy interjections, awkward pauses, and equipment failures can immediately increase tension during family meetings.

Ethicists at MedStar Washington Hospital Center recently conducted a pilot study to see if tele-ethics consults were feasible for clinical rounds.[1] Researchers used videoconferencing to provide real-time interaction between rounding clinicians and a remote clinical ethicist. Not surprisingly, most technical problems involved issues with audio. Of the 30 patient encounters analyzed, 14 were judged to be "inaudible" by the remote ethicists. Adjustments to the microphone improved audio quality. Remote ethicists also reported an obstructed view of the rounding team, addressed by repositioning the camera to more of a bird's-eye view.

Tele-ethics consults are conducted by phone at Kaiser Permanente's Northern California region. "The problem is we have hospitals that are super high-tech and some are not. And there are usually only or two rooms where these care conferences normally happen," says Pauley. Some sites lack the equipment or staff to use videoconferencing.

Technology also can get in the way when consults are performed by phone. As a remote ethicist, Pauley listens to what others say, then interjects when it seems appropriate. Still, silence on the other end can be difficult to interpret.

• Remote ethicists sometimes lack familiarity with the hospital culture and access to available resources.

In recent years, Pauley has moved from serving as an in-hospital clinical ethicist to supporting hospital-based ethicists remotely. "In the past few years, my role has been nearly exclusively a teleconsultant," he says.

The region's 21 hospitals do not employ full-time ethicists. Instead, they rely on co-chairs of ethics committees, or small groups of members. "When the case gets beyond them, they call us," says Pauley. "We are trying to help people do ethics consults from afar. It's very different — and, in a way, very difficult."

Typically, ethicists call on many different resources within the hospital — administrators, chaplains, social workers, or clinical leaders.

"Knowing how the hospital runs and its culture are resources we would normally have. In my disconnected role from a regional office, I lack that integration," says Pauley.

• Remote ethicists lose information gained from in-person contact.

"This challenge can be overcome by appointing a person at the remote hospital who acts as the hands of the expert," says Klugman.

The question becomes: Is calling on a remote clinical ethicist better than employing a nonexpert on site? "It will probably be better than just the local resources doing the best they can to go through the ethics dilemma," says Nash. "But it should not be replacing the face-to-face interaction."

Ideally, the outlying hospital would have someone else present with the patient or family. "As ethicists, we often deal with highly charged emotional issues. Videoconferencing handcuffs a lot of our skill set," says Nash.

During the recent pilot study, researchers were surprised to see that the number of ethics consultation triggers was similar between onsite and remote ethicists, says Johnson.

"We had been concerned that the lack of 360-degree visualization for the remote ethicist would limit their ability to pick up on some of the more subtle body language cues that an ethical issue may exist," she explains.

Following up after the consult is another challenge. "Ethics consultation has a lot of moving pieces. If you are not integrated enough into the hospital itself, it's very hard," says Pauley.

Most of the tele-ethics consults involve the issue of nonbeneficial treatment, which sometimes results in moral distress. Tele-ethicists cannot just walk into the break room with nurses and talk things through.

Nuances such as the need to provide tissues during family meetings and consider where various people are seated can go unrecognized. "People who feel vulnerable don't like to sit away from the door," explains Pauley. "It's the little things that you just learn over time."

"ETHICS CONSULTATION HAS A LOT OF MOVING PIECES. IF YOU ARE NOT INTEGRATED ENOUGH INTO THE HOSPITAL ITSELF, IT'S VERY HARD."

• The tele-ethicist's recommendations will be conveyed to family by someone else.

Pauley consulted on a recent case with a conflict between a patient's daughter and wife on who would make decisions. The clinicians were focused solely on who should be the decision-maker when CPR was not an ethically appropriate intervention under the circumstances. "Clarification of the issues was helpful for the physicians — that regardless of what either family member said, it should not be a choice for them to make," says Pauley.

Pauley was able to assure the team they were ethically justified in not offering nonbeneficial care. But it was up to the onsite ethicists to work with the family and come up with an agreeable plan of care. This brought another limitation of tele-ethics to light: It is one thing to give recommendations, and quite another to convey these to family.

"You can give advice on how to say it, but the person can say it wrong. You are basically sending a missile out to the hospital, because when those things go wrong, they go wrong really badly," says Pauley.

While some individuals serving on the ethics committees are highly competent clinicians with PhDs in ethics, others are recently appointed and have little or no experience. "It's the equivalent of helping a layperson land a plane," says Pauley. ■

REFERENCE

1. Johnson LS, Brenner DM, Sederstrom NO. Technical considerations for implementation of tele-ethics consultation in the intensive care unit. *J Clin Ethics* 2018; 29:285-290.

SOURCES

- **Laura S. Johnson**, MD, FACS, Assistant Professor of Surgery, Georgetown University School of Medicine, Washington, DC. Phone: (202) 877-7347. Email: Laura.S.Johnson@medstar.net.
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Legal Requirements May Conflict With Clinicians' Ethical Obligations

It is simply not possible for clinicians to do the right thing if ethical principles and legal requirements are in direct conflict.

"But it is important not to lose sight of what the right thing is, even if that goal cannot always be reached," says **Dena S. Davis**, JD, PhD, endowed presidential chair in health and professor of bioethics at Lehigh University in Bethlehem, PA.

The following are some examples of scenarios where the law and ethics collide:

• Gag laws make it a criminal offense for physicians, nurses, or other medical staff to ask patients and families about gun possession.

Physicians who broke this Florida law faced possible disciplinary action. Here, says **Matthew DeCamp**, MD, PhD, "the conflict was between physicians' obligations to inform and protect patients' welfare, and the threat of legal sanction were they to violate the law in doing so."

For physicians who saw discussing gun safety as part of fulfilling their primary obligation to a patient's welfare, the law presented a clear ethical conflict.

"Hospital ethicists can help individual physicians think through these complicated issues just as they do for other areas where law and ethics intersect," says DeCamp, adding that it allows clinicians to protect their moral integrity.

Ultimately, the Florida chapter of the American Academy of Pediatrics, other medical societies, and six individual physicians filed a lawsuit, and the gag law was overturned.[1] "This demonstrated how physicians can be effective in advocating to change laws that conflict with core ethical obligations," says DeCamp, an associate professor at the University of Colorado's Center for Bioethics and Humanities.

• Laws in some states require abortion providers to give patients specific information.

"I don't think a healthcare professional should ever lie to a patient about medical information, such as a spurious link between abortion and breast cancer," says Davis.

"HOSPITAL ETHICISTS CAN HELP INDIVIDUAL PHYSICIANS THINK THROUGH THESE COMPLICATED ISSUES JUST AS THEY DO FOR OTHER AREAS WHERE LAW AND ETHICS INTERSECT."

Some providers compromised by qualifying the information with statements such as, "The state requires me to tell you."

"But that concerns me," says Davis. The mere fact that information comes from a doctor's mouth, or is on a piece of paper handed to someone by a doctor, carries considerable weight. Despite providers' attempts to downplay it, says Davis, "it may be difficult to comprehend that it is baseless and false information."

Ethicists cannot simply advise physicians to break the law in this type of scenario. Yet, they still can be of help in addressing resulting moral distress. "Ethicists could help physicians see the full depth of this sort of issue by recognizing it as a fundamental ethical or professionalism problem, not just one of discomfort," says DeCamp.

• Requests by law enforcement violate patients' rights.

There have been recent cases involving local sheriffs who presented to hospitals with a person in custody. "They seemed to think they could drag their suspect into an emergency room and demand that hospital personnel perform X-rays or exams without the person's consent," says Davis.

Ethicists can make it clear that legal constraints against performing an exam without consent still apply, and help develop an institutional policy with clear guidance.

The ethicist's job in such cases, says Davis, is to "sort out which legal constraints can be complied with, albeit reluctantly; which can be sidestepped; and which are lines in the sand that cannot be crossed."

• For unrepresented patients who lack capacity, the only available mechanism in some states is to get a court-appointed guardian or conservator.

"But that could take weeks to months. What should clinicians do in the meantime?" asks **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.

Some institutions have developed internal policies on how to make

treatment decisions for unrepresented patients. These are not specifically prohibited by law. "They are simply not expressly permitted," says Pope. "Institutions and systems can develop policies to fill in these gap areas where the law is silent."

Policies should require the following steps be taken, says Pope, to be consistent with guidelines from the American Geriatrics Society[2]:

1. Assess capacity very carefully.

Patients who appear unrepresented may, in fact, be able to participate in their own healthcare.

2. Undertake a diligent search for potential surrogates.

"Social workers are often able to find available surrogates for patients who appeared to be unrepresented," notes Pope.

3. Take a broad view on who may serve as a patient's surrogate.

State default surrogate laws often include only limited categories of family relations. "But clinicians should look to any family or friend who knows and cares about the patient," says Pope.

4. Specify a process for making treatment decisions when none of the above measures are successful.

"Ideally, this would be a multidisciplinary committee independent from the attending physician," says Pope. ■

REFERENCES

1. *Wollschlaeger v. Governor of Florida*, 760 F.3d 1195 (11th Cir. 2014).
2. Farrell TW, Widera E, Rosenberg L, et al. AGS position statement: Making medical treatment decisions for unbefriended older Adults. *J Am Geriatr Soc* 2017;65:14-15.

SOURCES

- **Dena S. Davis**, JD, PhD, Professor of Bioethics, Lehigh University, Bethlehem, PA. Phone: (610) 758-6082. Email: dsd311@lehigh.edu.
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Unique Informed Consent Challenges of Sequentially Randomized Trials

Repeat consent conversations are necessary sometimes

Elizabeth F. Krakow, MD, encountered some unexpected ethical challenges with informed consent after designing a sequentially randomized trial for patients with newly diagnosed acute myeloid leukemia.

The objective was to assess the utility and optimal timing of allogeneic stem cell transplantation compared to alternative treatment options.

"The treatments and timing of the treatments offered in the trial would depend on the disease response," explains Krakow, a researcher at Fred Hutchinson Cancer Research Center in Seattle.

The traditional informed consent model required researchers to explain possible trajectories at the outset; however, this was not appropriate for the study. "When it came time to select a subsequent treatment, it would be difficult for patients to remember a conversation that occurred weeks beforehand," says Krakow.

Conceivably, patients might refer to the original consent form as a reference, assuming they kept it — and understood it. "These documents are dense and long," notes Krakow. "And much of the information would not be relevant to the treatment choices at hand."

Even if patients fully understood all the complexities, an important piece of information still was missing.

"The risk-benefit ratio of the treatments proposed could not possibly be known at the outset since many clinical events would occur in the interim," says Krakow.

Some people initially appear to be good candidates for transplant. But complications of treatment, such as renal insufficiency, may develop — changing the risk-benefit analysis. It became apparent that a repeat consent conference was necessary before each sequential randomization.

This change raised broader questions of how best to inform cancer patients about the decisions they face in any randomized trial. As someone who regularly seeks patient consent for high-stakes experimental oncologic interventions, Krakow puts a lot of thought into how these trials are presented to patients: "Yet, I still

don't think I communicate the nature of clinical trial participation well enough."

Krakow and a colleague sought answers in a recent analysis of 27 studies.[1] None of the studies specifically addressed problems posed by multiple sequential randomizations, but many of the issues were relevant. Some of the identified barriers to informed consent could be addressed fairly easily, including shortened consent forms or provision of a concise summary.

Deeply ingrained, flawed perceptions of medical research are considerably more challenging. "Beliefs such as the 'therapeutic myth' often lead patients to filter what they hear, and prove difficult to change," says Krakow.

The paper was rejected by two leading oncology journals. "The editors sent almost apologetic rejection letters," says Krakow. "They did not cite flaws in the paper, but noted that the findings would not surprise their readership."

To the researchers, this was an indication that problematic informed consent processes are commonplace. "This leads to the question of why we allow these inadequate methods of soliciting informed consent to persist ubiquitously," says Krakow.

Consent forms and processes may provide some legal protections to clinicians. However, they are not serving the needs of patients, concludes Krakow.

The paper suggests that researchers consider newer, lesser-used methods, such as:

- animated videos;
- decision aids developed with the help of patients;
- the presence of trained patient advocates during patient/physician discussions on treatment options.

It is not uncommon for a provider to become aware of a significant change in the patient's medical or psychosocial condition from the time the consent form was signed. In this case, another conversation is needed about whether the patient wishes to remain in the study, says Krakow.

This is especially important if study-mandated treatment is ongoing, says Krakow. "The possible risks and benefits of receiving treatment might have changed substantially." ■

REFERENCE

1. Nathe JM, Krakow EF. The challenges of informed consent in high-stakes, randomized oncology trials: A systematic review. *MDM Policy Pract* 2019;1: 2381468319840322.

SOURCE

- **Elizabeth F. Krakow**, MD, Fred Hutchinson Cancer Research Center, Seattle. Phone: (206) 667-3410. Email: efkrakow@fredhutch.org.

Study: Trust in Physicians Declined When Industry Ties Reported

Very few people accessed publicly available information

Public disclosure of industry payments made to doctors had an unintended effect of decreased trust in the medical profession, according to authors of a recent study.[1]

"We were interested in doing a rigorous evaluation of the effect of transparency of industry payments on patients," says **Genevieve P. Kanter**, PhD, the study's lead author and an assistant professor in the department of medical ethics and health policy at University of Pennsylvania Perelman School of Medicine in Philadelphia.

The Physician Payments Sunshine Act was passed to increase transparency of doctors' financial ties with industry. "We wanted to see the degree to which that actually happened," says Kanter. "We were interested in how this would play out in a real-world policy setting."

Declining Trust

Researchers surveyed 1,388 individuals before the public disclosure of industry payments, and again two years later, about trust in their own physicians and in the medical profession overall. "We didn't know what to expect with the trust measures because theory suggested that trust could move in either direction," says Kanter.

The Centers for Medicare & Medicaid Services Open Payments database was launched to increase public trust. But research suggests that when patients know that individual doctors receive industry payments, the patients trusted those specific doctors less. The researchers found that transparency negatively affected both patient trust in their own doctors and in the medical profession.

Trust declined by 2.7%. "It may not seem large, but in the context of the medical literature on trust, where it's hard to find any factors that move the trust measure to any appreciable degree, it's a big deal," says Kanter.

The 2.7% decline is similar to the negative trust effects of patients knowing about managed care incentives. There, says Kanter, "is a perceived tradeoff between patient care and cost-cutting."

Few Find Out Directly

Industry payments have been publicly disclosed for more than two years. Yet, only 3% of U.S. adults knew whether their physicians received an industry payment, found another study.[2]

"The one consistent finding in transparency programs, both inside and outside of medicine, is that individual members of the public rarely access this information directly," says Kanter, the study's lead author.

Some people do not know about Open Payments, or have not looked up their physicians. Others have heard about industry ties indirectly from news reports or other sources.

"Because people aren't accessing the database, they are painting physicians with too broad a brush," says Kanter.

Media coverage typically focuses on bad actors, or doctors who receive particularly high payments. This makes people skeptical of all physicians, including their own. "There are reputational effects for all physicians based on the industry interactions of some physicians," Kanter concludes.

This suggests it is in the best interest of physicians without industry ties to let it be known. "This can be done simply — maybe via a website notice, a link to the Open Payments website, or a sign in the waiting room," says Kanter. ■

REFERENCES

1. Kanter GP, Carpenter D, Lehmann LS, et al. US nationwide disclosure of industry payments and public trust in physicians. *JAMA Netw Open* 2019; 2:e191947.
2. Kanter GP, Carpenter D, Lehmann L, Mello MM. Effect of the public disclosure of industry payments information on patients: Results from a population-based natural experiment. *BMJ Open* 2019; 9:e024020.

SOURCE

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Ethics Champion Program Empowers Clinical Teams

As healthcare organizations become more complex, there is a greater need for ethical discussion. Ethics champion programs are one way of encouraging discussions, according to **Angela Knackstedt**, BSN, RN-BC, bioethics clinical coordinator in the Pediatrics Bioethics Center at Children's Mercy Kansas City (MO).

The organization's nursing ethics forum started in 1988 after two nurses participated in interdisciplinary discussion regarding the impact of the "Baby Doe laws" on the NICU. The law was enacted in the early 1980s for staff to report medical neglect after the widely publicized deaths of disabled infants after parents chose to withhold medical treatment.

"This experience made them realize that nurses needed more awareness and education regarding ethics and ethics resources," says Knackstedt.

A more recent focus on "taking ethics to the bedside" focuses on nurse champions doing so within their own units and organizationwide.

"In addition, an annual day-long retreat allows a dedicated time for more in-depth ethics education, discussion, and strategic planning," says Knackstedt.

The program helps mitigate moral distress, provides ethics education, and helps clinicians recognize and act on ethical issues, says Knackstedt, who co-authored a recent paper on ethics champion programs.[1]

Knackstedt says these steps are needed to create an effective program:

- Identify interested nurses who are passionate about ethics;
- Secure administrative support;
- Collaborate with ethics committees;
- Develop an ethics curriculum based on current issues (pediatric mental health, staff safety, health disparities, and self-care).

"With the support of ethics

champion programs, ethics consultation can be utilized more because of the increase confidence in utilizing this essential resource," says Knackstedt.

At Massachusetts General Hospital, the Ethics in Clinical Practice Committee (EICPC) was formed more than three decades ago. The goal to educate frontline clinicians in healthcare ethics has not changed, even while new ethical challenges have emerged. "Certain ethical issues challenge clinicians perennially," says EICPC advisor **Brian Cyr**, RN, a nurse at Massachusetts General Hospital. These include care of vulnerable populations and helping families navigate end-of-life decisions.

"However, in the last few years, clinicians are increasingly raising concerns as they weigh the benefits and burdens that accompany ever-more advanced medical technologies that can prolong life," says Cyr. These include continuous venovenous hemofiltration and mechanical cardiac support.

For some clinicians, this has led to moral distress. The EICPC has implemented several evidence-based strategies, including a formal structure for ethics support.

When requested, the EICPC also provides input on organizational projects with ethical implications. Recent examples include:

- Updating to the organization's life-sustaining treatment policy;
- Improving the functionality of the electronic medical record's advance care planning module;
- Creating a patient education brochure on healthcare proxies, titled "Planning in Advance for your Healthcare."

"Our group offers practical ethics education and resources to our members, who then share these skills and resources with colleagues," says Cyr. ■

REFERENCE

1. Trotochaud K, Fitzgerald H, Knackstedt AD. Ethics champion programs. *Am J Nurs* 2018;118: 46-54.

SOURCE

- **Angela Knackstedt**, BSN, RN-BC, Health Literacy & Bioethics Clinical Coordinator, Bioethics Center, Children's Mercy Kansas City (MO). Phone: (816) 701-5297. Email: aknacksted@cmh.edu.

New Data Shed Light on Scientific Misconduct

Questionable research practices are well-documented in biomedicine.

"But we have limited information about such behavior in our field of health professions education," says **Lauren Maggio**, PhD, associate director for technology and distributed learning of the graduate programs in health professions education at the Uniformed Services University of the Health Sciences, Bethesda, MD.

Maggio and colleagues surveyed 590 health professions education researchers in 2017.[1] "As educators and leaders in graduate programs, we wanted to determine which research characteristics and practice factors might explain the frequency of irresponsible research practices," says Maggio. Some key findings include:

- Older researchers tended to report misconduct less. This may be in part because they have been involved in research for much longer, with more opportunities to act unethically. "And yet, our results suggest they do not [act unethically]," says Maggio.

> "WE SHOULD BE AWARE OF THE RESEARCHER CHARACTERISTICS AND PRACTICE FACTORS THAT EXPLAIN THE FREQUENCY OF SUCH IRRESPONSIBLE PRACTICES."

- The strongest individual predictor of misconduct is publication pressure.

The greater the publication pressure, the greater the reported misconduct.

"Unfortunately, we were unsurprised by this. This is a finding that has been replicated in several other fields," says Maggio.

- Researchers with more publications had higher misconduct scores.
- Researchers in Asia tended to have higher misconduct scores compared to researchers in North America.
- Those who defined their role as researcher showed higher misconduct scores than those of clinicians.

"We think our findings, which speak to the way in which research is conducted, have implications for

all health practitioners, including hospital ethicists," says Maggio.

The take-home message, Maggio says, is that misconduct and unethical research practices could seriously damage the quality of scientific work.

"We should be aware of the researcher characteristics and practice factors that explain the frequency of such irresponsible practices," she adds.

Despite the known prevalence of questionable research practices, it is not actively discussed, says Maggio. This can exacerbate the problem.

Ethicists could help, suggests Maggio, "by raising awareness of and facilitating discussions on questionable research practices." ■

REFERENCE

1. Maggio L, Dong T, Driessen E, et al. Factors associated with scientific misconduct and questionable research practices in health professions education. *Perspect Med Educ* 2019; Mar 26. doi: 10.1007/s40037-019-0501-x [Epub ahead of print].

SOURCE

- **Lauren Maggio**, PhD, Associate Director for Technology and Distributed Learning of the Graduate Programs in Health Professions Education, Uniformed Services University of the Health Sciences, Bethesda, MD. Email: lauren.maggio@usuhs.edu.

Ethics of Cellphone Use in Clinic Waiting Rooms

A busy dermatologist recently walked into a treatment room to find her patient talking on a cellphone. The patient put her finger up, indicating the physician should wait until she was through with her conversation.

"We realized that with the vast majority of Americans now owning a cellphone, this probably wasn't an uncommon scenario," says **Madeline DeWane**, a student at the University of Connecticut and co-author of a recent paper on this topic.[1]

This is especially true for busy practices with long wait times. "Beyond the etiquette question of how best to react in the moment, we felt the situation raised some interesting ethical questions," says DeWane.

Ethical issues related to patient cellphone use center around the physician-patient relationship. At issue: How to balance the value of both physicians' and patients' time.

"In some cases, cellphone use may be appropriate and helpful," notes DeWane. Patients may want to be distracted during an uncomfortable procedure. It also is an easy way to include family or loved ones during decision-making. Additionally, cellphones distract patients during long waits.

"However, when cellphone use disrupts a clinical encounter it can make communication challenging," says DeWane.

Cellphone use can interfere with the establishment of trust and rapport. "This has the potential to stress the physician-patient relationship and interferes with the process of shared decision-making," says DeWane. A patient immersed in a phone conversation forces the physician to choose between treating the patient at hand and their duty to other waiting patients.

The potential privacy implications of cellphone use in the clinical setting are another ethical challenge. "This is especially complex because what's legal is not always ethical," says DeWane.

Most U.S. states require only single-party consent to legally record a conversation. However, many people would agree it is unethical to record someone without their knowledge. "In a clinical setting, there is an expectation by both patients and physicians that conversations are private," says DeWane.

Similarly, individual patients are not bound by patient privacy regulations. Thus, they are legally allowed to take photos or videos in close proximity to other patients. "But these actions could be considered unethical if they violate another patient's privacy," notes DeWane. ■

REFERENCE

1. DeWane M, Grant-Kels JM. Cell phone use in the clinic: "Please hang up now, the doctor is ready to see you!" *Int J Womens Dermatol* 2018; 4:238-239.

COMING IN FUTURE MONTHS

- New data on ethical issues encountered by hospitalists
- Many ethical concerns with HHS Conscience Rule
- Unethical hospital billing and collection practices
- Ethical responses to burnout in critical care providers

Few Cardiology Treatment Recommendations Based on High-Quality Evidence

Findings suggest incremental changes are not enough

Less than 10% of treatment recommendations for heart patients are based on high-quality evidence, according to the authors of a recent study.[1] "We may need wholesale changes in the way we conduct clinical research," says senior author **Renato D. Lopes**, MD, MHS, PhD.

More than a decade ago, researchers from Duke University examined the evidence supporting guideline recommendations in cardiology for the first time. They found that only 11% of recommendations in American College of Cardiology/American Heart Association (ACC/AHA) guidelines were supported by evidence from randomized controlled trials — the highest-quality level of evidence.

The researchers called for greater collaboration among investigators and funders in identifying key research questions, streamlined clinical trial methods, and more funding for clinical research.

"Over the past 10 years, some of these steps have been taken. But it is unclear how the evidence supporting guideline recommendations has changed," says **Alexander Fanaroff**, MD, the study's lead author.

Researchers analyzed 51 current cardiovascular guidelines — 25 from the European Society of Cardiology (ESC) and 26 from the ACC/AHA. Overall, 8.5% of ACC/AHA guideline recommendations and 14.3% of ESC guideline recommendations were supported by evidence from randomized controlled trials.

The proportion of recommendations supported by data from randomized controlled trials actually decreased from 2008. In looking at updated guidelines, the researchers found that fewer recommendations were supported by randomized controlled trials than in the prior versions.

"Despite the efforts of so many over the past 10 years, it seems we haven't moved the needle on evidence generation," says Fanaroff.

The incremental changes made in the last decade may not be enough, says Lopes, a professor of medicine at Duke University Medical Center in Durham, NC. More dramatic change is needed, he argues, including:

- Systems to use data generated in the course of routine clinical practice into randomized controlled trials;
- Relaxation of regulations on enrolling patients into clinical trials and monitoring during trials;
- A greater focus on funding collaborative, multicenter efforts to conduct critical clinical trials.

"It will also take a concerted effort to demonstrate to patients the importance of clinical trials," says Lopes. A small proportion of patients participate in clinical trials currently.

"Many important questions don't lend themselves to clinical trials as the clinical research ecosystem is currently constructed," adds Lopes. Most studies are funded by the pharmaceutical and device industries. "But the medical research community should change the system so that these questions can be answered in a rapid fashion," says Lopes. This will take a team effort from researchers, physicians, the pharmaceutical and device industries, hospitals, insurance payers, and patients.

Changing the structure of informed consent is one possibility. "Randomization at a level other than the patient, community consent, and other mechanisms could help generate evidence that helps many, many people," he says.

However, research participants' rights also need to be protected. Ethicists play an important role in this balancing act, says Lopes.

"An understanding of the lack of evidence underlying clinical guidelines and decision-making, and the benefit of generating this evidence, will help them best guide this process forward." ■

REFERENCE

1. Fanaroff AC, Califf RM, Windecker S, et al. Levels of evidence supporting American College of Cardiology/American Heart Association and European Society of Cardiology guidelines, 2008-2018. *JAMA* 2019; 321:1069-1080.

SOURCE

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MEDICAL ETHICS ADVISOR®

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **Ethicists should do what regarding legal requirements and ethical obligations, according to Thaddeus Mason Pope, JD, PhD?**

   a. Advise physicians not to follow laws they view as unethical.
   b. Caution physicians against discussing gun safety with patients.
   c. Help to develop internal policies on decision making for unrepresented patients.
   d. Develop guidance requiring clinician to comply with local law enforcement requests to avoid conflicts with institutional policies.

2. **Which was an effect of laws requiring public disclosure of industry payments to physicians?**

   a. Most patients have accessed publicly available information on their own doctors
   b. Decreased trust in individual physicians
   c. Increased trust in the medical profession
   d. A significant decrease in industry payments made to cardiologists

3. **Which of the following was a finding of a recent study on scientific misconduct?**

   a. Older researchers report less misconduct.
   b. Individuals involved in research for more than a decade are less likely to behave unethically.
   c. Publication pressure is no longer a predictor of misconduct.
   d. Researchers with more publications have lower misconduct scores.

4. **Which of the following did a recent study find regarding tele-ethics consultations?**

   a. Declining demand for ethics services forced many hospitals to switch to remote consults.
   b. Informal "curbside" consults are linked to unethical practices.
   c. Ethicists working remotely dislike making their own notations in the electronic medical record because it conflicts with clinical documentation.
   d. About half of patient encounters were initially inaudible to remote ethicists.