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YOUR PRACTICAL GUIDE TO ETHICS DECISION-MAKING

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## INSIDE



RELIAS MEDIA

# ICU Team Members' Ethics Knowledge Varies Widely

ICU team members vary widely in their ability to apply ethical concepts, according to the authors of a recent study.[1]

"Often, pregraduate education seems to be a focus. But simulation in the classroom is not the same as real-life clinical practice," says **Janice Firn**, PhD, MSW, the study's lead author and a clinical ethicist at the University of Michigan's Center for Bioethics and Social Sciences in Medicine.

The ethicists interviewed 12 professionals from medical and surgical ICUs to gauge what they knew about medical ethics. The study started shortly after the ethics program received funding in 2016, says Firn: "We began thinking about how we could be of service to the institution."

Ethicists already knew that most consult requests came from the ICU. Less well-understood were the somewhat different perspectives of the various interdisciplinary team members. "Social workers, nurses, and physicians have different professional training. Codes of ethics are similar, but the priority is somewhat different," Firn notes. These differences shape how ICU professionals think about an ethical dilemma — or even whether something is viewed as an ethical dilemma at all.

The researchers wanted to know more about how ICU team members viewed ethics. They asked those members to consider some ethically challenging cases.

"We found really wide variation between the units, within the units, and also within and between professions," Firn reports.

It became apparent that team members lacked a common language to talk about ethical problems. "If you have similar terminology, it's at least a good starting place," Firn offers.

Then, team members can discuss some possible ways to move forward. "If teams can't have a dialogue around ethics, it can lead to poor outcomes for patients and dissatisfaction for providers," Firn says.

Based in part on the study's findings, ethicists began "preventive ethics" rounds in the ICU. "That is a space to target some of the areas we found were lacking," Firn notes.

It gives ethicists a chance to model the correct language to describe ethical



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issues; concerns are taken more seriously. Previously, providers made vague statements such as, "The plan of care doesn't make sense. What are we doing?" Now, providers express the same concern differently, such as: "I am worried about how we balance supporting this patient's autonomy with our obligation to avoid harm."

Firn says conversations are most beneficial when they are facilitated by someone aware of hierarchies within various professions. That could make someone reluctant to bring up a concern.

"We want to build an ethical culture, with an opportunity for personal reflection for folks," Firn explains. "It's also an education piece to get at the most frequent topics we are seeing coming up in consults."

A recent case of a young patient's parents requesting additional chemotherapy at the patient's end of life was an opportunity for ethics education. The clinical opinion of the healthcare team was that chemotherapy would be toxic for the patient. But they were uncomfortable withholding it, given the parents' strong desire for the treatment. "The idea of not offering further chemotherapy in this circumstance is well-established. But actually saying 'no' to grieving parents' requests feels very different for providers," Firn says.

Ethicists outlined the reasons why withholding chemotherapy is an ethically justifiable action. They discussed nonbeneficial treatment, medical futility, autonomy, and providers' obligations for beneficence and nonmaleficence. "We explored the deeper 'why,'" Firn recalls.

Creating ethical language to support the clinical decision helped the healthcare team feel less moral distress about withholding chemotherapy.

"It gave them greater confidence when speaking with the parents about the decision," Firn adds. This type of ethical reflection will help providers deal with future cases.

"We are trying to be a smoke alarm rather than a fire extinguisher," Firn says.

Identifying specific areas of need for ethics education can be handled in several ways, according to **David A. Fleming**, MD, MA, MACP, co-director and scholar at University of Missouri Center for Health Ethics:

• Systematic random or selective case review using established quality improvement techniques. "Though time-intensive, this is an excellent evidence-based approach," Fleming offers;

• Periodic patient and multidisciplinary provider surveys;

• Simply asking, "How can I help?" This allows ethicists to identify learning opportunities "on the spot while facilitating discussions about actual events in the ICU," Fleming notes;

• Conducting regular ethics rounds in clinical areas where moral conflict often occurs (like the ICU). "This can be useful as long as clinical teams are welcoming to consults strolling through the unit when they haven't actually been consulted and it is not intrusive," Fleming adds.

Ethicists should take advantage of opportunities to mentor and instruct whenever that door is opened.

"But do so without being overbearing or authoritative," Fleming cautions. "Allow opportunities for open exchange of ideas, questions, and concerns."

In Fleming's experience, questions about medical futility and limiting aggressive treatment are by far the most common reasons for ethics consults. Ethicists educate care teams on the importance of

early discussions on prognosis and treatment preferences. "We have found that our ICU teams have become much more facile in dealing with the moral complexities and minimizing conflict," Fleming says.

Role-modeling demonstrates how to handle difficult discussions successfully. "Offer to meet with team members, either formally or informally, when there is the luxury of time and space to delve more deeply into complex issues," Fleming suggests.

Formal didactic sessions can be informative. "Brief informal communication is often the most productive in building expertise for dealing with ethical concerns," Fleming says. ■

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# Ethical Concerns if Opioids are Given in ED

Medicaid recipients are at moderate risk for conversion to opioid misuse after just one new prescription issued in the ED, according to the authors of a recent study.[1]

Researchers identified adults with no record of any opioid prescriptions in the previous year who filled a new opioid prescription after they were discharged from an ED in 2014. Of 202,807 ED visits, 23,381 resulted in a new opioid prescription. Of these, 13.7% led to persistent or high-risk opioid prescription fills within 12 months.

"The crux of the ethical issue is that you definitely have people who need help with pain," says **Ken Marshall**, MD, assistant professor in the department of emergency medicine at University of Kansas Medical Center.

For many years, ethical concerns regarding undertreatment of pain were emphasized strongly. "It was drilled into our head that we needed to do a better job of managing pain," Marshall recalls.

Now that the risks of opioid addiction are well-known, physicians have to make some difficult prescribing decisions, Marshall notes. Some patients (e.g., those with psychiatric comorbidities) are known to be at higher risk for addiction. That makes the decision to prescribe more ethically complex.

"For physicians, it's a really difficult balancing act," Marshall laments. "It's likely that those people are at risk for having pain undertreated. However, they also are at risk for addiction."

A patient with a substance abuse disorder may present to the ED with a fractured arm. "If the patient is in recovery, they often will be their own advocate, and you can use some shared decision-making," Marshall explains. A brief prescription with timely follow-up is one possibility. The best approach is to use as few opioids for as short a time as reasonably possible. "With each increasing day that the prescription lasts, risk increases," Marshall says.[2]

Also important: Managing patients' expectations. Physicians do not always properly convey that living pain-free is not a realistic expectation and that the solution is not to continue opioids indefinitely, Marshall says. He tells patients: "As a doctor, I am obligated to do what's best for you. Increasing the length of your prescription will put you at higher risk for developing an opioid dependence. This prescription is to try to get you through the worst of it. If you were my sister or mom, this is exactly the amount I would give to you."

Most people respond positively to this. "That kind of conversation, instead of the patient leaving dissatisfied and angry, can turn it into a much more therapeutic interaction," Marshall says. ■

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## COMING IN FUTURE MONTHS

- How certification has changed the field of ethics
- New data on attitudes toward medical assistance in dying
- Tactics to create a more effective ethics committee
- Ethics of recruiting research participants via social media

# New Guidance Targets Informed Consent for Stem Cell Therapies

Clinics offering stem cell "treatments" often use advertising and other materials that almost certainly will confuse patients, according to a new guidance on informed consent for stem cell-based interventions.[1]

"Longstanding therapies, clinical trial interventions, and wholly novel and as-yet-untested interventions are all discussed in the same few paragraphs," says **R. Alta Charo**, JD, a member of the International Society for Stem Cell Research (ISSCR) task force that developed the guidance.

According to Charo, patients need to understand what is offered, whether a governmental authority has asserted its legislative right to regulate, and whether the intervention has complied with all applicable regulations. Further, patients need to understand the risks of adverse effects (and where those data come from), the probability of good outcomes (and of which type) and where that prediction comes from, and if the clinic personnel are medically qualified. Also, patients need to know their options for alternative treatments or enrollment in clinical trials.

"The FDA has recently increased its enforcement efforts and its success in the courts when clinics attempted to challenge FDA's regulatory authority," says Charo, professor of law and bioethics at the University of Wisconsin.

It is important to distinguish between stem cell therapies that have been shown to be beneficial and sufficiently safe and those that still are experimental, says **Philip M. Rosoff**, MD, MA, professor emeritus of pediatrics and medicine at Duke University and former chair of Duke Hospital's ethics committee.

For example, some kinds of bone marrow transplantation for relapsed leukemia now are considered to be the standard of care. "This does not mean that informed consent is not required, simply that the additional features demanded by human investigation are not needed," Rosoff cautions.

The level of information and the manner in which it is presented can be problematic, regardless of whether the proposed therapy is under investigation in a clinical trial or is standard treatment. "However, the former at least has the assurance of IRB oversight. The latter is pretty much unregulated," adds Rosoff, noting that an apt analogy is the use of "off-label" drugs given for non-FDA-approved indications.

As it stands now, if stem cells are removed from a person's body and then put back in the same person, there is scant regulation over what can be done to them. "The FDA finally seems to be aware of the problem after a number of patients have been injured or died as a result of these unregulated clinics," Rosoff says.[2]

The ethical concerns, says Rosoff, "are similar to those situations where vulnerable, desperate persons are being taken in by hucksters and crooks."

Charo says that the ISSCR guidance was published "in the hope that clinics not yet subjected to FDA scrutiny will nonetheless think it is good medical practice to ensure patient consent is truly informed."

If the clinics fail to do this, says Charo, the paper's description of what constitutes good informed consent can serve as a benchmark against which state medical societies can evaluate disciplinary actions. "Judges and juries can measure the behavior of any clinic that is sued for malpractice," Charo says. ■

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# Is It Right to Screen All Adults for Illicit Drug Use?

Primary care clinicians should screen all adults for illicit drug use, including nonmedical prescription drug use, according to a draft recommendation from the U.S. Preventive Services Task Force (USPSTF).[1]

"If everyone is asked, it means we start to destigmatize illicit drug use," says USPSTF Vice Chair **Karina Davidson**, PhD, MASc. "We found substantial new evidence that showed that many more patient-reported adult screening measures had been validated and found to be accurate."

Also, more behavioral counseling and treatment services showed evidence of benefit.

"We are really encouraging clinicians to first understand the needs of their patient population and connect the patients with services," Davidson explains.

Clinicians are encouraged to consider the recommendations in light of what they know about each patient. "That always has to be prioritized," Davidson stresses.

Nevertheless, at this point, illicit drug use is one of the most common causes of preventable injuries and death. "There are many patients out there who could be helped if the conversation is started by their clinician," Davidson offers.

There's no question that screening for illicit drug use among all adult patients "is the right thing to do," argues **Lydia Dugdale**, MD, MAR (ethics), associate director of clinical ethics at Columbia University Medical Center. As a primary care doctor, Dugdale has been screening her patients for illicit drug use for decades.

"There exists within medical training a long tradition of screening for a variety of factors that can affect a patient's health," Dugdale observes.

To complete the "social history" component of a patient's history of present illness, medical students are trained to ask patients about their occupation, sexual practices, smoking, drinking, and drug use.

"All of these items and more have potential to cause health problems," Dugdale says.

No harm can result from this kind of screening, Dugdale adds. In fact, it may identify large numbers of people who could benefit from interventions to decrease drug use or identify and treat conditions such as hepatitis C that may result from illicit drug use.

"Working toward the good of our patients and toward eliminating harm to our patients are ethical principles at the core of patient care," Dugdale says.

However, there remains an important caveat for primary care doctors, according to Dugdale. It is not uncommon for primary care doctors to have only 10 or 20 minutes to address a patient's medical concerns. What happens if a patient screens positive for illicit drug use, but a doctor (for whatever reason) fails to address it?

"Here, we have the possibility of inadvertently harming our patients through an act of omission," Dugdale says.

The USPSTF recommendation specifies that screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. Dugdale says primary care practices are morally obligated to help patients when substance use disorders are identified. Some practices employ social workers or mental health practitioners who follow up with patients.

"Primary care doctors carry a tremendous burden of responsibility for all of a patient's general medical concerns, from substance use to diabetes to marriage problems and everything in between," Dugdale notes.

It is not uncommon for patients to withhold or underreport sensitive information. Often, time constraints demand that doctors must focus on the pressing issue of the day (such as dangerously high blood pressure) and put off other issues (such as a substance use problem) until they become problematic.

"This is the unfortunate reality of how the American healthcare system has chosen to value and, thus, pay for primary care," Dugdale observes. "There is simply never enough time with patients." ■

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# All-Volunteer Model Risks Marginalizing Ethics

It is hard to imagine tasking a hospital risk manager with reviewing legally problematic cases without compensation just because they enjoy handling that task. Yet, that is what some hospitals ask of their "volunteer army" of ethicists.

"The real tragedy is that so much of the clinical ethics work that goes on happens based on the goodwill of the people who do that work," says **Joseph J. Fins**, MD, MACP, FRCP, chief of the division of medical ethics at Weill Cornell Medical College.

Many individuals who perform clinical ethics consults or serve on ethics committees do so on a strictly volunteer basis. That, in addition to their other role as a clinician, administrator, nurse, or chaplain. "While volunteer efforts are laudatory, the failure of the organization to recognize this activity as worthy of support marginalizes it in comparison to other clinical activities," Fins argues.

Some hospital administrators just do not see the value of ethics. That makes it easy to cut any resources that already are dedicated to it.

"It will be the first thing to go when people are pressured by economic constraints," Fins observes.

Financial support for ethics varies widely. Many major academic medical centers include divisions, departments, or centers of medical ethics.

"There is support for many people to do some of this work," Fins notes. "I suspect that the falloff might be in places like community hospitals."

Evidence that ethics consultations are cost-effective can help move the dial toward compensating the people who do it. According to Fins: "It's good for patients and families, and may be very good for the fiscal well-being of institutions."

The advice that ethicists give "can be incredibly consequential," Fins adds. For example, many consults result in decisions on whether to withdraw or withhold care. The operational aspects of those clinical activities are compensated.

"It seems kind of anachronous that counsel that might lead to certain kinds of decisions would not be similarly supported," Fins says.

Ethics consultation services are helpful in building resilience, says Fins, "both for individual clinicians and also institutionally."

Ethicists can help clinicians talk about difficult cases and enlighten them on the ethical issues behind particular actions, such as withdrawing life-sustaining interventions.

"Clinicians can deal with their angst and then pick themselves up and continue to serve patients and families," Fins offers.

Ethicists often find a way to resolve conflicts that otherwise would have ended up in the legal system.

"One significant lawsuit that's prevented can pay for an ethics service for many years," Fins says.

Reduced length of stay, less unwanted care, and better patient satisfaction are other factors that demonstrate the utility of ethics services from an economic standpoint. "It's important that we get a better handle on the epidemiology of the economics of ethics case consultations," Fins argues.

Of course, saving money is not the sole reason to offer ethics consultation services. Fins emphasizes: "There is a moral and value-driven rationale for that. Nonetheless, there is economic justification."

Speaking the language of healthcare economics can help ethicists move toward paid positions. "You can write the treatise on why this is important, or you can present a one-page spreadsheet that the people who make budgetary decisions understand," Fins offers.

Healthcare systems can take advantage of well-intentioned ethicists. Many people freely volunteer their time because they are passionate about ethics. "People so enjoy doing clinical ethics that their goodwill may be taken advantage of a little bit," Fins admits.

However, it is not just ethics. Other hospital services such as palliative care, chaplaincy programs, and consultation liaison psychiatric programs also struggle to receive financial support. "There is a kind of family resemblance here," Fins says. "These are all activities that are essential but often are not compensated commensurate with need."

Frequently, a staff member will stop an ethicist walking through the hospital because someone wants to ask a question or express a concern. These "curbside consults" are less than ideal because the ethicists do not know all the facts. "There is a risk of giving advice to a partially complete story," Fins says. "But it's a biomarker of need."

It still is hard for some organizations to view ethics services as something that needs to be paid for. "We value the technical procedures. We probably overcompensate for technical ability, but we underpay for instrumentalism or pragmatism in the clinical context," Fins says.

One reason is that the effect of ethics — on clinicians, on patients and family, on the institution — is difficult to measure. After a successful ethics consultation, the family might end up making the same decision they would have made otherwise. "But the process is a lot better. It is more considered, more thoughtful, and deliberative," Fins says.

A family who went through this kind of process may experience less complicated bereavement or be less likely to sue. A nurse who went through it may be less likely to experience burnout or leave the profession. "We don't tend to think of that longer arc of consequence," Fins adds.

Proof that ethics prevented a lawsuit, a nurse quitting, or an unhappy family is often elusive. "These considerations are apparent to more visionary leaders," Fins says. "They may be less obvious to people who have not been thinking about this in a more holistic way."

Compared to other programmatic requests, ethics does not require a large amount of resources to sustain itself. "There is no capital investment here. It's all about people. It's not a lot of money, generally," Fins says. Building alliances with the clinical services that use ethics is one way to engender support. Fins offers a few approaches:

• **Identify clinicians who support ethics.** "An endorsement from a clinical leader or department chair

could be incredibly valuable," Fins says.

**• Invite people helped by an ethics consult to consider joining the ethics committee.** The goal is to build a community of people who are like-minded. Ultimately, all of them can be advocates for improving ethics at the institution.

"The ethics committee member is an ambassador between ethics and their home department and can serve as an intermediary between those two areas," Fins explains.

If the head of a clinical department warmly introduces the ethicist during grand rounds, it grants the ethicist considerable credibility. "It brings clinical ethics into the clinical mix," Fins says. "We are all, after all, in the common pursuit of quality care."

**• Go on a "listening tour" to better understand what clinicians need from ethics.** "Taking all of those points together, summarizing them, and presenting them to leadership is a way to engender an interest in this," Fins says.

**• Educate clinicians on ethics as a way to improve the quality of care.** "This sensitizes people to a need that exists, that they were not aware of," Fins notes.

This can happen even if ethicists lack the resources to set up a clinical consultation service. "The person doing the education could be a cultural change agent within the institution, helping to promote the service that will eventually come to pass," Fins says.

The work of ethics takes time, a precious commodity to today's clinicians.

"Increasingly, clinicians are unable to cost shift within their sphere to be as generous with their time as they have been," says Fins, noting that some volunteer ethicists are expected to assist whenever someone requests a consult at any time of the day. "Like any clinical service, it's not sustainable to do as a volunteer activity."

If clinicians do not have the time to devote to ethics work, then the work will not be completed.

"These activities will die of attrition, to the detriment of patients," Fins says.

Ultimately, ethics is a service that patients and families need. If hospitals and health systems do not recognize that and support it so it is sustainable, says Fins, "it's really an abdication of responsibility. It's like saying, 'We're not going to have lawyers or chaplains or infection control.' This is part of what a modern hospital requires."

Recently, Fins was taking a review course for a board of internal medicine recertification exam. The group was given five choices for each question, with about 80% choosing the correct answer each time — until an ethics question came up. Suddenly, the responses were evenly split, with each answering right at about a 20% response rate. The instructor noted Fins' presence and asked him to explain the reasoning behind the correct answer.

"What it showed me was that all these people who were so well-trained in every clinical area, when it came to ethics, were all over the map," Fins observes. "Their level of preparation was not commensurate with all the other areas they were studying."

This encounter underscores the need for professionals with ethics expertise in the hospital setting, Fins says. The question that hospital leaders should be asking, says Fins, is "Why should this activity, alone among all activities, be the sole activity that is not supported?"

"It is illogical and is untenable," Fins argues. "And it doesn't make sense economically."

A few years ago, ethics leaders at a half-dozen hospitals in northern New England hospitals informally compared funding at each of their hospitals. The range of support ran from none to two full-time ethicists.

"Naturally, ethicists with more funding felt they had more time to support the needs of patients, clinicians, and leaders," says **Tim Lahey**, MD, MMSc, director of clinical ethics at University of Vermont Medical Center.

Small, rural hospitals usually only worked with volunteer ethicists charged with few responsibilities. Larger healthcare systems employed several ethicists in paid positions, which came with more responsibilities.

Whether ethicists are paid is connected, at least in part, to how well they quantify the avoidance of unnecessary or unwanted care, lawsuits, or regulatory problems, according to Lahey.

"Our preventive role and engagement in the most complex cases poses a structural quandary. Our impact is either uncountable or detectable only in expensive, outlier cases," Lahey says.

Lahey says ethics probably will be better supported in value-based care systems. There is no billing code for clinical ethics work. "Funding it via doing clinical consults piecemeal in the same way other clinical work is funded in a fee-for-service environment isn't feasible," Lahey explains. Therefore, hospitals need to invest in ethics just because they believe it contributes to quality of care.

"In a value-based system, by contrast, hospitals can invest in preventive measures like clinical ethics without having to consider how many widgets of clinical care that work equates to," Lahey says. ■

# Number of Ethics Consults Could Be Tip of Iceberg; Many Concerns Go Unvoiced

Clinicians frequently struggle with ethical issues, but that does not mean they are going to call ethics.

"In general, the indications for an ethics consult are 'softer' than they are for a pulmonary or nephrology consult," says **Douglas S. Diekema**, MD, MPH, attending physician and director of education at the Treuman Katz Center for Pediatric Bioethics at Seattle Children's Hospital.

Providers may not have a clear "trigger" that causes them to think about ethics consultation.

"There may also be a psychological barrier to getting an ethics consultation," Diekema adds.

To some, calling ethics seems like admitting they are deficient in their knowledge of the subject.

"In cases involving disputes between individuals on the healthcare team, calling ethics may feel like whistleblowing," Diekema offers.

When pediatric ethics consults are called, some sort of conflict usually is the reason, often between the parents and the medical team. Parents may refuse to give consent for a procedure or test that the medical team believes is important.

But sometimes, people are uncertain as to the appropriate ethical course of action. Both the parents and the medical team believe that withholding medically provided fluids and nutrition might be the best thing for a dying patient, but are unclear on whether it is ethical to do so.

"In these cases, the request is for guidance rather than conflict resolution," Diekema explains.

Ethicists at Children's Hospital Colorado suspected that consults were underused and that many ethical issues encountered by hospital staff were going unaddressed. "If you were to query people in the hospital on what is ethics for, it's for death and dying and decision-making problems. But as ethicists, we know it's a lot more than that," says **Joel Friedlander**, DO, an associate professor of pediatrics at University of Colorado.

To find out if ethical concerns really were going unaddressed, researchers conducted a chart review of ethics consults occurring from November 2013 to January 2014.[1]

> TO SOME, CALLING ETHICS SEEMS LIKE ADMITTING THEY ARE DEFICIENT IN THEIR KNOWLEDGE OF THE SUBJECT.

"We set out to answer the question, 'How good of a job are we actually doing?'" says Friedlander, one of the study's authors. "We found that our ethics consults were focused on what people classically thought of as ethics — death and dying and those kinds of things."

The researchers came up with a way to determine what ethical issues were occurring in the hospital and whether these issues actually are addressed during consults. A flyer was posted throughout the hospital, directing people to a website with a 12-question survey.

One question asked participants if they encountered an ethical issue, and if so, to describe it. "It turned out that there were a lot of issues going on in the hospital that the ethics team was not addressing," Friedlander reports.

Only five ethics consults were documented during a three-month period. Yet, 63 staff members reported having an ethical concern during that same period. Notably, most of these issues involved moral distress in some way. "There are a lot of morally distressing things going on in hospitals that don't involve death or dying," Friedlander notes.

The results "were definitely very-eye opening. It was interesting to read about all of these issues happening in the hospital you work in," says **Kelsey Watt**, MD, the study's lead author and an Aurora, CO-based pediatrician. "One thing that I found fascinating is that 80% of participants felt moral and emotional distress regarding what they experienced, yet few sought help in an ethical consult."

Now, ethicists hold informal classes and rounds in various units to try to address some of these issues. For example, some respondents reported interpersonal problems between doctors and nurses.

"The ethics consultant could really have been a third-party intermediary in those cases," Friedlander suggests.

For ethics, says Friedlander, the results were a "wake-up call. We want to make sure we are applying the same rigor to ethics as we are to GI or neurology or anything else. We want to become better consultants." ■

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# Spreading the Word About Ethics is Challenging

Cases may involve conflicts between the family and clinicians, confusion over the decision-making process, moral distress, or all these factors and more. Still, no ethics consult may ever happen. Sometimes, it is because clinicians have no idea ethics services exist at the organization.

"Development of a vibrant ethics service begins with strong institutional support," says **Leslie M. Whetstine**, PhD, a bioethicist at Aultman Hospital and a professor of philosophy at Walsh University, both in Canton, OH.

Whetstine offers several approaches ethicists can use to spread the word:

**• Arrange for administrators and unit directors to introduce the ethicist at various departmental meetings.** Then, the ethicist can give a brief overview of their role and outline their activities.

**• Post information on ethics on the organization's website.** "Showcasing the ethicist's qualifications and specialization in this medium can reach a broad audience, including patients and their families," Whetstine says.

**• Integrate ethics within the clinical team.** "Rounding across units and floors can be particularly helpful," Whetstine offers. This raises awareness of the ethics service and lets ethicists respond to issues proactively.

**• Provide educational offerings, both formal or informal.** "This can build an ethicist's reputation as a resource," Whetstine says.

Such offerings can be held in conjunction with annual ethics symposia offering continuing education credits, ethics grand rounds, or more intimate ethics "huddles" with small groups. "Huddles can focus on clinical issues the team is dealing with: limits of confidentiality, surrogate decision-making, or even current events," Whetstine suggests.

**• Invite individuals from various areas of the hospital to serve as active members on the ethics committee.** "This can foster a collaborative environment that benefits all," Whetstine says.

Typically, ethics committees draft and review policies, provide medical education, and participate in case consultation. Diverse membership ensures representation from all areas for all these important activities.

"Ethics committees are strengthened by membership across various departments," Whetstine says. "It contributes to the culture of institutional ethics as a whole."

Ethicists should consider including risk management, legal, human resources, mental health, pastoral care, social work, and critical care. "Some committees require a community member as well to provide an external perspective," Whetstine adds.

**Paul Hofmann**, DrPH, LFACHE, an ethics consultant and former hospital CEO, has found it helpful to conduct ethics rounds in ICUs and other clinical units while participating in medical staff grand rounds. He has enjoyed success with some approaches like these:

**• Presenting at medical staff, management, and board meetings.** Hoffman has given presentations to a wide variety of audiences on an equally wide variety of ethical topics. These include reasons for promoting the completion of advance directives, ethical challenges in making resource allocations in healthcare, and ethics in critical care medicine.

**• Preparing an annual report on ethics committee activities.** One recent report at a hospital Hofmann consulted for covered an expansive list of issues, including (but not limited to): conversations about organ donations, Do Not Resuscitate orders, and critical care policies; how to handle ethics requests; and a review of controversial proposed legislation that might affect existing facility policies.

**• Surveying staff to find out what they know about ethics and what they want from ethics.** Recently, Hofmann designed a staff survey for a Program for All-Inclusive Care for the Elderly organization in San Francisco. The brief survey asked respondents these questions such as "Did you know that the organization has an internal ethics committee?" and "Do you know how to refer a case to the ethics committee?"

The survey also asked what respondents believed should be the top three roles of the ethics committee. The listed choices were: to make treatment decisions on ethical matters; to provide consultation and make recommendations on ethical matters, cost control, quality review/utilization review, corporate compliance, review/comment/write policies and procedures related to ethical matters; and to provide education to staff regarding ethical matters. Also, the survey included questions about expected outcomes or results respondents would like to receive from an ethics consultation.

Hofmann says collecting this information is beneficial in several ways. The process reminds recipients of the range of available ethics services and identifies possible gaps in awareness of these activities.

"Having baseline data permits comparisons with results from periodic surveys in the future," says Hofmann, adding that the process gives staff members an opportunity

to submit questions and make suggestions.

"Over time, this modest investment should maximize the number of clinicians who have a deeper appreciation for the contribution made by ethics expertise and support," Hofmann says.

According to **Nancy S. Jecker**, PhD, the single best way to contact clinicians is through ethics education forums that reach clinical audiences. "If consults can be helpful but are not being called upon, it might also be productive to recruit and train clinical staff from different services to serve on the ethics committee," says Jecker, a professor in the department of bioethics and humanities at the University of Washington. Most important: for hospital leaders to model the importance of ethics. "This sends a clear message to everyone that ethics matters," Jecker adds. ■

# Controversial 'Public Charge' Rule Sparks Ethical Outcry

Ethical debate, controversy, protests, and lawsuits all have resulted from the U.S. Department of Homeland Security's recently announced "public charge" rule.[1,2] According to the rule, using public benefits, including Medicaid, may affect individuals' ability to enter the United States or adjust to legal permanent resident status.

The rule "creates barriers to appropriately caring for the sick and injured and to keeping people healthy," said **Rick Pollack**, president and CEO of the American Hospital Association (AHA), in a public statement.[3] "Failure to provide such services also has public health implications that could have widespread impact."

Multiple lawsuits have been filed to prevent the rule from taking effect.[4] According to a brief filed by the AHA and other hospital groups, "Although the Public Charge Rule will have the greatest impact on immigrant communities, the hospitals that serve them will also be affected. Coverage losses will lead to sicker immigrant populations and increased emergency room visits, forcing hospitals to provide more uncompensated care and divert resources from expanding access to healthcare and other community services."[5]

**Ken Cuccinelli**, acting director of U.S. Citizenship and Immigration Services (USCIS), said in a statement: "Self-reliance, industriousness, and perseverance laid the foundation of our nation and have defined generations of hardworking immigrants seeking opportunity in the United States ever since. Through the enforcement of the public charge inadmissibility law, we will promote these long-standing ideals and immigrant success."[6]

Hospitals routinely screen patients for Medicaid eligibility. "The public charge rule limiting the ability of legal residents to obtain citizenship if they use social support services, including Medicaid, likely will cause some legal residents to avoid applying for Medicaid," says **Joyeeta G. Dastidar**, MD, an associate clinical ethicist at NewYork-Presbyterian Hospital and an assistant professor of medicine at Columbia University Vagelos College of Physicians and Surgeons.

This could increase the number of uninsured or underinsured patients, says Dastidar, "thereby shifting the costs of healthcare coverage from the government to the patient and/or healthcare system."

A USCIS spokesperson declined to comment on this specific concern due to pending litigation. According to the final rule, "DHS appreciates concerns expressed about increasing healthcare costs, worse health outcomes, increased use of emergency rooms, and the economic health of hospitals."

The rule further details that "DHS has made a number of changes in the final rule itself. DHS has excluded the Medicare Part D LIS, receipt of public benefits by children eligible for acquisition of citizenship, and Medicaid receipt by aliens under the age of 18 from the definition of public benefit in the public charge determination. In addition, DHS is not including CHIP in

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the public benefit definition. DHS also adopted a simplified, uniform duration standard for public charge determinations for assessing the use of public benefits."

Another potential consequence is that the length of stay and overall costs of hospitalization would increase in the population, according to Dastidar. "If these predictions are borne out as a consequence of the public charge rule, it seems unethical," she says. "It penalizes poorer residents for needing government assistance." ■

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## CME/CE QUESTIONS

1. **Regarding ethics expertise and ICU team members, the authors of a recent study found:**
   a. ICU team members vary widely in their ability to apply ethical concepts.
   b. ICU team members were using overly precise terminology to talk about ethical problems.
   c. ICU members were instructed to avoid terminology with which others might be unfamiliar.
   d. ICU team members preferred formal didactic sessions over informal communication.

2. **Regarding opioid prescribing, the authors of a recent study found:**
   a. Treatment of any level of pain nearly always overrides the risk that a patient could become addicted.
   b. Evidence suggests a single prescription carries far less risk of misuse than was previously thought.
   c. Patients with psychiatric comorbidities are at somewhat lower risk for addiction than the general population.
   d. Medicaid recipients are at moderate risk for conversion to opioid misuse after just one new ED prescription.

3. **Which is true regarding informed consent for stem cell therapies?**
   a. Stem cell clinics often use advertising that confuses patients.
   b. The probability of good outcomes is only necessary to address with patients if the treatment still is experimental.
   c. Stem cell clinics have been successful in court in challenging the the FDA's regulatory authority.
   d. Currently, bone marrow transplantation for relapsed leukemia is not a standard of care.

4. **Which is an ethical concern involving recommended screening for illicit drug use?**
   a. Routine screening has been shown to stigmatize illicit drug use.
   b. If patients screen positive, doctors may inadvertently harm the patient by failing to address the problem.
   c. No behavioral counseling and treatment services have been validated yet, so there is no evidence-based help to offer patients who screen positive.
   d. Routine screening is deleterious to the patient/physician relationship.

## 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.

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