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INSIDE

RELIAS MEDIA

Demand for Ethics Education Surges at Medical Schools

The COVID-19 pandemic has underlined the importance of ethical expertise for hospitals and healthcare providers. The same is true of future clinicians.

"Students seem to now sense more fully the vital importance of ethical considerations in medical care," reports **Robert Klitzman**, MD, a professor of psychiatry and director of the online and in-person bioethics master's and certificate programs at Columbia University.

Ethics education "should be a lifelong process, not only a one-time course in medical school," says **Maya Sabatello**, LLB, PhD, an associate professor of clinical bioethics at Columbia University. Look closer at some current approaches:

• **Ethics training is timed to coincide with the transition to clinical practice.** Hearing about ethical principles several years before ever encountering an actual patient is not ideal. "Students often find it hard to apply classroom lessons to the emotionally fraught moral quandaries they face," Klitzman observes.

Case examples are a tried-and-true way to stimulate discussion of ethics. "However, learning about ethics through direct experience, and by observation, is often more powerful, and with longer-term impact," Sabatello offers.

Real-life clinical practice does not always match what students learn in the classroom. "Unfortunately, they see physicians who, not uncommonly, fail to optimally follow ethical principles. This can lead to jadedness and disillusionment," Klitzman laments.

For instance, new clinicians may observe patients who are poor or from certain ethnic and racial groups receive worse care. "Students may feel that these disparities are somehow acceptable because these persist without much comment," Klitzman says.

Not all clinicians are respectful to all patients every time. Patients do not always understand procedures adequately. "Ethics education should explore challenges to optimal ethical behaviors," Klitzman suggests.

That way, students enter clinical practice already aware that competing pressures on clinicians exist. "Training

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should address ways of overcoming these barriers. It should also examine larger systemwide impediments to ethical care," Klitzman adds.

More pre-medical and medical students, residents, fellows, and other physicians are taking bioethics courses and obtaining certificates and master's degrees in bioethics, according to Klitzman. "The field is rapidly growing. That is helping physicians and hospitals take better care of their patients."

Louise P. King, MD, JD, teaches professionalism to incoming first-year students at Harvard, using a case-based format.

"The focus is very much on discussion. Their favorite part of ethics is interacting with their peers," says King, an assistant professor of obstetrics, gynecology, and reproductive biology.

When students repeat the course in their third year, they are asked to share ethically nuanced case examples with the group from their own clinical experience. "The key is having everybody, including senior leadership, being very open to hearing from students on everything they are seeing," King reports.

Ethics training is most effective when it correlates to what the trainee is exposed to in the clinical setting, says **Autumn Fiester**, PhD, associate chair for education and training in the department of medical ethics and health policy at the University of Pennsylvania Perelman School of Medicine. "For many years, it has been clear to me that medical students are far more receptive to bioethics training in their fourth year of medical school," Fiester says.

By that time, students have experienced some clinical training. In contrast, in the first year, students are steeped in book learning. Even in the fourth year, after two and a half years of clerkships and electives, many bioethics issues remain theoretical, according to a study on which Fiester worked.[1]

Fiester and colleagues argued bioethical training should be postponed until residency. "It is surprising that it is taking the field so long to tailor bioethics training to student need," she notes.

A lot of bioethics training in medical school still occurs "at a time that's convenient for the curriculum planning. It is not correlated to what students need to know, and when," Fiester adds.

• Instructors are looking at ethics more broadly. "Ethics education calls for consideration of values and principles that are beyond medicine per se," Sabatello explains.

Much training narrowly focuses on topics such as informed consent. "Medical ethics needs to be taught across contexts, including disability ethics, race/ethnicity, and community engagement," Sabatello offers.

Sabatello says education should focus on "ethics action, highlighting the responsibility to speak up against injustice in medical practice and healthcare, and to act to make a change."

• Ethics training is tailored to specific specialties. "Our goal has been to introduce a rigorous framework around which we could measure success in the teaching of ethics. This continues to be a work in progress," says **Alexander Langerman**, MD, SM, FACS, director of the second-year medical student clinical ethics course at Vanderbilt University Medical Center in Nashville. The ethics curriculum is based on these core ethics competencies, specific to various clerkships:

- **Medicine**: advance planning and end-of-life discussions;

- **Surgery**: informed consent;
- **Pediatrics**: the patient/family/provider triad;
- **Obstetrics and gynecology**: women's autonomy, unborn child's interests, and partner's rights;
- **Neurology/psychiatry**: decision-making capacity.[2]

During their clerkships, students encounter a surprisingly wide range of ethical topics. Some were not initially included in the key competencies. "Many involved the challenges of real medical care, where you encounter ethical dilemmas with no 'right' answer," says Langerman, core faculty at Vanderbilt's Center for Biomedical Ethics and Society, where he directs the surgical ethics program. For example, patients' social support or cognitive abilities can pose challenges to the use of potentially life-saving therapy. Faculty continually tweak the competencies to better prepare students for difficult cases. "We are doing so methodically. We're also continuing to update our methods for assessment of understanding," Langerman says.

Ethics educators are well-aware many demands compete for students' time. "Ethics doesn't lend itself well to multiple choice. Yet we can't also expect a five-page dissertation," Langerman notes.

Faculty tried asking students for short narratives on relevant ethical topics, but grading such submissions objectively was difficult. Currently, faculty are fine-tuning a new method: Asking students to apply analytic frameworks to cases. "This will most closely approximate how physicians use ethics to help make clinical decisions," Langerman says. ■

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Students Shadow Chaplains, Connect with Patients

A group of students at The Medical College of Georgia at Augusta University perceived a need for more bioethics education. They asked the ethics committee for assistance, leading to the creation of a new grassroots Leadership through Ethics program for medical students.

"The student leaders created some founding documents, and had a vision for their work to become a graduate certificate program," says **Richard Sams**, MD, MA, associate professor in the department of family medicine and the Center for Bioethics and Health Policy at Augusta University.

The novel program includes lunch-and-learn sessions, ethics presentations, faculty-student mentorship sessions, student ethics committee discussions, and an ethics capstone scholarly project. Students learn to recognize ethical issues in everyday medical decisions as they transition to providing direct patient care on clinical wards, Sams says.[1]

Before expanding the program to graduate-level certification, students were surveyed to gauge demand for it.[2]

"We wanted to see what an interprofessional cohort of graduate students in healthcare thought was the need for and value of additional bioethics education," Sams says. Of 562 students surveyed:

- 47% had received no medical ethics training;
- 60% desired more bioethics education;
- 92% said bioethics education was important for their future careers.

Also, another one-quarter of respondents were interested in graduate-level training in medical ethics.

"This bolstered our work in starting a graduate certificate in bioethics, which is thriving," Sams reports. "We have a long-term vision of offering an MA in bioethics."

Shadowing pastoral care is an important part of the Leadership through Ethics program. Students accompany chaplains to see how they talk to families about various topics. "I do not change one thing about the patients we see or my approach. They simply go with me," says **W. Jeffrey Flowers**, DMin, BCC, director of pastoral care.

Chaplains and students spend about 90 minutes visiting patients and checking in with family in intensive care unit (ICU) waiting areas. The next half-hour is spent reflecting on what the students observed. "The natural day of a chaplain is we're going to have difficult conversations," Flowers notes.

The program is entirely voluntary. "It's not for credit or graded in any way. It's just an opportunity

that is offered to them," Flowers reports. Only 16 first-year medical students are accepted each academic year. Students who are not selected may ask chaplains if they still can participate in the shadowing aspect of the program, and they are never turned down. "We take all comers," Flowers adds.

During patient encounters, it is understood that students are to respond only if patients speak to them directly. Since they are not physicians yet, they should not be offering clinical information.

"We worked out a signal so that if I feel they are interfering or things go awry, they will back away," Flowers explains.

It has never become necessary during three years of shadowing. "Students have been very respectful, and have asked wonderful questions," Flowers observes.

Students soon realize communication is not just about test results or diagnoses.

"We are also communicating hope and empathy," Flowers says.

Most students have no personal experience with family members' end-of-life issues. "They are getting exposure earlier, in a controlled environment, with immediate feedback," Flowers says.

Sometimes, students receive advice from patients directly. Chaplains sometimes asks patients, "This is your chance to be a medical educator. What would you say to this first-year medical student about what makes a good physician?"

"Families and patients take a moment to teach," Flowers says. Almost always, patients tell students something along the lines of: Bedside manner matters much more than physicians realize.

"Students learn that there's a way to deliver difficult news but still be kind. There's a way to be in a hurry but still give patients the attention they need," Flowers says.

During the shadowing, Flowers also makes a point of stopping by the nurses station to ask, "What would you tell this student about how they can they work with you better in the day-to-day care of patients?" Most say they wish physicians would take time to listen to what nurses have to say. One nurse told a student, "Physicians spend 15 minutes with the patient, and we spend 12 hours. We can help you understand family dynamics and the patient's desires, needs, and fears. We are more than happy to do that if you will take the time."

The COVID-19 pandemic has put the shadowing program on hold for now while everyone involved figures out a way to do it safely. Students may be able to safely observe by staying outside a certain radius, but near enough to see and hear what goes on. This might allow students to use only mask and gloves, which are not currently in short supply, as opposed to more extensive personal protective equipment. "We're going to work out something," Flowers promises.

Medical students saw firsthand the ethical challenges of virtual communication between patients and families, usually handled with tablet computers. Sometimes, it is just updates and encouragement conveyed. In other cases, end-of-life decisions are made this way. "It's one of the most heart-wrenching things to witness," Flowers laments.

Collectively, all the students' observations teach the importance of building relationships. Even after the program is completed, some students make arrangements to check in on certain patients on their own time. Patients ask chaplains how the medical student is doing, and express the hope that the student will come by again.

Students also learn about the unique role of the chaplain. "We don't go in with an agenda. We go in, and the person takes it down the path they choose," Flowers notes.

Students see how critically ill patients appreciate a chance to talk about what is on their mind. "[Patients] need to know, first of all, that you are a human being who cares about them. It's the joy of what we get to do," Flowers says.

Flowers tells students, "Ten years from now, I hope you will remember your conversation with Mrs. Smith. In the midst of not feeling very healthy, she wanted you to know that your ability to comfort her meant a great deal."

Sometimes, the discussion is not about anything clinical. Instead, patients talk about their grandchildren. Students express surprise the chaplain did not discuss the patient's condition at all. In reality, Flowers explains, the chaplain was conducting a spiritual assessment the entire time. "The patient was talking about what's meaningful to them — their grandchildren — and their fears, that they won't be able to spend time with [grandchildren]," Flowers says.

There is nothing high-tech about the shadowing program. Yet it succeeds in teaching one of the most crucial skills in healthcare. "We teach people how to go into a room, pull up a chair, and have a meaningful conversation with people who are in [difficult] times [in] their life," Flowers says. ■

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PEACE Rounds Promote Better Communication in Neonatal ICU

In nine years serving as the nurse ethicist at a children's hospital, **Patricia S. Robinson**, PhD, APRN, NE-BC, has led dozens of consults.

"Almost every time, it was the result of one profession not trusting the intentions of another profession," says Robinson, scientific director at AdventHealth Research Institute Orlando (FL).

Conflicts continually happened between nurses and physicians, families and physicians, and social workers and families. "It seemed to me that it reflected a lack of mutual trust, and led to a lot of unnecessary moral injury," Robinson observes.

Weekly PEACE (Patient Experience and Communication Excellence) rounds, implemented in 2016 in the pediatric intensive care unit (ICU) at Riley Hospital for Children at Indiana University Health, had been shown to ameliorate healthcare providers' moral distress and shorten length of stay for some patients.[1] "It resonated as a potentially helpful tool," Robinson says.

A similar approach was implemented at AdventHealth for Children's neonatal ICU in 2018. Sessions are held biweekly or monthly, depending on the unit's needs. "The idea was to have conferences about staff self-care and care of one another in cases that were sure to lead to moral distress without this intervention," Robinson explains.

Rounds are scheduled 30 minutes after shift change. Doctors and nurses are so eager to voice concerns that some call in on their days off to participate. If a difficult case is under discussion, the family's caregivers can attend when colleagues agree to cover their shifts. "We have equal participation between shifts because the night shift craved the ability to be heard," Robinson adds.

To learn more about the benefits of PEACE rounds in the NICU, researchers interviewed 24 NICU healthcare providers and observed 12 interventions.[2] The findings suggest PEACE rounds:

- improve interdisciplinary communications and collaboration;
- relieve employee distress;
- reduce the number of ethics consultations;
- do not need to be facilitated by a trained ethicist.

"Anyone with conflict management skills, whose focus is the team, would be appropriate," Robinson notes.

Most cases center on misunderstandings due to poor communication, not ethical conflicts. "What we are really providing is a communication consult. We found a nurse educator, who was familiar to all clinical staff, to be an excellent facilitator," Robinson reports.

Since PEACE rounds started, there has not been a single ethics consult in the NICU. Instead, "difficult questions have been answered by the medical team," says **Laura Baran**, MS, BSN, RNC-NIC.

As a nurse educator for AdventHealth, Baran is viewed as a neutral member of the team, neither leadership nor a bedside nurse. "Even when it is not what bedside staff want to hear, there is more respect and understanding for decisions," Baran says.

Team members tend to be more comfortable talking about patients and procedures than about their own distress and emotions. "Dedicated time for interdisciplinary self-care is the novel aspect of this intervention," Robinson says.

That is particularly resonant during the COVID-19 pandemic. "This is a scalable approach in a time when moral injury is high, and there are not enough ethicists to go around," Robinson offers.

A recent PEACE round revealed nurses wrongly assumed physicians ordered what the nurses viewed as nonbeneficial treatments to avoid litigation. In reality, the physicians were carrying out family directives, Robinson reports.

Additionally, another PEACE round revealed night shift nurses believed decisions made by the day shift seemed inappropriate. In one case, a night shift nurse was caring for a fragile neonate with no hope of long-term survival. During a procedure, the nurse noted grimacing and vital sign changes that indicated pain. "Parents and ordering physicians were not there to witness the suffering," Robinson notes.

The problem was that family conferences and attending rounds happened only during the day.

"This left the night shift voiceless," Robinson says.

The team created a handoff tool that allows outgoing shifts to convey the reasons behind their treatment decisions. "With an ability to share information back to day shift providers, night shift staff felt more included and less isolated," Robinson says.

The incorrect assumption in this particular case was that day shift nurses did not care about the baby's suffering. "In fact, they were unaware of it," Robinson adds.

The night shift nurses acknowledged they were obligated to communicate effectively to the day shift. Team members were asked to assume their colleagues had good intent. "There is increased trust that the treatment team, and families, intend to act in the best interest of patients," Robinson reports.

In the NICU, families often are making critical medical decisions for a baby they have just "met."

"Sometimes, they have months of preparation to consider their goals and values in light of abnormal ultrasound findings. Sometimes, they find themselves in the NICU completely by surprise," says **Kim Sawyer**, MD, MA, a pediatric palliative care physician and bioethicist at St. Jude Children's Research Hospital in New York City.

If infants' gestational age and birth weight are major concerns, evidence-based data on survival and developmental outcomes help inform decisions. "However, how to apply that data to an individual baby's care decisions, in light of a family's values and preferences, can be difficult," Sawyer says.

The emotional weight of making decisions for a new baby, which significantly affects the child and family, raises some unique ethical issues in the NICU. "This is not to say those issues don't arise outside of the NICU. But a family typically has had more opportunities to get a sense of who their child is that may help guide them," Sawyer says.

Ethics rounds can be a more casual forum in which to discuss complex ethics questions. Hopefully, this happens before conflicts arise.

"This may help prevent moral distress, by giving staff a well-rounded, informed way to think through tough situations," Sawyer adds. ■

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When Clinicians Ask Urgent Ethical Questions, Time Is of the Essence

Clinicians may be hesitant to call ethics consults, anticipating a slow, unwieldy response.

"They feel that there won't be anything of value by doing it. They don't think ethics can help them care for the patient," says **Edward Dunn**, MD, medical director of palliative care for Louisville, KY-based Norton Healthcare.

Ethics consults entail gathering people together, carefully listening to perspectives, and thoughtfully considering the patient's values and goals. "That kind of dialogue can take some time," says **Hannah I. Lipman**, MD, MS, director of bioethics at Hackensack (NJ) University Medical Center. Some clinicians end up wishing they called ethics sooner. To encourage early involvement, Lipman says ethicists must be easily reachable and visible. "It must be widely known in the organization that ethics is an open-access service, meaning anyone involved in the care of the patient can request a consultation," Lipman notes.

To streamline ethics response times, Norton Healthcare recently implemented a new model of ethics consultation at its five hospitals. "The primary purpose for making this change was to provide a response to the clinician's 'cry for help' in a more timely, robust, and effective manner," Dunn reports. Years earlier, Dunn was a practicing cardiovascular and thoracic surgeon in another city at a hospital that used the ethics committee model. "It consisted of hospital staff, nearly all of whom were well-meaning but none trained in ethics consultation," Dunn recalls.

This traditional model was inefficient. Typically, ethics committees meet regularly and respond when someone requests an ethics consultation. "This process was untimely, unwieldy, and rather ineffective," Dunn says.

Most committee members were not trained in ethics consultation and typically never directly communicated with the stakeholders. In contrast, the new model requires a two-person ethics team to respond to a request within 24 hours.

"When busy nurses or physicians are asking for help due to an ethical dilemma, they need help now, not weeks later when a committee can get together," Dunn says. Ethics' response should be just as timely as any medical or surgical subspecialty service, he adds.

Right away, ethicists go to the bedside and begin talking with stakeholders on both sides of the conflict. "There is no time to waste when patient well-being is at risk," Dunn stresses.

Ethicists meet with the requesting individual and attempt to discern the ethics question. "If we identify a conflict, then we go to work," Dunn says.

Most ethics consultation requests receive same-day responses. One recent case involved a patient with COVID-19 pneumonia who had been on a ventilator for a month and extracorporeal membrane oxygenation for two weeks. He was not improving, and his wife advised the critical care team that the family wanted to discontinue life-sustaining treatment to allow him to die with dignity. "The critical care team was committed to continuing [life-sustaining] support. Hence, the ethical conflict," Dunn says.

Ethicists facilitated a resolution, with an agreement to withdraw critical care support. "The family was grateful for our involvement," Dunn reports. Sometimes, it becomes apparent there is no ethical issue. For example, patients may ask for a different nurse or attending physician because they are unhappy for some reason. "There is no ethics question here," Dunn notes. Instead, ethicists refer the matter to management of the clinical unit.

Ethicists promoted the new system via email, newsletters, posters, and social media. "Most of these efforts are ineffective," Dunn laments.

Busy clinical professionals simply do not have time to digest this information. "The most effective way to stimulate interest is by demonstrating our ability to resolve ethical conflicts in real time," Dunn offers.

When clinicians receive a quick, helpful response from ethics, "word spreads quickly in healthcare organizations, large and small," Dunn observes. About 50 ethics committee members have taken a seven-week ethics consultation course, which Dunn provides. Participants are a diverse group of social workers, clinicians, chaplains, respiratory therapists, lawyers, and senior hospital administrators. Students attend weekly 90-minute sessions, including role-playing in hypothetical clinical scenarios.

"We take them through the basis of our ethical duties in healthcare, some moral philosophy, and go through many clinical scenarios that have ethical dilemmas," Dunn explains.

The goal is to build a strong team of people who are interested in ethics consultation. "If demand increases, we want to respond promptly and effectively to support our colleagues, patients, and their families," Dunn says.

There is no expectation that all the individuals who receive training are going to end up volunteering to handle ethics consultations. "In fact, most of them will not do it," Dunn predicts. "The hope is for a broader appreciation for clinical ethics in our workforce."

Informed clinicians will be more likely to seek help from ethics. "We are starting to see evidence of this. We are seeing more requests for ethics consultations, especially from our nursing staff," Dunn adds. ■

ICU Length of Stay Linked to Burnout in Critical Care Nurses

Burnout in critical care nurses is linked to longer length of stay for patients, according to the authors of a recent study.[1]

"The literature about burnout in clinicians, and in the ICU [intensive care unit] in particular, has grown significantly over the past few years," says **Lakshmana Swamy**, MD, MBA, the study's lead author and a pulmonary/critical care fellow at Boston Medical Center/VA Boston Healthcare.

The effect of burnout on clinicians and health systems is clear, especially regarding the costs of turnover. "Unfortunately, one missing item has been the impact of burnout on critically ill patients," Swamy laments. Researchers analyzed burnout in critical care nurses at 113 VA sites between 2013 and 2017, based on 12,540 nurse responses to the VA All Employee Survey. Overall burnout rates increased from 30% in 2014 to 33.6% in 2017. Based on burnout rates over time, hospitals were divided into three groups: High, medium, and low burnout. Compared to the lowest burnout group, medium and

high burnout sites were less likely to be rated as a "best place to work." Also, turnover rates were likely to be higher among the medium and high groups.

The study revealed significantly longer lengths of stay in the highest burnout group. "Many studies have used ICU length of stay as an important clinical outcome," Swamy says.

Considering longer length of stay is a possible consequence of burnout, there is an ethical concern that patients are harmed when exposed to healthcare systems with high rates of clinical staff burnout, according to Swamy. Six sites out of 111 were characterized as high burnout. "Interestingly, these sites did not have a higher ICU complexity rating or differences in weighted case severity," Swamy observes.

The link between burnout and length of stay could be because of inefficiencies in patient care that prolong illness and contribute to delays in transfer of care. "The answer here is not to protect patients from burned-out staff. That is a backward approach," Swamy argues.

Rather, closer attention must be given to clinician well-being. "Patients, clinicians, and health systems suffer when critical care clinicians burn out," Swamy adds. ■

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Ethical Guidance Needed if Someone Wants to Override Patient's Wishes

A patient requested a do not resuscitate (DNR) order. Later, when the patient loses capacity, her surrogate directs staff to rescind the order. This is a surprisingly common scenario, says **Robert N. Swidler**, vice president of legal services at St. Peter's Health Partners in Albany, NY.

"'Because I say so' is not a good enough reason. As hard as it is to defy the surrogate, the treatment team has an ethical, and in many states a legal, obligation to follow the patient's clearly documented decision," Swidler cautions.

Still, in some cases, surrogates have legitimate reasons to override the decision. According to Swidler, these reasons could include the patient lacked capacity at the time the DNR was requested; the patient had capacity, but did not understand what the DNR order meant; the patient later changed his or her mind, but the DNR order was not rescinded; or the patient never meant for the decision to apply under the current circumstances (e.g., if the patient is about to undergo surgery for a reversible condition). If the surrogate can substantiate any of these assertions, it is possible that overriding the DNR is the most ethical step to take. "The treatment team has to consider whether the surrogate's assertion seems true. That's always difficult," Swidler notes.

The appropriateness of the patient's decision under the circumstances is another important factor. Surrogates may demand to override a medically appropriate DNR issued with the consent of a patient who is dying.

"The treatment team should be skeptical about a surrogate's thinly supported assertion that the patient changed his or her mind, or never meant the DNR to apply under the circumstances," Swidler offers.

Swidler says the hospital should put a policy in writing to make clear the obligation of staff to follow a patient's previously expressed decisions and the obligation of the surrogate to make the decision the patient would want (not the decision the surrogate would want). "A hospital should also consider creating a pamphlet that the treatment team may use with a surrogate who asks to override a patient's prior decision," Swidler adds.

This shows the obligation to honor the patient's decision is not the treatment team's opinion; rather, it is a matter of hospital policy. Surrogates cannot accuse the treatment team of taking an ad hoc approach. "It can deflect pressure against the providers," Swidler says.

Many surrogates struggle to make medical decisions for an incapacitated patient. "There are a plethora of ethical dilemmas that inevitably arise," says **Amber R. Comer**, PhD, JD, assistant professor of health sciences at Indiana University in Indianapolis. Clinicians frequently request ethics consults for specific reasons, including:

- resolving disputes between multiple surrogates about medical decisions;
- surrogates who do not appear to be acting in the patient's best interest;
- conflicts arising from a surrogate's desire to pursue a plan of medical care the clinical care team does not recommend;
- surrogates who need help with medical decision-making.

"The gravity of being put in a position where they are making life

and death decisions can lead to emotional distress and confusion," Comer observes.

Surrogates often wonder: "Should I do what is best for the patient? Or should I do what I think the patient would want if he or she could decide for themselves?"

"This is a particularly troubling conflict when what the patient may want would result in prolonged suffering and poor quality of life," Comer says.

It can be ethically acceptable to override a stated wish because it is in the patient's best interest. Some patients request aggressive interventions before a major change in their medical condition and expected outcome. "A significant change in the patient's condition may change the surrogate's desire to continue aggressive interventions," Comer says.

Some surrogates ask for treatment the patient specifically indicated was unwanted. "These cases are always ethically challenging," Comer acknowledges. Ethicists need to discern if there is an ulterior motive. One man with severe chronic obstructive pulmonary disease (COPD) was intubated and unlikely to recover. Physicians recommended he be extubated and made comfortable. However, the man's daughter insisted he be kept alive at all costs, contrary to the man's stated wishes. "The patient told his physicians that if he were to decompensate, he would not want prolonged intubation and aggressive interventions if he had no chance of meaningful recovery," Comer recalls.

Ethicists questioned the daughter further. She finally stated, "My father has always taken care of me and my two small children. We are currently living in his house and are supported by his retirement income. If you let my dad die, you will be making me and my kids homeless. I know that my dad would rather live like this than watch his daughter and grandchildren become homeless."

Clearly, the daughter was acting in her own best interest. Nevertheless, the case was ethically challenging. "It placed the patient's interest against the surrogates' interest," Comer explains.

That leaves the clinical team to determine whose interest is most important. More typically, surrogates' request for life-sustaining care stems from being overcome by grief and fear. Some surrogates even demand invasive interventions, such as permanent intubation or a permanent feeding tube, although it is clear the patient never wanted them. "Ethics consultants can help sort through and resolve the multiple ethical dilemmas," Comer says.

At the University of Rochester Medical Center, a recent ethics consultation involved a previously competent woman with COPD who had fallen and suffered a mild head injury, rendering her confused. She also sustained a hip fracture. "Her MOLST [Medical Orders for Life-Sustaining Treatment] indicated 'no ventilator,' a decision likely made in anticipation of future respiratory failure," says **Marianne C. Chiafery**, DNP, PNP-BC, a nurse practitioner and clinical ethicist.

The clinical team believed all injuries were recoverable. They wondered if intubating and placing the woman on a ventilator to perform hip surgery would be ethically justifiable. The medical team expected the patient to be off the ventilator within 72 hours of surgery, as her COPD was mild.

"Her proxy indicated that the patient would want to proceed with the plan if it meant she could get back to being her usual independent self," Chiafery says.

Surgeons performed the procedure, and the patient was extubated within 48 hours. Afterward, the patient stated her daughter and the team had made the right decision. "There must be a compelling reason to override the MOLST," Chiafery cautions. "This should not be done lightly." ■

Ending Race Disparities: 'Less About Clinical Interventions, Much More About Ethics'

Since 1986, **Stephen B. Thomas**, PhD, has been studying racial health disparities.[1,2] Thomas, a professor of health policy and management at the University of Maryland and director of the Maryland Center for Health Equity, sat with *Medical Ethics Advisor* (MEA) to share some insights about this subject. *(Editor's Note: This transcript has been lightly edited for length and clarity.)*

MEA: *Why do healthcare disparities persist despite being so well-documented?*

Thomas: In 1985, Health and Human Services Secretary Margaret Heckler issued the first *Report of the Secretary's Task Force on Black and Minority Health*. For the first time, the federal government put into one place all the data documenting excess death among [minorities] who were dying before their time. If they were white, they would not be dying this soon. They would not be living this sick. The following year ... the federal Office of Minority Health was created. That's the beginning of what

we would call the modern period of acknowledging premature death based on race and ethnicity. In the 1990s, there was a new initiative [from the National Center for Health Statistics] called Healthy People, with targets for every 10 years. In the early phases, they actually set different goals based on race. As an example, the objective for infant mortality was different for whites than Blacks. In the 2000s, they changed that, [set] one set of goals for everybody, and charged the field to close the gap. Now, there is a National Association of State Offices of Minority Health.

But this infrastructure is not being talked about. Under the Affordable Care Act, the Office of Minority Health now reports directly to the secretary of Health and Human Services. But I have never heard [current HHS] Secretary Alex Azar mention this office.

We've been marginalized. Progress has come as a result of struggle, not as a result of enlightenment. People have been clawing their way into the mainstream, yelling at the top of their lungs. Health disparity scholars have been documenting the association between health disparities and poverty, premature illness and death, and lack of access to healthcare for decades. We are demonstrating, and publishing, the fact that racial discrimination exists in our healthcare delivery system. It would be easy to ignore if it were not so well-documented.

MEA: *What is the role of ethics?*

Thomas: It's less about clinical interventions and much more about ethics, about caring. You've got to care. You have to have some empathy.

In the aftermath of the Tuskegee study, which is the quintessential story of research abuse, there were congressional hearings and the creation of the Belmont Report, which identified the ethical principles to be used in research involving human subjects.[3] The first principle is respect for persons — autonomy and respecting the person's right to make an informed decision. The second is beneficence — to do no harm. But the third principle is justice — that those who bear the burden of research should not be denied the benefits. It's the ethical principle of justice that has been ignored and underdeveloped by healthcare professionals.

Ethicists' focus is on end of life — who gets an organ, allocation of scarce resources, conflict of interest. But what about justice? What about the fact the gynecological surgical procedures that are standard operating procedure right now were developed during a time when Black women were used like guinea pigs, often without anesthesia?

MEA: *How did the COVID-19 pandemic bring race disparities to light?*

Thomas: The pre-existing conditions [that can exacerbate COVID-19] we are hearing about — asthma, diabetes, obesity — those are all the disparities that we [have been] studying for the past 30 years. My first question was: Why are they not giving any information on the racial and ethnic breakdown? Members of Congress demanded that data be released by race, ethnicity, and ZIP code. Only a few states did it ... it's a patchwork. This is an ethical concern. Using surveillance data and computer models, our science is so good and so precise that if you tell me your ZIP code, I can predict your life expectancy. Your ZIP code should not determine your life expectancy.

We in public health underestimate how our epidemiologic data will be used. We are so excited to have analytics, but we are observing these people as though they are simply data points. We can pinpoint these things. But while we are doing all that pinpointing, those people still suffer. They are sick and tired of their suffering to be used to advance the careers of others. It's very interesting that it's a novel infectious disease that has brought attention to this in a way that nothing else has. If data would have done it, we would have been here a long time ago.

MEA: *Why is there good reason to hope that things will actually change this time?*

Thomas: It's the confluence. It's the racism exposed by the murder in front of our very eyes, the outpouring of demonstrations not just in Minnesota or nearby states, but around the world. It's a worldwide phenomenon.

There is a reckoning going on. Health and medicine and even physicians are not immune from the history of racism. It's time that we, too, looked in the mirror. There should be a laser focus on the COVID-19 vaccine and treatment trials. Who will ultimately be in the clinical trials? If the people in those trials are not diverse, what does that tell us? If the people cannot afford treatment that comes from clinical trials, what does that tell us? We've been here before, and we must fight today for a better tomorrow. ■

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Did Parent Refuse Vaccine? Nurses Offer Strong Opinions on Dismissal

When a nurse midwife recommended delaying the administration of the hepatitis B vaccine (typically given within 48 hours after an infant's birth), **Michael J. Deem**, PhD, took the advice, and the family's pediatrician accepted the decision.

Years later, the family was establishing themselves as new patients at a different pediatric practice. There, staff asked if they planned to delay or refuse any vaccines, explaining that vaccine-refusing families are automatically dismissed without further discussion. "It struck me how different the approach was," says Deem, an assistant professor at the Duquesne University School of Nursing and the Center for Healthcare Ethics in Pittsburgh. The realization of how widely disparate practices' policies were regarding vaccine refusal sparked an interest in exploring whether the same was true of nursing staff. Usually, nurses are the first to learn a family is hesitant or opposed to vaccines. "Nurses often are the ones who counsel families about vaccines. Yet their views are not typically solicited," Deem observes. Researchers surveyed 488 primary care nurses in 2018 on their attitudes toward dismissal of vaccine-refusing families, and found significant polarization. Some key findings:

- 28% of nurses agreed or strongly agreed they would support a decision to dismiss families who refuse all vaccines, and 39% disagreed or strongly disagreed with this practice.
- 12% supported dismissal for refusal for some, but not all, vaccines; 50% disagreed or strongly disagreed with this practice.

Researchers also asked nurses, "Do you think it's ethical to dismiss vaccine-refusing families?"

"That is where we found deep polarization," Deem reports. "We think their voices need to be heard, given this polarization."

Vincent Staggs, PhD, another of the study's authors, did not expect to see so many respondents stand clearly on one side or the other of the issue. Many nurses reported feeling "strongly" one way or the other.

"This can become an ethical issue for nurses if their practice has a dismissal policy that conflicts with their strongly held convictions about the right response to vaccine-refusing families," says Staggs, an associate professor of pediatrics at Children's Mercy Kansas City and the University of Missouri-Kansas City School of Medicine.

There also were some interesting regional differences in nurses' attitudes. Respondents from the South reported more positive attitudes toward dismissal than respondents from the Midwest and West. Respondents who practice in rural areas held less favorable attitudes toward dismissal.

"It's important to note, however, that negative attitudes toward dismissal don't necessarily coincide with a belief that vaccines are any less important," Staggs cautions.

For example, nurses serving rural areas did not rate vaccines as any less important than nurses serving urban areas. Nurses from the West, where attitudes toward dismissal were least favorable, scored the same on perceived vaccine importance as nurses from the South.

Notably, a significant portion of nurses find the practice of dismissal unethical or inappropriate. "Physicians may assume that because it's my practice and nurses are working for me, that nurses just have to go along with whatever I decide," Deem says. Some practices dismiss all families who refuse vaccines, while others consider it on a case-by-case basis. "If nurses are expected to adhere to a dismissal practice, but their opinion wasn't solicited, there is a breakdown in professional ethics," Deem notes.

The issue is perhaps even more important for practices to sort out, considering the anxiety over an anticipated COVID-19 vaccine. "Families who are otherwise on board with vaccines might be hesitant. There are safety concerns since it is being rushed through the process, and we don't know the long-term risks," Deem says.

This is an excellent time for physicians to consider their interprofessional obligations to nurse colleagues, according to Deem. "While one would hope that the full burden of addressing vaccine hesitancy would not fall entirely on the nurses, nurses nonetheless might be particularly well-disposed to handle objections to vaccines and build trust with families," Deem offers.

Ultimately, the physician still might decide to dismiss the vaccine-refusing family. "But getting nursing input would go a long way toward recognizing that nurses have a real stake in a situation that has significant effects on their professional relationships with families," Deem adds. ■

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CME/CE QUESTIONS

1. **Which is true regarding ethics education?**
   a. Students retain information longer with case examples than observation.
   b. Ethics education is most effective in the first year of medical school.
   c. Ethics training is most effective when it correlates to what the trainee is exposed to in the clinical setting.
   d. Competencies in ethics curricula should not vary depending on the specific clerkships.

2. **Which is true regarding PEACE rounds in the neonatal intensive care unit (ICU)?**
   a. It was determined that nearly all cases involved ethical conflict.
   b. Most nurses are too busy to attend the discussions.
   c. Facilitators require conflict management skills.
   d. Physicians acknowledged ordering aggressive interventions to avoid litigation.

3. **As part of the consultation response at Norton Healthcare, ethicists:**
   a. require ethics to respond to a request within 24 hours.
   b. encourage clinicians to contact them whenever patients request a different physician.
   c. have found email to be the single most effective way to stimulate interest in ethics.
   d. use two-person teams only for complex end-of-life cases.

4. **Which did researchers find in ICUs in hospitals with a high burnout rate?**
   a. Longer lengths of stay
   b. More ICU complexity
   c. Differences in weighed case severity
   d. More aggressive treatments at end of life

CME/CE OBJECTIVES

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

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