



➔ INSIDE

Race disparities identified in end-of-life care . . . 111

When leaders lack ethics expertise . . . 112

Ethics services need nuanced data on consult volume . . . 113

Using force on psychiatric patients . . . 115

Ethical responses to mistreatment of medical students . . . 116

End-of-life experiences vary by region . . . 117

ICU nurses and end-of-life discussions . . . 118

Sepsis care for minorities trails others . . . 119

The Wide Variability in Ethics Consult Mandates

Only half of hospitals have put any policies in place mandating ethics consults in certain situations, according to a recent analysis.¹

“Even at major teaching centers where lots of difficult cases get referred, we found a lot of variability on whether they had a policy in place,” says **David Y. Hwang**, MD, one of the study’s authors and an associate professor in the division of neurocritical care and emergency neurology at Yale School of Medicine.

Researchers analyzed 36 of the top academic teaching hospitals in the United States (based on 2016 rankings). In the 18 sites that had created some type of policy, these were the two most common scenarios mandating an ethics consultation:

- requests from family for possibly inappropriate treatment;
- medical decision-making for patients without representation or decision-making ability.

Overall, the hospital policies listed named widely varying situations requiring ethics consults. These included posthumous sperm donation,

initiation of extracorporeal membrane oxygenation, valve replacement denial for patients with subacute bacterial endocarditis, and organ donation after circulatory death.

Guidelines from critical care societies recommend institutional review by multidisciplinary committees (as opposed to ad hoc decisions by individual clinicians) in cases involving potentially inappropriate treatment or decisions for unrepresented patients.^{2,3} The consensus in the literature is that physicians really should not be trying to handle those kinds of cases on their own. “But beyond that, it’s up to the discretion of any individual hospital,” Hwang notes.

The study’s findings “highlighted the fact that there can be a discrepancy between what professional societies put out as guidelines and actual practice, even at hospitals with name recognition,” Hwang explains.

Of the 18 sites with mandatory policies for ethics consults, only 67% said the policy was formally documented in writing. It is hard to know if anyone is following the policies. Without mandatory ethics consults, it is highly

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AUTHOR: Stacey Kusterbeck
EDITOR: Jonathan Springston
EDITOR: Jill Drachenberg
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS DIRECTOR: Amy M. Johnson, MSN, RN, CPN

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possible that two similar cases could be handled differently. Important, complex, life-or-death decisions would depend entirely on which clinicians happened to be involved.

Hwang offers this example: A patient sustained a devastating brain injury, and the family is asking for aggressive management. The clinical team strongly disagrees, arguing it is not the right thing to do. “Two providers could walk into that situation and have the discretion to manage the situation completely differently,” Hwang suggests.

One provider may choose to call ethics right away to discuss the conflict and come up with the best possible solution as a group. Another provider may decide that treatment is not an option. That kind of approach would put the family in a position where they would need to decide whether to put up a legal fight. “Families are a little bit at the mercy of the medical team on what’s offered and what’s not,” Hwang says.

If there is a mandate to call in ethics on a case, it means uninvolved parties are going to review the issues and air everyone’s views. “When you give unilateral power to the physician, you put the family and patient in a vulnerable situation,” Hwang says.

Sometimes, it becomes clear there is no reasonable argument in favor of aggressive care. Other cases are more ethically complex. “Treatment decisions are not just a matter of right or wrong, but reflect people’s values,” Hwang says.

The physician may insist the amount of recovery the patient will make is too minimal to justify aggressive treatment. The family might be willing to accept a poor quality of life for valid reasons — because they prioritize the patient’s survival or believe the patient would

have chosen it. In those cases, it is ethically troublesome for the outcome to come down to one clinician’s opinion vs. one family’s opinion. “It is important to get several voices in the room as opposed to the luck of the draw and whatever physician you get,” Hwang says.

Mandatory consults could put clinicians in the habit of involving ethics, even in cases that do not happen to fall under the policy. “Ethics consultants sometimes answer a question that was not asked but should have been asked. Mandatory consultations, therefore, can make sure that things are not missed,” says **James Kirkpatrick**, MD, adjunct assistant professor in the department of bioethics and humanities at University of Washington Medical Center.

Early involvement of ethics in a conflict can defuse situations before larger problems arise. “This prevents the conflicting parties from ossifying in their positions. In some cases, early conflict resolution can save resources and hospitalization time,” Kirkpatrick offers.

On the other hand, each situation is unique. Too much standardization is an ethical concern in itself. “Making consults mandatory risks removing the personalized aspect of ethics consults, both for the team and the consultant,” Kirkpatrick cautions.

Hospital policies do not generally require clinicians to seek mandatory consults for other medical specialties. Instead, the choice on whether to consult with a specialist is left up to individual clinicians. “It makes little sense to standardize ethics consultants more than we standardize consultations for coronary angiography,” Kirkpatrick says.

A middle ground is to encourage clinicians to call ethics without mandating they do so. “Rather

than specifying specific situations in which ethics must be called, such as initiation of a DNR order, clinicians should be educated as to general situations in which ethics can be helpful,” Kirkpatrick suggests.

Ethicists can make it clear they can help any time clinicians are addressing tricky conflicts or sorting out complex ethical dilemmas. Certain clinicians may even come to resent someone forcing them to call ethics. This is especially likely if people do not recognize the value of ethics. “The last thing we want as a service is to be seen by clinicians as outsiders who police people or add inefficiency,” says **Tim Lahey**, MD, MMSc, director of clinical ethics at University of Vermont Medical Center.

Currently, ethics consultation is required by policy when abortion (which has no legal limits in Vermont) is considered at 22 weeks of gestation or later. Ethicists make sure to ask clinicians for input while drafting the mandatory policy. “We made sure the reasoning behind rare mandatory consults was convincing, and that the process was efficient and reasonable,” Lahey says.

Regardless of whether ethics consults are mandatory, the real goal is to be sure they are helpful. “If we in ethics deliver high-quality support, that helps to defuse any residual concerns,” Lahey adds. ■

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Race Disparities Identified in End-of-Life Care

Minority patients receive more aggressive end-of-life interventions than white patients, according to the authors of a recent study.¹

Researchers analyzed 349 Medicaid beneficiaries diagnosed from 2011 to 2015 with breast or colorectal cancer and died by January 2016. Of this group:

- 271 received at least one form of aggressive end-of-life care (27% were hospitalized more than once, 31% visited the ED more than once, 30% were admitted to an ICU, and 34% underwent chemotherapy);

- Non-Hispanic Black patients were more likely to receive aggressive end-of-life care than white patients.

“The ethical implications depend entirely on whether these interventions offer any benefit,” says **Lydia Dugdale**, MD, MAR (ethics), associate director of clinical ethics at NewYork-Presbyterian and director of the Columbia Center for

Clinical Medical Ethics. Aggressive interventions for a dying patient are unlikely to provide any benefit at all. Dugdale says the more important ethical question is: Why do racial and ethnic minorities elect to undergo more aggressive and potentially futile treatments at the end of life?

“The answer has to do, in part, with the history of maltreatment of vulnerable populations,” Dugdale explains.

Some minority patients, or their family members, have been the recipients of substandard medical care previously. “It makes sense that members of such communities would insist, when death is imminent, that doctors use all the tools in their bags,” Dugdale offers.

Another possibility is that white doctors simply may not communicate effectively with non-white patients, Dugdale says. While doctors in rural Pennsylvania used similar verbal cues in discussing end-of-life issues

with white and Black patients, they exhibited “significantly fewer positive, rapport-building nonverbal cues with Black patients,” according to the authors of one study.²

When compared with their white peers, racial and ethnic minorities also are less likely to have completed advance directives or appointed healthcare agents, Dugdale notes. “If no one has taken the time to educate persons of color about aggressive medical interventions, it is less likely they will be positioned to make fully informed decisions about care at the end of life,” she says.

Current racial disparities in healthcare may exacerbate disenfranchisement, leading to a cycle of lower health engagement and negative interactions with healthcare providers, including conflicts at the end of life, says **Leslie M. Whetstone**, PhD, a bioethicist at Aultman Hospital in Canton, OH, and a professor of philosophy at

Walsh University. These experiences may engender skepticism toward the medical establishment generally.

In the context of end-of-life care, marginalized populations may question whether their best interests are safeguarded and whether all curative measures have been explored sufficiently.

“A reluctance to move from aggressive interventions to palliative care may be tied to medical mistrust compounded by centuries of structural injustices,” Whetstine says.

When clinicians consider disparities in hospice use at the end of life, the first reaction usually is to find ways to close the gap.

“But you must think about why that gap exists in the first place and why it continues to exist,” says **Joshua D. Uy**, MD, program director

of the geriatric medicine fellowship at Penn Medicine.

For example, denial of cutting-edge healthcare is something that has occurred historically. “Experimentation on Black Americans and the mistrust that comes from it has continued,” Uy says. “Race-discordant care is the norm for Black patients.”

These issues facing Black Americans further complicate already-complex end-of-life decision-making. “When it comes to the end of life, and someone suggests pulling the patient off a ventilator, it comes with a different context than for a white patient,” Uy says.

A paternalistic “knee-jerk” reaction to force the gap to close could do more harm than good, according to Uy. “It is also about kindness: What

is the kind response to the awareness of this gap?” he asks. “For physicians like myself, who are not Black, the next step would be to bridge a much deeper understanding of the issues that Black Americans face in end-of-life care, both historically and structurally.” ■

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Lack of Ethical Leadership Can Be Source of Moral Distress

There is much at stake if leaders lack ethical leadership skills — and not just for the people they supervise.

“Organizations fail when ethical principles are not maintained,” says **Melissa M. Bottrell**, MPH, PhD, CEO of Berkeley, CA-based Ethics Quality Consulting.

When people take on a leadership role for the first time, they often look at things from only one perspective: Their own. “They use that narrow understanding for guiding staff and decision-making,” Bottrell observes.

The problem is ethical leadership requires perspectives of all stakeholders be considered. If managers do not actively encourage staff to offer input, people are going to be reluctant or unwilling to voice concerns. “Middle managers who

are not great leaders can themselves be great sources of moral distress for staff,” Bottrell says.

This common problem may become apparent during times of major organizational stress, as is occurring now with COVID-19. “Leaders get focused on the perspectives of those above them,” Bottrell says.

Frontline staff do not realize why decisions are made, so what the organization is doing seems unethical. Managers do not take time to translate the organization’s values and rationales for change. “Staff may disengage from the organization, thereby eroding commitment to the organizational mission,” Bottrell cautions.

Hospitals should consider these solutions:

- **Make ethical principles (and guidance on ethical decision-making) part of required orientation for all managers and supervisors.** “The orientation must be interactive and show the impact of ethics on culture and viability of the organization,” Bottrell says.

- **Provide ongoing forums for discussing ethical principles.** “All decisions should be made with ethical principles in mind. The best approach to this is to include discussion of ethics in all meetings,” Bottrell says. This includes meetings at the frontline unit level all the way to the boardroom.

- **Give employees easy access to the ethics consultant service.** “This service should not be an arm of risk management or the ‘ethics police,’” Bottrell offers.

- **Leaders should round in all departments to discuss directly with staff whatever issues they are experiencing at the moment.**

Specific questions to ask staff include: What are the issues that keep you up at night? Do you see any ways we could provide care that is safer or that encourages patient autonomy? What do you need to improve your ability to meet the needs of patients and/or staff?

- **Establish a unit-based ethics conversations program.** “What seems to work best is to have this program part of the ethics consultation service,” says **Robin Cook**, co-developer of the Veteran Affairs’ Integrated Ethics program.

To launch the program, long-term care units or ICUs are a good place to start. In those units, ethically complex end-of-life issues are common. Ethicists can start discussions after

particularly difficult cases in which there are multiple sides of an ethical issue. “The intent is not to solve the issue, but to explore the various aspects of how staff felt during the situation,” Cook says. Ethicists may discover something that could have been handled differently that would have provided better communication. “The ultimate goal here is to have ethics as part of the fabric in the organization,” Cook says. ■

Many Ethics Services Need Better Information on Volume

In 2017, hospital administrators at Marietta, GA-based Wellstar Health System wanted to know more about ethics consultation volume.

“They were particularly interested in learning how many consults our institution should have,” says **Jason Lesandrini**, FACHE, LPEC, HEC-C, assistant vice president of ethics, advance care planning, and spiritual health.

The goal was to create a higher-volume ethics service. Hospital leaders wanted to know what staffing model ethics should be using to meet the needs of providers, patients, families, and the community.

The questions sounded simple enough, but were quite challenging to answer. “Currently, there is no standard method to assess how many consults should be performed,” Lesandrini explains.

To learn more about the issue, researchers reviewed the literature. They analyzed 19 studies on volume of ethics consult services that were requested from 2000 to 2017, institutional surveys on consult volume, and statistical analyses that estimated the volume of ethics consult services.¹ After gathering

some additional data from the study authors, the researchers concluded the inconsistent way ethics consult volume was reported was problematic. This made estimates of growth over time inaccurate.

It turned out that many factors were omitted from the volume predictions. For instance, types of physician services that were available (or not) at a given hospital or changes in the number of hospital beds were not factored in.

The researchers created a methodology to allow these and other factors to be weighed. This means ethics services can accurately estimate how many consults they should be performing. “We were surprised to answer a question that we thought was unanswerable,” Lesandrini reports.

The methodology uses published research, survey responses, and many other factors (including hospital admissions and bed size) to predict low-, moderate-, and high-consult volume. Some key findings:

- **Institutional variables (such as religious affiliation) and hospital settings (including the presence or absence of a palliative care or**

- pediatric unit) did not affect ethics consultation volume.**

The researchers viewed this finding with skepticism. It is counterintuitive that the presence or absence of these units do not affect ethics consult volume, says **Thomas V. Cunningham**, PhD, MA, MS, a co-author of the study.

More likely, the finding reveals the limitations of data collection currently, and the fact that a small sample of mostly homogenous hospitals was used. “Our methods of measuring ethics consultation service activity are too crude to show that these other variables impact consult service activities,” says Cunningham, bioethics director of Kaiser Permanente West Los Angeles Medical Center.

- **Ethics consultation services using an individual ethicist or sole consultant model recorded higher consult volumes than committees, small teams, and hybrid models.**

“We expected the data to show this. It is consistent with anecdotes that are widespread in the field,” says Cunningham, adding that with a larger sample size, the effect probably would be even more pronounced.

Institutions usually see a large spike in volume when they invest in an individual ethicist to cover a hospital ethics consult service. In light of this, says Lesandrini, “administrators thinking about expanding capacity should explore allocating resources and funding an individual ethicist.”

There is no standardized way to report data on ethics consultation. Therefore, there is no reliable way to analyze, interpret, or estimate ethics consult volume across institutions. “Creating a consistent metric that assesses volume will demonstrate the value, sustainability, and impact of offering healthcare ethics consultation services,” Lesandrini offers.

Many ethics services have been measuring volume for a long time. “But volume isn’t the whole story,” Cunningham notes.

Practices vary in terms of how many people handle ethics consults, the size of ethics committees, and whether there are full-time ethicists. A hospital might report many ethics consults or only a few, but that says nothing about the quality of those consults. “If consults are really well done, and are exactly the cases that need to be heard in the hospital, it’s likely a high-quality service,” Cunningham reports.

Service leaders may want to move from low-volume to moderate-volume, but they do not know how to get there. With more nuanced data on the number of consults, ethicists can move forward with confidence. “It will give you a better handle on where

you rank compared to other hospitals and understanding where you want to go,” Cunningham suggests.

Some ethics consult services are not even measuring their volume at all. Others measure, but inconsistently. “The big difference between ethics and other clinical areas is that in ethics, the data [are not] being collected unless the ethicist collects it,” Cunningham explains.

Some EMRs provide a way to track the number of consults. Ethicists can collaborate with the quality department to capture these data. “But once you count them, now you have to analyze them. We can compare volume, but it hides so many things because systems are so different,” Cunningham cautions.

An ethics consult service may report much lower volume compared to a nearby hospital that serves a different, more complex patient population. On the other hand, low volume could be a sign that clinicians are unaware of the ethics service or do not consider it helpful.

Changes in volume also are difficult to interpret and require some more context to understand what is behind it. “As for whether volume fluctuations are a good or bad thing, that really requires other information to answer that question,” Cunningham says.

In hospitals without an established ethics consultation service, a “good” reason for increased volume would be funding a full-time clinical ethicist. “That should lead to significantly more volume,” Cunningham says.

If the institution already has an established ethics consultation service in place, Cunningham says these would be some “good” reasons for more volume:

- The institution offers more services to cover care that was not provided (e.g., bariatric surgery, transgender surgery, a higher-level neonatal ICU, more ICU beds);
- The institution provides additional administrative support to the ethicist, which allows him or her to round more — and putting more attention on ethical issues;
- There are changes in the federal or state legal or regulatory landscape in ways that affect medical ethics (e.g., laws that allow clinical ethicists to support physicians in making decisions for unrepresented patients, legalize physician aid-in-dying, or restrict the way DNR orders can be enacted in the hospital).

More context on volume “is essential for strategic planning within the ethics committee and for comparison,” Cunningham stresses.

At the institutional level, ethicists need good data to compare the work, over time, of multiple ethicists in the hospital, and to compare the work of ethicists who are working across multiple hospitals. On the regional level, different hospitals need to compare ethics services in a meaningful way. “If we had data across facilities, and knew more about the kind of cases they were seeing, we could have a powerful data set to be able to say what’s normal for an ethics consult service in a particular setting,” Cunningham says. ■

COMING IN FUTURE MONTHS

- Ethical concerns if hospitals limit Medicaid patients
- Ethical controversy over whistleblowing staff
- Make ethics committees much more diverse
- Prevent ICU conflicts over withdrawal of care

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Unnecessary Restraint and Seclusion of Psychiatric Patients Is Ethical Concern

Many hospitals report high seclusion and restraint rates of psychiatric patients, according to the authors of a new study.¹

“Large-scale research on use of seclusion and restraint in psychiatric care nationally is surprisingly scarce,” says **Vincent Staggs**, PhD, the study’s author.

Staggs analyzed data from 1,642 hospitals gathered between 2013 and 2017, using the CMS Hospital Compare site. “The CMS data on seclusion/restraint haven’t received much attention from researchers,” notes Staggs, an associate professor of pediatrics at the University of Missouri - Kansas City School of Medicine.

A dearth of data makes it impossible to know what practices are acceptable vs. unacceptable. “A starting point would be having a sense of what is typical in terms of both frequency and duration of seclusion and restraint episodes,” Staggs says.

What is typical is not necessarily ethical. “There are calls to eliminate mechanical restraint altogether,” Staggs notes.^{2,3}

The available CMS data at least give some idea of what typical and atypical seclusion and restraint rates look like. This is a way to identify facilities that clearly are outside the normal range. However, Staggs found hundreds of errors in the data. “In the absence of accountability and incentives for accurate reporting, I suppose this shouldn’t be too surprising,” Staggs says.

Sixty-seven percent of hospitals reported comparably low rates of seclusion and restraint. Ten percent of hospitals reported rates five to ten times higher than even the facilities at the upper limit of the “normal” range.

“When we see this kind of extreme variability in healthcare practices, it suggests there are opportunities to improve care by standardizing practice,” Staggs offers.

The problem is there are no recommendations quantifying what is considered an unacceptably high rate of seclusion or restraint. “Without such guidelines, these outlier facilities may not even realize their practices are so far outside the norm,” Staggs notes.

Violation of patient autonomy and the possibility of harming people (physically or psychologically) are major ethical concerns. Restraint and seclusion can become necessary, as a last resort, to protect patients or staff in extreme situations. “But it seems clear, from the duration of some of the reported episodes, that use of these measures goes well beyond what might be needed in an emergency,” Staggs reports.

The power differential between staff and vulnerable psychiatric patients is a major ethical concern. “We need better regulation, oversight, and accountability in this aspect of inpatient psychiatric care,” Staggs concludes.

Sometimes, the stage is set for needless escalation before patients even arrive at the hospital. “This really begins at the point of contact in the community. All too often, people are handcuffed and brought to the hospital in the back seat of a police car,” says **Robert L. Trestman**, PhD, MD, professor and chair of psychiatry and behavioral medicine at Virginia Tech Carilion School of Medicine and Carilion Clinic in Roanoke.

EMS technicians’ use of ketamine on agitated people is a controversial practice.⁴ The American Society of

Anesthesiologists issued a statement firmly opposing the use of ketamine “to chemically incapacitate someone for a law enforcement purpose and not for a legitimate medical reason.”⁵

“It’s all part of a fabric. Our culture is uncomfortable dealing with conflict resolution in general. We very quickly resort to brute force,” Trestman observes.

Some rural EDs in critical access hospitals have only a single PA or nurse practitioner available. That clinician might lack any training at all in de-escalation skills. Even in large urban EDs with far more resources, overwhelmed staff may not know how to manage agitated people. Providers resort to whatever is necessary to protect people in the immediate time frame. “If a shot of something is going to be safer than someone taking a swing at a clinician or attempting to commit suicide, that’s what they are going to do,” Trestman says.

Hospital policies aimed at reducing the use of restraint or seclusion are only useful if staff actually know about the policies and can follow them. Likewise, training is only useful if it is practiced; whether that means simulated exercises, videotaped practice interviews, or feedback on active listening skills. “People in crisis need to be seen by somebody clinical, to feel they are being respected, and to be heard,” Trestman says.

Many times, these elements can prevent the use of force. There always are going to be rare exceptions, such as if someone is grossly psychotic. “Even there, body language and level of stimulation matters,” Trestman notes.

EDs are bright, loud, and crowded. Creating a quieter space

within the department is one way to create a more humane and safe environment. If restraint and seclusion are the default for ED providers, says Trestman, “more people are likely going to be hurt.”

This means problems for hospitals, since health department investigations, CMS audits, and accreditation problems with The Joint Commission all are definite possibilities. “There will be more resources bogged down in preparing for audits, paying for corrective actions, and paying out for wrongful death injury lawsuits,” Trestman says.

Calling for security often is the first instinct if a patient shows signs of agitation. “Everyone — not just clinicians, but even environmental services — should know the basics of how to be humane and to do so under pressure,” Trestman says.

Someone who yells, “I’m tired of being ignored!” might be confronted by a uniformed security guard moments later. Too often, situations like that escalate to a dangerous confrontation. Trestman says that in this kind of case, anyone (including environmental services staff who happen to be nearby) can help de-escalate the situation. A staff person could say, “You are right. Let me go find someone. I will be back as soon as I can. But are you OK right now?”

“From a purely pragmatic, administrative perspective, it’s in everyone’s best interests — financially, ethically, and clinically — to avoid unnecessary restraint and seclusion,” Trestman says. ■

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Data Show Mistreatment of Medical Students Is Common

As a resident physician, **Anees Bahji**, MD, and colleagues experienced various forms of intimidation, harassment, and discrimination. They set out to learn more about the true extent of the problem.

“We undertook a meta-analysis in order to capture as much data from as many residents as possible,” says Bahji, the study’s lead author and an addiction psychiatry fellow at University of Calgary.

The researchers analyzed 52 studies to establish how often resident physicians reported intimidation, harassment, and discrimination.¹ Most (64.1%) reported it had happened to them at one time or another. The biggest surprise was just how common it was. “Prevalence

was incredibly high — over 90% for some forms of harassment and intimidation,” Bahji reports.

The most common perpetrators were relatives or friends of patients, nurses, and patients. “It is also concerning from a prevention perspective. The data indicate prevalence is on the rise despite implementation of anti-harassment programming,” Bahji observes.

It is hard to say if the problem is worse, or if residents are just reporting it more. “We could not tease this out specifically with the methods available to us, as most of the data came from surveys,” Bahji explains.

Regardless, this is a longstanding problem, as another survey of 87 healthcare students about intimidation, harassment, and

discrimination while in their clinical training revealed.² “We started hearing more and more about patients who were not treating our student learners well,” says **Patricia A. Findley**, DrPH, MSW, the study’s lead author and an associate professor of social work at Rutgers.

Physicians were listed as the leading cause, followed by nurses and fellow trainees. “We were surprised by the number of students who reported ‘fat shaming’ or comments related to their bodies,” Findley says.

Few effective solutions or prevention tactics have been implemented.

“Part of it is a combination of negative traditions. Learners are at the bottom of the academic hierarchy,” Bahji says.

Residents and other medical trainees rely on their superiors for evaluations and promotions to the next stages of their training. While women were more likely to experience harassment, male residents also experienced significant levels of intimidation, harassment, and discrimination. “This suggests that all residents, regardless of sex, gender, ethnicity, training level, country of origin, [or] program of training, are vulnerable,” Bahji says.

The authors of some studies included in the review by Bahji and a colleague also examined the effect of abuse in residency. “Quite often, residents reported symptoms of psychiatric illness: anxiety, depression, suicidal thoughts, substance use, burnout, and demoralization,” Bahji says.

This carries important ethical implications, considering the increasing recognition of the problem of physician burnout. “It is possible that burnout begins in residency if trainees are mistreated,” Bahji offers.

In recent years, awareness of medical student mistreatment has “grown tremendously,” according to **Janet Malek**, PhD, an associate professor at the Baylor College of Medicine Center for Medical Ethics and Health Policy.

This is mainly due to information made available from the Association of American Medical Colleges’

Medical School Graduation Questionnaire, which asks specific questions about mistreatment.³ “Responding to these incidents requires a response on the institutional level because they are often the result of an organization’s culture,” Malek says.

Medical school administrators should develop reporting mechanisms (electronic or in-person, anonymous or not) and ensure students and others are aware of these mechanisms. It also is important to develop clear policies against retaliation and to institute faculty development initiatives to change a toxic culture.

Ethicists who work in medical schools can team with administrators to develop good policies. They also can encourage people to report issues. At times, ethicists become aware of an ongoing problem with an individual because a student describes it, or because the ethicist observes it directly. “We have a duty to raise the concern with those individuals’ supervisors when it is possible to do so in a way that protects the confidentiality of the students who have experienced the behaviors,” Malek says.

One reason medical student mistreatment persists is because an evaluation from a single person can determine a student’s whole future career, says **Rosalind Ekman Ladd**, PhD, a visiting scholar in philosophy at Brown University. This motivates

students to stay on the good side of their supervisors.

Unfortunately, this may mean no one reports mistreatment. Instead, students may simply put up with racist and sexist insults. “Mistreatment and how to report it certainly could be a topic of discussion in orientation sessions for new med students,” Ladd suggests.

Select hospital policies offer a safe reporting system and explicit statements of ethical standards, but those are no guarantee. “It is also necessary to get buy-in from the students themselves in order to change the culture and make it acceptable to report mistreatment,” Ladd adds. ■

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End-of-Life Experience Varies Depending on Geographical Region

There are important regional variations in site of death, according to the authors of a recent study of Medicare claims from 306 regional healthcare markets.¹ For example, more than one-third of

Manhattan patients were hospitalized at the end of life vs. less than 14% of patients in Ogden, UT; Greeley, CO; or Amarillo, TX. Prior studies suggested a nationwide trend, across all ages, toward increasing death at

home and decreasing death in the hospital.²

“We wondered how these patterns looked among older, sicker people who commonly would need medical care for troublesome symptoms or

progressive complications toward the end of life,” says **Jason H. Maley**, MD, the lead author of the most recent study. Maley is a fellow in the pulmonary and critical care fellowship, a collaborative program between Beth Israel Deaconess Medical Center and Massachusetts General Hospital.

Maley and colleagues expected to see regional variation to some extent. Variation in healthcare practices, access to care, and intensity of care has been described in previous studies.³ “We were, however, somewhat surprised by the striking degree to which the use of hospitalization and hospice varied across the U.S., even among large metropolitan areas,” Maley reports.

It is unlikely such variation would be entirely due to regional differences

in patient preferences or needs at the end of life, according to Maley. More likely, it reflects differences in the availability of primary care and the availability of inpatient hospital beds relative to hospice beds.

The main ethical concern is patients could be receiving different end-of-life care for reasons other than their personal preferences, values, and needs. This could be happening because of differences in rates of referral to hospice or lack of availability of hospice services. Conversely, high density of hospital beds in larger urban areas could result in regional practice patterns toward hospitalization at the end of life.

Regardless of the underlying reasons, says Maley, “we would like all patients to receive care that aligns with their personal values, rather than

their end-of-life experience depending on the practice patterns of healthcare where they live.” ■

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ICU Nurses Feel Marginalized During Ethical Conflicts

At a large, academic medical center, researchers recently overheard this concerning comment made by a critical care nurse: “Realistically accepting that nurses often have little control over ethical dilemmas in their practice is one way of coping with ethical conflict.”¹

“We do not want nurses to become complacent or lose their motivation to advocate for patients and their families,” says **Natalie S. McAndrew**, PhD, RN, ACNS-BC, CCRN, the study’s lead author and an assistant professor in the College of Nursing at University of Wisconsin-Milwaukee. McAndrew and a colleague analyzed open-ended responses from a survey with ICU nurses, and identified three themes:

- **ICU culture, practices, and organizational priorities affect**

patient suffering. Reluctance to talk about death and dying contributed to nurses’ distress. “That can delay important discussions with patients and their family members,” McAndrew says.

Nurses feel caught in the middle. They worry that decision-making is delayed. Team discussions with families on possible outcomes of the patient’s critical illness are not frequent enough. “We feel terrible for these families and want to allow them to continue to have hope. But then there’s this idea of false hope that can lead to delayed decision-making,” McAndrew notes.

In the eyes of nurses, this leads to prolonged patient suffering. Life-sustaining treatments may continue for prolonged periods without any clear benefit. “We have to take a

step back and realize that every team member’s perspective is important,” McAndrew adds.

- **During ethical ICU conflicts, nurses are marginalized.** One nurse remarked, “Nurses are the ones constantly in the rooms, holding [the patient’s] hand and giving families the support they need. But doctors don’t understand how we feel.”

“Nurses are very inquisitive about ethical issues and want to be a part of that discussion,” McAndrew observes.

Informal discussions with ethicists can help. Formal ethics consults do not happen daily.

“Chatting with ethics experts biweekly or using a process of monthly rounding could really help nurses process some of the things they have questions about,” McAndrew offers.

Nurses have asked questions such as: “I have a patient care situation, and I am not sure if there is an ethical conflict or not. Can you help me talk through this case?” “How do you, as an ethicist, conduct your assessment of a case when a formal ethics consult is called?” “What is your approach to addressing conflicts about goals of care?” “How do you think ICU teams can improve their communication with families about life-sustaining treatments?”

• **Use organizational resources to alleviate ICU nurses’ moral distress.** “There will always be ethical dilemmas in the ICU,” McAndrew

says. Prognostic uncertainty plays a big role in this.

There are times when the clinical team has to wait to see how patients will respond to treatment before making a decision on whether to withdraw life-sustaining interventions.

“That can be difficult for nurses who may provide care to a patient for an extended period,” McAndrew explains.

One nurse put it this way: “It seems that frequently we do so many interventions on patients when it will not change the outcome of the situation. I feel like more effort

should be made to talk with families and patients about the quality of life, rather than quantity.”

Ethicists know how to help nurses raise these valid concerns. “We should be building relationships with ethicists and welcoming them into the ICU environment,” McAndrew suggests. ■

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Sepsis Outcomes Improve, But Not at Minority-Serving Hospitals

Critical care outcomes in ICUs have improved steadily over the past decade, but only for hospitals with few minority patients, according to a recent analysis. (*Read more at: <https://bit.ly/2GLbKW9>.*)

“The motivation for this study was to determine the impact of being treated in a minority hospital would have on outcomes in sepsis,” says **Barret Rush**, MD, MPH, the study’s lead author and an assistant professor of medicine at the University of Manitoba.

Rush and colleagues analyzed ICU length of stay and mortality data from more than 200 U.S. hospitals collected between 2006 and 2016. They compared the data at minority-serving hospitals (defined as seeing more than 25% African American and/or Hispanic patients in its ICU) or non-minority hospitals. Racial disparities have been demonstrated across all aspects of healthcare. “However, the analysis here determined that the minority-serving hospital itself is a risk factor for worse outcomes, regardless

of the individual patient’s race,” Rush reports. ICU deaths declined 2% steadily annually at non-minority hospitals. This was not true of minority-serving hospitals. Those hospitals also reported longer lengths of stay and more critical illness than non-minority hospitals.

Since the treatment for sepsis is well-established, the researchers were unsure if there would be worse outcomes in patients treated in hospitals that were disproportionately minority-serving. “In fact, we demonstrated, after adjustment for severity of illness, comorbidities, race, socioeconomic status, and more, that all patients, regardless of race, treated at minority-serving hospitals had significantly

worse outcomes,” Rush says. There were particularly stark differences in care for critically ill African Americans. If treated at non-minority hospitals, this group exhibited a 3% decline in mortality each year compared to no change in mortality for minority-serving hospitals. “The ethical implications are quite vast,” Rush observes.

The next step is to explore whether further funding should be directed to disproportionately minority hospitals to improve care delivery, according to Rush.

“Attempting to understand the reasons for this significantly disparate outcomes is crucial to improving the healthcare delivery to these minority patients,” he says. ■

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.

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CME/CE QUESTIONS

- 1. Which is true regarding mandatory ethics consult policies?**
 - a. Half of hospitals have instituted policies mandating ethics consults in certain situations.
 - b. Of hospitals with mandatory consult policies, all included organ donation after circulatory death.
 - c. None of the policies included family requests for potentially inappropriate treatment.
 - d. Most hospitals encourage physicians to unilaterally handle requests for potentially inappropriate treatment.
- 2. Which is true regarding volume of ethics consults?**
 - a. Changes in the number of hospital beds should not be factored into volume predictions.
 - b. The presence of palliative care units is linked to higher ethics consultation volume.
 - c. Ethics consultation services using an individual ethicist reported higher consult volumes than committees or small teams.
 - d. Data show smaller consult volume is evidence of poor-quality service.
- 3. Which is true regarding restraint and seclusion of psychiatric patients?**
 - a. About 10% of hospitals were outliers, with rates five to 10 times higher than facilities at the upper limit of the "normal" range.
 - b. Many hospitals have eliminated mechanical restraint altogether because of injury risks.
 - c. Hospital staff are injured more frequently because of inappropriately low restraint rates.
 - d. There is a clear consensus in favor of ketamine used by EMS to chemically incapacitate patients for law enforcement purposes.
- 4. Which did a recent study show regarding end-of-life care?**
 - a. A nationwide trend toward in-hospital deaths and decreasing death at home
 - b. Widely varying use of hospitalization and hospice, even among large metropolitan areas
 - c. Regional variation is due to patient preferences
 - d. High density of hospital beds in urban areas results in regional practice patterns that decrease hospitalization at the end of life