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INSIDE

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Policies Support Clinicians if Asked to Provide Inappropriate Care

When a family demands possibly inappropriate life-sustaining interventions, clinicians often turn to hospital policies for guidance. The authors of a recent study examined the effectiveness of Yale New Haven Hospital's Conscientious Practice Policy.[1]

The policy outlines a procedure to limit potentially inappropriate care. Researchers already knew the medical futility policy was used frequently and that ethics committee members discussed it often.[2] "We were interested in exploring it in a deeper, more rigorous way. Rather than just how often it was used, we wanted to know why," says **Bryan Kaps**, MD, MHS, the study's lead author.

Researchers held three focus groups of attending physicians and ethics committee members. They asked four questions as a starting point for the discussions: What was your personal experience with the policy? When and in what settings is the policy used? What happens to families and care providers during the use of the policy? How would you change the policy?

A theme emerged, focused on the inconsistent use of the policy. Whether it was used depended mostly on how resistant the family was to limiting interventions. "One thing I found fascinating was just how ineffective it was. If you got to the point of having to use this policy, it didn't work super great, for a whole host of different reasons," Kaps observes.

Participants also stated they turned to the policy because they were distressed morally over providing inappropriate treatment. "They decided to activate the policy to try to alleviate that," Kaps explains.

Most of the time, physicians discussed the situation with the families first. It was only if the families continued to insist on the treatment over the physician's objections that the policy was consulted. "It was almost always brought up in the context of conflict. In and of itself, that's problematic," Kaps notes.

Some attendings made references to other providers, such as surgeons, who were perceived as finding it easier to say no to certain interventions. In contrast,

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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

the critical care attendings often turned to the policy to try to resolve the tension they felt over a request to provide inappropriate care. "It didn't really work," Kaps says.

Attendings wanted to improve the policy. "They liked the idea of cleaning up the language in it, and making it clear when to use it," Kaps says.

The main point the attendings made was the policy was applied inconsistently. "Sometimes, individuals would say yes, sometimes they would say no," Kaps says. "It doesn't necessarily come with the same result every time."

Often, the family's resistance influenced the result. The attending physicians liked the idea of participating in feedback sessions to discuss the justification for decisions made. "They also wanted some clear guidance on when to actually use the policy," Kaps adds.

The complexity of the process also arose. First, the attending has to decide to use the policy. Another attending has to give a second opinion, and the ethics committee gives its opinion on whether the policy should be used. After all that, the legal department is notified, and the medical care team needs to see if they can transfer the patient to another institution that will provide the requested care.

Next, someone still needs to consult with the chief of staff, who signs off on it (or not). At that point, the patient's family can prolong the situation by requesting a court hearing.

"If the policy ends up being a set of roadblocks rather than an effective way to determine something, then it is really not that helpful," Kaps says.

Whatever the policy states, it should be communicated clearly to everyone involved.

"If the policy is not available and accessible to the team, it's a problem, and they're not going to be able to make use of it," says **Benjamin Tolchin**, MD, MS, FAAN, assistant professor of neurology at Yale School of Medicine.

It is important the policies clearly outline the criteria for activation and the criteria for not offering a specific life-prolonging intervention. Depending on the institution, clinical teams, ethicists, administrators, or lawyers all might be involved in deciding when to activate the policy. The wording and terminology used in the policy can be problematic.

"In my experience, I've seen policies that refer to 'futility,' and a lot of ethicists view that as a somewhat problematic term," Tolchin shares.

The term can be interpreted several ways. One is the intervention cannot possibly achieve the intended aim. However, many clinicians use the term "futile" to refer to an intervention that will not achieve an aim the clinicians view as worthwhile. An example would be an intervention that keeps the patient alive for a short period, even with the understanding they will never be discharged.

Some families view that as a worthwhile aim, with the intervention able to achieve its goal, but some clinicians may describe it as futile. "Futility is a term that's confusing and ambiguous unless you are very clear on what that means. A better terminology is to talk in terms of harms and benefits," Tolchin suggests.

For example, life-prolonging interventions may be judged clinically to be much more likely to harm the patient than to benefit the patient. That can be reasonable

grounds for hospitals not to provide an intervention.

"But there is a need to clarify it's not because the intervention is futile, it's because the cost to the patient far outweighs the benefits," Tolchin explains.

An example would be an elderly, frail patient with vascular disease and gangrene who is not a surgical candidate for amputation because the risk of mortality is extraordinarily high. The family wants a tracheotomy and PEG tube to keep the patient alive, but the clinicians believe that is inappropriate.

In this case, the interventions are not futile because they will keep the patient alive longer. However, the prolonged physical pain probably outweighs the benefit of spending a couple more weeks of life in the hospital.

To help in these tough cases, Tolchin says policies should answer two questions: Who makes the judgment? How high is the threshold to make the judgment?

"I've seen policies with an infinitely high threshold — basically, 'we will never withhold a requested intervention,'" Tolchin reports.

Other policies state interventions can be held back against the family's wishes, but still require a high threshold to make that judgment. Policies also vary on who makes the final decision; sometimes, it is the chief clinical officer, other times it is the attending physician with an ethics consultation.

"There's definitely been a shift toward a lower threshold during the pandemic because of concern of hospital systems being overwhelmed," Tolchin says.

Those changes likely will inform hospital policies going forward. "Policies that were modified during the pandemic may provide models on how to think about policies in the future," Tolchin adds.

There are times when the mere use of policies inflames the family/clinician relationship.

"It can become more confrontational when a policy like this is used," Tolchin says.

For cases in which a patient is clinically declining and nearing death, the invocation of a policy to limit inappropriate care can be perceived as a signal the team is giving up. "The sadness and anger that families naturally experience around the death of a loved one can become channeled toward the clinical team," Tolchin says.

This severely undermines the therapeutic clinician-patient-family relationship at a critical juncture. "Such damage is more likely if communication is limited, inconsistent, or delivered in a less-than-empathic manner," Tolchin notes.

It is better if the transition in care is conveyed not as a "withdrawal of care" but as a change from one form of care (that has proven not beneficial) to another form of care (that can be beneficial — by improving the quality of the patient's remaining time). "It's very important to have experts — ethicists, lawyers, administrators — to provide [guidance], but also to provide moral and legal support," Tolchin suggests.

An explicit policy tells clinicians what the healthcare system will and will not do to support clinicians. If the hospital is not willing to overrule a surrogate requesting an intervention that is judged to be more harmful than beneficial, it is important that be understood clearly.

"If the hospital is willing to intervene, at least in certain situations, that's also important to be documented," Tolchin says. ■

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Changing Practice Models in Healthcare Raise Some Ethical Concerns

With all the ongoing changes in healthcare, such as physician contract clauses, new regulatory requirements, private equity ownership, and physician leadership, hospitals worry about the implications on revenue, patient satisfaction, and compliance. There also are important ethical considerations.

The authors of a new policy paper from the American College of Physicians (ACP) examined these.[1] "This paper was generated in response to the significantly changing practice environment," says ACP President **Jacqueline W. Fincher**, MD, MACP.

Current central ethical concerns include the patient-physician relationship, putting patient welfare over the physician's self-interest, and the role medicine plays as a moral community. Incentives in the shift to value-based care and physician contract clauses that affect care also carry major ethical implications.

"There is more consolidation of healthcare organizations and practices, changes in physician employment, and practice model shifts," Fincher says.

Concurrently, clinical priorities are shifting from individual patient health to population health. "There is a need for more physician leaders," Fincher adds.

Overall, the changing practice dynamics place greater focus on the business aspects of medicine.

"We, as internal medicine physicians, are absolutely committed to patient-centered, high-value care," Fincher says. "We don't want the financial bottom line and shareholder profits dictating care of patients."

On the other hand, physician practices are businesses that must be run efficiently, or they will close and be unable to provide care to anyone.

"As physicians, we have a high ethical calling to be good stewards of the resources we have. We just want to make sure that the financial bottom line and profit-making are not the focus and at the center of what physicians do," Fincher explains.

There are many potential ethical implications for hospitals. Many facilities are consolidating to create better economies of scale and increase the number of "covered lives" in their regions.

"They do so knowing that consolidation will provide more leverage with payers for payment," Fincher notes. "But, in turn, it may well have more accountability for quality and fiscal prudence."

Hospitals seek to align all physicians to support "in-network" referrals to specialists and for diagnostic testing. All this generates more revenue. "But this consolidation also can have a 'feed the beast' mentality, a sense of pressuring or incentivizing physicians to provide the referrals for specialists and procedures," Fincher cautions.

This could interfere with physicians' ethical obligation to the patient.

"There are clearly differing obligations of corporations to shareholders vs. physicians' obligations to patients," Fincher adds.

Considering all these concerns, ethicists can provide a moral compass. "Ethicists and ethics committees can help identify emerging issues," Fincher says.

Ethicists also can use their expertise in bringing various stakeholders together "to keep patient care and the trusted physician-patient relationship at center of these discussions," Fincher offers. ■

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Is It a Problem to Pay Research Participants?

Paying people to participate in clinical research can be seen as ethically problematic. Yet community members expressed the opposite view, according to the results of a recent study.[1] Researchers interviewed 58 participants (many of whom were Black women) about their attitudes on financial compensation for research participants. Respondents strongly believed study participants should be compensated because they take risks and give time.

"I was shocked by the findings. I thought that people were going to agree that a high compensation amount was exploitative, but they felt the opposite," says **Amie Devlin**, MPH, MA, the study's lead author. The community members

did express a few concerns. Some thought compensation could entice low-income populations to hide harmful side effects so they would continue to be paid.

Others pointed out participants might knowingly provide false information to bypass exclusion criteria. Either scenario could invalidate the study results.

"My personal interest in this topic began when I was working with an IRB to review research protocols. There was constant discussion about what level of compensation we could approve before it became coercive," says Devlin, former research program manager at Temple University.

Devlin was inclined to agree that high payments were problematic. Then, she started working with Temple Health: Block by Block, a long-standing cohort study conducted in North Philadelphia. During that time, Devlin heard what people outside of IRBs thought. Many people believed it was exploitative not to compensate people for their role in the study.

"In listening to the interviews and thinking more about it, I have to say that I completely changed my stance," Devlin says.

Financial compensation acts as a motivator in many other areas, such as employment. "Yet with clinical research, we tend to think that people can no longer think clearly and should no longer be permitted to make their own decisions," Devlin explains.

Ethics reviewers tend to look at the dollar amount "in a vacuum," Devlin notes. The question is framed as "Is $40 too much money?" instead of asking, "Does $40 appropriately compensate a person for their time, effort, and discomfort?"

"To some extent, I think that the view of financial compensation as inherently exploitative comes from within the research establishment," Devlin offers.

IRBs tend to be "nervous about payment," says **Holly Fernandez Lynch**, JD, MBe, assistant professor of medical ethics at the University of Pennsylvania. Typically, IRBs focus on whether overly high payment could cause people to make poor judgments against their own interests.

"The worry is that if people can make more money in research than they can make in other activities, then money may be an undue inducement," Fernandez Lynch says.

It also could cause people to lie about their eligibility or any adverse events they experience out of fear they will be removed from the trial. Still, unfairly low payments also are an ethical concern.[2] Researchers are asking participants to give time and accept certain burdens.

"Why shouldn't they be paid for that?" Fernandez Lynch asks. "We don't expect people to always be altruists in their other endeavors, including risky work."

Another ethical concern is a fear that payment will only attract those who are economically vulnerable. "That can perhaps be improved by offering even more payment so that participation becomes more attractive to a wider variety of people," Fernandez Lynch suggests.

Researchers, IRBs, and ethicists can advance discussions on the ethics of payment, using available resources.[3,4] "For example, policies can encourage researchers to provide justifications for the amount of payment they are offering and why it is fair," Fernandez Lynch says.

IRBs also can justify any concerns raised about payment amounts. IRBs must differentiate between mere influence (in which payment may affect someone's choice but not necessarily cause them to do something unreasonable) and undue influence.

"Keep in mind that we are all reasonably influenced by money every day," Fernandez Lynch says. "Payment doesn't make the research ethical, and it doesn't make it unethical, either." ■

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Challenges with Surrogate Informed Consent

Informed consent usually refers to conversations between patients and clinicians. It also is necessary when surrogate decision-makers are involved.

"Improvement of the informed consent process for surrogates is achievable by emphasizing the healthcare decision is being made on behalf of this patient," says **Gavin Enck**, PhD, a clinical ethicist at OhioHealth.

There are two standard models of judgment for surrogates. One is substitute judgment (i.e., making a decision as the patient is likely to have made).

"The central ethical question is whether a surrogate's judgment for consenting or refusing a medical intervention on behalf of a patient is consistent and congruent with this patient's preferences, interests, and values," Enck explains.

Another model is the best interest standard (i.e., making a decision that is in the best interest of the patient). "The informed consent process could be started by clearly stating at the onset that the surrogate is not being asked to make a decision for this patient," Enck offers.

Instead, the surrogate must indicate which healthcare decision best honors the patient's values and commitments. But surrogates might not know what those are. "The process can be flawed when a surrogate is appointed by a patient, but the patient never has a serious discussion with them regarding their own preferences and values," says **G. Kevin Donovan**, MD, MA, director of the Pellegrino Center for Clinical Bioethics at Georgetown University Medical School.

In other cases, it is clear the patient would have wanted to withhold or withdraw life-sustaining interventions, but the problem is the surrogate is incapable of making those hard decisions.

Erica K. Salter, PhD, an associate professor and PhD program director of healthcare ethics at Saint Louis (MO) University, says the "known wishes" standard (i.e., basing decisions on oral or written advance directives communicating a patient's treatment preferences) is challenging for a few reasons.

First, not too many people complete advance directives in the first place. Even if they do, people cannot always predict future treatment decisions well enough to give specific enough guidance. "Advance directives are difficult to interpret and apply to specific clinical situations," Salter notes.

Completed advance directives are not always accessible at the right time, and surrogates might not know what they contain.

"As it turns out, patients rarely discuss treatment preferences with family members," Salter observes. "Perhaps as a result, proxy decision-makers are typically no better than the flip of a coin at predicting patient preferences."

Surrogates also might not be good at predicting a patient's quality of life, either. Clinicians might worry surrogates cannot separate their own emotions from the decision at hand, or make decisions driven by guilt or conflicts of interest. "These expectations may be unfair to surrogates by setting an unrealistic standard for the 'ideal' surrogate, one that is not allowed to have their own complex psychological and emotional response to a loved one's critical illness," Salter explains.

Ethicists can help by inviting surrogates to share their own feelings, thoughts, and concerns about the situation, and acknowledging the immense difficulty of the situation. To fulfill their role, surrogates need extended, multiple conversations about goals of care and treatment options; enough time to process new information; affirmation of their emotional responses; and guidance on how to apply the patient's wishes to a specific clinical decision. "Surrogate decision-makers should be viewed as partners, not adversaries," Salter stresses. ■

Some Code Status Discussions Are Rushed, Incomplete, or Misleading

At Switzerland's Lausanne University Hospital, several physicians expressed concerns about how CPR was discussed with geriatric patients. A group of researchers set out to investigate the subject further by listening to recordings of these CPR discussions.[1] "The results were not surprising. There were scarcity of explanations [or] explanations focusing on the steps of the procedure," says **Anca-Cristina Sterie**, PhD, chair of geriatric palliative care at Lausanne University Hospital.

Initially, certain patients said their preferences were clear; in reality, these patients were not well-informed. Sterie and colleagues concluded physicians needed to assess what patients actually understood about the situation before asking about their preferences. "This discussion is an opportunity to clarify what makes sense for the patient and what doesn't," Sterie says.

Sterie and colleagues are using the findings to develop a training course for physicians on how to discuss CPR with their patients. "Physicians have an ethical responsibility to give information that helps patients establish their preferences. But how this information is structured is also important," Sterie says.

Explanations might frame CPR as desirable or undesirable. Another ethical question is whether CPR should be discussed at all with patients who would not benefit from the procedure. "We argue that there is a benefit to discussing this topic with all patients, as long as it's done with a 'goals of care' perspective and not as a binary issue — 'Do you want CPR or not?'" Sterie explains.

Conversations about CPR are extremely common at the time of admission, but can "exacerbate confusion and distrust during a critical time in the patient's care," says **Paul J. Hutchison**, MD, MA, HEC-C, assistant professor of medicine and bioethics at Loyola University Chicago's Stritch School of Medicine in Maywood, IL. Patients who are admitted often are acutely ill and highly stressed. "The uncertainty of their condition, and their complete reliance on the nurses and physicians caring for them, underscores their vulnerability," Hutchison observes.

If patients at low risk for cardiac arrest are asked if they would want CPR, some take it as an ominous sign that their condition is dire. "They may even feel as if the clinician caring for them is not entirely committed to their improvement or survival," Hutchison suggests. This is an obstacle to trust in the clinician-patient relationship.

There are ethical concerns if a conversation about CPR clearly is appropriate, as with critically ill patients. "Explaining CPR in a value-laden or incomplete manner may result in the selection of a code status that does not accurately reflect the patient's authentic values and preferences," Hutchison says.

Clinicians must be aware of their own biases regarding CPR so they can present the choice objectively. A statement such as, "If you survived, you wouldn't have any quality of life" is an example. "While it is important to portray the success rate of CPR as accurately as possible, this should be done in a way that avoids introducing value judgments," Hutchison explains. Code status conversations are appropriate for many patients, but many jurisdictions do not require an explicit conversation about CPR on admission. "These conversations should be selective based on the clinician's best judgment," Hutchison says.

Under the federal Patient Self-Determination Act, hospitals are required to ask patients at the time of admission about advance directives and living wills "This is a safe question to ask, even if it is asked by the registration staff or the intake nurse because it seeks to understand whether a patient has already made decisions," Hutchison says.

If the patient has not created an advance directive, it is an opportunity to let the hospital know about it. If not, says Hutchison, "then it is up to the clinician to choose the most appropriate time to address these questions with the patient."

In the ED, while the patient is unstable, it is not the best time for a half-hour discussion on the specifics of CPR and mechanical ventilation. Instead, a clinician might ask about existing advance directives or treatment limitations to give patients the chance to indicate previously decided preferences.

Many patients have never considered these complex therapies, and are now arriving to the hospital in a state of significant vulnerability. In cases like that, "it is appropriate to treat them as full code," Hutchison says.

A more thoughtful conversation can occur after a day or two, once the patient's condition stabilizes. "This approach aims to minimize patient anxiety and optimize the conditions under which CPR conversations occur," Hutchison says. "Most importantly, it augments the trust established between clinician and patient at the time of hospital admission."

Many patients' perceptions of CPR are affected by what they see on

TV, notes **Cheyn Onarecker**, MD, MA, chair of the healthcare ethics council at Trinity International University Center for Bioethics & Human Dignity in Deerfield, IL. Popular medical dramas depict successful CPR about 70% of the time.[2] Family members usually believe resuscitation will be successful in most cases. "The actual numbers, though, tell a different story," Onarecker says.

Overall, CPR for hospitalized patients resulted in survival to discharge in 22.3% of cases in 2009, according to one study of 84,625 hospitalized patients in cardiac arrest.[3] Another study of 86,426 patients with in-hospital cardiac arrest found a median discharge survival rate of 34%.[4]

The success rate also depends on the patient's underlying illnesses. For example, adults with cancer survive to discharge only 6% of the time; for cancer patients already in the ICU, survival to discharge decreases to only 2%.[5] Additionally, some patients who were independent before CPR require nursing home admission after resuscitation, or suffer neurological deficits, kidney failure, and rib fractures. "Patients and family members should be aware that many patients who survive suffer significant complications after resuscitation," Onarecker says.

Discussing CPR should not scare people with worst-case examples, nor should it paint an overly optimistic outcome. Rather, the goal is to present a realistic picture of what CPR would mean for a particular patient, says **Monica L. Gerrek**, PhD, co-director of MetroHealth System's Center for Biomedical Ethics in Cleveland. That can change during the hospitalization as the patient's prognosis becomes clearer.

"Such conversations can be very challenging," notes Gerrek, an assistant professor of bioethics at Case Western Reserve University.

Even knowing their loved one has a dismal chance of a successful resuscitation, surrogate decision-makers might feel pressure from other family members to request CPR. Surrogates may feel they are giving up on the patient otherwise. "A compassionate and empathetic approach can assist the surrogate in making the tough but appropriate decision to avoid CPR when a poor outcome is predicted," Gerrek says.

That is not just relevant upon admission, but at any time.

"If patients and surrogates aren't given adequate information regarding what happens during an attempt at CPR or of how successful it might be in a particular patient's case, then they can't make an informed decision about it," Gerrek explains.

Lack of information results in some families asking for "everything" to be done, even in situations where significant harm is likely to occur. "This puts providers in a very difficult position, of feeling obligated to perform actions that they feel violate their Hippocratic Oath and are in conflict with the principle of nonmaleficence," Gerrek says.

For the sake of everyone involved, code status conversations should cover what medical interventions the order indicates should or should not be administered.

"The question 'Do you want everything done?' generally is not a very useful question," Gerrek says. "Everything" does not convey what interventions a DNR order includes.

Code status conversations also should include details about under what circumstances medical interventions should or should not be administered. Once a DNR is in place, what exactly will happen? All parties should discuss this, along with details about how the provider anticipates a patient's course will proceed and potential complicating factors.

After consenting to a DNR order, patients might experience an unexpected, unrelated medical issue. "These types of situations can cause confusion for not only the patient or surrogate, but also for medical providers tasked with treating the patient, who in many cases were not involved in discussions about the DNR," Gerrek reports.

Learning how to engage in code status conversations is as important as learning how to perform medical procedures, according to **Elizabeth Dzeng**, MD, MPH, PhD, an assistant professor of medicine at the University of California, San Francisco.

"The implications of not communicating well are also as dangerous as if one hasn't been trained in putting in a central line and there are complications due to incorrect placement," Dzeng warns.

Some clinicians are reluctant to provide their medical opinion because of worries about compromising patient autonomy.

"But everything we do in medicine needs to be taken in light of the risks and benefits and the patient's prognosis," Dzeng stresses.

Clinicians would not ask patients in completely neutral terms whether they want a procedure that has no chance of working or would inflict serious harm. Dzeng says it is similarly problematic when doctors say something like: "In the event your heart were to stop, would you want us to do CPR?"

"Any conversation around resuscitation status should take into account a patient's goals and values, what is important to them in life, and what is the minimum acceptable quality of life they would be OK with," Dzeng offers.

This should be taken into account, along with the prognosis and the likelihood of survival after CPR.

"Oftentimes, a decision is made around the broader goals of care," Dzeng adds. "The decision around CPR naturally follows from that." ■

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No Evidence of Bias on Pediatric Ethics Rounds

Michigan Medicine's clinical ethics service recently started weekly proactive ethics rounds in the three ICUs at C.S. Mott Children's Hospital. "Given the known systemic biases within healthcare, we were concerned that this new service could unintentionally perpetuate existing biases," says **Janice Firn**, PhD, MSW, a clinical ethicist at Michigan Medicine Center for Bioethics and Social Sciences in Medicine.

Ethics rounds can help providers, patients, and families address complex issues. "We also acknowledge that bias can be present and is something not easily eradicated," Firn says.

Healthcare providers display a similar level of implicit bias as found in the general population.[1] "There is risk for bias, stereotyping, or prejudice when the care team and patient or family are dissimilar in terms of race, ethnicity, religion, or culture, and when there are power imbalances between privileged providers and underprivileged patients and families," Firn observes. During the rounds, ethicists routinely ask providers to reflect on patients and elicit ethical concerns. "We were concerned that minority groups and/or those with less privilege socially, who are more likely to be subject to bias, may be disproportionately identified as having ethical issues," Firn explains.

Ethicists wanted to better understand the effect of the ethics rounds on socially vulnerable groups. "As clinical ethicists, we have an obligation to regularly evaluate whether and how our services impact socially vulnerable populations and work to address and reduce bias through the services we provide," Firn says.

Firn and colleagues compared sociodemographic factors between patients admitted to an academic children's hospital during ethics rounds in the PICU, PCTU, and NICU in 2017 and 2018 who were identified as having ethics issues and all other patients admitted to those same units during the same period.[2] The researchers expected racial and/or socioeconomic differences between the groups, with socially vulnerable patients disproportionately identified as having ethical issues on rounds.

However, Firn and colleagues did not find this to be the case. There were no significant differences on the basis of sex, religion, ethnicity, age, primary language, or socioeconomic status. "There is concern that bias could go the other direction and that minority patients could be less likely to have ethical issues identified, and have less access to ethics review and support," Firn notes.

Still, investigators found no racial, ethnic, or insurance differences between the groups, suggesting an equal level of access. "We were both surprised and relieved to find that patients with ethical issues identified during interprofessional ethics rounds are demographically similar to overall patients admitted in these units," Firn says.

The exception was patients who were ventilator-dependent were much more likely to be identified as having an ethical issue. This was the case regardless of other demographics.

Ethical issues in those cases included disagreements about the goals of care; concerns about medical futility, inappropriate, or non-beneficial treatment; identifying the correct decision-maker; disagreement between parents or joint decision-makers; and concerns about discharge details and placement options. "This suggests that patients with increased medical severity are more likely to have ethical issues identified during interprofessional ethics rounds," Firn concludes. ■

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Novel Program Decreases Transport to ED for Hospice Patients

EMS was designed to treat and transport acutely ill patients. However, paramedics often find themselves caring for patients for whom this approach may not be best: those enrolled in hospice.

"Transport to the ED may not be in the best interest of a patient's expressed goals of care," says **Mike Taigman**, MA, an assistant professor in the Masters in Healthcare Administration and Interprofessional Leadership Program at the University of California, San Francisco.

Patients in hospice care were routinely arriving by ambulance at several EDs in Ventura County, CA. It was happening because well-meaning family members called 911. Hospice providers expressed frustration about the transports. "This results in unnecessary suffering and can disrupt their hospice insurance coverage," Taigman says.

Paramedics are obligated to honor documented, expressed wishes of patients or their surrogate decision-makers. However, in hospitals, there often are more time and resources to clarify goals of care. The same luxury does not exist in the prehospital setting. "Often, the documentation is not visible at the patient's bedside," Taigman says.

There was a clear need to provide paramedics with the skills to better communicate and care for hospice patients and their families. To address this, clinicians implemented a Mobile Integrated Hospice Healthcare (MIHH) program project in 2015 in Ventura County. Paramedic supervisors were given 30 hours of hospice training, with a focus on crisis counseling, grief, and palliative care. When EMS responded to a 911 call and determined a patient was in hospice, they contacted trained MIHH staff.

During the three-year study period, 523 hospice patients were cared for by MIHH.[1] The percentage of hospice patients transported to the ED was 36% in the first year, 33% in the second year, and 24% in the third year. This was compared to 80% of hospice patients transported, on average, during the six months before project implementation. "Several paramedics, after months or years of observing the specially trained MIHH paramedics, stated that they now felt more comfortable communicating with hospice patients," says **Amelia Breyre**, MD, the study's lead author.

Many paramedics now contact hospice nurses independently. "More needs to be done to include, recognize, and encourage EMS providers and the compassionate care they can give," Taigman says.

It is important to note that caring for hospice patients is just one of the ethical challenges paramedics face. While caring for patients, it is common for EMS to find illegal drugs. "If law enforcement is on the scene, paramedics must decide whether to let the police know what they have found or quietly dispose of the drugs," Taigman notes.

Paramedics also are mandatory reporters for child abuse and are regularly faced with situations that could be abuse but are not clearly abuse. "EMS has to decide whether to report a vague suspicion," Taigman says.

Paramedics also encounter teenage girls with abdominal pain who report they are sexually active, but ask EMS not to tell their parents. In the hospital, "bioethicists should be mindful of the spectrum of healthcare providers that exist beyond the hospital setting," Breyre says.

In terms of transporting hospice patients, ethicists should be aware of any protocols that are in place. These may include specific provisions about palliative care, hospice, or grief counseling. Breyre says these are two important questions for ethicists to ask: Is there education to give EMS providers communication skills and better understanding of hospice? How can EMS protocols be improved to support both paramedics and patient care? It also is important for clinicians to involve patients and families proactively. "It is helpful to make sure families are prepared with a clear understanding of the role of hospice — and when they should and should not call 911," Breyre says. ■

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Ethical Responses Needed if Clinicians Say Discharge Is Unsafe

Sometimes, a patient is medically OK to leave the hospital. But, for other reasons, the clinical team perceives the discharge as unsafe. Ethics can help "when conflict of opinions arises amongst the care team as to the best way forward," says **Nico Nortjé**, PhD, MA (Psych), MPhil, HEC-C, a clinical ethicist at The University of Texas MD Anderson Cancer Center in Houston. For some patients, there are no caregivers at home. Others may be living in unsafe conditions. Ethicists can help by "brainstorming scenarios, and trying to connect resources accordingly," Nortjé offers.

Andria Bianchi, PhD, a clinician-scientist and bioethicist at University Health Network in Toronto, says ethicists can help in real time during complex discharge consults. Bianchi offers these examples:

• A patient is admitted to a physical rehabilitation facility and learns to use a rollator walker, but cannot walk independently. When the patient is clinically stable and the team starts to plan for her discharge, they learn the patient lives by herself in a four-story walk-up apartment. The patient is adamant about remaining there, and has no desire to move to a more accessible building.

• A patient is admitted to the hospital and seems to struggle with medication management. When the patient is medically stable and about to be discharged, the team learns the patient has no family or friends and lives in the shelter system. "Ultimately, there are minimal-to-no supports available for the patient. The patient's health will almost inevitably decline as a consequence of being insecurely housed," Bianchi laments.

In either case, an ethicist can help the team grapple with the discharge complexities "in a reflective, thoughtful, and methodical way," says Bianchi.

Other times, clinicians have their own beliefs about patients living in seemingly risky scenarios, but the patient's perspective is different. For instance, a patient who has lived in the shelter system for 30 years may not see his or her living conditions as inherently bad, risky, or unsafe. "In other circumstances, it may be the case that a discharge is, in fact, unsafe, and the team is trying to figure out how to mitigate potential harms," Bianchi says.

Options exist that teams will only think of if an ethicist poses certain questions. Despite best efforts, clinicians still can remain uncomfortable with the discharge. "Ethicists can help clinical teams unpack the moral distress that may arise as a consequence of the discharge," Bianchi offers.

Kevin Rodrigues, BA, MTS, a clinical ethicist at University Health Network's Toronto General Hospital, often sees patients who are in vulnerable housing situations or are experiencing homelessness. "Additionally, patients whose living situations are unable to accommodate new medical realities and levels of ability could pose serious risks," Rodrigues says.

Some patients are capable of understanding the risks and choose to live at risk. Others have limited housing options. Still others are incapable of understanding the risks, and options are limited. "Safety is a complex ethical issue when it comes to discharge," Rodrigues says.

It involves questions of autonomy but also larger questions of justice. "Hospitals must face the question: How far do their obligations to maintain safety extend?" Rodrigues asks.

In one recent case, an elderly patient was brought to a hospital by ambulance after neighbors found the patient lying on the floor at home. "The patient was not coping well at home, but insisted on being discharged back into an environment viewed as unsafe," Rodrigues says.

In another case, a capable patient wanted to be discharged home, but clinicians suspected domestic abuse was occurring. "Ethicists can explore the options available, within our legal obligations," Rodrigues says. In these complex cases, clinicians may ask questions like "Is this the right thing to do? Shouldn't we do more?" Ethicists can help facilitate discussions where values are in conflict. "Ethicists can also bring a justice lens to the discussion as, often, the brunt of discharge burdens fall on patients of lower socioeconomic status," Rodrigues says. Ethicists can ensure all ethical obligations are met, "those to the patients being discharged, those to patients who may require hospital resources currently or in the near future, those to the community, and those to professional integrity," Rodrigues adds. ■

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 surrogate informed consent?**
   a. Clinical teams are ethically justified in viewing surrogates as adversaries because evidence shows surrogates usually fail to honor patients' wishes.
   b. It is a mistake to start the informed consent process by telling surrogates to indicate which healthcare decision best honors the patient's values.
   c. Surrogates require guidance on how to apply goals and preferences to specific clinical decisions.
   d. Evidence shows surrogate decision-makers are better than physicians at predicting patient preferences and quality of life.

2. **Which is recommended regarding conversations about CPR?**
   a. Clinicians should not be asking low-risk patients about CPR preference to avoid the perception that the patient's condition is dire.
   b. Clinicians should be aware that all jurisdictions require an explicit conversation about CPR at the point of admission.
   c. After asking patients if they have advance directives upon admission, clinicians should engage in an in-depth conversation once the patient's condition stabilizes.
   d. Regardless of the patient's stability, the ED is required to address advance directive issues with patients, as urgent treatment decisions might need to be made.

3. **Which did the authors of a recent study find regarding policies to limit potentially inappropriate care?**
   a. Use of the policy was inconsistent, with outcomes dependent on how strongly the family resisted.
   b. Use of the policy resulted in more requests for inappropriate care.
   c. Clinicians were consulting the policy too early, even before discussing the situation with the family.
   d. Families were less likely to threaten litigation if the policy was used.

4. **Which did a recent study reveal regarding financial compensation for research participants?**
   a. Community members strongly objected to the idea that any amount of compensation would entice low-income populations to conceal side effects so they could remain in the study.
   b. Community members believed study participants should be compensated for time, effort, and risk-taking.
   c. Community members saw high financial compensation as exploitative, even for high-risk research.
   d. Community members strongly disagreed that participants might knowingly provide false information to bypass exclusion criteria.