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Clinicians Reveal Why They Never Request Ethics Consults

Some clinicians request an ethics consult once, but never again. Others never call ethics a single time in their entire careers. Ethicists are left to wonder why.

"We wanted to solicit feedback from our faculty and staff regarding people's experiences and opinions about the ethics consult services," says **Lynette Cederquist**, MD, director of clinical ethics at UC San Diego Health.

Cederquist and colleagues surveyed 150 physicians, 35 advanced practice providers (APPs), and 109 nurses in 2019 on their reasons for never requesting an ethical consult (or, if they had called an ethics consult previously, why they would not do so again).¹ Most respondents in each group of providers (85% to 92.1%) stated they had encountered an ethical dilemma. However, only about half asked for an ethics consult. "I was also curious about how nursing and APPs' responses might vary compared to physicians," Cederquist says.

The primary reason for not requesting ethics consults did, in fact, differ by provider type. Of 150

physicians surveyed, 41% said it was because they never believed they needed help from ethics. Of 35 APPs surveyed, one-third said it was because they did not know ethics consult service was available. "The biggest surprise was the percentage of long-time faculty and staff who were not even aware we existed. We have had a consult service since the 1980s. I assumed everyone knew we were around," Cederquist says.

Of 109 nurses surveyed, 30.8% said they did not know how to contact the ethics service. "This surprised me, since we can easily be paged, just like any other consult service," Cederquist explains.

Just 2.7% of physicians said one reason for not calling ethics was they "did not feel the attending of record would agree," whereas 16.7% of APPs and 16.9% of nurses said this was the case. "Nursing felt less empowered to impact the course of care of their patients, and had a more frequent sense that ethics consults were not helpful," Cederquist reports.

Based on this finding, the ethics service conducted additional outreach

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Financial Disclosure: None of the planners or authors for this educational activity have relevant financial relationships to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Medical Ethics Advisor®, ISSN 0886-0653, is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Medical Ethics Advisor*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.

GST Registration Number: R128870672.

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to nurses by adding weekly ethics rounds on three critical care units. During this time, nursing leaders in the ICU identify a case to discuss. “This has been a great way to let people know who we are and what we do,” Cederquist notes.

Ethicists also encourage nurses to attend annual clinical ethics seminars. Ethicists give an overview of the consult service, and cover care of unrepresented patients, conflicts involving nonbeneficial care, decisional capacity determination, and conflicts between staff. “Don’t assume people know you are around. You may think you are more visible than you actually are,” Cederquist adds.

Cheyn Onarecker, MD, MA, chair of the healthcare ethics council at Trinity International University’s The Center for Bioethics & Human Dignity in Deerfield, IL, says clinicians never request ethics consults for these reasons:

- The clinician did not know an ethics consult was available.
- The clinician had a previous negative experience with the ethics committee.
- The clinician did not think the ethics consult would be helpful.
- The clinician did not recognize the need for a consult.

“The makeup of our hospital medical staff undergoes fairly significant change over a two- or three-year period,” Onarecker notes.

The ethics committee tries to continuously engage with staff to educate members and offer help. “We need to let the staff know that we can do more than just opine on end-of-life decisions,” Onarecker suggests.

Ethics attend medical staff functions and department meetings, send brochures, and place announcements on system screensavers. “We use whatever

means are available to remind physicians, nurses, and mid-level providers that we are here to help them care for their patients,” Onarecker says.

The ethics committee is made up of people from diverse backgrounds with expertise in multiple fields. “We are good facilitators when there are conflicts, and we can bear some of the burden of difficult decisions so clinicians don’t feel alone,” Onarecker explains.

Ethicists act quickly on consultation requests and make a point of communicating clearly with everyone involved. “Unnecessary delays and confusing reports lead to physicians being less likely to enlist help from the committee in the future,” Onarecker cautions.

Some clinicians worry calling ethics will result in retaliation or “upsetting the team dynamic,” says **Marianne C. Chiafery, DNP, PNP-BC**, a nurse practitioner and clinical ethicist at University of Rochester Medical Center. Hospital policy states anyone may make an ethics consult request, and there is to be no retaliation if a person does. Still, clinicians see ethicists and instantly worry, “Does someone see me as unethical?” Some angrily ask why they were not consulted. “We convey that we are not there to judge, but to help,” Chiafery says.

Ethicists meet with new staff during orientation. “We make them aware of the service and ways we can be of help,” Chiafery says.

This does not have to be a formal consult. Ethicists also meet with small groups to work through morally distressing cases, or to debrief after a particularly challenging case. Ethicists do not wait to be called. Once a month, they hold routine meetings on units with a lot of ethically challenging cases, such as

the medical ICU or neonatal ICU. “We make connections with persons in palliative care, chaplaincy, and social work,” says Chiafery.

Ethicists treat people who request their help as part of the solution. “This indicates respect and humility, and fosters communication and rapport,” Chiafery says.

In particular, ethicists talk with bedside caregivers to hear their view on the situation. Sometimes, nurses report issues no one else has. Some patients confide, “I don’t want to be put on life support, but my family won’t listen to me.” Surrogates might admit the patient probably would not want aggressive treatment, but the surrogate does not know what to do. “Being part of the conversation and understanding the reasons for

decisions empowers nurses. It can mitigate moral distress,” Chiafery says.

Other times, clinicians do not recognize the ethical issue as such. “It’s just a difficult patient or a difficult family. That’s how it gets labeled,” says **Zita Lazzarini**, JD, MPH, director of the Division of Public Health Law and Bioethics at UConn School of Medicine.

Clinicians fear a formal consult will only complicate matters. “But you don’t need to have a consult come out of every interaction with the ethics committee,” Lazzarini says.

Perhaps after a quick conversation, ethicists realize the person needs to be referred to another department, such as patient relations or risk management. “Sometimes, people

just need some support in figuring out the next step going forward,” Lazzarini observes.

In other situations, clinicians simply need to engage in a short conversation about a difficult case. “We don’t always have to get everybody in a room and interrupt people’s schedules. It’s not necessarily going to take up a huge chunk of your time,” Lazzarini says. ■

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Ethicists Challenged to Respond to Physicians’ Inappropriate Behavior

Recently, a nephrologist was arrested and charged with assault after a verbal dispute with a cardiologist escalated.^{1,2} The well-publicized case spotlights the continuing problem of disruptive physician behavior.

“There can be a legitimate ethical disagreement about a patient’s care,” says **Charles E. Binkley**, MD, director of bioethics at Markkula Center for Applied Ethics at Santa Clara (CA) University.

A physician believes strongly it is appropriate to stop life-sustaining interventions, but a nurse, physician, or family member disagrees. It is not always an ethical dilemma. “People can be unkind to each other or not be professional, and it’s not necessarily an ethical issue,” Binkley explains. “Ethics should limit its scope to addressing the ethical issue.”

If a physician yells at a nurse or patient because of a disagreement over the treatment plan, involvement by human resources or another department is needed. “But if a physician’s belligerence or disrespect impacts someone’s decision-making, that is when you run into an ethical problem,” Binkley says.

If family members want to stop treatment and the physician is berating them to continue (or vice versa), it is an ethical issue. “It would be very appropriate to call the ethics committee if the disagreement is not being addressed in a reasonable way,” Binkley offers.

In those cases, there is a legitimate disagreement about care, but it is complicated by a lack of professionalism. A well-meaning physician has the patient’s best interest in mind, but a mental health

issue or poor communication skills get in the way. “Simply punishing people for this doesn’t strike me as the best approach,” Binkley says.

Ethicists can facilitate physicians obtaining emotional intelligence training or some sort of counseling, with regular check-ins. Ethicists also can give input on disruptive behavior policies. “When behavior is unduly influencing decision-making, you want to be sure that principles of justice, nonmaleficence, and beneficence are being followed,” Binkley says.

Physician misconduct can be a significant problem “for patients, for the institutions in which they work, and for society in general,” says **Philip M. Rosoff**, MD, MA, former director of the clinical ethics program at Duke University Hospital. Rosoff says there are two main ethical issues

at stake: Breaches of professional ethics by the physician, and breaches of organizational ethics by the institution. “When physicians act unprofessionally, it raises the question of how the institutions for which they work should respond,” Rosoff says.

Professional standards, state and federal laws, and institutional policies are fairly straightforward on what is expected of physicians. “What to do with individual transgressors is not always clear cut,” Rosoff notes.

Certain types of “unambiguously egregious” misconduct merit immediate dismissal, or at least removal of the accused offender from the hospital until the case is properly investigated and adjudicated, says Rosoff. For less clear-cut offenses, a warning, probation, or mandatory remedial education may suffice. Unfortunately, some misconduct falls under the radar entirely. “Some physicians are well-known to their colleagues and subordinates for being racists, misogynists, or just plain jerks, prone to abuse those who have less power,” Rosoff says.

Misconduct of senior clinicians, prominent researchers, or productive fundraisers may be tolerated to some extent due to the perceived value to the institution. “Others who are less well-placed may be offered the opportunity to resign without prejudice, avoiding the tiresome and often-tedious process of firing someone,” Rosoff explains. As terminating tenured physicians in academic institutions can be quite complex, accepting a resignation instead can seem like a good alternative. “Unfortunately, this just kicks the can down the road to another hospital, which offers a job to someone who hasn’t changed — and has glowing recommendations,” Rosoff cautions.

Three recent ethics consults have involved perceived inappropriate

behavior by physicians at Baylor College of Medicine. Two of these consults came from nurses, and one came from another physician. “All of them seemed to be a source of moral distress for these clinicians,” says **Joelle Marie Robertson-Preidler**, PhD, a clinical ethics fellow at Baylor.

Inappropriate physician behavior “can lead to a whole host of negative consequences — inadequate or harmful patient care, loss of patient or family trust, poor stewardship of healthcare resources, and increased moral distress,” Robertson-Preidler says.

Ethicists are called to resolve issues such as physicians thought to be providing inadequate pain management, altering standard practice to make data look better, or taking part in implicitly discriminatory practices. “Ethicists should appreciate that these are cases of perceived inappropriate behavior,” Robertson-Preidler says.

The first step is to investigate the claims. The ethics consultant speaks with the physician directly to better understand the situation. If behavior seems to be inappropriate, ethicists can offer mediation and negotiation to come to a consensus.

“Sometimes, it can be tremendously helpful to get the stakeholders in the same room, hear out concerns, and refocus on providing the best care for the patient,” Robertson-Preidler says.

If these approaches are inadequate to resolve the issue, the situation is brought to the attention of administration, says Robertson-Preidler, “especially if patient care is at risk.”

In other situations, it is all a misunderstanding. For instance, a nurse perceives a physician is providing inadequate blood pressure medication to a patient whose family

members are requesting aggressive treatment. However, the physician offers sound medical reasons to provide certain levels of medication. “The ethicist can facilitate better communication and resolve misunderstandings,” Robertson-Preidler suggests.

Good policies can lead to better physician accountability. These guidelines can help standardize practices to normalize expectations and help clinicians check their biases. For example, a policy on providing pain management after a cesarean delivery can mitigate the effects of unconscious biases around race. “Nurses may be uncomfortable confronting physicians directly due to unequal power dynamics,” Robertson-Preidler says.

If a nurse believes a physician is not giving adequate pain medication to a patient based on race, the nurse probably will feel more comfortable pointing to hospital policy than directly questioning the physician. “Policies serve as an accountability mechanism for the physician, as well as a protective mechanism for the nurse,” Robertson-Preidler explains.

Ethics consults can serve “as a type of third-party accountability mechanism,” Robertson-Preidler says. Ethicists learn the root of the problem is systemic issues. “Such issues can then be addressed at the administrative level and through education and policy development,” Robertson-Preidler adds. ■

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New Data on Pediatric Clinical Ethics Consults

Data on pediatric ethics consultation, once scarce, are growing. “But many reports are based on small sample sizes or specialized populations,” says **Pamela G. Nathanson**, MBE, HEC-C, program manager and clinical ethics consultant in the department of medical ethics at Children’s Hospital of Philadelphia.¹⁻³

To gain additional insight, Nathanson and colleagues analyzed 245 pediatric clinical ethics consultations conducted from 2013 to 2018.⁴ They identified the two most prevalent reasons for consult requests: intensity or limitation of treatment (38.8%) and treatment adherence or refusal (31%).

The ethical issues that commonly came up were benefits vs. harms of treatment, decision-making, and autonomy. Whereas previous studies concerned clinical situations that resulted in consults and identified ethical concerns, Nathanson and colleagues went further.

“We also collected data about an expanded set of key emotional, relational, and pragmatic attributes,” Nathanson explains.

The authors wanted to determine whether the attributes identified in the ethics consults (e.g., lack of knowledge, miscommunication, avoidance, or discord) were associated with the clinical problems, ethical considerations, or type of consult process used.

“We were interested to find that certain contextual attributes were significantly associated with specific types of clinical problems, and also with the type of consult process used,” Nathanson says.

“Articulate disagreement” was much more likely to be present in consults related to requests outside the standard of care. “Nonadherence” was much less likely to be present

in cases related to withholding or withdrawing life-sustaining treatment or moral distress. “Avoidance” was more likely to be present in cases of withholding or withdrawing life-sustaining treatment and moral distress, and less likely to be present in cases of nonadherence or patient safety.

The findings reinforced the usefulness of identifying and paying attention to these contextual attributes. “It can provide important insights regarding how to best approach a particular consult,” Nathanson says.

The researchers also tracked the process used for each consult: Single conversations, meetings with the clinical team, separate meetings with the clinical team and the patient or family, or combined meetings with all stakeholders.

“For instance, if stakeholders are angry, it might require multiple separate meetings or a mediation in order to identify some common ground,” Nathanson observes.

In contrast, large meetings with all parties sharing their feelings might be the best approach in cases involving significant conflict or a general sense of discontent, or where the parties are upset or at a loss for what to do next. “Including these unique elements in our analysis added to the pediatric ethics consultation literature,” Nathanson says.

At St. Jude Children’s Research Hospital in Memphis, most ethics consults involve helping the medical team determine what is a medically reasonable plan of care in seriously ill children with poor prognosis.

“Some cases centered on clinicians’ obligation to offer a burdensome therapy when the potential for benefit is very low,” says **Liza-Marie Johnson**, MD, MPH, MSB, chair

and bioethics consultant of the hospital ethics committee.

In other cases, parents might refuse chemotherapy or blood transfusions. Staff struggle to determine if the refusal should be respected, or if further action is warranted to protect the child from preventable harm.

“This is different than common issues in adults, which often include assistance with decision-making in patients without capacity and recommendations around capacity assessments,” Johnson says.

Many pediatric ethics cases focus on complex medical decision-making, according to **Danielle Novetsky Friedman**, MD, MS, a pediatrician at Memorial Sloan Kettering in New York. Pediatric cases involve, at a minimum, three stakeholders: The patient, the parents, and the healthcare team.

“This decision-making triad can lead to a multitude of ethical quandaries,” Friedman says.

Ethicists determine how best to proceed when parents do not agree on the best course of treatment for their child. Sometimes, the problem is minor patients’ wishes conflict with their parents’ wishes. Friedman points to the two most common ethical issues in the pediatric oncology setting: clinician’s ethical obligations if families want nonbeneficial treatment and decision-making on resuscitation preferences.

“Communication conflicts were an important and frequent contextual issue that [often] impacted these consultations,” Friedman says.

For ethicists educated in predominantly adult settings, additional training in communication on pediatric cases can be beneficial. “These cases require some reframing from traditional modes of ethics

consultation focusing on adults,” Friedman says.

The pediatric patient often is not the ultimate decision-maker, but should still be involved in conversations around care in a developmentally appropriate way. “This can be a complex balancing act for ethicists, even among those trained in pediatric settings,” Friedman says. ■

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Controversy Developing Over Vaccine Passports

Ethical concerns over vaccine “passports” are emerging. Some concerns revolve around potential violation of liberty. “Everyone has a right to make decisions about their own health, but we don’t have the right to expose others to a dangerous infectious disease,” says **Lawrence O. Gostin**, JD, faculty director at the Georgetown O’Neill Institute for National and Global Health Law in Washington, DC.

Another central ethical concern is equity. “Vaccine passports are unethical as long as they leave people behind. We must first ensure that anyone who wants a vaccine can get one,” Gostin argues.

Gostin says ethicists should “speak out strongly in favor of vaccine equity and the ethical importance of reaching disadvantaged populations.”

In addition, there are ethical concerns on who would enforce vaccine passports. “Enforcement could lead to profiling certain groups based on their membership in a racial, religious, or social group that has lower rates of vaccination,” says **Nancy S. Jecker**, PhD, a professor of bioethics and humanities at the University of Washington School of Medicine.

Using vaccine passports for international travel is ethically

problematic, says Jecker, “due to inequalities in access to vaccines between rich and poor nations. Testing and masking are fairer because they are more widely available.”

Vaccines should not be mandated, argues Jecker, “until vaccines are widely and equitably available to all segments of a population, privacy is protected, allowance is made for conscientious objectors, and mandates flex or are rescinded in the face of new evidence, such as waning immunity due to new virus variants.”

Mark A. Hall, JD, director of the health law and policy program at Wake Forest University, says there are two core concerns on vaccine passports. “From the left, there is concern about undermining social solidarity in coping with the COVID-19 pandemic if vaccine passports were seen or felt to create or accentuate inequitable divisions in society. From the right, the concern is more about privacy and freedom, the idea that government or corporate actors would be forcing vaccinations, limiting our freedoms, or tracking our movement and health data,” Hall says.

According to Hall, there are developments presenting ethical issues. For instance, private actors are starting to use vaccine certification to

determine whether people can engage in certain activities, such as large gatherings, employment, or school. Some states have banned private actors from using proof of vaccination as the basis to lift restrictions.

“Ethicists can engage in this debate and consider what uses of vaccine certification appear to be more acceptable than others so that appropriate guardrails can be maintained to prevent the truly unacceptable uses,” Hall offers.

As for the hospital setting, Gostin says healthcare professionals owe a special duty to keep patients safe. “Thus, COVID-19 vaccines are just as, if not more, important than flu vaccines,” he says.

Mandatory vaccination is accepted in a wide range of circumstances, including healthcare. “Because COVID-19 currently is a greater threat than most others, and because the vaccines have proven to be as safe and effective as they are, I do not see a serious ethical concern about requiring vaccination to work with patients,” Hall says.

The bigger ethical concern, according to Hall, is healthcare providers insisting they have a right to expose patients to either unnecessary risk “or even simply unnecessary worry.”

All these ethical concerns are under debate in the midst of uncertainty regarding duration of vaccine protection along with emerging virus variants. “Vaccine

passports could backfire, posing a risk to public health if they create a false sense of protection and people mingle as usual,” Jecker cautions. Ethicists should “join the

public conversation” about vaccine passports, says Jecker. “During a global pandemic, it is a social responsibility to reach beyond the ivory tower,” she says. ■

Evolving Efforts to Integrate Critical Care and Palliative Care

If the first palliative care consult happens on the same day clinicians are going to withdraw life support, palliative care can still manage the patient’s symptoms and comfort the family. “But just showing up at a doorstep and trying to fulfill my role as a caregiver and a witness to suffering, and trying to be therapeutic in that context, is very hard,” says **Billy Rosa**, PhD, MBE, NP-BC, FAANP, FAAN, a psycho-oncology postdoctoral research fellow at Memorial Sloan Kettering Cancer Center in New York.

When palliative care is involved only at the end of life, says Rosa, “I don’t think we are serving the patient or their family to the best of our abilities. I think we are missing the mark.”

Palliative care “can and should” be integrated into serious illness care at any point following diagnosis, Rosa argues. This can happen in conjunction with curative treatment, or as a standalone intervention focused on comfort at the end of life. “Palliative care goes beyond just end-of-life care. There are many contributions we can make upstream in the disease process,” Rosa says.

Providing palliative care education to nurses in clinical and academic settings is necessary for high-quality care.¹ Rosa and colleagues reviewed the National Consensus Project’s *Clinical Practice Guidelines for Palliative Care* and literature in the palliative care field.

“Critical care nurses spend the highest proportion of time in direct

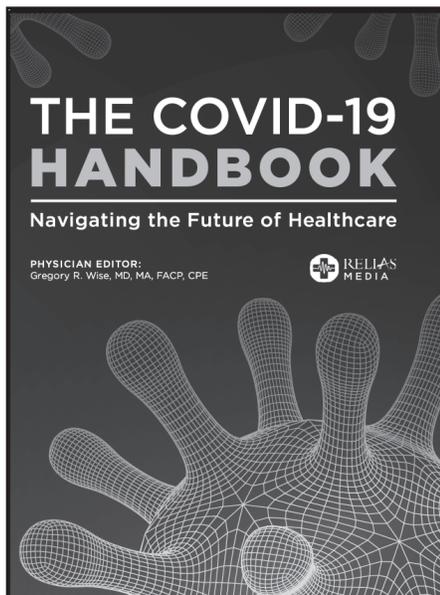
patient care of any health professional in the intensive care unit,” notes **Betty Ferrell**, PhD, RN, FPCN, FAAN, one of the study’s authors and principal investigator for the End-of-Life Nursing Education Consortium.

Nurses are ideally positioned to integrate palliative care, critical care, and ethical care, Rosa and a different research group argued in another recent paper.²

“Palliative care is not some added extra — it’s really just good care,” says Rosa, the paper’s lead author.

The goal is to promote holistic patient care — physical symptom management, and also addressing psychosocial, spiritual, cultural, and ethical needs.

“When we look at the critical care setting, we are still helping people



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understand the role palliative care can play. We're not there yet," Rosa says.

To a lot of healthcare providers, palliative care is viewed as a failure of medicine to save a life. Many ethics consults involve cases with a serious illness diagnosis. Patients and families are struggling with symptom management, complex psychosocial dynamics, and spiritual distress.

"Ethicists can be critical in identifying the need for increased palliative care involvement," says Ferrell, director of the division of nursing research and education at City of Hope in Duarte, CA.

There are a few reasons palliative care involvement still does not happen as early as it should (or in some cases, at all):

- A lack of understanding on what palliative care really is. "One of the biggest challenges to our work is that people confuse hospice and palliative care," Rosa reports.

Many families do embrace palliative care once they see its benefits (i.e., the patient finally feels pain relief or receives assistance with psychiatric or psychological needs).

"Healthcare workers are recalibrating their understanding of palliative care in a way that is improving the quality of experience of patients and families," Rosa says.

However, resistance to palliative care persists. One reason is the term "palliative care" itself. To remove the stigma, some institutions now refer to palliative care service as "supportive care."

"While I personally use the term 'palliative care,' there is some research that suggests that when patients hear 'palliative care,' they think they are on death's doorstep. When they hear 'supportive care,' they feel like they have a friend watching out for them," Rosa says.³

- Clinicians do not always identify the need for palliative care specialists. "The model is broken in a sense," Rosa laments.

As a consultation team, palliative care specialists still need permission from the primary team to engage the patient or family. There may be some challenges to access the patient. That is true even if hospitals use automatic palliative care referrals for certain cases, such as patients who have been on ventilators for several days. "Even though policywise, the provider can't object to an automatic referral, palliative care still has to come through the unit and talk to the attending," Rosa explains.

- There can be tension between the clinical and palliative care teams. "A culture shift is needed, where all teams can understand palliative care as collaborative and as expanding the work they are already doing," Rosa offers. Problems often stem from clinicians' mistaken belief that palliative care requires giving up life-saving interventions or switching to comfort care. "Palliative care can truly be delivered in conjunction with curative treatment if that's appropriate for the circumstance," Rosa argues.

- The clinical team does not realize palliative care is there for them, too. "A lot of clinicians don't understand that part of the palliative care role is to assist them in terms of the suffering that they are witnessing as frontline caregivers," Rosa notes.

Clinicians cannot engage with patients who are sedated or unconscious. Palliative care can assist clinicians with the communication skills needed to offer their families support. "Part of the reason palliative care is so powerful is it's not only a patient-centered model, but also a family-centered model," Rosa observes.

- Clinicians might contact palliative care much too late. "If the palliative care consult is delayed to the point of no return, we are seeing patients and families at the extreme end of crisis," Rosa says.

This forces palliative care to engage in a difficult conversation when there are few, if any, medical decisions left to be made.

"The palliative care team that shows up at that point may not represent support anymore. That team may now represent death's doorstep," Rosa says.

It will be that much harder to build a therapeutic relationship with limited time, in high-stakes emotional circumstances.

Ideally, the family already knows the palliative care team, who has been addressing their social, religious and spiritual, legal, ethical, and cultural needs for some time, and addressing anticipatory grief and preparing for loss. Then, at the end of life, when the patient is decompensating and dying, trust has been established.

"Palliative care is all about relationship-based care," Rosa explains. ■

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Poor Agreement Between ED Patients and Physicians on Goals of Care

Emergency providers often misunderstand the goals of care of patients who come to the ED at the end of life, according to the authors of a recent study.¹

“Particularly if it’s an unexpected visit to the ED, the patient may not have thought about or discussed end-of-life care with their own physician,” says **Robert J. Hyde**, MD, MA, the study’s lead author and an emergency physician (EP) at Mayo Clinic in Rochester, MN.

Even if the patient has engaged in such conversations, their wishes might not be documented (or, if so, not readily accessible). “In the ED, we are wanting to know what those preferences are. We may be making certain assumptions on our understanding of what the patients want,” Hyde says.

The ED has seen increasing numbers of geriatric patients in recent years. “We are interested in trying to improve care for this patient population,” Hyde says.

To learn how well EPs understand patients’ goals of care, Hyde and a colleague surveyed 80 ED patients age 65 years and older in 2019 about their goals of care and end-of-life preferences. They also surveyed 30 physicians (16 attending and 14 resident physicians) about which

goals of care were important to their patients and which goal was the most important. “Not surprisingly, we did find some discrepancies,” Hyde reports.

Patients and attendings identified the same “most important” goal of care in only 20% of cases, and residents and patients agreed in just 27% of cases. “In our culture, there’s a presumption toward aggressive care unless someone indicates otherwise,” Hyde observes.

ED providers do not want to provide unwanted aggressive care. “We’re trying to get it right, and that can be tough to do,” Hyde admits.

Patients often arrive with a critical illness, and already are struggling with that medical problem. “We don’t have enough time to discuss the matter adequately,” Hyde says.

ED providers do their best to learn the information from the patient, align care with the patient’s wishes, and ensure the patient understands his or her options. “In some cases, they don’t know, or have misunderstandings, on what it means not to choose a treatment,” Hyde notes.

Goals of care discussions “are imperative to ensure that medical interventions received are in alignment with the patient’s values

and preferences,” says **Amber R. Comer**, PhD, JD, assistant professor of health sciences at Indiana University in Indianapolis.

Ideally, goals of care discussions do not happen for the first time when the patient presents to the ED. When goals of care conversations are held earlier in a patient’s disease course, advance care planning is possible. “This can alleviate the use of aggressive interventions in the event that the patient decompensates or does not make a meaningful recovery,” Comer says.

If a patient is receiving aggressive end-of-life treatments that are not beneficial, ethicists can assist with engaging in goals of care conversations and advance care planning. “Additionally, ethicists can help the clinical care team implement hospital policies on withholding and withdrawing life-prolonging interventions in instances where the interventions the patient is receiving are futile and causing the patient to suffer,” Comer offers.

A case example: A frail 89-year-old patient received an emergency laparotomy, is on a ventilator in the ICU, and is not expected to make a meaningful recovery. The patient is decompensating quickly and is unlikely to survive cardiac arrest. The



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patient does not have a surrogate medical decision-maker, and there is no time to pursue a court-appointed guardian to make medical decisions. “Situations such as this are, unfortunately, not uncommon,” Comer laments.

Ethicists could be used to help change this patient’s code status to Do Not Resuscitate (DNR) to ensure the patient does not suffer at the end of life. Sometimes, these cases start out in the ED. Many hospitals maintain policies that allow ethicists to change a patient’s code status when it is appropriate and no surrogate is available. “Most policies have the ethicist work with the chief

medical officer and legal to make this happen,” Comer says.

Eileen F. Baker, MD, PhD, FACEP, an EP at Riverwood Emergency Services in Perrysburg, OH, says the central ethical issue stems from “misunderstandings regarding the patient’s goals of care on the part of patients, families, as well as physicians.”

Some of that confusion comes from variations in terminology found in all the different end-of-life documents. These include DNR orders, Physician Orders for Life-Sustaining Treatment, living wills, and healthcare power of attorney documents. It is difficult for patients,

families, and physicians to know under what circumstances advance directives should be applied.

“The ethical implication of such confusion involves patients receiving life-prolonging care they did not wish to receive, or enduring treatments that they did not foresee and would not have agreed to, with better knowledge of what such treatments would entail,” Baker says. ■

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Effective Remote Communication Improves End-of-Life Care

Researchers interviewed family members of 328 veterans who died in an inpatient unit at one of 37 VA medical centers during the pandemic in 2020. Most (69.5%) who reported that remote communication was “very effective” reported “overall excellent” end-of-life care.¹

In contrast, of participants who said remote communication was “mostly, somewhat, or not at all effective,” only 35.7% said end-of-life care was “overall excellent.” Additionally, most family members (81.3%) who made positive comments about communication reported “overall excellent” end-of-life care vs. just 28.4% who made negative comments about communication.

When engaging in end-of-life discussions, “face-to-face communication is the optimal way to communicate,” says **Robert Klitzman, MD,** director of the online and in-person master of bioethics program and a professor of psychiatry at Columbia

University. Clinicians, family, and ethicists can pick up on expressions and body language that otherwise are missed. In initial conversations with multiple family members, one member may dominate and others lean back, shift uncomfortably in their chair, and withdraw a bit from the group. “Yet later, when subsequent decisions are faced, these initially quiet members suddenly decide to object to the course of decisions that have been or are being made,” Klitzman says. This complicates the decision-making process. “Awareness of their body language initially could have allowed the clinician to address these tensions earlier,” Klitzman says.

Still, remote communication plays “a definite role” in the post-COVID-19 era, Klitzman suggests. One example is the ability to keep out-of-state family in the communication loop on an ongoing basis. Some ethics consults involve family members who suddenly arrive

in person to demand aggressive treatment, in conflict with what other family and clinicians believe is in the patient’s best interest. “Cases occur where a sibling or child from out of state shows up at the last minute and says, ‘Don’t unplug my mother, or I’ll sue you,’” Klitzman says. Including all family members, if they are interested, early in a meaningful way (even if they cannot travel across the country but can participate remotely) prevents sudden last-minute disagreements.

Although facial expressions and body language are not always caught when people participate in family meetings remotely, “it’s better than nothing, and it’s better than a phone call without any video,” Klitzman says. “But I would hope that people wouldn’t say, ‘we don’t need to have the family come in.’ It would be unfortunate if it were to replace face-to-face communication.”

During the pandemic, visitors were strictly limited in ICUs. “Dying

alone is tragic. Families are fraught with grief and guilt for not being able to be present,” says **April N. Kapu**, DNP, APRN, ACNP-BC, FAANP, professor of clinical nursing at Vanderbilt University School of Nursing.

Remote communication via tablet computers have become well-known communication tools in ICUs. “Not only can the patient and family members see one another, family members can also have conversations with the healthcare team,” Kapu observes.

It ranges from care updates to difficult end-of-life conversations or ethical concerns. “Ethicist involvement can be crucial to navigating questions about the situation, how everything has transpired, and what decisions need to be made going forward,” Kapu explains.

Trying to manage many patients and also find the time to facilitate remote communication has been difficult for staff. At Vanderbilt University Medical Center, nurse practitioners and physicians volunteered to form a “family liaison” team. Providers sign up to come to ICUs, check in with the care team, and facilitate communication between family members and patients.

Some only volunteer for a day or two, while others sign up for several days. The volunteers coordinate the remote family meetings, explain lab results and the plan of care, and facilitate end-of-life discussions.

To prepare for the family liaison role, providers consulted palliative care, chaplain services, counselors, and ethicists. “Our ethics team was invaluable during this very new and difficult time to all involved — patients, families, and team members,” Kapu reports.

COVID-19 changed the way clinicians use technology in communicating, beyond just end-of-life care. “We

had it before, but now we use it in our everyday communication with patients and families,” Kapu says.

Visitor restrictions were one of the biggest challenges that arose during the pandemic, says **Olivia Schuman**, PhD, a clinical ethics fellow at the Baylor College of Medicine Center for Medical Ethics and Health Policy. “You’d have a patient who, prior to admission for COVID, was relatively healthy — working and seeing their family,” says Schuman, a clinical ethics consultant at Houston Methodist Hospital.

Several weeks later, it would become clear to the healthcare team the patient is not going to recover. Many families could not accept this fact, partly because they were never at the bedside. “So many nuances of communication are lost when the team cannot interact with the family in person,” Schuman laments.

Families struggled to appreciate how truly sick their loved one was. This often led to families wanting to prolong life-sustaining treatment (e.g., ventilators or ECMO) that no longer benefitted the patient. One tactic employed to address this issue were “iPad visitations.”

“The medical team could livestream the patient, with all their tubes and machines, directly to family members located anywhere in the world,” Schuman says.

The time-consuming task fell on the shoulders of already-overworked nurses. It did help families see a better picture of their loved one’s dire situation. “This led to better substituted judgment by the families, and better communication with the team overall about what direction would most benefit the patient,” Schuman says.

Going forward, the iPad visitations are used anytime family cannot visit the patient in person. Non-medical

staff, like social workers or patient liaisons, can facilitate it for cases in which the patient does not have an infectious disease. “iPad visitations will become part of the norm, a service that families will come to expect,” Schuman predicts.

It shifts substituted decision-making from simply family members who are geographically nearby to family members who are most informed and invested, regardless of distance. “There are psychosocial benefits for the patient and their family and better informed decision-making,” Schuman adds.

Remote communication removes barriers for families who cannot be present at the bedside due to work, transportation, or geographic location, says **Leslie M. Whetstone**, PhD, a bioethicist at Aultman Hospital in Canton, OH, and a professor of philosophy at Walsh University. Often, a single point person is responsible for sharing medical updates concerning a loved one across their extended family. “In such a scenario, a physician who uses remote communication could present information to many family members at once and answer questions in real time,” Whetstone says.

At Houston Methodist Hospital, the iPad visitations allow clinicians to see the family standing behind the patient. “The family sees the team of experts working hard to help their loved one,” Schuman says. “It humanizes both sides.” ■

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CME/CE QUESTIONS

- 1. Which was physicians' primary reason for not requesting ethics consults, according to a recent survey?**
 - a. Physicians did not believe they needed help from ethicists.
 - b. Physicians worried colleagues would disagree.
 - c. Physicians feared legal repercussions.
 - d. Physicians were aware that ethics consultants were working with limited resources.
- 2. Which is true regarding disruptive physician behavior?**
 - a. Clinicians should be required to call ethics whenever there is a legitimate disagreement about a patient's care.
 - b. Ethics consultation is appropriate when a physician's disrespect to a nurse or patient affects decision-making in patient care.
 - c. Evidence shows reprimanding disruptive physicians is far more effective than emotional intelligence training.
 - d. Policies should require conflicts between nurses and physicians be brought to the attention of hospital administration to prevent moral distress.
- 3. Which did a study reveal on end-of-life care in the ED?**
 - a. ED providers often misunderstand the goals of care of patients who come to the ED at the end of life.
 - b. Most ED providers strongly disagreed with patients' wishes for more aggressive treatment.
 - c. ED providers were not following clearly documented patient wishes.
 - d. ED nurses and physicians were in conflict on whether to follow family demands for aggressive treatment.
- 4. Which is true regarding palliative care involvement in critical care patients?**
 - a. Symptom management is not possible if a palliative care consult happens on the same day clinicians are going to withdraw life support.
 - b. Palliative care can be integrated into serious illness care at any point following diagnosis.
 - c. Palliative care generally cannot be performed in conjunction with curative treatment.
 - d. Palliative care typically requires giving up life-saving interventions.