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Study shows link between student burnout, professional misconduct

New study has implications for hospitals

Fresh research on burnout in the medical profession makes it clear that hospital ethics boards need to be proactive on this issue. Their role could include educating and suggesting policies to prevent physician and resident burnout and any resulting repercussions.

A survey of more than 2,500 medical students at seven U.S. medical schools has found that more than half experience burnout. Among those who described burnout, unprofessional conduct behavior was higher, as were non-altruistic attitudes.¹

“We found a high prevalence of burnout among medical students,” says **Liselotte N. Dyrbye, MD, MHPE**, an associate professor of medicine at the Mayor Clinic Rochester in Rochester, MN.

The study found that 52.8% of students had burnout according to the Maslach Burnout Inventory.¹

“Students who had burnout were much more likely to say they engaged in unprofessional behavior, such as cheating,” she says. “We also found that students with burnout were less likely to hold altruistic views about physicians’ responsibilities to society, and they were less likely to think they would be able to make an impact on meeting the needs of the underserved.”

The research has broader implications.

“I think it was a very important study because it confirms what a lot of us were concerned about — that this measure of burnout carries with it some significant consequences,” says **Jonathan A. Ripp, MD, MPH**, an assistant professor of medicine in the division of general internal medicine in the department of medicine at Mt. Sinai School of Medicine in New York, NY.

Ripp has studied burnout among medical residents and interns and found that an anxious personality or feeling insecure about one’s skills was correlated with experiencing burnout.

His research and the recent medical student study raise questions about how physician burnout might impact patient care and ethical

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behavior in hospital settings.

“Our concern is that it might lead to suboptimal patient care,” Ripp says.

At the very least, the medical student study suggests that burnout can result in a less humanitarian attitude toward patients. Burnout degrades the principles of humanism in medicine, Ripp notes.

“The study shows there may be two ends of the spectrum: humanism and idealism on one and burnout on the other,” Ripp says.

Studies repeatedly have shown there is a high prevalence of burnout among physicians and resi-

dents, Dyrbye notes.

“We wondered where this burnout had its origin, in residency or earlier?” she explains.

“Our first study was in Minnesota in 2006, and we found 50% of medical students had burnout,” she adds. “Then we conducted a series of studies subsequently and, at last in 2009, we had several U.S. medical schools involved.”

One of the common factors among medical students experiencing burnout was having had a recent negative life event, Dyrbye says.

“They’re standing on the end of a diving board and just getting by because medical school is stressful and they’re experiencing death and dying for the first time,” she explains. “Then their mom gets sick, and that tips them over the edge.”

The study found that minority students generally report less burnout and tend to be more resilient, with one exception: If they perceive that their race has adversely impacted their experience, they report more burnout, she says.

Another factor that appeared to have some relationship to burnout’s long-term impact involves work.

“Students who work for an income while in medical school are less likely to recover from burnout,” Dyrbye says.

Investigators checked on students’ reported burnout symptoms over two time periods separated by one year, and found that having any kind of job made recovery more difficult.

“It’s yet one more responsibility on their plate, and it doesn’t matter how many hours they work,” Dyrbye says. “Also, having children adds an extra stress and a layer of complexity, so people who have children while in medical school struggle more.”

One factor that seems to result in a lower burnout status is faculty support: “Students who perceive they are getting a high level of support from faculty are less likely to have burnout,” Dyrbye says.

Again, these types of nuances and findings have some potential implications for hospitals and ethics boards, particularly when viewed within the context of previous research showing that residents who are burned out are more likely to believe they’ve made a medical error, she says.

“Whether or not burnout among resident physicians is impacting their ethical standards, we don’t know that,” she says. “We can speculate that if we see [ethical lapses] in students it might persist in residents.”

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EDITORIAL QUESTIONS

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Likewise, the findings that faculty support can help with burnout suggests that hospitals could play a role in reducing burnout among physicians through education, improved leadership support, and policies that improve job satisfaction and autonomy.

“Those who report less fatigue and stress seem to be more resilient to developing burnout over the span of one year,” Dyrbye says.

Hospital ethics boards also can take the lead in preventing unethical and non-altruistic behaviors among physicians by providing education and training in the areas of professionalism and ethics, she suggests.

Ethics boards might also address a hospital’s hidden curriculum. Some hospitals might teach physicians to treat all patients equally, but simultaneously send the message that low-income patients are less important when they give these patients less attention and second-class treatment and care.

“If there is the appearance of people getting care based on their socioeconomic status, then this is a clear message to trainees about what is valued,” Dyrbye says.

Another way hospital ethics boards can promote physician professionalism is through ensuring hospitals have policies that adhere to the American Medical Association’s (AMA’s) policies on appropriate ways to handle pharmaceutical industry representatives and other representatives. They also should stress staff education on these policies.

The medical student survey found that very few students (14%) agreed with the AMA’s ethics policy on appropriate ways to interact with industry, Dyrbye says.

“We asked them questions, such as, ‘Do you think it’s appropriate to attend an industry-sponsored dinner at a nice restaurant?’” she says. “That is not acceptable by AMA standards, but 46% of students said it was fine.”

About 27% of students said it was okay to accept a free day of skiing following a medical talk at an industry-sponsored event, and 22% of students said it was okay to accept \$500 from an industry representative after taking a five-minute survey, she adds.

“These obviously are not fine, and that’s another piece of the puzzle that needs some attention,” she says. “We did not find a consistent relationship between burnout and students’ attitudes toward the pharmaceutical industry;

it’s just a big piece here that’s missing in terms of student education.”

The medical student study suggests burnout will erode future physicians’ altruism, professionalism, and service to society, Dyrbye says.

“We need physicians who are advocates for patients and promote public health,” she adds. “Burnout threatens to impede this process.”

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SOURCES

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How to avoid ethics consultation pitfalls

Experts should receive financial compensation

Clinical ethics consultations still are infrequent in most hospitals, but their use is beginning to enter ethics board conversations, and it’s an area that should be approached with cautious preparation, an expert says.

“If it’s done correctly, it’s valuable to people who ask for the help,” says **Anita Tarzian**, PhD, RN, an ethics and research consultant in Baltimore, MD. Tarzian also is the program coordinator for the Maryland Health Care Ethics Committee Network, University of Maryland School of Law and an associate professor at the University of Maryland School of Nursing in Baltimore.

When clinical ethics consultations are done poorly, they may take two or three weeks for an answer that essentially boils down to an “It depends...”

This type of consultation adds no value to the process of making a decision, Tarzian says.

Health care institutions can improve their use of clinical ethics consultations by addressing

potential pitfalls and writing policies that will enhance the process. Here are some of Tarzian's list of common pitfalls and suggestions for avoiding these:

- **Pitfall — using ethics consult as an add-on.**

“One major pitfall is that most people are doing this as an add-on to what they're already doing and not valuing the service the way they should,” Tarzian says.

Hospitals fall into this trap when they assign a staff nurse, physician, or social worker the additional work of ethics consultation without providing appropriate support.

When done correctly, ethics consultations are time-consuming. They require an expert sorting through facts, meeting with stakeholders, coming up with an ethical analysis and recommendation, and they need proper documentation, Tarzian says.

It's a process that must have institutional support to be done correctly, she adds.

One solution would be for an accreditation organization to give health care institutions an incentive to provide adequate resources so that clinical ethics consultations are done correctly.

“Hospitals could provide resources for people to become properly educated, sending them to conferences or helping them obtain certification,” Tarzian suggests. “Hospitals also could pay ethics consultants at the minimum an honorarium for being the lead consultant.”

When an appropriate clinical ethics consultation request comes in, it requires the consultant to meet with stakeholders, talk with the medical team, and be responsible for documenting in the consult service's records and the patient's medical record, she explains.

“That person should be paid part of a salary or be paid an honorarium and not expected to do this work as a volunteer,” she says. “So there is a need for resources, budget money, and time and respect for their doing quality work.”

- **Pitfall — developing competent consultants.**

“There is this idea that we have not reached a consensus yet on what the standards are,” Tarzian says. “Some say we have and some say we haven't.”

However, there are some standards available, including the American Society for Bioethics and Humanities' report, titled, “Core Competencies for Health Care Ethics Consultation,” which originally was published in 1998. The report has been updated, and the second edition is scheduled to be

published this winter.

The report lists basic knowledge competencies and basic skills competencies. The updated edition will have a new section on emerging procedural standards that are not related to the competency of individuals, but cover ethics consultation services' operational policies and procedures.

“Some people say it would be better to evaluate the service and not focus on individuals,” Tarzian says. “That's a compelling idea and more consistent with this document.”

If a health care institution has a team of people providing ethics consultations, then they could pool their competencies, and one person would not have to be an expert in all areas, she adds.

- **Pitfall — taking away ethical responsibilities from frontline staff.** “There is a big concern about what happens if you focus on advanced competency,” Tarzian says. “Will frontline health care professionals be replaced with experts from the outside?”

“The concern is this would diminish the ethical climate of an institution if you are encouraging the health care professional to farm out ethical decision-making to some other body,” she says.

This concern has been debated with some research weighing in on the side of using professional ethics consultants.

“Some research has shown that if people are more educated about ethics they're more likely to involve ethicists in complex cases and show a higher level of care about ethics,” Tarzian says.

Proponents of ethics consults answer that these do not make medicine softer. They say it's a value-added service that enhances the ethical climate of the institution, and, at any rate, it's unavoidable in today's medicine, she adds.

“Medical decision-making has reached a state of complexity that we need people with specialized ethics skills and knowledge to help address ethical questions and dilemmas,” Tarzian says.

If done well, clinical ethics experts assist patients and staff in addressing ethical issues and concerns and should bring a benefit to an institution's ethical climate, she says.

SOURCE

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Ethics committee debates end-of-life treatment

Palliative sedation policies reviewed

As hospitals add more palliative care services, ethical issues arise that sometimes cannot be handled solely by a hospital ethics board because a broader community perspective is necessary.

For instance, what is the hospital's policy regarding cardiopulmonary resuscitation (CPR) when all attending clinicians agree the patient cannot be resuscitated? Or should physicians provide palliative sedation, and how should this be described to patients and families? (*See story on CPR policies, p. 30.*)

The Harvard Community Ethics Committee is a potential model for how these issues might best be handled. The committee is comprised of 16 men and women who are diverse by age, profession, language, ethnicity, religion, and in other ways.

"The Harvard Community Ethics Committee was set up within the division of medical ethics as a resource for faculty and fellows of the Harvard-affiliated community to have access to a diverse group of lay people when they wanted to ask for a public response to things," says **Christine Mitchell**, MTS, MS, associate director of clinical ethics in the department of global health and social medicine at Harvard Medical School in Boston, MA.

A recent example of how the committee fulfills its role occurred when a couple of physicians from the Harvard Medical School community asked the committee how the public understood and felt about palliative sedation.

The committee met with experts in palliative sedation, reviewed various policies on the subject, and eventually wrote a report that answers a list of questions, such as these:

- What does the community understand when asked about palliative sedation?
- What sorts of patients would be appropriate for this treatment option?
- How sick or close to death do you think someone ought to be before this person is considered for palliative sedation?
- How do members of the committee feel about the distinction between palliative sedation, euthanasia, and physician-assisted suicide?

During the committee's discussions, members expressed discomfort with the terminology, Mitchell recalls.

"People asked, 'Why don't we call it what it is?'" she says. "So we ended up deciding to call it 'continuous deep sedation as comfort care until death.'"

The ethics committee defined a whole set of terms used in the report, including addressing the issue of what it meant to say someone was imminently terminal, Mitchell says.

"They noted that these were patients for whom other ways of treating their pain have not been successful, she says.

The committee looked at how palliative sedation might be linked to euthanasia or physician-assisted suicide, beginning at first with some member confusion over the various terms and their meanings. They ended up being convinced that there is no legitimate link between palliative sedation and the intent to end a sick patient's life, Mitchell says.

"It's not close to the illegal or controversial methods of dying, the committee said," she adds. "This is something that should be considered as a reasonable treatment option for patients dying of pain and who couldn't be treated in other ways."

The aim of euthanasia and physician-assisted suicide is to end a patient's life; the primary goal of palliative sedation is to relieve a patient's pain, the committee decided.

"We had people lined up in opposing camps at the beginning, saying, 'You can't do it,' and others saying, 'Of course you want to treat someone's pain if they're dying — even if they're asleep,'" Mitchell says.

After conversations with nurses and physicians in palliative care, the committee members' views evolved.

The Harvard committee handles its broad diversity in opinion and experience by drafting a survey of questions for each member to consider and answer. The questions include those with just "yes" and "no" responses and those that require a more detailed description of the member's thoughts. This ensures each member's thoughts and concerns are taken into account, Mitchell explains.

Committee members are seeking input on these ethical issues from friends, as well.

"We have a second step that gets the issue beyond this committee that has thought about it and out to people who don't think about it," Mitchell says. "Everybody completes the survey and gives their reasons on paper for their thoughts."

The palliative sedation discussion lasted for nearly a year, with some interruptions for other ethical considerations. Each part of the report's wording needed full committee agreement and review.

The final report is not the same as policy, but it's sent to members of the Harvard Ethics Leadership Group, the division of medical ethics at Harvard, and to ethics committees at Harvard teaching hospitals and health care facilities.

Each institutional ethics group could use and adopt the report as policy, if desired.

Sometimes a hospital will use the report to inform and assist with policies, Mitchell says.

"I know within the Children's Hospital at Harvard, they were working on a policy about social media, and our committee's report on the topic influenced their policy," she adds.

SOURCE

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Ethics committee tackles issue of CPR

Hospital policies could be changed

The default policy of many hospitals is to have clinicians perform cardiopulmonary resuscitation (CPR) on dying patients except when there is a do-not-resuscitate (DNR) medical order signed by the patient.

This policy has continued even when the case is considered futile, when there is no true hope that the patient will be revived.

Now hospital ethics boards are taking a look at this policy, wondering if this should be changed.

The Harvard Community Ethics Committee in Boston, MA, spent months reviewing this issue, eventually writing a report and publishing a poster at the 2010 annual meeting of the American Society for Bioethics and Humanities (ASBH), held Oct. 21-24, 2010, in San Diego, CA, says **Christine Mitchell**, MTS, MS, associate director of clinical ethics in the department of global health and social medicine at Harvard Medical School in Boston, MA.

"A lot of places are revising their policies about

the decision to not resuscitate, and they address those circumstances in which clinical consensus of CPR would not be beneficial for the patient," Mitchell says. "Some are saying, 'Just say no'; others are saying you need a process for overriding people who want to have CPR."

Harvard clinicians asked the community ethics committee to address the issue of DNR orders in the event of cases where physicians agree performing CPR would be the less humane route to take.

"When the person is going to die even with an intervention, CPR is not a nice way to go," Mitchell says. "It's putting a needle in the heart, pushing on the person's chest, using IVs and medications — it's awful!"

The Harvard Community Ethics Committee, which is comprised of 16 diverse members of the public, began the discussion of futile CPR with some of the same assumptions that most people who do not work in health care might have, she notes.

"Community members came to this with the assumption that CPR is an effective treatment that should be done whenever anybody has a heart attack," Mitchell says.

After months of learning more about CPR and discussions with health care providers, committee members had a change of heart. One member wrote in the committee's report: "We learned that CPR is rarely effective, even when administered in a hospital setting, and we learned that it can sometimes be an incredibly intrusive and violent procedure — not the gentle tap tap on the chest that our media exposure would have us believe," she adds.

CPR can prolong the dying process, and the committee addressed the terminology and ethics of unilateral DNR in a report about what the committee called "nontherapeutic CPR."

The committee thought the language of "unilateral DNR" was draconian and misunderstood, Mitchell says.

"'Medically futile CPR' was problematic and involved value judgments that went beyond just medical evidence, the report said," she adds. "The ethics committee thought those were not good ways of describing it; they thought it was clearer to say 'non-therapeutic' or 'non-beneficial CPR.'"

The problem with the word "futile" is that it can be used as a value judgment, as well as a medical judgment, Mitchell explains.

So the committee used the term "non-therapeutic CPR" to make the meaning clearer.

Once the report was complete, the committee

sent it to ethics committees at Harvard-affiliated institutions.

“At the Harvard Children’s Hospital we took this report into account when we revised our CPR policy,” Mitchell says. “We put in a section on non-therapeutic CPR and listed procedures to follow for not doing CPR when it wouldn’t benefit the patient, and we changed our language because of this report.”

These procedures include having a clear consensus among physicians that CPR should not be done. This policy is communicated to patients and families, she adds.

The ethics committee’s purpose is to think about these broader ethical questions and write reports with members’ conclusions, Mitchell notes.

“We don’t write policy,” she says. “We give the lay public response from people who are not health professionals, but who are willing to take time to learn about an issue and let health care providers know how it strikes them.” ■

Hospital staff need cross-cultural training

Intercultural framework is needed

Hospital ethics boards should take the lead in promoting greater intercultural understanding between clinical staff and patients, according to an expert. This begins with education focusing around cultural awareness.

“Health care professionals from different cultural backgrounds from patients have an ethical responsibility to be aware of cultural differences,” says **Marcia Carteret**, MEd, director of intercultural communications at the Colorado Children’s Healthcare Access Program (CCHAP) in Aurora, CO. Carteret also is an instructor in the department of pediatrics at the University of Colorado School of Medicine in Aurora.

“Everyone experiences reality differently, largely based on their culture,” she says. “So it’s an ethical responsibility to recognize cultural differences and interact at a level that demonstrates being more aware and responsive.”

Intercultural education can begin with teaching health care professionals a framework of cultural differences.

For instance, audiences often chuckle when Carteret asks them to think about the American

culture’s relationship with time. In the United States, people think of time in adversarial terms.

“Americans as a group are the only ones in the world who have an adversarial relationship to time,” Carteret says. “We think of time as something we’re battling, that we have a shortage of it, and we’re always worried about making the most of the time we have.”

Americans also are multitaskers who think of time as a commodity, she adds.

“Even our language indicates this: saving time; never wasting time, and even ‘killing time,’” she says. “We take for granted that this is the way time functions in the world, but in actuality in many places in the world, people have a much more fluid sense of time.”

So when someone is late, people in other parts of the world do not attach a value to this occurrence, thinking the late person is inconsiderate, Carteret says.

“In the U.S., health care appointments are set at such specific intervals and people are always in a hurry, and the doctor can never get through his day with all the patients he has to see,” she explains. “To the person who has a different cultural perspective, this person can’t even slow down long enough to see him or her as a person or relate to this patient’s reality and life.”

So when health care professionals are dealing with people from other cultures, time is their number one challenge, Carteret says.

“People from other cultures might not show up for appointments, or they’ll arrive 45 minutes late and not understand why they can’t see the doctor,” she says.

Another common cultural clash involves the issue of self-sufficiency. In the U.S. culture, people value independence and self-sufficiency above reciprocity and group integration.

“You pull yourself up by your bootstraps and figure things out, not relying on other people unless you have to,” Carteret says. “Many cultures are more group-oriented or people are collectivists, and their society is glue.”

In these cultures, reciprocity is what keeps things running.

“You learn to rely on a network of close family and friends, and we’re not talking about Facebook friends,” Carteret says. “That’s your safety net in life.”

When American health care workers work with patients from a collectivist culture, they’ll likely find that the patients do not demonstrate self-

sufficiency.

This cultural difference is compounded by the formal and structured nature of the U.S. health care system. But there are strategies health care professionals can employ to bridge the cultural gaps.

For instance, clinicians can learn how to ask questions in a culturally sensitive way. There is a list of such questions available for a free download at a CCHAP website: www.dimensionsofculture.com. Among those listed are questions under the category of family dynamics and decision-making. Here are several examples of questions on that list:

- Who helps you make decisions about health care for your child?
- Who else have you asked for help/advice about the problem?
- Who should be told about the doctor's diagnosis? (In your culture would you give bad news to the patient directly?)

Another strategy is for health care facilities to give patients information about how to navigate the system. For example, Americans might be used to having to deal with automated telephone responses and pressing buttons to obtain the information that is needed. But these types of systems can turn into barriers to treatment for people from other cultures.

So providers should give patients from other cultures phone numbers to call where they can speak with a person, rather than an automated response. Or, at the very least, they could give patients a handout that describes how patients can talk to their doctors. The dimensionsofculture.com website provides an English and Spanish-language, one-page sheet on this topic.

Perhaps the most important strategy is for clinicians to acknowledge and examine their own cultural attitudes, such as ethnocentrism, in which one believes his or her own culture is central to reality, Carteret says.

CCHAP provides a framework called ETHNIC that offers suggestions for improving one's cultural competence. Here is a sample of questions suggested by the ETHNIC framework:

- **Explanation:** What do you think may be the reason you have these symptoms?
- **Treatment:** What kind of medicines, home remedies, or other treatments have you tried for this illness?
- **Healers:** Have you sought any advice from alternative/folk healers, friends, or other people (non-doctors) for help with your problems? Tell me about it.

- **Negotiate:** Negotiate options that will be mutually acceptable to you and your patient and that do not contradict, but rather incorporate your patient's beliefs.

- **Intervention:** Determine an intervention with your patient. It may include alternative treatments.

- **Collaboration:** Collaborate with the patient, family members, other health care team members, healers, and community resources.

The idea is to help providers understand that their own approach to a patient's medical problem may not be the same approach the patient will have.

"When you're in a dominant cultural group, you accept that your culture is normal," Carteret says. "We need to understand that all cultures are equally complex, and understanding that complexity of culture requires a framework for learning about cultural differences."

SOURCE

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Should patient records be used for research?

Ethical debate is about patient privacy

Ethical concerns and privacy regulations make for a more complicated situation when health care researchers desire to view patient records to find potential research subjects.

"The regulations governing access to private information are fairly vague in some ways, especially with respect to research," says **Joseph S. Brown**, PhD, a professor of psychology and vice chair of the University of Nebraska Medical Center IRB in Omaha, NE. Brown also is the Schumacher Chair of Ethics at the University of Nebraska – Omaha.

"The regulations talk about adequate protection for privacy, but they don't specify what adequate protection would mean," Brown says. "The common practice is to have fairly wide access, respected under HIPAA, but it's not clearly defined."

This results in the ethical perspective that ethics boards should have more oversight over privacy

and require greater restrictions on access to medical information, he adds.

For example, a physician who is a partner in a practice that sees diabetic patients might decide to engage in research involving diabetics. The physician investigator needs to know who to approach to ask to be in the study, so how does he or she find out?

An obvious solution is to look through the medical practice's patient files.

"Typically, the IRB would grant access to files of every patient at the practice, but we would find that to be an overexpansion of access because damage could be done to patients when more people know about their condition," Brown says.

This ethical perspective is that no harm is done if the person looking through the patient files is the patients' physician. The patients' own physician would already have access to these files and could use these to recall particulars of patients' medical histories. Then he or she could contact patients to see if they would be interested in participating in a research study — or at least allowing an investigator to review their files to see if they might meet the study's criteria, he explains.

"I think most hospitals and IRBs would extend access to files to a physician's partner because this second doctor has the potential of caring for the patient," Brown says. "But we argue the potential to look in files is not the same as looking in files."

Once the partner looks in the files there is no expansion of privacy rights that would make it ethically palatable for the physician partner to approach these patients to ask if they would like to be in a research study, he explains.

"It's different if the doctor who is taking care of them looks at the file," he says. "There are confidentiality issues, but no privacy issues here, and we draw distinction between those two cases."

But if the patients' physician's partner is the one who is looking at the files without their knowledge, then there are potential harms, Brown says.

"The physician might see the file of his or her next-door neighbor or child's teacher," he says. "In general, we believe it's best if patients believe their data are held privately and only viewed when they are sick."

If patients believed their private medical records could be viewed without their permission by researchers or other individuals, then they might be less willing to divulge some types of information, and this could negatively impact their health care, he adds.

"This is a controversial proposal, and plenty of people would disagree with our analysis," Brown says.

There are other ways to conduct research involving screening medical files without infringing on patients' privacy rights, he notes.

One strategy would be for investigators to ask physicians to approach their own patients and ask if it's all right if the investigator looks at their medical files to see if they're eligible for a study, he suggests.

Or, hospitals and physician practices could create a blanket permission form that asks if patients would allow their records to be accessed by other health care or research professionals solely for screening purposes.

"You could ask patients in the hospital if it's okay if they're screened, and the hospital intake could include asking them explicitly for permission," Brown says.

Researchers do have the option of reviewing medical data that contains no identifiers, which eliminates the privacy concerns.

"One alternative of last resort is to consider an institutional review board or privacy board offering a waiver of consent," Brown says. "This is done under narrow circumstances if risk is minimal and if — according to another portion of regulations — subjects' rights won't be seriously compromised."

Another option would be to sift through electronic medical files in which patient identifiers are encrypted and the key is available only to patients' providers. In this scenario, the investigator might find out that a particular hospital or physician's practice has X number of patients diagnosed with diabetes. Then it would be up to the investigator to ask the provider to contact these patients and inquire if they would be open to sharing their medical files with a researcher for the purpose of seeing if they would be eligible for a particular study.

If this electronic screening method were used to send out generic letters to people, there are ethical concerns that go beyond privacy issues, Brown says.

"There might be concerns on the part of the hospital or practice ethics board if patients were receiving solicitations to be in research based on private health information," he says. "Their perception might be: 'Who are you? Why are you contacting me, and how do you know this about me?'"

Many hospitals might require that before a patient can be asked to participate in a study that his or her primary physician is consulted.

Sometimes researchers use the strategy of sending

a study recruiter to a hospital emergency department to sit and wait for patients meeting a specific disease criteria to come through the ED doors.

The recruiter would have asked intake staff to see if these patients would be all right with having a researcher approach them to talk about the study.

In this scenario, the patients have the right to say, “No,” and so their privacy rights are protected, Brown says.

SOURCE

• **Joseph S. Brown**, PhD, Professor of Psychology, Vice Chair of the University of Nebraska Medical Center IRB, and Schumacher Chair of Ethics at the University of Nebraska – Omaha, Omaha, NE. Email: josephbrown@mail.unomaha.edu; telephone: (402) 554-2313. ■

Educating hospital staff about palliative care

Hospitals increasingly recognize need for it

Palliative care once was a rare treatment option in the hospital setting, but in recent years it has grown in popularity to the point that most major hospitals and many small-to-mid-sized hospitals have palliative care programs available for patients, an expert says.

Hospital administrators and providers have come to realize that palliative care is not the same as hospice or end-of-life care. It’s a way to provide patients with more comfortable care than they’d receive while in the hospital or nursing home, which is where many patients spend their last days. With palliative care, patients often transition more smoothly from the hospital to home care or nursing home care, often receiving better quality and more cost-effective care, according to the Center to Advance Palliative Care in New York, NY.

“It’s a simultaneous care model that should be administered at the point of diagnosis of serious illness, cognitive impairment, or multiple illnesses,” says **Diane E. Meier**, MD, director of the Center to Advance Palliative Care at Mt. Sinai School of Medicine in New York, NY.

“Palliative care is what we do to prolong life, improve the quality of life, mood, depression, family caregiver well-being, and reduce the likelihood of someone ending up in the hospital or intensive care unit (ICU),” she adds.

There are more than 1,500 hospitals in the

United States with palliative care programs, and 80% of the largest hospitals have palliative care programs, Meier says.

“Palliative care serves the sickest 5% to 10% of patients, the group that tends to have long and costly hospital stays that don’t benefit the patient and are paid by DRGs,” she explains. “The longer these patients stay in the hospital, the less money the hospital makes, so hospitals lose money on these very sick patients.”

Also, there are various ethical considerations: First, these very sick patients would have a better quality of life in a palliative care program, where it was presented at home or in another care setting; and, two, other patients who need the hospital beds occupied by the very sick patients are prevented from getting the care they need, Meier says.

“This small group of patients blocks up the intensive care unit (ICU) and emergency department and increases the rate of ED diversion — which is a huge financial hit for hospitals,” she adds. “They reduce efficient throughput, and that’s why so many hospital CEOs have not only invested in palliative care programs, but have recruited leadership to lead these programs.”

In these poor economic times, hospitals are under incredible financial stress, so anything they can do to provide better patient care while strengthening their financial reserves is important, she says.

Hospital ethics boards might address palliative care, looking at whether their own facilities properly identify and refer patients to these services, and they might help educate staff and providers about palliative care, Meier suggests.

“They might take the lead in educating physicians and the nurse community within the hospital about how palliative care is not end-of-life care,” she says. “They should show data on the impact of palliative care on quality, survival, family well-being, and patients getting the kind of care they need in a setting they want, while avoiding risk.”

Hospital stays are in themselves a risk factor for higher morbidity and mortality, she notes.

People who are very ill often are at the greatest risk of infection or having complications while in the hospital, Meier says.

“There’s the risk of medical error and the risk of hospital-acquired infection,” she adds. “So when you have serious and advanced chronic disease, an infection acquired in a hospital can be life-threatening.”

Research has shown that hospice care itself can

prolong life in congestive heart failure patients and among people with some types of cancer, Meier says.

Hospice care can positively impact patients' psychosocial well-being, social support, and mood/depression. Since palliative care provides some of the same pain relief and psychosocial support that hospice provides, it's likely this type of service also would have a positive emotional impact on patients.

"You can't separate the body and the mind," Meier says. "When people are incredibly stressed, anxious, and not sleeping, they die sooner."

These are all potential reasons for the beneficial outcomes of palliative care.

"I think it's important for ethics committees to not see palliative care as a means for people we've given up on," Meier says. "Palliative care helps people live longer, and ethics committees should be at the forefront of promoting early and widespread integration of fundamental palliative care principles."

Hospital ethics committees also might look at their health care institutions' policies and procedures to identify what's in place to promote the timely application of palliative care.

"Ethics boards should ensure the fundamental competencies of palliative care for front-line staff, including care managers, critical care doctors, oncologists, and other groups who take care of this 5% to 10% of the hospital population," Meier advises. "The staff should be encouraged to get additional training, skills, and expertise in palliative care."

Hospital staff can obtain checklists, policy templates, and other materials about palliative care from the website of the Center to Advance Palliative Care at www.capc.org.

There are referral checklist tools available for a free download, as well as a tool that offers suggested communication phrases in palliative care and guidance on how to respond to emotion.

"Ethics committees could see that hospitals have the checklist integrated into required care," she says.

At admission, nurses could find out whether patients have appointed surrogate decision-makers in the case of loss of capacity and ask whether the patient or family have any questions about what to expect regarding the illness, she adds.

"The screening list would be done by admitting nurses with a daily checklist done during work rounds by whoever is responsible for the patient,"

she says. "There would be continuous assessing for these issues."

SOURCE

• **Diane E. Meier, MD**, Director of Center to Advance Palliative Care, Mt. Sinai School of Medicine, New York, NY. Email: diane.meier@mssm.edu. ■

CME INSTRUCTIONS

Physicians participate in this continuing medical education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge.

To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity with the June issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a credit letter. When your evaluation is received, a credit letter will be mailed to you.

CME OBJECTIVES

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

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

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CME QUESTIONS

9. In a recent study of medical students and burnout, investigators found that approximately what percentage of students had burnout according to the Maslach Burnout Inventory?

- A. 24%
- B. 38%
- C. 53%
- D. 74%

10. When the Harvard Community Ethics Committee met to discuss palliative sedation, the committee wrote a report answering questions about this topic. Which of the following questions did the group address?

- A. What does the community understand when asked about palliative sedation?
- B. What sorts of patients would be appropriate for this treatment option?
- C. How do members of the committee feel about the distinction between palliative sedation, euthanasia, and physician-assisted suicide?
- D. All of the above

11. Which of the following is (or are) a good example(s) of a question to ask a patient who is from a different culture, according to a cultural awareness expert?

- A. Who helps you make decisions about health care for your child?
- B. Who else have you asked for help/advice about the problem?
- C. Would you like the lab results in writing or left on your telephone voice mail?
- D. Both A and B

12. True or False: Hospitals increasingly are adding palliative care programs because these help reduce the costs of caring for the sickest 5% to 10% of patients who otherwise might have long hospital stays and because palliative programs provide a better quality of life for patients.

- A. True
- B. False

Answers: 9. C; 10. D; 11. D; 12. A

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