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JANUARY 2015 Vol. 31, No. 1; p. 1-12

INSIDE

Study suggests policies empowering physicians not to offer CPR can protect patients from harm . . . . . cover

Global health inequity is an overlooked ethical concern with Ebola 3

Will bundled payment models incentivize undertreatment? . . . 5

Bioethicists share their own best practices to prevent end-of-life conflicts. 7

Updated position statement on feeding tubes in advanced dementia patients . . 9

What to do if physicians attempt to interfere with ethics consults. 10

AHC Media

Study: Physician CPR policy not disproportionately applied

Approach can "protect seriously ill patients from harm"

There is a long-standing concern that policies empowering physicians not to offer cardiopulmonary resuscitation (CPR) are disproportionately applied to vulnerable populations, including the elderly, the disabled, and racial or ethnic minorities. However, a study conducted at Massachusetts General Hospital in Boston suggests otherwise.[1]

"We found no evidence to support this concern at our hospital," says **Andrew Courtwright**, MD, PhD, the study's lead author. In 2007, the hospital's clinical ethics consultation committee introduced a "Do No Harm" policy. This permits not offering CPR in some circumstances, after careful exploration of the patient's values and medical situation.

Researchers examined case records from 2007 to 2013 and found 134 cases involving a disagreement over whether to offer CPR. They found no association between age, race, or functional status and a recommendation by the ethics committee not to offer CPR.

Other findings include the following:

EXECUTIVE SUMMARY

There is no evidence that a policy empowering physicians not to offer cardiopulmonary resuscitation (CPR) is disproportionately applied to vulnerable populations, according to a recent study.

- Researchers found no association between age, race, or functional status and a recommendation by an ethics committee not to offer CPR.
- CPR isn't always a reasonable treatment option in the context of the patient's values and illness.
- Patients often do not have a realistic sense of outcomes after CPR.

Financial Disclosure: Consulting Editor **Arthur R. Derse**, MD, JD, Executive Editor **Russ Underwood,** Associate Managing Editor **Jill Drachenberg,** and Contributing Editor **Stacey Kusterbeck** report no consultant, stockholder, speakers' bureau, research, or other financial relationships with companies having ties to this field of study.

MEDICAL ETHICS ADVISOR®

Medical Ethics Advisor®,
ISSN 0886-0653, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.

Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.
GST Registration Number: R128870672.

POSTMASTER: Send address changes to:
Medical Ethics Advisor
P.O. Box 550669
Atlanta, GA 30355.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
customerservice@ahcmedia.com.
www.ahcmedia.com
Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.- 4:30 p.m. Friday.

SUBSCRIPTION PRICES:
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• Orders to withhold CPR were more common among critically ill patients and were associated with high in-hospital and 90-day mortality.

• In about 25% of the cases the committee did not support the view of the clinicians, and instead recommended that CPR be offered.

• In 45 of the cases (33.6%), the patient or surrogate agreed to a Do Not Resuscitate (DNR) order after an initial ethics consultation.

"We concluded that a carefully formulated hospital policy on not offering CPR, combined with consultation from a clinical ethics committee, can simultaneously maximize respect for patients' values and protect seriously ill patients from harm at the end of their lives," says Courtwright, a physician at Massachusetts General Hospital's Institute for Patient Care.

At times, patients and surrogates request that CPR be provided in the event of cardiopulmonary arrest even when clinicians believe it would be non-beneficial, or more harmful than beneficial. "Little is known about the use and impact of policies that allow physicians to order CPR to be withheld in these circumstances," says Courtwright.

In the researchers' view, there are times when CPR is not a reasonable treatment option in the context of the patient's values and illness. For example, if a patient will die imminently from widespread, untreatable, metastatic cancer and resultant multi-organ system failure, and if exploration of the patient's values revealed no religious, cultural, or personal reason why CPR would be more beneficial than harmful in this situation, CPR would not be a reasonable treatment option.

"In this situation, we think the most ethical course is not to offer CPR and to compassionately explain why it will not be offered," Courtwright says.

As more numerous, complex, and powerful life-sustaining treatments become available, he says, it becomes increasingly important to determine carefully whether any treatment being considered for an individual patient has a reasonable chance of bringing more benefit than harm.

"These decisions can be complex," says Courtwright. "They require nuanced understanding of the patient's values and medical situation, as well as of the capabilities of the treatment in question."

In some cases, a DNR order might be appropriate even without surrogate consent, says **Thaddeus Mason Pope**, JD, PhD, director of the Health Law Institute and associate professor of law at Hamline University School of Law in Saint Paul, MN. "For some patients, CPR is very unlikely to work to restore pulse or to get the patient out of the ICU [intensive care unit]," he notes.

In Texas and Virginia, the ability to write a DNR without consent is a function of state law governing disputes over "appropriate" life-sustaining treatment. "But it is unclear what the clinical thresholds are for triggering a determination that CPR would be non-beneficial or inappropriate," says Pope. "There is high variability in practice."

Even if consent is not required, consultation usually is. "Clinicians should be open and transparent about what they are doing and why," says Pope. "The family should not 'discover' a DNR order on the chart." Recent cases in the U.S. and the United Kingdom have clarified the duty to consult.[2]

"A related issue, though separate from the issue of unilateral DNR orders, is the issue of defaults," says Pope. "This is less intrusive on

individual liberty." Even if it were determined that some populations of critically ill patients should be presumptively DNR, that would still leave them opportunity to opt into CPR.

"In other words, patients would have to opt into CPR, instead of opting out of CPR," Pope says. Recent research suggests this would ensure more patients get treatment consistent with their preferences and values.[3]

"But changing such a well-ingrained custom is going to be very, very hard," says Pope.

Unilateral DNR orders are "only one small example of problems with the way we talk about end-of-life care," says **Alana Sagin**, MD, an instructor for the Palliative Care Service at Hospital of the University of Pennsylvania in Philadelphia.

"When thinking about the topic of unilateral DNR orders, we really need to look at how we present CPR to people in general," says Sagin.

Disagreements between the medical team and the family or patient involving DNR orders and the appropriateness of CPR occur for many reasons. Unrealistic expectations are one.

"Television and other media often portray an overly optimistic depiction of outcomes after CPR," says Sagin. "Patients may not have a realistic sense of outcomes."

Other reasons for disagreements include lack of prognostic awareness, unresolved family conflicts, mistrust of the medical system, and difficulty coping with a poor prognosis. "Disagreements often arise because many physicians leave the patient and family to make the decision about CPR without much guidance," adds Sagin.

Patients and families wonder, "Why would my doctor offer this if it isn't a good idea?" "As physicians, we should make recommendations about CPR to our patients, just as we do with other medical interventions," says Sagin.

For instance, it's known that CPR outcomes are very poor in certain populations. "With our very sick patients, we probably should be recommending against CPR more often if it is unlikely to help them meet their goals," says Sagin.

On the other hand, if the goal is prolongation of life for any length of time and with any quality of life, CPR may be appropriate. "In any case, the discussion about CPR should take place within a larger discussion about the patient's general goals of care and prognosis," says Sagin.

With good communication and careful eliciting of patient values, the need for unilateral DNR enforcement is "very unlikely to be needed," says Sagin. "Ethics or palliative care consults can help to facilitate communication in these difficult cases, and help bring about a consensus."

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Global health inequity in Ebola treatment is major ethical concern

Bioethicists have important role to play

Much of the ethical debate involving Ebola has centered on whether healthcare workers should be quarantined, and how clinical trials should be run.

"There is less discussion about the ethical issues that really have to do with the global health situation," says **Mary Devereaux**, PhD, director of biomedical ethics seminars and assistant director of the research ethics program at The University

of California, San Diego. "Both for ethical and pragmatic reasons, the issue of inequity in global health is one that we need to address."

The Ebola epidemic spotlights the fact that there are parts of the world with completely inadequate public health infrastructure. "This is not going to be the last outbreak of some unexpected infectious disease. But until the effects of such outbreaks come to the U.S., people tend to be highly indifferent," says Devereaux. The lack of healthcare infrastructure in developing countries is the most fundamental ethical issue Devereaux sees with Ebola, but it remains to be seen whether long-term changes in international health policy will occur.

"If the Ebola epidemic occurred somewhere other than Africa, my guess is that we would have responded with more urgency," says Devereaux. "I think there is a racial and cultural dimension to this crisis that can get missed."

Bioethicists can shift the discussion to our ethical obligations to low-resource countries as members of a shared community.

"Even if you don't buy the ethical argument that we're all connected, the fight to contain Ebola does demonstrate that, in terms of infectious disease, we are all connected," says Devereaux.

Here are experts' other primary ethical concerns involving Ebola:

• Engaging the local population.

Ethical concerns involving prevention and treatment of Ebola mirror those surrounding other public health threats in developing countries. Involving the local population is one example.

"The central role of bioethicists is to make sure the conversation is grounded in the countries where the problem is, rather than conference centers in first world countries," says **Steven Miles**, MD, professor and Maas Family Endowed Chair in Bioethics at the University of Minnesota Medical School's Center for Bioethics in Minneapolis.

Miles saw great success using this approach to control neonatal tetanus at a refugee camp in Cambodia. "I found a sentence in an infectious disease textbook that said that Japan got rid of neonatal tetanus after WWII by changing cord care practices," he says. A midwife who spoke fluent Cambodian met with local midwives to discuss cord care.

During the lengthy discussion that ensued, it was discovered that many were comforting crying babies by grinding up wasp nests with contaminated ground water, and placing the mixture onto the infant's umbilical cord. "Since the cord was just cut, it was a fresh open wound, and they were inoculating the kid with clostridia," says Miles.

After the local midwives learned this practice was harmful, however, they stopped it. "Instantly, we saw a 90% drop in neonatal tetanus. The only cases we were seeing came from outside the camp," says Miles.

Finding a way to refrigerate tetanus vaccine was a costly, logistically difficult problem to solve. In contrast, a simple conversation "really changed the game on neonatal tetanus," says Miles.

The same is true regarding Ebola transmission, he notes, after local populations were educated on funeral and burial practices. "It's clear that that locally based measures regarding changing how bodies are prepared for funeral and how they're buried is the most cost-effective strategy to meeting the immediate needs of the epidemic," says Miles.

Researchers and health officials, Miles says, "should be very careful about not allowing our natural tendency to think about prevention, particularly in relation to innovative drugs, to divert resources away from highly effective strategies that can be applied now at the village and township levels."

• Challenges in obtaining informed consent.

Informed consent is a central ethical issue involving clinical trials for an Ebola vaccine, according to **Donald P. Owens**, Jr., PhD, James A. Knight, MD Chair of Humanities and Ethics in Medicine Chaplain at Tulane University School of Medicine in New Orleans.

"It is imperative that those involved with the design of the clinical trials take time to fully educate the patients involved in the trials, both pros and cons," says Owens. This will involve speaking in terms that can be readily understood by the patients and their families.

"Without this informed consent, patient compliance will be compromised," says Owens.

• The poverty of the affected

EXECUTIVE SUMMARY

Ethical concerns involving prevention and treatment of Ebola mirror those surrounding other public health threats in developing countries. Experts' concerns include:

- There is a need to involve local populations in solutions.
- Vaccines and treatments must be accessible to the local population.
- Long-term changes in international health policy are needed to address future outbreaks in countries with inadequate public health infrastructure.

population must be considered, Devereaux says.

"International aid workers don't want to do anything that appears to be lowering ethical standards because people are in less developed parts of the world," Devereaux explains.

• Some argue it's unethical for experimental Ebola treatments to be given in randomized, controlled trials, since this requires that some patients not get the experimental treatment.

"The argument in favor of randomized, controlled trials is the usual scientific and ethical one," Devereaux says. "We have a research design that is familiar and tested and gives us rigorous results."

The ethical challenge in using randomized trials is that there doesn't appear to be clinical equipoise — a situation in which researchers have no reason to think one treatment better than another, or better than no intervention at all.

"I'm not sure we have clinical equipoise in the case of Ebola — certainly not in the setting of countries like Sierra Leone, where mortality is 50% or higher," Devereaux says.

Researchers may have reason to believe that a given intervention has been protective or has improved the odds for people already infected with Ebola. In this case, if patients are informed and fully aware that they're being offered an experimental vaccine or treatment, says Devereaux, "it seems to me, then, that there may be an argument against the standard of randomized controlled trials."

Many healthcare workers, for instance, were given blood products from recovered Ebola patients. "Some argue that since the death rate is higher, you can do things that are riskier," says Devereaux. "However, we need to be careful that we don't lower the bar for consent or rigorous trial design and data collection."

• Treatments must be accessible to the local population, Miles says.

A primary ethical concern with research projects conducted in low-resource countries, says Miles, "is that that we tend to price the resulting products at a level that those countries can't afford."

According to guidelines from the Council for International Organizations of Medical Sciences, research projects in low-resource countries should ensure that "any product developed is made reasonably available to them, and as far as possible leave the population in a better position."[1]

"In the case of Ebola, which is highly localized in extremely poor countries, the idea that one would develop a vaccine that would charge first world rates is not an acceptable strategy," Miles says.

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Will bundled payment models incentivize undertreatment?

Bioethicists can help guide institutions

New bundled payment models included in the Affordable Care Act (ACA), which assign a fixed, negotiated fee to cover a set of treatment services, are expected to reduce overall healthcare expenditures.

"Bundling, however, is not entirely benign," says **Jason Morrow**, MD, PhD, a palliative care specialist on the faculty of the Center for Medical Humanities & Ethics, part of the School of Medicine at the University of Texas Health Science Center at San Antonio.

One reason is that bundled payments have the potential to incentivize undertreatment. "A shift towards accountability and value-based purchasing offers a potential ethical remedy," says Morrow.

Rewarding health systems that are reimbursed through bundled payments and achieve meaningful population-level outcomes is "a powerful way to align marketplace incentives with the overall mission of healthcare, which is to improve the health and productivity of our at-large population," says Morrow.

There is an inherent conflict between any for-profit insurance system and good medical care, says **Neil J. Farber**, MD, FACP, professor of clinical medicine at the University of California, San Diego. "Yes, they need to keep costs down and make a profit," he says. "But you can't withhold medical care from patients to keep down costs."

It's not difficult to imagine physicians feeling pressure from plan administrators to reduce the number of costly diagnostic tests ordered. "Physicians need to resist that pressure," says Farber. "You can't restrict tests simply because it's expensive to the ACO [accountable care organization]. That is not acceptable."

Some patients with high-deductible plans are likely to delay seeking medical treatment. "This would certainly diminish the potential health benefits of having mandatory insurance," says Morrow. "But a high-deductible plan is better than no plan."

To make care more affordable for the likely ill, Health Insurance Marketplace plans are charging higher premiums for the likely well, says **Paul T. Menzel**, PhD, professor of philosophy emeritus at Pacific Lutheran University in Tacoma, and affiliate professor of bioethics and humanities at University of Washington in Seattle.

"When you are putting everybody in the same pool, you have to split the cost," he explains. Thus, some people pay more in order to cover individuals who would otherwise be priced out of the insurance market by their high-risk status. "You can't have it both ways," says Menzel. "You either have to subscribe to the 'common pool' idea, or you have to put more tax subsidy into it."

The underlying ethical conviction to cost-sharing is that those who are well need to share the burden of those who are ill.

"If you don't prohibit plans from dropping people who start incurring costs, you will have terrible cases of medical bankruptcy," says Menzel. "A frighteningly high percentage of bankruptcy cases in any given year are from medical expenses."

Morrow believes the potential shortcomings of the ACA are no worse than the shortcomings of the previous system.

"If our country is going to continue to rely on an insurance model for healthcare coverage — a model that has historically struggled to accommodate high-risk or high-cost pools — then universal coverage is the most ethically sound and cost-effective strategy," says Morrow.

This means some people will be at a financial disadvantage. "But we are a better society to have made some significant attempt to reduce the number of uninsured," says Menzel.

Bring issue to forefront

Potentially unethical practices involving new payment models won't come up during ethics consults. "These are sort of 'hidden' ethical issues, if you will," says Farber. In order to call attention to these, bioethicists can first familiarize themselves so they can speak with authority to physicians and administrators.

"There are white papers on the ethical traps involved [in the new payment models]," says Farber.[1,2] Bioethicists can also cover the topic during grand rounds. "An ethicist in a healthcare concern has to be independent from any kind of pressure — that is the sine qua non of an ethicist," says Farber. "They have to feel free to bring up these kinds of issues to help guide the institution."

Bioethicists can continue to articulate the ethical imperatives at stake in healthcare delivery and consumption, says Morrow, "and, importantly, persuade clinicians, local leaders, and even consumers."

EXECUTIVE SUMMARY

Bundled payments aim to contain healthcare costs, but some say this new payment model has the potential to incentivize undertreatment. Other ethical concerns resulting from the Affordable Care Act include the following:

- Some patients are paying higher premiums to cover the cost of care for others.
- Physicians may feel pressured to reduce the number of costly diagnostic tests ordered.
- Individuals with high-deductible plans may delay seeking medical treatment.

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Good communication can prevent end-of-life conflicts

Early involvement with palliative care is key

When ethics consults are called involving end-of-life care conflicts, real differences in values are sometimes the cause, such as a family member insisting that the patient would want to live at all costs.

"But these are in the minority," says **Edwin Forman**, MD, a professor of pediatrics in the division of pediatric hematology/oncology at Icahn School of Medicine at Mount Sinai in New York City.

In Forman's experience, the vast majority of conflicts are rooted in poor communication between providers and the patient or family. "Involving palliative care from the beginning can avoid conflict," he says.

At University of California, Davis Health System, challenging cases are identified during ethics and palliative care rounds in the intensive care unit (ICU).

"Approaches to patients, or more often families, are formulated for reframing the goals of care in a manner consistent with the patient's prognosis and personal values, when known," says **Ben A. Rich**, JD, PhD, professor and School of Medicine Alumni Association Endowed Chair of Bioethics at UC Davis Health System.

This approach has the potential to ameliorate conflicts between clinicians and families. "The focus of such rounds is as much about communication strategies as it is clinical considerations or governing ethical principles," says Rich.

Forman gives examples of poor communication that can lead to conflicts:

• Providers aren't clear about the patient's prognosis.

"They are reluctant to take away a family's hope. Often, the prognosis is not made clear early enough," says Forman.

Some families don't realize that while a treatment might improve one aspect of the patient's condition, this doesn't mean it should be offered to a patient with multiple life-threatening conditions.

"The treatment might improve heart failure, but it isn't going to improve the liver or kidney. So the ultimate goal of survival is not reachable," says Forman.

In such cases, says Forman, providers should never say, "There is nothing more we can do."

"There is always treatment. But the treatment involves palliative care," says Forman. Palliative care might comprise 10% of the patient's care in the early stages of illness and increase to 90% or even 100% later, he adds.

• Providers often put off difficult conversations.

"If the provider suddenly appears and says, 'We really should stop therapy,' you run into intractable

EXECUTIVE SUMMARY

Poor communication between providers and the patient or family is the underlying reason for many ethics consults involving conflicts over end-of-life care.

- Bioethicists can identify challenging cases early in their development.
- Providers can ask open-ended questions and make the prognosis clear.
- Both disease-directed and palliative measures should be provided simultaneously where appropriate, experts say.

problems," says Forman. "Once you are in conflict, it's very hard to try to mend that. It's better to prevent conflict than to try to manage it."

To do this, Forman recommends asking open-ended questions such as "What are your goals and why do you have them?" This conveys that the physician is competent and caring.

"Out of that comes a relationship which provides trust. Then when the hard days come, they are going to listen to you," says Forman.

• Providers don't always listen to the family's concerns.

"A lot of family members say, 'When we meet with the doctor, he talks 90% of the time,'" says Forman. In cases where there is a conflict over discontinuing treatment, he suggests providers keep the discussion going by stating, "Let's keep talking. Maybe you'll convince me, but maybe I can help you move on."

"If after that, resolution hasn't been accomplished, explain to them they have the right to transfer the patient's care to a willing and competent provider," says Forman. At many institutions, if no other hospital will accept the patient, the provider can go to the chairman of the department and if he or she agrees with the provider's position, care can be discontinued.

"But it rarely gets that far," says Forman. "Some hospitals have had that plan in place for a decade and never used it. It leaves the family with a bad memory."

The more sophisticated critical care has become, says Rich, the more difficult it is for clinicians to either discern that a patient is dying or accurately prognosticate which patients will survive the hospitalization and which ones will not.

"The obsessive focus on artificially maintained vital signs as evidence that the patient is neither dead nor dying poses major problems," he adds.

When the patient enters the critical care setting and a host of therapies are introduced in the hope of reversing or remediating the patient's disease or injury, the family typically views this as appropriately aggressive medical treatment.

"However, in those unfortunate circumstances in which the therapies do not work and the patient continues to decline despite all of these measures, critical care physicians naturally begin to discuss why discontinuation of these measures is now medically appropriate," says Rich.

> "OUT OF THAT COMES A RELATIONSHIP WHICH PROVIDES TRUST. THEN WHEN THE HARD DAYS COME, THEY ARE GOING TO LISTEN TO YOU."

Providers might explain that goals of care are shifting to allow the patient to experience a peaceful death unencumbered with superfluous and burdensome technology.

"Not infrequently, at this point some families will push back and charge the physicians with 'playing God,'" says Rich. He points to the 1995 Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), which found substantial shortcomings in care for seriously ill hospitalized adults.[1]

"I have seen no compelling evidence that in the intervening 20 years we have become markedly improved in our practices," says Rich. There are serious deficiencies in even the most distinguished academic medical centers, he adds, with regard to communication about patient values and preferences, the goals of care, and the relief of patient distress.

"This is despite a voluminous literature on strategies for bringing about such improvement," says Rich. The principal investigators for the SUPPORT study recommended that critical care physicians ask themselves, "Would I be surprised if this patient died within the next two weeks?" If the answer is no, then both disease-directed and palliative measures should be provided simultaneously.

"This ensures that at the very least, dying in the ICU is not routinely characterized by pain and suffering," says Rich.

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Updated position statement on feeding tubes in advanced dementia patients

Assisted oral feeding is preferred approach

Once persistent eating difficulties arise in a patient with advanced dementia, caregivers are confronted with a heart-wrenching decision: Should a feeding tube be placed?

"Naturally, people want their family members to be comfortable. From the beginning of life, we have learned to associate food with comfort and nurturing," says **Caroline A. Vitale**, MD, AGSF, director of the Geriatric Medicine Fellowship Program at the University of Michigan Health System in Ann Arbor.

It would be logical to assume that the nutrients provided by artificial feeding would increase comfort, energy levels and even length of life. "However, for older people with advanced dementia, this type of feeding can often have the opposite of the desired effect," says Vitale.

In fact, research shows that feeding tubes can be associated with agitation, ileus, increased propensity for emergency department visits due to tube malfunction, increased risk of pressure ulcers, and increased use of physical and chemical restraints, without improving functional status or quality of life.[1,2]

In light of this growing body of evidence, The American Geriatrics Society (AGS) released an updated position statement in July 2014 on the use of feeding tubes in advanced dementia patients.[3] "The statement advocates for careful assisted oral feeding as tolerated, as the preferred approach in patients with advanced dementia," says Vitale, vice chair of the AGS' Ethics Committee.

The position statement was first published in 1993, and updated in 2005. "This time, our efforts were focused on updating this same position statement to reflect the publication of several recent studies elucidating the disease trajectory of advanced dementia and detailing treatment burdens associated with tube feeding in such patients," says Vitale.

There is a growing acceptance of palliative approaches to care in non-cancer conditions with poor prognoses, including advanced dementia. "Overall, the AGS position statement advocates for a palliative approach to care when eating problems arise in patients with advanced dementia," says Vitale.

Autonomy is concern

Any aggressive nutrition intervention requires the practitioner to consider two important principles, says **Ronni Chernoff**, PhD, RD, FADA, director of the Arkansas Geriatric Education Center and professor in the Reynolds Department of Geriatrics at University of Arkansas for Medical Sciences in Little Rock. These are, "First, do no harm," and, "What would the patient want?"

"It appears that dementia patients do well when hand-fed. But that is time-consuming and labor-intensive," says Chernoff.

Technology has made it easier to use feeding tubes. "We know that about one-third of U.S. nursing home residents with advanced dementia have them," says Vitale.

Clear objectives should be determined before instituting tube feedings for any patients, says Chernoff, but particularly in patients with advanced dementia who may be impaired in their ability to express their wishes.

"Not only is it hard to see what benefits are derived from artificially feeding terminally demented patients, but the risks associated with tube feeding might make it somewhat dangerous," she adds.

Perhaps the greatest ethical consideration is the principle of autonomy, says Chernoff. Decisions about nutrition and hydration

EXECUTIVE SUMMARY

In light of multiple recent studies linking feeding tubes in patients with advanced dementia with numerous treatment burdens and complications, the American Geriatrics Society released an updated position statement in July 2014 on this practice. According to the statement and studies:

- Feeding tubes are associated with agitation and pressure ulcers.
- Feeding tubes have not been shown to improve functional status.
- The statement advocates for assisted oral feeding as tolerated.

are legally considered medical interventions, as are other life support methods, and should be based on patient preferences.

"Every effort must be made to uncover what the patient would want," says Chernoff.

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Is physician interfering with ethics consult? Determine his or her intention

Bioethicist must remain neutral, non-judgmental

Amy M. VanDyke, MSW, PhD, vividly recalls a particular ethics consult that occurred years ago, because of the attending physician's unpleasant response.

The consult involved a patient who lacked decision-making capacity, with no readily available surrogate decision-maker. "The attending had been unilaterally making non-emergency treatment decisions because it was for 'the patient's health,'" she recalls

One of the patient's nurses requested an ethics consult, believing that the physician's actions were unethical and in violation of a hospital policy.

"The physician made it very clear that she did not wish to have the assistance of ethics in any form, because she was the attending and knew what was best for her patient," says VanDyke, now medical bioethics director at Kaiser Permanente West Los Angeles Medical Center.

The attending physician publicly accused the nurse of being insubordinate. "It was a very confrontational situation overall," says VanDyke.

Attempts to squelch or divert ethical discussion can come up in many forms, some more difficult to manage than others. "Not all attempts to impede ethical discussion are the same. Intentionality is very important," says VanDyke. Here are some reasons that physicians may try to impede ethical discussions, she says:

• Physicians don't want to slow down the clinical process.

VanDyke once got an unpleasant response from a physician, with whom she'd had a solid working relationship for years, because an ethics consult was requested.

"He made a face at me and said something to the effect of, 'Great, I guess I will be here for another several hours till you get done doing your ethics stuff. Then I can finally finish up with the patient's discharge,'" says VanDyke.

The physician clearly saw ethics as an unwelcome intrusion. "I couldn't disagree with him that the ethical discussion which needed to take place would likely slow him down a bit that day," says VanDyke. "It all turned out fine for the patient in the end."

EXECUTIVE SUMMARY

Physicians or other healthcare professionals occasionally try to impede ethical discussions for a variety of reasons. Some approaches experts recommend include:

- Inform the individual that the process will occur with or without their participation.
- Ask the department chief to explain the importance of the process.
- Respect the primacy of the clinician-patient relationship.

If physicians display this attitude, VanDyke advises stating, "I hope that you will actively participate in this process, but you can choose not to. If you choose not to, the ethics consultation will still happen, it will just happen without your input. Your choice and reasons for abstaining from the process will be noted in the ethics consultation."

Sometimes, this is enough to get a reluctant physician to participate.

"If not, it may be important to have recourse to the department chief, who can explain the importance of the process and the involvement of all parties," says VanDyke.

• Physicians may view an ethics consult as an indication they aren't providing good care.

"Generally, all orders go through the attending physician — except this one particular kind of consult, which is out of their control," says **Mathew David Pauley**, JD, MA, MDR, director of medical bioethics for Kaiser Permanente, San Bernardino County Service Area in Fontana, CA.

In this situation, it can be helpful to remind the physician that ethics is a consultative service. "Like other services, the attending can choose to disregard what is written in the recommendations of an ethics consult," says VanDyke.

Bioethicists need to be careful to remain neutral. "An ethics consultation interference can also make the ethics consultant defensive and positional — 'Don't you know that you can't cancel ethics consults, doc?'" says Pauley.

Recently, a physician became upset because a social worker called an ethics consult to determine who the appropriate surrogate was for a patient.

"My initial reaction was to point out what the policy says — that anyone can request an ethics consult, and that attendings do not need to give permission," Pauley says. Instead, Pauley reminded himself that such resistance "is likely an indicator of lack of trust, uncertainty, and ultimately vulnerability, on the physician's side."

It also helps to bear in mind that only very rarely is a physician acting irresponsibly or without a desire to do good for the patient. "They are human beings struggling with this as well," says Pauley.

• Physicians may want to continue with more aggressive treatment because they believe it will help the patient.

"If the physician feels they can get the patient out of their current condition, they may fear that ethics will come in and convince everybody that the patient should be allowed to die," says Pauley. In this scenario, the physician takes on a patient advocate role in their mind.

This can be very difficult to confront because physicians sometimes don't see their own personal bias, says VanDyke, "and even if they do, they may wrongly believe they can impose their values, citing a lack of futility of the treatment."

Things become more difficult if the ethicist practices in a system where the balance of power is skewed in favor of physicians as the primary moral arbiters.

"In essence, in these facilities the doc holds the moral power," says VanDyke. "The moral agency of other healthcare professionals is not as readily recognized."

• Physicians may perceive that clinical ethics consultants are subjugating the doctor-patient relationship or overriding clinical decision-making.

In order to preserve the trust and respect of the involved parties, ethics consultants should be ever-mindful to respect the primacy of the clinician-patient relationship, says **Andrew G. Shuman**, MD, assistant professor at the Center for Bioethics and Social Sciences in Medicine at University of Michigan Medical School in Ann Arbor.

"It behooves ethics consultants to remain non-judgmental and respectful of the intentions and motivations of the involved protagonists, whenever possible," says Shuman.

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CME QUESTIONS

1. What did a recent study find regarding a policy empowering physicians not to offer cardiopulmonary resuscitation (CPR)?

A. The policy was disproportionately applied to vulnerable populations.
B. Researchers found no association between patients' age, race, or functional status and a recommendation by the ethics committee not to offer CPR.
C. Recommendations by the ethics committee not to offer CPR were closely associated with the patient's functional status.
D. There was no association between orders to withhold CPR and high in-hospital and 90-day mortality.

2. Which is an ethical concern involving bundled payment models, according to Neil J. Farber, MD, FACP?

A. Bundled payments have the potential to incentivize overtreatment.
B. Physicians will face increasing pressure to order unnecessary diagnostic tests.
C. Physicians may feel pressure not to order costly diagnostic tests.
D. Physicians no longer have any reason to consider the cost of treatments or tests.

3. What does the American Geriatrics Society's updated position statement say regarding feeding tubes in patients with advanced dementia?

A. Assisted oral feeding as tolerated is the recommended approach.
B. Feeding tubes have been shown to improve the patient's functional status.
C. There is no evidence that feeding tubes are linked to pressure ulcers.
D. Feeding tubes should be routinely used to improve quality of life.

4. Which is recommended if physicians interfere with ethics consults, according to Amy M. VanDyke, MSW, PhD?

A. Policies should state that only physicians are allowed to request ethics consults.
B. Attending physicians should be allowed to cancel ethics consults called by other caregivers.
C. Bioethicists should inform physicians that if they don't participate in the process, the consult will be cancelled.
D. Bioethicists should inform physicians that the consult will occur with or without their participation.

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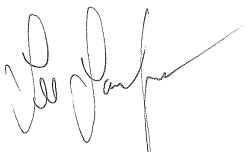

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