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Hospitals Sued for Wrongful Prolongation of Life: Ethicists Offer Unique Expertise

A patient completes an advance directive specifically to avoid aggressive care; nevertheless, that patient is resuscitated and put on a ventilator. In addition to the obvious ethical concerns of such cases, hospitals also face potential legal repercussions for failing to follow advance directives.

“The growing threat of liability for value-discordant care illustrates how clinical ethics consultation advances not only improve patient care but also advance risk management and compliance objectives,” says **Thaddeus Mason Pope**, JD, PhD, HEC-C, professor of law at Mitchell Hamline School of Law in St. Paul, MN.

There are a growing number of successful wrongful prolongation of life lawsuits.^{1,2} “The point of the litigation is it’s a medical error to provide too much treatment, just as it is to provide too little treatment. If it’s clear they didn’t want it, then you shouldn’t provide it,” Pope says.

Wrongful prolongation of life lawsuits are proliferating in part because

more people have created advance directives and also because of outreach efforts to promote physician orders for life-sustaining treatment (POLST) forms. More people are aware they can control their end-of-life care. “This has really sunk into the public consciousness,” Pope observes. “It’s perceived, in 2021, as a real violation of rights that might not have been perceived that way 10 years ago.”

Recent successful lawsuits also have received significant media attention.³ All this means more families in this situation are consulting attorneys — and more attorneys are agreeing to pursue claims. “Plaintiff attorneys now have more confidence that there will actually be a judgment, settlement, or verdict of a size large enough to make it worth their time and effort,” Pope notes.

If an advance directive is disregarded, family members “are pursuing these cases now with vigor,” says **Samuel D. Hodge, Jr.**, JD, a professor of legal studies at Temple University.⁴ When wrongful prolongation of life cases first

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occurred, courts ruled in favor of medical providers, reasoning that no cause of action existed.⁵⁻¹⁰ That has changed in recent years, with courts allowing the cases to proceed and for some type of remedy.¹¹⁻¹⁵ “From an ethical point of view, a patient has the right to decide their end-of-life treatment, and that decision must be respected,” Hodge says.

Physicians, primarily focused on saving lives, do not always consider the legal implications of their actions, which may be contrary to the wishes of the patient. To avoid conflicts that can end up in court, ethicists can act as a liaison between the physician and the patient’s family. “If the physician does not understand the legal implications of his or her actions in prolonging life, an ethical or philosophical approach might be more successful,” Hodge suggests.

Somewhere along the line, healthcare providers might fail to honor patients’ expressed wishes. Here are some reasons it happens:

- **Most people have not created an advance directive.** The patient might have verbally expressed end-of-life wishes at some point to a surrogate or clinician, but never actually followed through and completed the advance directive in writing. “They are likely to get treatment that they don’t want,” Pope says.

- **Even if the patient did complete an advance directive, it might be lost.** Patients may give the advance directive to a healthcare provider, but somehow it is never entered in the system. “That is a systems communications problem,” Pope notes.

- **Some clinicians erroneously assume if there is an advance directive, it means the patient is DNR.** “That is a training issue,” Pope offers.

- **Even if advance directives are in the chart, the document could be too vague to provide specific guidance.** “Assuming we get past all of that, at that point there can still be problems,” Pope laments.

When the situation appears to be in hand, some surrogates disagree with the directive and provide contradictory instructions. In that situation, says Pope, “generally, clinicians will follow the surrogate. The surrogate is a human and they’re yelling, whereas the advance directive is just a document.”

No healthcare agent or surrogate can contradict the advance directive. “Unfortunately, the mere threat of a suit is sufficient to scare clinicians because they are afraid of not only liability but also of litigation itself,” Pope explains.

In other cases, a clinician disagrees with the patient’s expressed wishes. “Sometimes, it’s paternalism. The clinician may say, ‘Let’s go ahead and do it now, we can always undo it later,’” Pope reports.

Clinicians may reason life-sustaining treatment can be reversed, whereas withdrawing or withholding it is permanent. “That’s a fair judgment call to make when you are honestly unclear, and there’s a gray and fuzzy situation on whether the advance directive applies to the situation or what it means,” Pope admits. However, the situation is completely different if there is a clear advance directive, a POLST, and a surrogate all saying in unison not to intubate the patient. In that kind of case, clinicians have no grounds to intubate. “When there’s a conflict, typically, advance directives lean toward declining treatment, and surrogates lean toward demanding treatment,” Pope notes.

Ethicists can help by reminding clinicians of the appropriate

standards for healthcare decision-making and of the relevant decision-making standards for incapacitated patients. Usually, these standards are not up for debate. “There is generally a really well-settled set of rules baked into the law and probably into their own institutional policies,” Pope says.

There are situations when the patient’s surrogate decision-maker is reluctant to assume the responsibilities he or she has been given, even after agreeing to serve in this capacity. “The legally authorized proxy may be in conflict with other family members, making it difficult to reach a decision,” says **Robert S. Olick**, JD, PhD, associate professor emeritus of bioethics and humanities at SUNY Upstate Medical University in Syracuse, NY. “In rare cases, the proxy may act from self-interest.”

A clear-cut example of this would be someone insisting on prolonging aggressive treatment to continue collecting Social Security benefits, even though the patient’s wishes are to refuse life support. It also is problematic if the patient made statements that contradict what is in the advance directive. “There may be uncertainty about whether the patient’s current circumstances fit with those the directive tried to anticipate and provide for,” Olick says.

New treatment options might have become available since the directive was written. “A careful consideration of the patient’s wishes, beyond the written document, is called for,” Olick says.

When the patient’s life is wrongfully prolonged for only a short time, and families have time to grieve, they are less likely to seek damages later, according to Olick. Also, the behavior of the hospital and healthcare team are critical. “When families feel respected and

supported, even in the face of serious disagreement, they are less likely to look to the courts,” Olick offers.

Courts can be called on to intervene and resolve disputes about whether to withdraw life support before the decision is made. For example, the proxy might be making decisions that appear to conflict with the patient’s advance directive. “These cases are typically focused on a declaration of rights, on who has the ultimate voice in the decision, and whether the advance directive, if there is one, must be honored,” Olick explains.

To prevent conflicts, Hodge says ethicists should emphasize to clinicians how important it is, both from a moral and legal point of view, to honor patients’ end-of-life decisions. “One should not wait until the decision is at hand to talk about the problem. At that point, emotions are running high and logic may not prevail,” Hodge stresses.

Advance directives are critical tools to allow people to exercise autonomy and should be respected in most cases. “But they are imperfect instruments. A common misconception is that advance directives are binding documents that should simply be followed,” Olick says.

In reality, advance directives are designed to anticipate a future state of serious illness and disease and medical conditions in which the patient would want life support withdrawn or withheld. Ethics consultants can help interpret advance directives and mediate family disagreements. “But the ethics consultant’s role is advisory only. Decisional authority resides in the patient-proxy-physician relationship,” Olick cautions.

Proxies often are the preferred approach to advance care planning. That is because the proxy can apply personal knowledge of the patient’s

values and wishes to the current medical circumstances to make the best possible decision. “The proxy stands in the shoes of the patient and engages in an informed consent dialogue,” Olick adds. ■

REFERENCES

1. *Lanzetta v. Montefiore Med. Ctr.* (Bronx Sup Ct NY, Feb. 2021).
2. *Greenberg v. Montefiore Hosp.* (Bronx Sup Ct NY, Feb. 5, 2021).
3. Span P. Filing suit for ‘wrongful life.’ *The New York Times*. Updated Jan. 26, 2021. <http://nyti.ms/3l2htHf>
4. Hodge SD. Wrongful prolongation of life — A cause of action that may have finally moved into the mainstream. *Quinnipiac Law Review* 2019;37:167-198.
5. *Anderson v. St. Francis-St. George Hosp.*, 671 N.E.2d 225 (Ohio, 1996).
6. *Allore v. Flower Hosp.*, 699 N.E.2d 560 (Ohio Ct App, 1997).
7. *Wright v. Johns Hopkins Health Sys. Corp.*, 728 A.2d 166 (MD, 1999).
8. *Taylor v. Muncie Med. Inv’rs*, 727 N.E.2d 466 (Ind Ct App, 2000).
9. *Scheible v. Joseph L. Morse Geriatric Ctr., Inc.*, 988 So. 2d 1130 (Fla Dist Ct App, 2008).
10. *Cronin v. Jamaica Hosp. Med. Ctr.*, 875 N.Y.S.2d 222 (NY App Div, 2009).
11. *Doctors Hosp. of Augusta, LLC v. Alicea*, 788 S.E.2d 392 (GA, 2016).
12. *Complaint at 2, Weisman v. Md. Gen. Hosp., Inc.*, No. 24-C-16-004199 (Baltimore City Cir Ct, July 25, 2016).
13. *Koerner v. Bhatt*, No. L-002983-13 (NJ Super Ct Law Div, Morris Cty, 2017).
14. Pope TM. Legal briefing: New penalties for disregarding advance directives and DNR orders. *J Clin Ethics* 2017;28:74-81.
15. Pope TM. Clinicians may not administer life-sustaining treatment without consent: Civil, criminal, and disciplinary sanctions. *J Health Biomed Law* 2013;9:213-296.

'Blatant Wrongdoing': Wrongful Prolongation of Life Cases Surge

What is behind the recent uptick in allegations of wrongful prolongation of life? **Ryan R. Nash**, MD, MA, director of The Ohio State University Center for Bioethics and the chair in medical ethics and professionalism, has served as an expert witness on multiple wrongful prolongation of life cases. Nash also has advised health systems on how to avoid these cases. He talked with *Medical Ethics Advisor (MEA)* recently about this subject. (*Editor's Note: This transcript has been lightly edited for length, clarity, and style.*)

MEA: What is the outcome of the cases you have reviewed?

Nash: Most of the cases are settled out of court because it is just blatant wrongdoing. Some of the cases do end up going to court. The plaintiff always wins, in my experience, because it is so obviously malpractice.

MEA: What leads to a lawsuit?

Nash: In 100% of the cases I have reviewed, the critical distinguishing factor is that resuscitation was refused in advance, it was known, it was communicated, and the hospital medical teams failed to honor that refusal. Almost always, they refused to do that based on a failure of their own system. It is a failure of communication, a failure to read the chart, or a failure to put the right order in. In one case, a 92-year-old hospice patient was brought to the ED. The exhausted daughter gave the advance directive and DNR form and says, "Mom is on hospice and is having a lot of symptoms we couldn't control at home. Don't do anything without contacting me." She comes back, and all of a sudden mom is in the ICU on a ventilator and had procedures done. This is an obvious case of failing to respect the patient's wishes. In the chart, it

clearly stated "Patient is on hospice, is here for symptom management, no aggressive measures." But someone messed up. Then, you can have someone come in with heart disease who asks to be DNR in the chart. The DNR order is put in the chart, the wristband is on, the patient is found unresponsive. They call a code, they resuscitate. Eventually, they notice the DNR bracelet and ask, "Did we do the right thing?" No, they did not. In several of these cases, the patient or their proxy made it abundantly clear they did not want resuscitative measures. The team failed to follow their own hospital's protocols. In a lot of hospital protocols, if a code is called, someone immediately is supposed to confirm code status. When that is not followed, they are violating their own policy and violating the standard of care.

MEA: What are the central ethical issues involved in these cases?

Nash: The respect of self-determination and advance refusal. In none of the cases I'm aware of was it a gray matter. It was clearly communicated that the person refused the intervention, usually resuscitation. The hospital will always try to say, "We always err on the side of life." That does not cover our willful negligence to ignore refusals. When someone has refused an intervention in advance and you do it anyway, that could be considered assault. If you ignore that wristband, or ignore the DNR, or ignore the documentation of advance planning in the chart, it is a failure to respect an informed refusal. In medical ethics, the right to refuse is the bedrock of the informed consent process. Just as we should never be doing surgery on the wrong side,

or giving the wrong medication, or giving the wrong dose, we should never fail to honor a DNR that is known.

MEA: What can ethicists do to prevent these situations?

Nash: I would really encourage ethicists to get to know their legal and risk people well, and have a conversation around this. People need to be aware that it clearly violates medical ethics standards. Ethicists also need to confirm that their institution not only has best practice policies and procedures, but to diligently and repeatedly work to make sure that staff are educated and empowered to follow them.

MEA: What do the families in these cases usually want?

Nash: When you are a family member who is grieving, and you know your loved one did not want this, and that the hospital did this to them and you could not protect them, it is very painful. It changes lives. People have to leave their jobs to care for the family member. There are financial consequences.

But the families usually do not want much. They usually just want an apology and medical bills covered, and then they want some reassurance that this will not happen to anybody else. These usually are not litigious people. I have just been surprised at how many times when the initial ask is a small, modest ask. Amazingly, in some of these cases, when the hospitals or physician digs in and starts fighting it, they usually end up paying far more because of all the needless legal costs. I do not want to see any more of these cases. They should not happen. When they do, it should be obvious to hospitals that they are in the wrong. ■

Survey Reveals Widespread Discrimination in Healthcare

Almost one-quarter of U.S. adults have experienced some type of discrimination while seeking medical care, according to the results of a study.¹ Most commonly, it was racial/ethnic discrimination.

“The prevalence of racial discrimination in the U.S. healthcare system is stark,” says **Paige Nong**, the study’s lead author and a PhD student in the department of health management and policy at the University of Michigan School of Public Health. “This is not surprising, given what we know about racism in the U.S. But it does highlight the urgent need for response in the healthcare system.”

Nong and colleagues surveyed 2,137 U.S. adults. Of the group that indicated they had experienced discrimination in healthcare, 72% said it happened more than once.

In addition to racial/ethnic discrimination, respondents reported discrimination based on education, income level, weight, sex, and age. “Our findings add to the larger picture of the role of racism and other types of discrimination in healthcare, with multiple implications for future work,” Nong reports.

Nong says researchers and ethicists play a major role in applying

methodological and theoretical tools to respond effectively to discrimination in healthcare.

“Hospitals can also apply our findings by understanding how discrimination is operating in their own systems at the organizational level, intervening and dedicating resources to support patients,” Nong adds. ■

REFERENCE

1. Nong P, Raj M, Creary M, et al. Patient-reported experiences of discrimination in the U.S. health care system. *JAMA Netw Open* 2020;3:e2029650.

Palliative Care Integrated into Critical Care Settings, Including EDs

There is growing momentum toward incorporating palliative care services into the ED. Virtually all ED clinicians reported an overall positive perception to embedded palliative care, according to one analysis.¹

Of 101 ED clinicians surveyed, 98% believed including palliative care in the ED was valuable or very valuable.

“The ED is not the optimal place to have discussions about advance care planning or end-of-life care. But, often, patients and families are forced to confront these issues when emergencies strike,” says **Elizabeth Clayborne**, MD, MA, an adjunct assistant professor at University of Maryland School of Medicine.

At times, physicians are not well-equipped to provide quality palliative care in the ED. “This results in poor patient outcomes that do not address

palliative care needs,” Clayborne laments.

Although palliative care is integral to providing quality care, in the ED the focus tends to be on aggressive and life-saving measures.

“This puts patients whose goals of care do not align with these treatments in a vulnerable and often mismanaged state,” Clayborne observes.

More education and training is needed to make ED providers more comfortable with integrating palliative care there. This could include adding triage triggers to alert physicians when a patient would benefit from palliative services, such as advance care planning or improved pain management.

EDs are “both appropriate and effective places to provide palliative care,” says **Chadd K. Kraus**, DO, DrPH, FACEP, system director of

emergency medicine research at Geisinger in Danville, PA.

In addition to symptom management and acute clinical care, the ED provides referrals to palliative care, initiates palliative care, admits patients to hospice, and consults with palliative care specialists. However, there are some challenges.

Emergency physicians often believe they lack time to involve palliative care. Even when they do try, palliative care specialists are not always available. “The availability of palliative care in the ED can be dependent on the location of the ED — rural vs. urban — and on local and institutional resources,” Kraus explains.

In many settings, palliative care specialists are not readily available to assist with patients in the ED. In contrast, at university hospitals or large academic medical centers, EDs

frequently employ physicians with additional, specialized training in palliative care. “These physicians can champion and lead the clinical care of patients with palliative needs,” Kraus offers.

Implementing effective ways to equip emergency physicians in a range of ED settings with a foundational skill set in palliative care has become an active area of education in emergency medicine. “[Many] patients with conditions that benefit from palliative care present to the ED for acute,

unscheduled care,” Kraus says. Palliative care for these patients is best delivered when and where they need it. Frequently, that is in an ED — and it happens during off-hours (nights, weekends, and holidays) when outpatient clinics or other sites of care are unavailable.

“Optimizing the patient-centered, interdisciplinary team approach with emergency physicians who have primary palliative skills is most effective,” Kraus suggests.

Geisinger offers a dedicated palliative medicine service and

employs several emergency physicians with a strong interest in the topic. “We should continue to strive for widely available, high-quality palliative care service in emergency departments everywhere,” Kraus suggests. ■

REFERENCE

1. Aaronson EL, Petrillo L, Stoltenberg M, et al. The experience of emergency department providers with embedded palliative care during COVID. *J Pain Symptom Manage* 2020;60:e35-e43.

Ethics Services Taking First Steps Toward Preventive Work

Ethics services often are challenged to keep up with the volume of requests for consults, let alone tackle larger systemwide issues. However, preventive ethics is important work.

“Preventive ethics work, aimed at topics of high institutional concern, shows how ethicists can not only comment on issues but also sometimes prevent them from occurring,” says **Tim Lahey**, MD, MMSc, director of clinical ethics at University of Vermont Medical Center.

The ethics committee can be asked to address recurring issues, including how clinicians should manage potentially violent patients and balancing the duty to deliver the standard of care with patient autonomy when patients refuse treatment. Committees also might set boundaries on clinician self-treatment and manage requests for non-beneficial care.

The ethics service provides educational outreach to other teams managing these recurring issues.

“Also, sometimes, we’re part of teams developing new systems to manage such situations,” Lahey explains.

“We work with partners in quality to develop metrics to follow, and adjust systems in response to what those metrics show.”

The work benefits clinical areas. It also benefits the hospital overall in terms of patient satisfaction, risk management, and less burnout. “It demonstrates to leaders that ethicists are important to good institutional function,” Lahey adds.

There is not one consistent definition of what preventive ethics is. “That can be confusing to people,” says **Melissa M. Bottrell**, MPH, PhD, CEO of San Francisco-based Ethics Quality Consulting.

At some hospitals, just staying involved in writing policies is considered preventive ethics. For ethics services that have never worked on preventive ethics, policies might be an ideal place to start, says Bottrell, former chief of the Veterans Health Administration (VHA) Integrated Ethics program.

In contrast to this limited approach, the VHA Integrated Ethics program focuses broadly around the principles and methods of quality improvement (QI).

“Anything from the classic Six Sigma or Plan-Do-Study-Act [PDSA] models, that mindset is about actually intervening to make change. That is the approach that I come from,” Bottrell says.

When it comes to an introduction to preventive ethics, consider a project with a limited scope. “The ethics committee is not a bad place to start to get your feet wet,” Bottrell offers.

Since the ethics committee controls all aspects of the issue, approval or involvement from other hospital areas is not necessary. Examining the quality of consultants’ educational training is one example. “To take a preventive ethics focus, we could do a proficiency assessment, develop an education plan, and use it to drive our practice,” Bottrell suggests. “That is, in fact, a PDSA cycle, and can give the team a handle on it.”

In similar fashion, ethics could review the last few consults. Ethicists could assess whether the consults met best practice standards of what good consults should include, using guidance from the American Society for Bioethics and Humanities.

Another possibility is to examine the last dozen consults to identify common themes, such as putting advance directives in patients' charts or issues with handoffs between the ICU and stepdown units. By starting with those issues that are squarely within the control of the ethics committee, "the committee can get that experience, and get used to the materials and the methods of QI," Bottrell says.

After learning some basic QI, ethics committees can move on to organizationwide issues. "Preventive ethics is more looking at the systems issues, so there is a need for a more coordinated systems focus," Bottrell explains.

It is important for ethics to identify an appropriate issue for which preventive ethics makes sense. Some areas do need attention, but are not necessarily appropriate for an intervention. "It may have to be referred to leadership for more immediate intervention," Bottrell notes.

There must be a values conflict to require a preventive ethics approach. "Those issues come up all over the hospital. They come up at the boardroom as well as the bedside," Bottrell observes.

Paying attention to the root causes of consults can reveal the true issue that needs to be addressed. "If a senior manager is calling you because they have an issue that's driven by an individual patient case, but is actually something broader, that may be your entrée to support them in a small cycle," Bottrell says.

Ethicists must engage in an up-front conversation with clinical teams first. It is necessary to secure their buy-in before starting. "You cannot walk onto a nursing unit and tell staff to do things differently. That's just not reasonable," Bottrell cautions.

When a healthcare institution wants to include ethics within the QI arena, there should be some careful consideration about the infrastructure that is needed to support the effort, says **Robin S. Cook**, RN, MBA, integrated ethics manager for preventive ethics at the National Center for Ethics in Health Care in Washington, DC. Some institutions have built a strong, centralized QI structure. "Ethics experts should be part of that structure to assist in identification of ethics initiatives and to discuss ethics implications on other QI initiatives," Cook says.

If the institution works under a more decentralized approach, then establishing a preventive ethics team is best. The team should include someone with QI expertise. "There are many options for identifying potential ethics issues amenable to a QI approach," Cook says. Determining whether ethics policies are producing the anticipated outcomes is one example.

One hospital was asking for ethics consults on patients who left against medical advice (AMA). It turned out these cases needed a preventive ethics approach. Sometimes, there were hard feelings on the part of clinicians that got in the way of providing the best possible care for AMA patients.

For example, some patients leaving AMA did not receive a discharge plan, or clinicians did not fully check their medications. In some cases, future follow-up outpatient appointments were canceled automatically. "The process was punitive. There was a feeling that patients were rejecting

the hospital," Bottrell reports. In reality, patients were leaving for entirely different reasons. One older patient left AMA not because he wanted to, but because he had to take care of his wife, who was at risk staying home alone. "Yes, the patient is taking risks we would not be advising. But our processes should not be punitive," Bottrell stresses.

Ethicists worked with clinical teams to identify and address the ethical concerns in AMA cases. "That was done by a committee that had done some smaller scale efforts before taking something on that large," Bottrell says.

With AMA patients, there were multiple concerns and a clear conflict in values. "Using ethics expertise from the ethics consultation service, the team can develop what is the best ethics practice for addressing patients who wish to leave AMA," Cook reports.

The team can identify the system issues that are involved. As potential process improvements are developed, it is important to include ethics. "Ethics expertise is needed to assure the best ethics practice is fully defined, and that any strategies that are developed are also ethical," Cook explains.

That does not mean ethics needs to take the lead on every issue identified. It could be that if it is a legal issue, risk management is better positioned to take the lead. "Ethics can then be a subject matter expert for the ongoing initiative," Bottrell says.

Overall, the best issues for preventive ethics are "areas that require QI but don't, right now, have a home," Bottrell says. Clinical areas might need somebody to help them think about their practices from the ethics perspective. "That's what the ethics committee is uniquely able to do," Bottrell adds. ■

Healthcare Professionals Should Complete Their Own Advance Care Planning Directives

It is well-established that few U.S. adults, even those who are older and terminally ill, have completed advance directives for end-of-life care.¹ However, not as much is known about the advance care planning of healthcare providers.

“Doctors, lawyers, social workers, and other professionals can play an important role in motivating their patients and clients to do advance care planning,” notes **Deborah Carr**, PhD, professor and chair of sociology at Boston University.

Yet these professionals do not consistently initiate advance care planning conversations with patients.² In some cases, it is because of clinicians’ own discomfort with end of life. Researchers wanted to know if those most integrally involved with end-of-life decisions have finalized their own directives. If healthcare providers manage their own plans, they can share firsthand insights. “They will be in a better position to inform, guide, and support their patients. It will make them a more effective, trusted, and knowledgeable resource,” Carr says.

Carr and colleagues analyzed data from the Health and Retirement Study (HRS) and Wisconsin Longitudinal Study (7,668 and 5,464 subjects, respectively).³ As expected, frontline healthcare workers were more likely to create advance care directives compared to other

professionals. However, researchers were surprised that workers in the “social and health services” category (social workers, chaplains, and others who work with dying patients and their families) created directives at a lower rate.

For instance, in the HRS sample, 78% of doctors had drawn up a living will vs. just 41% of social workers. The proportion naming a durable power of attorney for healthcare was 64% and 32%, respectively. Non-professional workers (e.g., factory workers, food service workers, and other manual labor) recorded the lowest rates of advance care planning for the occupational groups that were studied.

“This is an important finding. As we have learned from the COVID-19 pandemic, people working in physically grueling jobs, often with high levels of interaction with the public, are at particular risk of illness and premature death,” Carr explains.

Advance care planning is especially important for economically disadvantaged populations, although they may be the least likely to have the means or support to do so.

“Healthcare providers, social workers, and other professionals who work with lower-income populations or those working in physically risky jobs should take extra care to encourage their advance care planning,” Carr says.

Handling this work up front can prevent the need for some ethics consults. If the patient’s treatment preferences have been made clear, there is less chance of a conflict at the end of life. “Bioethicists also should be encouraged to do their own advance care planning so that they have firsthand knowledge of the kinds of struggles their hospital’s patients may be managing,” Carr offers.

A common end-of-life conflict is family disagreements about the types of treatments the patients should receive. “This can cause lingering tensions among siblings or between widows [or widowers] and children after their loved one dies,” Carr says.

Bioethicists who have discussed their own treatment preferences with family members are better equipped to help hospital patients do the same. “The exercise of completing one’s own advance directive, and understanding what each potential treatment option entails, may also help them to understand the potential risks and benefits their patients are considering,” Carr says. ■

REFERENCES

1. Yadav KN, Gabler NB, Cooney E, et al. Approximately one in three U.S. adults completes any type of advance directive for end-of-life care. *Health Aff (Millwood)* 2017;36:1244-1251.
2. Belanger E, Loomer L, Teno JM, et al. Early utilization patterns of the new Medicare procedure codes for advance care planning. *JAMA Intern Med* 2019;179:829-830.
3. Carr D, Kalousova L, Lin K, Burgard S. Occupational differences in advance care planning: Are medical professionals more likely to plan? *Soc Sci Med* 2021;272:113730.

COMING IN FUTURE MONTHS

- Hospital policies on demands for inappropriate treatment
- Ethical ways to help patients with DNR decision-making
- Ethical responses if clinicians believe discharge is unsafe
- Reasons for pediatric ethics consultations

Lack of Metrics, Specificity, and Regulations Concern Some Ethics Services

The Joint Commission requires hospitals to develop a mechanism to address ethical issues, and recommends a multidisciplinary ethics committee. But in the experience of **Edward Dunn**, MD, ScD, ethics services really have not been an important area of focus during previous surveys. “During surveys, the unfortunate reality is The Joint Commission often only takes a superficial glance,” says Dunn, medical director of palliative care for Louisville, KY-based Norton Healthcare.

The Joint Commission surveyors have checked for evidence of committee notes taken during the quarterly meetings that occur in Norton’s five hospitals.

“Nevertheless, the two surveys that were two years apart in the past four years never raised any questions about our ethics program. I’ve never seen them do a deeper dive into the substantive activities of an ethics program,” Dunn reports.

Dunn would like to see The Joint Commission scrutinize issues such as what checks and balances are used to address ethical conflicts between medical staff and administrators, or why few patients present with advance directives even at many large health systems with cancer care programs.

“Professional societies in medicine, nursing, and the allied health professions all have interests in ethics,” Dunn notes.

For example, the American Academy of Hospice and Palliative Medicine maintains several groups that communicate regularly and convene at the annual national assembly to discuss ethical issues in palliative care.

“The professional societies may have some influence on the ethical elements of practice in the health

professions, but their influence is largely driven by the interests of local leadership in healthcare organizations, large and small,” Dunn argues.

States delegate the regulatory oversight of health systems to accreditation organizations.

“If a health system fails to meet the quality standards set by Medicare based upon audits of The Joint Commission, there will be financial penalties. However, there are no quality metrics for ethics in a health system,” Dunn says.

Ethics consultations do not generate any revenue from payers like Medicare, Medicaid, or commercial insurers.

“In the most recent Joint Commission surveys I have witnessed in my health system, I was never questioned by the survey team about our ethics program,” Dunn explains.

Norton’s ethics committees are multidisciplinary, and include nurses, social workers, chaplains, physicians, patient safety employees, and quality improvement staff. However, the meetings are only quarterly and often poorly attended.

“The bottom line for health systems is that ethics sounds good, but it doesn’t generate revenue. Therefore, it is simply not a priority for executive leadership in health systems,” Dunn laments.

A related issue is that regulators “have never taken a serious look at the role of clinical ethics in health systems,” according to Dunn. “They have really never attempted to define what a robust ethics program should look like in a health system.”

Reviewing the minutes of a quarterly ethics committee meeting, as The Joint Commission surveyors did during the health system’s

previous survey, does not paint a complete picture.

“It illuminates very little about the role of ethics in a healthcare organization,” Dunn says. “In fact, if committee meetings are the only evidence of any ethics activity, I would say that ethics barely has a pulse in that organization.”

Thomas V. Cunningham, PhD, MA, MS, has seen Joint Commission surveyors look for ethical practices during patient tracing when interviewing staff about policies and procedures, and when reviewing policies that cover care.

“Although ethical issues can arise in any area of care, surveyors often seem to look more for them in practices like informed consent and respecting patient’s wishes as stated on advance directives,” says Cunningham, a bioethics director within Kaiser Permanente’s Southern California region, covering the West Los Angeles Medical Center.

Surveyors also may ask how a nurse or other staff member would request an ethics consult. If hospitals fail to meet minimum standards for clinical care, “there are all kinds of repercussions,” Cunningham warns.

If clinical areas such as cardiology or neurology are not meeting CMS quality measures, lost reimbursement is a real concern for that hospital. “You won’t get paid, and the hospital will lose accreditation or will have to shut down a unit,” Cunningham cautions. “The stakes are very high.”

Therefore, hospital leaders should be strongly motivated to ensure performance benchmarks for clinical quality are met. “In ethics, there is no such thing. No one is paying attention to quality measures of ethics consultation activities during

regulatory surveys. No one is counting,” Cunningham says. “Until that happens, from an external point of view, hospitals have no reason to put resources into ethics.”

While there may be internal recognition that the ethics service is important to the organization, external benchmarks inevitably take priority. An example would be meeting criteria to become certified as a primary stroke center.

“If you can’t meet that threshold, people will lose jobs over failing to do that,” Cunningham notes.

There are multiple licensing, regulatory, and professional societies that set benchmarks for clinical care.

“It’s reasonable for an administration to be aware of that. You’re going to focus on what all these other bodies are making you focus on,”

Cunningham says. “But none of these make any real demands on ethics as a clinical service.”

Regulatory agencies still assess ethics “as though it is a small-volume service done by volunteers on a committee, not as a high-volume service run by ethics staff,” Cunningham adds.

If ethics services had to meet metrics that similarly affected revenue or hospital operations, administrations would have to invest in resources accordingly.

“We would welcome it, to send a signal to all the administrators in the country that they better figure out how to pay for ethicists,” Cunningham says. For instance, if The Joint Commission required the ethics consult to maintain a certain amount of volume, the questions

would become: How do we verify that the service is achieving the expected volume? If the service is not meeting the expected volume, what needs to be done? “If you want to try to ask the question, we’ll try to start getting an answer,” Cunningham says. “That’s how administration, in my judgment, figures out how to resource.”

Most hospital leaders recognize ethicists are thoughtful practitioners who are dedicated to resolving ethical dilemmas to benefit patients and the organization. The problem is that there are no external bodies that set specific benchmarks for ethics, according to Cunningham. He argues ethicists should address this: “Someone has to go out and advocate for strengthening expectations and standards with the regulatory bodies,” he says. ■

The Joint Commission Sets Specific Ethical Expectations

The Joint Commission (TJC) accreditation requirements address ethical principles in several specific areas.

“First and foremost, leadership is expected to establish an ethical framework on which all operations, policies, procedures, and services are based, and in a manner that supports the delivery of safe, quality care, treatment, and services,” says

Robert Campbell, PharmD, BCSCP, director of TJC’s Clinical Standards Interpretation Group.





These are some examples of ethical requirements in TJC’s leadership standards:

- **To ensure the ethical framework is maintained, organizations are required to establish a process that allows staff, patients, and families to address**

ethical issues or issues prone to conflict (LD.04.02.03).

“While establishing a formal ethics committee is an example of one way an organization may handle such issues, such a structure is not a requirement,” Campbell notes.

- **Organizations are required to define, in writing, conflicts of interest that could affect safety and quality of care, treatment, and**

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services (LD.02.02.01). “Conflicts of interest can challenge ethical principles,” Campbell says.

For example, such conflicts can occur between leadership, the governing body, and the medical staff. These could negatively affect patient care. Additionally, hospital policies must define the ongoing process for managing conflicts among leadership groups (LD.02.04.01).

- **Care, treatment, and services must be provided based on patient needs, regardless of compensation or financial risk-sharing.** “Ethical issues can also find their way into

decisions regarding the delivery of care based on financial issues,” Campbell adds.

When such care, treatment, and services are denied because of payment limitations, the decision to continue providing care, treatment, and services or to discharge the patient should be based solely on the patient’s identified needs (LD.04.02.05).

“There may be times when patients need to be informed before, or at the time of admission, of charges for services available that may not be covered by a third-party payor, such as Medicare,” Campbell explains.

- **Medical staff are obligated to ensure privileged practitioners demonstrate behaviors that reflect a commitment to continuous professional development; ethical practice; an understanding of and sensitivity to diversity; and a responsible attitude toward patients, their profession, and society.**

“Monitoring of such behaviors is often accomplished by establishing criteria that are evaluated as part of an ongoing professional practice evaluation process that is required by our standards,” Campbell says. ■

Unanticipated Ethical Issues Arise When Data Are Collected and Analyzed

At Seattle Children’s Hospital, the information services department was becoming increasingly aware of the ethical implications of products and analyses they were asked to produce.

“They began to talk among themselves about these issues, and then decided to create a working group where these issues could be discussed among a broader group of information professionals,” says **Douglas S. Diekema**, MD, MPH, an attending physician and director of education for the Treuman Katz Center for Pediatric Bioethics. These are some examples of ethical issues that were arising:

- While working, data specialists could see private patient data. “This felt at times like a violation of privacy or confidentiality,” Diekema says.
- Information services might be asked to provide data or an analysis they thought could be biased in certain ways.
- Staff were asked to create algorithms they realized might pose

equity issues or build in unrecognized biases.

- Information services were concerned about someone using patient data for marketing campaigns.
- Some staff believed they were asked to provide metrics that might lead to organizational changes that were not necessarily appropriate, without understanding the context of the data.

For instance, clinical performance can be judged based on metrics like how many patients clinicians see in an hour, or the number of lab tests ordered in one day.

“Using metrics like that to determine incentives or promotion may not be fair, and may not really be a good indicator of quality care,” Diekema argues.

Seeing more patients per hour increases revenue, but might adversely affect the patient experience or increase the risk of safety events. It also might lead to equity issues.

Patients requiring an interpreter will take more time. Clinicians who

are overly focused on seeing a certain number of patients per hour may be tempted to avoid using an interpreter, or ask fewer open-ended questions, to save time.

Discussions about these ethical concerns led to the development of a data ethics checklist to raise awareness of ethical issues that arise in their daily work.¹ Diekema says a person trained in ethics can give in-person training, either monthly or quarterly, to a group of information services professionals who bring up cases from their own work.

“An ethicist can help moderate the discussion, ask probing questions, and provide an ethical framework for thinking about the issues,” Diekema explains. ■

REFERENCE

1. Montague E, Day TE, Barry D, et al. The case for information fiduciaries: The implementation of a data ethics checklist at Seattle Children’s Hospital. *J Am Med Inform Assoc* 2021;28:650-652.

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CME/CE QUESTIONS

- 1. Which is true regarding healthcare professionals' advance care planning?**
 - a. Healthcare providers are more likely to initiate advance care planning conversations if they have not completed their own advance care planning.
 - b. Frontline healthcare workers were more likely to engage in advance care planning compared to other professional workers.
 - c. More social workers and chaplains had completed advance care planning than physicians.
 - d. Completing advance care planning resulted in clinicians requesting more ethics consults for end-of-life care.
- 2. Which is true regarding ethical issues that arose at Seattle Children's Hospital?**
 - a. Data specialists could not perform their jobs because they could not access private patient data.
 - b. The information services department was asked to create algorithms they realized might pose equity issues.
 - c. Patient data were used in a way that unintentionally made the hospital look worse than competitors.
 - d. The number of patients clinicians see hourly was unacceptably low based on known best practices.
- 3. Which is true regarding prolongation of life lawsuits?**
 - a. There is no legal cause of action if hospitals can prove the advance directive never made it into the chart.
 - b. Clinicians should not assume the presence of an advance directive is an indication the patient is DNR.
 - c. Generally, surrogate decision-makers can override advance directives.
 - d. It is safer legally to provide life-sustaining treatment against patient wishes than it is to withdraw or withhold such treatment.
- 4. Which did the authors of a recent study find regarding palliative care in EDs?**
 - a. Virtually all ED clinicians surveyed believed palliative care in the ED was valuable.
 - b. Referrals to palliative care resulted in unacceptably long lengths of stay.
 - c. Triage triggers resulted in lower-quality palliative care.
 - d. Palliative care was available during off-hours, but few patients required it.