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RELIAS
MEDIA

Of Hospitalist Cases With Ethical Issue Identified, Few Formal Consults Occurred

Meeting subspecialty needs is “frontier” for clinical ethics

When **Matthew McCarthy**, MD, first became an attending physician at Weill Cornell Medicine in New York City, he was surprised at how many ethical issues came up on daily rounds. Few led to a formal ethics consultation.

“This meant that we made most of the decisions on our own. As a young doctor, that was a terrifying proposition,” says McCarthy, an assistant professor of medicine at Weill Cornell and a hospitalist at New York-Presbyterian Hospital, where he serves on the ethics committee.

Some healthcare proxies appeared to be making poor decisions on the patient’s behalf. In rare situations, “decisionally incapacitated surrogates” lost their proxy status, but most cases were not as extreme. “It’s hard to know what to do, especially if you don’t think the patient would’ve made those same decisions,” McCarthy explains.

As a new attending physician, McCarthy also saw doctors unsure if expensive antibiotics should be given to patients with a urinary tract infection and only days to live. The question raised ethical issues of futility and allocation of resources, which were not explored fully. “These are things that would never merit a full ethics consultation and are largely handled by doctors alone at the bedside,” McCarthy says.

McCarthy approached **Joseph J. Fins**, MD, MACP, FRCP, about his concerns. They decided to study the epidemiology of ethical issues facing hospital medicine. “Our study was the first prospective look at the ethical issues facing hospitalists,” says McCarthy, the study’s lead author.

Hospital medicine is the fastest growing specialty in medicine. Yet little was known about the ethical issues they face. “This is a brand-new massive

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subspecialty area and we needed to begin to understand: What are the ethics issues that they confront?" asks Fins, chief of the division of medical ethics and the E. William Davis, Jr., MD, professor of medical ethics at Weill Cornell Medical College. Fins also is director of medical ethics and chair of the ethics committee at New York-Presbyterian Hospital/Weill Cornell Medical Center.

To answer this important question, two attending hospitalists embedded themselves on hospitalist morning rounds and collected data on 270 patients from September 2017 through May 2018.¹ A total of 270 patients were evaluated, and 113 ethical issues were identified in 77 of those patients. However, only five formal consults were brought to the facility's ethics committee for these 270 patients.

The findings suggest that ethical issues raised during formal consultations are only "the tip of the iceberg," Fins says. "In fact, there are ethical issues everywhere."

Of the five formal ethics consults requested, "those involved treatment refusals, goals of care, decision-making capacity, and issues pertaining to medical futility," McCarthy notes.

Certainly, not every ethical issue necessitates an ethics consult. However, it is unclear whether the hospitalists knew it was an ethical issue and determined a consult was not necessary, or whether the ethical issue simply went unrecognized. In the context of research, the investigators did not try to ascertain this. "We tried to be invisible," says Fins, the study's senior author. "We were not there to weigh in. We were there just to note what was happening."

In one case, hospitalists discussed which antibiotic to give a patient

with a *Clostridioides difficile* infection. "Certain choices may go beyond the pharmacological question. It might be a sociological question or ethical question," Fins offers.

In deciding between two antibiotics, the hospitalist pointed out that one of the drugs was less toxic but was considerably more expensive. "That's a distributive justice issue," Fins notes. It was unclear whether the hospitalists considered this when choosing the less expensive antibiotic. It also is possible the patient's insurance status was a factor, another potential ethical issue.

"These are issues that, when you refract them in the context of an ethical prism, they may take on a different hue and lend themselves to a meaningful analysis," Fins adds.

Currently, there are more than 50,000 hospitalists working in the United States. Most have received no formal training in clinical ethics. "We wanted to know what hospitals are seeing so we can direct educational efforts to meet those issues head-on," Fins says.

In 2018, 75% of hospital patients were cared for by hospitalists.² "More importantly, perhaps, is that most of the professional and clinical education in the hospital setting is being done by hospitalists," Fins notes. The researchers intend to develop an educational program to help hospitalists become better teachers and role models. "If they are going to be teaching medical students and residents about professionalism and medical ethics, maybe we can do a better job of preparing them," Fins offers.

An ethics handbook specific to hospitals is planned, along with a conference on ethics and hospitalists. "We ultimately would like to begin to collect national data on the sorts

of ethical issues hospitalists are seeing around the country,” Fins says.

Many hospitalists are young physicians at the beginning of their careers. “Technically, they are superb,” Fins says. “But they may not have as much interpersonal experience. And they don’t have the advantage of knowing their patients.”

The extent of hospitalists’ ethical obligation to communicate with outpatient physicians whose patients are hospitalized, or to ensure continuity of care after discharge, is somewhat unclear.

“What’s your responsibility? Is it more than just getting a medication list?” Fins asks.

Hospitalists also face obstacles in establishing a doctor/patient relationship. “You are literally meeting a stranger at the bedside, and that person has to develop a relationship that is meaningful, and do so quickly during the stress of hospitalization,” Fins says. The hospitalist is assigned to a patient, in contrast to the traditional model of a patient choosing an outpatient doctor. Upon admission, that same doctor followed the patient throughout the hospitalization and provided follow-up care.

“A lot of physicians bewail the demise of the traditional patient/physician encounter,” Fins notes.

A good doctor/patient relationship still is possible with hospitalists, Fins says. Patients actually may spend more time with a hospitalist in a week

than they spend with their outpatient doctor in years. The care also is more intense, with a lot of weighty decisions made.

“That relationship might be more meaningful and life-altering than a longitudinal relationship over a period of general wellness,” says Fins, noting not all patients have access to outpatient physicians to begin with. “The notion that we are losing something is only true for those who had it in the first place.”

There is growing awareness of the unique ethical needs of various clinical specialties. “This is going to be the era of subspecialty clinical ethics,” Fins predicts.

The rise of hospitalists presents an important opportunity for the field, according to the authors of a recent paper.³

“Today, the real frontier is really at the interface of hospital medicine and clinical ethics. It is, really, an unexplored activity,” Fins says. Hospitalists are “so front and

center and in the thick of medical education and patient care,” Fins says. While some hospitalists focus on family practice or pediatrics, the vast majority specialize in general internal medicine.

“People maybe think that the traditional ethical reflections done by internists are translatable to hospitalists,” Fins offers. “A lot of it is. But some of it is particular to their domain of practice.”

While certain essential ethics elements (fiduciary responsibility, allocation of resources, and futility) are relevant to all physicians, “the details may get played out a little differently based on the realities of the hospitalist context of care,” Fins says.

Clinical ethics evolved out of end-of-life care in the ICU. Yet ENTs and neurosurgeons encounter somewhat different end-of-life issues.

“We need to move out of the origins of the field of clinical ethics to speaking intelligently with our colleagues in subspecialties,” Fins says. ■

EXECUTIVE SUMMARY

In a recent study of 270 patients encounters, hospitalists encountered 133 ethical issues in 77 patients but obtained only five formal ethics consultations.

Some implications for ethics:

- Hospitalists must establish a doctor/patient relationship quickly under challenging circumstances.
- Many hospitalists provide professional and clinical education without formal training in clinical ethics.
- Ethicists can provide specialty-specific ethics education to hospitalists.

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Debate Over Whether ‘Conscience Rule’ Engenders Diversity or Paternalism

Patient autonomy, beneficence at issue

The rights of healthcare providers who object to participating in certain services or procedures (such as abortion, sterilization, or assisted suicide) due to religious beliefs or moral convictions were bolstered by a rule released by the Department of Health and Human Services Office for Civil Rights (OCR).¹ “This rule ensures that healthcare entities and professionals won’t be bullied out of the healthcare field because they decline to participate in actions that violate their conscience, including the taking of human life. Protecting conscience and religious freedom not only fosters greater diversity in healthcare, it’s the law,” OCR Director **Roger Severino** said in a written statement.

The HHS rule “is nothing less than a return to paternalism, where

the physician has full power over the patient no matter their autonomy or medical need,” says **Craig M. Klugman**, PhD, a professor in the department of health sciences at DePaul University.

Klugman says the rule “places the physician above the institution or the patient.” Now, healthcare providers are free to refuse to perform any service they find objectionable if they can state a religious or conscience reason for it, says Klugman, even if necessary or desired by the patient and medically indicated.

Klugman says the rule violates healthcare providers’ most important duties: To do no harm, and to put patients’ needs above one’s own. The conscience rule, says Klugman, “tells providers that their own personal beliefs override both of

these foundational duties that have existed since the dawn of the medical profession.”

Students admitted to medical school should be asked if they have religious or philosophical objections to any procedures in medical care, Klugman says.

“If they do, then that person should not be admitted. This might be a draconian step, but is required if we are to put the patients’ medical needs first,” Klugman notes.

Medical offices or institutions should display signs stating the objections of healthcare providers and what procedures they will not perform, Klugman offers. This way, patients have the information before seeing their medical provider.

“If a healthcare provider has objections to performing certain procedures, that person should be moved to a service where those procedures are not offered,” Klugman adds.

Hospitals should create a way to provide necessary medical care in the event that one of their doctors or nurses claims a conscience objection to a particular treatment, says **Lawrence Gostin**, JD, director of the O’Neill Institute for National and Global Health Law at Georgetown University Law Center. A backup plan for providing services by qualified and willing providers is

EXECUTIVE SUMMARY

The recent HHS conscience rule sparked ethical debate over the duties providers owe to patients. Proactive responses to this ethically charged development:

- Hospitals can ensure there is a backup plan to provide services if a clinician claims a conscience objection to a particular treatment.
- Clinicians can assure patients they will not be discriminated against based on the service they are seeking or their racial or gender identity.
- Ethicists must balance the rights of providers who have genuine conscience reasons for withholding treatment with the rights of patients to high-quality treatment for all conditions.

needed, as is “assuring all patients that they will not be discriminated against based on the service they are seeking or their racial or gender identity,” Gostin says.

Gostin sees an important role for ethicists in educating clinicians about the duties of care they owe to all patients without discrimination. “Ethicists need to fairly balance the rights of providers who have genuine conscience reasons for withholding care with the rights of patients to high-quality treatment for all conditions,” he says.

It is difficult to ascertain whether a health worker has a genuine conscience reason, or is using the conscience rule as a subterfuge for discrimination, Gostin notes. A peer-to-peer assessment, with ethicists able to ask questions of the provider, can be helpful in this regard.

“That will influence health workers in exercising their conscience responsibly,” Gostin adds.

Bryan Pilkington, PhD, associate professor in the School of Health and Medical Sciences at Seton Hall University, says the discussion of conscientious healthcare practice is not a new debate. With the HHS rule, it has now been reinvigorated in a highly charged sociopolitical context.

“Claims of conscience are often seen as either attacks on vulnerable populations or as violations of a sacredly held, never-to-be-questioned protection of members of a profession,” Pilkington says.

Hospitals can take two steps to ensure that both the conscientious practice of healthcare practitioners and the interests and rights of patients are respected, according to Pilkington:

- Require practitioners to make known publicly the scope of the practice, including what procedures

and treatments they deem beyond their conscientious practice;

- Request reasons in favor of, or explanations for, their account of the scope of their practice.

“Abandoning patients or refusing to treat populations of patients are not approaches to medical practice that ethicists can support,” Pilkington notes.

However, ethicists also must be careful not to assume there is a single manner in which to practice medicine conscientiously. “One’s conscience, after all, is one’s own,” Pilkington adds.

Some ethicists agree with the HHS that the conscience rule simply supports diversity among healthcare practitioners. “This gives choices to Americans who are looking for practitioners who respect medicine’s historical ethical boundaries, such as the boundary against intentionally harming [patients],” says **Farr Curlin**, MD, Josiah C. Trent Professor of Medical Humanities in the Trent Center for Bioethics, Humanities, and History of Medicine and the Duke Divinity School at Duke University.

Curlin says that the central ethical question is: Should the profession of medicine remain open to any physicians willing to fully commit themselves to caring for the sick? “This rule essentially says yes, it should, that institutions that receive federal money should be hospitable to practitioners from all of the diverse moral communities that make up America,” Curlin offers.

As for assertions that the rule encourages insidious discrimination, Curlin counters, “Physicians are not objecting to classes of people. They are not refusing to care for gays or transgender patients or anyone else who is sick and in need of healing.” There is an ethical obligation for

physicians to have freedom to refuse to cooperate in practices that they believe contradict their profession and harm their patients, Curlin says. This includes sterilization, assisted suicide, abortion, and surgeries to change secondary sex characteristics.

“There are reasonable concerns that the practice in question is not good medicine, or medicine at all,” Curlin adds. It is important for physicians to “rely on their core values in their practice of medicine,” says **Cheyn Onarecker**, MD, MA, chair of the healthcare ethics council at Trinity International University’s The Center for Bioethics & Human Dignity in Deerfield, IL.

All physicians likely will encounter some procedure or treatment that they would find morally objectionable during their careers.

“Some would argue they should plan to set their personal morals aside when they encounter such procedures,” Onarecker says. Some argue that students should even be willing to sign a statement or oath to that effect as a condition of acceptance into medical school.

“However, I don’t think society is ready to accept an entire medical profession made up of men and women who would easily sacrifice their core beliefs in the face of shifting public opinions or when some medical society asserts that a practice or treatment is the standard of care,” Onarecker says.

What is considered standard of care today may be rejected in a decade’s time, Onarecker notes. But if a physician refuses to provide certain healthcare services, it makes it more difficult for patients to obtain access to those services.

“Those with more money could drive to another emergency room or pay for services from another physician. But the poor would not

have that luxury,” Onarecker says. Examples include rape victims unable to obtain emergency contraception because a provider invokes the HHS rule, or infertility specialists refusing to treat a lesbian couple. The central ethical question is: Should patients be denied potentially helpful procedures just because a physician finds them

distasteful? “It is not always the case that a physician must put a patient’s interests above her own. There has always been a balance between the two,” Onarecker says. It is not feasible to honor every providers’ objection in every situation. “However, we should go a long way to accommodate those rights,” Onarecker adds. ■

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Ethical Concerns When Pediatric Palliative Care Patients Visit EDs

Unfamiliar providers mean uncertainty for parents

Pediatric palliative care patients often present to the ED at the end of life. Goals of care are not always discussed, according to the authors of a recent study.¹

“One of the things the parents of kids with complex care needs worry about most is going to the emergency department with their child,” says **Rebecca Benson**, MD, PhD, medical director for clinical ethics and director of the ethics consult service at University of Iowa Hospitals and Clinics.

Researchers analyzed 290 patients followed by the pediatric palliative care team. Of this group, 94 presented to the ED, 36 died in the hospital after an ED visit, and 18 died within 72 hours of admission. Discussion about goals of care occurred with 37% of patients.

For all parents, ED visits often entail a long wait and painful tests and procedures. For parents of palliative care patients, it also means dealing with providers who are unfamiliar

with their child’s condition or specific medical background. “Adding to that stress is the concern about whether they will be clearly able to make their goals and preferences about their child’s care known,” Benson notes. Some patients or their parents have made decisions to avoid certain types of interventions, such as intubation. “During a health crisis in the ER is a very challenging time to have or explain these preferences,” Benson says.

For this reason, Benson encourages completion of a Physician Orders for Life-Sustaining Treatment (POLST) form where appropriate and available. This puts goals and advance care planning into a set of medical orders that are transferrable across healthcare settings. “If they do not want resuscitation attempted, they can produce the form,” says Benson. This shows they have talked to a licensed practitioner who knows their child. On the other hand, some pediatric palliative patients have received very good

responses to life-sustaining interventions. Therefore, parents want them attempted.

“But the medical team might balk based on the child having a diagnosis that is thought to be ‘lethal’ or ‘fatal,’” Benson says. Again, if the parents have documentation of goals of care as discussed with the team that typically cares for their child, it provides much-needed background.

Similarly, a completed Emergency Information Form (developed by the American Academy of Pediatrics and American College of Emergency Physicians) can shed light on presenting problems and management tactics.

If families prepare proactively for emergency situations, concludes Benson, “they are more likely to be successful in sharing their goals for their child’s care in a way that will lead to the best care being provided.” ■

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COMING IN FUTURE MONTHS

- Ethical concerns with “grateful patient” donations
- Ethical practices for ED patients with advance directives
- Challenges if ethics consultants are volunteers
- Efforts to simplify confusing informed consent forms

Study: Shared Decision-Making Occurs Too Late

“Goals of care” term is misused often

Documentation of patient and family engagement in treatment decision-making is not usually found in the EHR until available medical treatments fail to achieve physiologic goals.¹

“Our findings highlight the need for interprofessional and system-level efforts to engage patients and families in treatment decisions *throughout* the longitudinal course of critical illness,” says **Jacqueline Kruser**, MD, MS, the study’s lead author.

Researchers analyzed the records of 52 adult patients admitted to a medical ICU in 2016. Of this group, half had chronic critical illness. Half died or transitioned to hospice care in the ICU before developing chronic critical illness.

“For patients with life-threatening illness in the intensive care unit, we aim to provide medical interventions that align with patients’ values and goals,” says Kruser, an instructor in the division of pulmonary and critical care medicine at Northwestern University Feinberg School of Medicine.

Clinicians are ethically obligated to engage patients and families in medical treatment decisions.

“But this can be incredibly challenging due to the unpredictable, dynamic, and often urgent nature of providing critical care,” Kruser notes. Typically, the course of a critical illness unfolds over days to weeks in the ICU. Numerous individual treatment decisions are made during that time.

“We wanted to better understand how patients and their family members were engaged in decision-making,” Kruser explains. The researchers were struck by how often clinicians used the phrase “goals of care” in their notes. This phrase was found in almost every patient’s record.

“Our analysis uncovered several different uses for this phrase,” Kruser reports.

Importantly, it typically was *not* used to describe a patient’s actual goal for his or her medical care. Instead, the phrase was used to convey poor prognosis; describe conflict among patients, clinicians, and families; or provide a rationale for specific treatment limitations. The biggest ethical concern is that patients’ actual goal for their medical care may not have been addressed. “It appears

as if ‘goals of care’ is used, instead, to communicate about these three other concepts related to end-of-life care and the use of life-sustaining treatments,” Kruser offers.

Ethicists can help ensure that the phrase “goals of care” is used accurately to communicate patient-centered goals, Kruser says. This is important in various contexts — when used by individual clinicians, clinical teams, or administrators; or in the hospital’s written policies and procedures.

Close collaboration between ethics and the ICU clinical team can go a long way toward addressing this issue.

The overarching goal, says Kruser, is “to create a local culture in the ICU that prioritizes, values, and promotes patient and family engagement throughout the course of critical illness.” ■

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Unexpected Findings on Web-Based Tool for ICU Surrogates

First test for decision aid in an acute care setting

A decision aid for prolonged mechanical ventilation did *not* improve prognostic concordance between clinicians and surrogates, according to the authors of a recent study.¹ The tool did not reduce

psychological distress among surrogates or alter clinical outcomes.

“A decision aid had never been tested in an acute care setting before,” explains **Christopher Cox**, MD, the study’s lead author and director of

the medical ICU at Duke University. Researchers sought to help family members with the difficult task of making life-and-death decisions. They studied 277 adult patients who had been on life support at least 10 days,

416 surrogates, and 427 clinicians (ICU nurses and ICU physicians) at 13 medical-surgical ICUs at five hospitals. Key findings:

- Surrogates' post-intervention estimates of patients' one-year prognoses did not differ between intervention and control groups;
- Many surrogates (43%) favored a treatment option that was more aggressive than their report of patient preferences.

The researchers were surprised that the decision aid did not really change

the decisions made or the amount of time patients were hospitalized. "This is humbling because decision aids have been promoted as a way to reduce costs of care," Cox notes. Family caregivers answered questions about the patient's values, then the computer-based guide made treatment recommendations. However, these were disregarded in more than half of cases. Families frequently chose a more aggressive goal of treatment than the patient's values suggested.

"Our findings highlight the complexity of end-of-life decision-making," Cox says. ■

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New Ethical Guidance on Response to Physician Impairment

Physicians may be impaired due to substance use disorders, a medical or mental health condition, profound fatigue, or a decline in cognitive or motor skills due to age or disease. Whatever the reason, they usually struggle in silence and delay seeking help, says **Lois Snyder Sulmasy**, JD, director of the American College of Physicians (ACP)'s Center for Ethics and Professionalism.

"This can be for a variety of reasons, including vulnerability, concerns about privacy and confidentiality, the stigma of addiction, or fear of professional liability," Snyder says. New ethical guidance from ACP examines the

professional duties and principles that should guide the response of colleagues and the profession to physician impairment.¹ "This affirms the ethical duties of competence and self-regulation as core principles of professionalism and of the privilege of medical practice," Snyder explains.

The guidance states that questions about impairment should:

- address a physician's current status rather than his or her history;
- not distinguish between mental and physical health;
- elicit objective information about functional status.

"Physicians have an individual and collective responsibility to ensure patient safety *and* to assist

an impaired colleague," Snyder says. An important distinction that ACP's position paper makes is between functional impairment and *potentially* impairing illness. The guidance states: "*Impairment is a functional classification concerning the physician's inability to carry out patient care responsibilities safely and effectively. The presence of an illness does not necessarily signify impairment.*"

"The central ethical concern should be to appropriately assist an impaired physician, regardless of whether the illness is based in mental or physical health, while maintaining the safety of patients," Snyder says.

Ethicists working with physicians and others can be helpful by familiarizing themselves with (and helping educate clinicians about) local resources for seeking assistance, Snyder adds. "Physician health programs are an important means of assisting impaired physicians. More evidence-based best practices should be developed and supported."

A recent example is the Performance Enhancement Review

CME/CE OBJECTIVES

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

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

guidelines of the Federation of State Physician Health Programs. Started this year, the program will work with physician health programs to develop best practices and to identify areas for improvement.

“ACP has joined with other medical societies to participate in this new program,” Snyder reports.

A primary ethical concern is stigma against physicians who access mental health services.

“This stigmatization, present from the time a student enters medical school throughout their career, discourages accessing treatment,” says

Tyler S. Gibb, JD, PhD, a clinical ethicist and co-chief in the program in medical ethics, humanities, and law at Western Michigan University Homer Stryker M.D. School of Medicine.

Unless the culture of medicine becomes more tolerant of colleagues needing and accessing mental health services, many will choose not to seek help, Gibb says. Providers are at risk for burnout, substance abuse, and even suicide. Patients are cared for by providers with compassion fatigue who may be more likely to make medical errors.

“This is extremely concerning for the entire enterprise of healthcare,” Gibb laments. “This trend should be viewed as a public health crisis.” ■

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Chaplains Want More Inclusion in Patient Care Discussions

Role is viewed too narrowly, survey respondents say

As an oncology chaplain in an acute care hospital, **M. Jeanne Wirpsa**, MA, BCC, became the “go-to” person if there was a conflict between the medical team and family. “I frequently asked the hard questions about the goals of treatment that few others were prepared to ask,” Wirpsa says.

After a long course of treatment, some patients stated very clearly that they wanted comfort care only. “But then the next day their voice would get lost, as if the treatment plan had taken on a life of its own,” says Wirpsa, a clinical ethicist and chaplain researcher at Northwestern Memorial Hospital in Chicago.

Attending family meetings and care conferences helped Wirpsa to integrate the patient’s voice into the treatment plan. “My colleagues on the research team confirmed the same in other settings, such as advanced cardiac disease and intensive care,” Wirpsa reports. The

chaplain researchers wanted to see if this experience was shared by other healthcare chaplains across the United States. It already was well-established that when chaplains are involved with decision-making for serious or life-limiting illness, patients and families are more at peace with their decisions. “But the connection to medical decision-making had never been explored,” Wirpsa notes.

In a survey of 463 full-time chaplains, 38% reported being included in healthcare team discussions regarding

medical decisions “often” or “frequently.”¹ “What was more unexpected was the degree to which chaplains were involved in specific activities associated with decision-making,” says Wirpsa, the study’s lead author. Chaplains reported educating patients and families on specific medical concepts such as CPR or brain death.

“Chaplains provided rich examples of helping the medical team gauge when a family was ready to even engage in discussion about a difficult decision,” Wirpsa explains.

EXECUTIVE SUMMARY

Of 463 chaplains surveyed, about one-third reported being often or frequently included in clinical team discussions on medical decisions. Chaplains also reported:

- educating patients and families on specific medical concepts such as CPR or brain death;
- acting as a liaison between the patient, family, and medical team;
- slowing down the fast pace of medical decision-making.

The key role chaplains perceived themselves to play was as liaisons between the patient, family, and medical team. Survey respondents often used terms such as “mediator,” “interpreter,” “coach,” and “bridge” to describe this. Chaplains reported coaching patients to share their fears and concerns. They also believed it was important to deliberately slow down the fast pace of medical decision-making. “They discussed interrupting the clinical momentum that fails to ask: ‘Who is this patient?’ and ‘What really matters to them moving forward?’” Wirpsa says.

The barriers to involvement in medical decision-making voiced by the respondents sounded very familiar to the researchers. The least-experienced chaplains found it difficult to claim a place at the table or approach an attending physician with their insights into patient and family values. Even more experienced chaplains, well-versed in medical culture and trusted by their care teams, reported some difficulty with this. “They complained that they were stretched too thin to be able to participate fully in situations where their skills would be useful to the process of medical decision-making,” Wirpsa says.

Many chaplains indicated they were underused in their healthcare settings. They believed this was because their role was narrowly viewed or misunderstood altogether. “Core competencies of healthcare chaplains

were not recognized by other members of the healthcare team,” Wirpsa says.

This expertise includes knowledge of religiously derived health directives, the ability to identify values that affect healthcare decisions by listening to a patient’s story, and negotiation skills. “If experienced, proactive, and embedded in the care team, chaplains help ensure the care we offer is truly patient-centered,” Wirpsa offers.

Instead, chaplains said they were called only to provide religious counsel, rituals, and emotional support to help patients cope with illness and hospitalizations. “One aim of the study was to educate other members of the healthcare team about how the chaplain could be a valued partner in medical decision-making,” Wirpsa says.

Many chaplains are tapped to serve as ethics consultants because of their training in narrative methods, values, cultural diversity, and excellent communication skills. However, many have obtained little formal training in clinical ethics. Wirpsa developed a course for chaplains to address these knowledge gaps.

“Our research suggests that ethicists might benefit from the insights of a chaplain who has been involved with a patient or family,” Wirpsa says. Chaplains can offer insights on readiness for conversations, family dynamics, and the family’s religious beliefs. “An ethics consult is often called

late in the game,” Wirpsa notes. By that time, there are near-intractable value conflicts, both sides are firmly entrenched in their positions, and distrust has been building for a quite a while. Similarly, palliative care often is involved too late. Early involvement of chaplains can help both situations. Everyone involved “might more easily welcome the neutral, unbiased, non-threatening presence of the chaplain,” Wirpsa says.

Wirpsa says models for shared decision-making need to be revised. These approaches must take into account the unique role each member plays in promoting a care plan that aligns with patient values, beliefs, and preferences. “Interestingly, we see considerable overlap in roles between that of the professionally trained healthcare chaplain, palliative care, and ethics consultant,” Wirpsa notes.

Consulting a chaplain early could prevent the need for a consult altogether. “Conflicts between worldviews of medicine and those of faith could be avoided, or at least minimized, if a skilled healthcare chaplain were fully integrated into the care team,” Wirpsa adds. ■

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Pediatric Critical Care Providers at Risk for Compassion Fatigue

Chronic exposure to distress in patients and families puts pediatric critical care physicians at risk for compassion fatigue, according to the authors of a recent study.¹

“Compassion fatigue, burnout, and compassion satisfaction can have a significant impact on the personal well-being and professional performance of healthcare providers,” says **Jeanie Gribben**, the study’s lead author and a medical student at Icahn School of Medicine at Mount Sinai.

There has been much attention paid to burnout in physicians; in contrast, less attention has been paid to compassion fatigue and compassion satisfaction, Gribben notes. “Given their chronic exposure to patient and family distress among pediatric critical care providers, we were motivated to study this population to assess the prevalence and predictors of compassion fatigue,” says **Samuel Kase**, also a medical student at Mount Sinai and another of the study’s authors.

The researchers had positive professional experiences with pediatric critical care colleagues, who appeared to have high levels of job satisfaction. Thus, they were interested in assessing compassion satisfaction as well as compassion fatigue.

Of 252 pediatric critical care physicians, 21% reported severe burnout; about 90% of this group considered leaving their practice, according to the results of a recent survey.² The prevalence of burnout in pediatric critical care providers has been reported in various studies at between 39% and 50%.^{3,4}

“At 23.2%, the prevalence of burnout in our study population was appreciably lower,” Kase reports. The prevalence of compassion satisfaction

was only 16.8%. “This is significantly lower than what was found in other pediatric subspecialists,” Kase adds.^{5,6}

Higher compassion satisfaction scores were associated with:

- prayer or meditation practiced as a means of self-care;
- the presence of a chaplain when delivering bad news.

LESS ATTENTION HAS BEEN PAID TO COMPASSION FATIGUE AND COMPASSION SATISFACTION.

“It is not clear why the presence of a chaplain, as opposed to another supportive ancillary staff member, augments a provider’s compassion satisfaction,” says **Andrea Weintraub**, MD, the study’s senior author and an associate professor at the Icahn School of Medicine and neonatologist in the Mount Sinai Health System.

The researchers speculated that the chaplain may provide a unique layer of emotional and spiritual support to the pediatric critical care provider. Asking students to be present when delivering bad news also was associated with higher compassion satisfaction scores. This could be because it allows the provider to “transform difficult experiences into rewarding teaching and mentoring opportunities,” Weintraub offers.

Ethicists in the hospital setting may face a similar emotional toll as their pediatric critical care colleagues, Weintraub says. Both groups are

constantly exposed to challenging clinical scenarios, moral distress, and ethical dilemmas. Weintraub suggests asking a chaplain to be readily available for debriefing and discussion.

“It may be a tangible way to promote emotional processing and protect ethicist well-being.” ■

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CME/CE QUESTIONS

- 1. In a recent study on ethical issues facing hospitalists, researchers found:**
 - a. far fewer ethical issues came up during hospitalist rounds than expected.
 - b. hospitalists often requested formal ethics consults inappropriately.
 - c. many ethical issues were identified, but few ethics consults occurred.
 - d. few ethics consults were needed due to hospitalists' higher levels of clinical ethics expertise in comparison to other specialties.
- 2. Which is true regarding pediatric palliative care patients in the ED setting?**
 - a. Goals of care are not always discussed.
 - b. Providers refused to accept completed Physician Orders for Life-Sustaining Treatment forms.
 - c. Life-sustaining interventions were not offered to any patients with life-limiting diagnoses.
 - d. Documentation of goals of care resulted in many unwanted resuscitation attempts.
- 3. In a recent study on shared decision-making, researchers found:**
 - a. patients' goals of care were more likely met without palliative care consults.
 - b. providers frequently misused the term "goals of care."
 - c. the phrase "goals of care" was found rarely in clinical documentation.
 - d. "goals of care" was used correctly in patient charts to justify continuation of life-sustaining interventions.
- 4. In a recent study regarding chaplains and medical decision-making, researchers found:**
 - a. chaplains feel ill-prepared to educate families on medical concepts.
 - b. chaplains frequently act as a liaison between the patient, family, and medical team.
 - c. most chaplains reported specialized training in clinical ethics, making formal consults unnecessary.
 - d. chaplains admitted they had little knowledge about religiously derived health directives.