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INSIDE

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Do Clinicians Follow Ethics Recommendations? Relationships Are Important Factor

Ethicists often make recommendations after a consult — but does anyone actually follow them? "When consulting on an ethical dilemma, a hospital ethicist exists among several actors: Patients, families, healthcare providers, hospital legal counsel, and others," explains **Will Schupmann**, a doctoral student in the Department of Sociology at UCLA. Some of those people, inevitably, disagree with ethicists about what to do. Schupmann sought to learn more about ethicists' ability to enforce recommendations over the objections of others and how the social structure at hospitals supports or diminishes ethicists' authority. Schupmann conducted in-depth interviews with 31 clinical ethicists in 2021 about how they obtained administrative authority and cultivated trusting relationships.[1] Some key findings, based on the ethicists' responses:

• **Ethics consultation services vary significantly in terms of their authority.**

Some ethicists receive hundreds of consult requests a year, and clinicians, administrators and attorneys defer to their expertise. Other ethicists get very few consult requests, lack institutional support, and have difficulty getting clinicians to follow recommendations.

• **The social structure within hospitals affects the authority of clinical ethics consultants.**

At some hospitals, physicians tend to follow guidance from risk managers or surrogates' instructions over ethicists' recommendations. In contrast, some hospital attorneys routinely loop in ethics when a clinician seeks legal guidance on a case. "Clinicians and attorneys collZaborate with ethicists to come to a mutually agreed-upon solution," says Schupmann.

• **Ethicists' authority hinges partly on relationships with medical staff.**

Ethicists feel the need to prove themselves before certain clinicians will accept their expertise. "Cultivating key connections is essential for ethicists to have a voice in clinical decision-

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making," concludes Schupmann.

• Many clinicians view ethics as a compliance entity.

"Ethicists attempt to push back against that reputation, because they think it dissuades staff from calling them," says Schupmann. Ethicists found ways to assuage people's concerns about getting a visit from the "ethics police." One ethicist begins consults by reassuring the clinical team that ultimately, physicians still make the final call on treatment decisions.

• Some clinicians discourage colleagues from involving ethics.

Ethicists actively promote the ethics service and want to see more clinicians requesting consults. However, certain clinicians hinder those efforts by instructing others to avoid calling ethics. Ethicists shared these examples:

- A group of nurses explained to an ethicist that they wanted to call ethics earlier, but were discouraged from doing so by the attending physician.

- A department chair directly told clinicians to never call ethics.

- A nurse feared losing her job after calling ethics to report concerns about inadequate informed consent.

Ethicists work hard to win over physicians (or units) who rarely, if ever, call ethics. Some ethicists make a point of putting in "face time," while others sent articles of interest to skeptical individuals in the hopes of establishing a dialogue.

• Some ethicists are reluctant to push recommendations too forcefully.

One ethicist considered escalating concerns to the chief medical officer, but worried that the attending physician involved in the case might not call ethics in the future.

• Ethicists who lacked medical training find it harder to obtain buy-in from the clinical team.

Non-clinician ethicists are often viewed as outsiders in the clinical space. One ethicist without a clinical background usually asks a clinician-ethicist colleague to give recommendations to doctors.

Overall, the ethicists who participated in the study found various ways to obtain respect, assert authority, and counter misconceptions about their role. This stems in part from the fact that the clinical ethicist profession is still relatively new, suggests Schupmann. Some medical staff members are unfamiliar with the ethics role, particularly in smaller, non-academic hospitals. "The profession is still in the process of spreading awareness and recognition of their expertise, which is more or less what all professions go through," offers Schupmann.

Many ethicists struggle with how to inform people about the basics — who they are, what they do, and what they have to offer. "In terms of getting the word out, there's no real difference between a clinical ethics consultation service and any other service," says **Stuart G. Finder**, PhD, director of the Center for Healthcare Ethics at Cedars-Sinai in Los Angeles. Finder has found these approaches helpful:

• Have brochures about the ethics service readily available on units for patients, families, and staff.

• On institutional websites, have a dedicated web page for the ethics service that is easily discoverable using common search terms. The page should outline how the ethics service works, how to contact ethicists, and who can request consults.

• Include reminders about the ethics service in staff-oriented

publications and emails.

• Give presentations on the work of ethics at all levels of the organization — administration, clinical leadership, and frontline unit-based staff. Ethicists could give a brief overview at a unit staff meeting, give formal updates at relevant committee meetings, or give grand rounds-style lectures. "Don't be bashful about reaching out to leadership," says Finder. "It's OK to ask for the opportunity to share information about the ethics consultation service."

• Ask the question: What is the aim of the clinical ethics consultation service? "This a core question for any ethics service," says Finder. Generally speaking, Finder says that the mission of ethics services is to identify and clarify ethical questions arising within the context of patient care. Ethicists help everyone with a stake in the situation to think through various alternatives, articulate the possible choices and implications, and create space for all divergent voices to be heard. "Any recommendations made by ethicists must be responsive to all of these obligations," asserts Finder. Involved parties may object if ethics recommendations challenge their beliefs about what is best, right, or good. What is important is that all of the various stakeholders have the opportunity to voice their perspectives. "The ultimate aim is to foster open and honest engagement and develop understanding," says Finder.

Ethicists should align themselves with the mission of their particular health system, advises **Lynette Cederquist**, MD, director of clinical ethics and chair of the Hospital Ethics Committee at UC San Diego Health. Ethicists conduct weekly 30-minute rounds to discuss cases in two of the health system's intensive care units. "This is a great opportunity to create relationships, demonstrate the value of clinical ethics, and incorporate some teaching for staff. Even once-a-month rounds can have a significant impact," says Cederquist.

Ethicists ask hospital leadership what they are struggling with. "Willingness to help out will go a long way to having the hospital value the ethics service," says Cederquist. ■

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Nursing Students Have Knowledge Gaps on End-of-Life Communication

Burnout is causing many nurses to consider leaving the field of nursing altogether, as evidenced by multiple recent studies.[1-3] **Rebecca Dias**, MSN, FNP-BC, noted that lack of preparation for end-of-life care was the source of considerable stress for nursing students. "I have seen that nurses often express discomfort with providing end-of-life care. Student nurses tend to be strongly impacted by providing this care during clinical rotations," says Dias, an instructor of nursing at University of Maine at Fort Kent.

Dias and colleagues conducted a study to determine if improving nurses' comfort with end-of-life care could lessen the overall stress nurses experienced and, in the bigger picture, if it could mitigate the nursing shortage. Five nursing students participated in a simulation of a telehealth patient encounter.[4] Playing the role of a hospice nurse, the students assessed the patient's current status and needs and provided guidance to the patient and caregiver about the progression of the patient's condition and what to expect going forward.

Overall, the study participants were comfortable with the clinical aspects of end-of-life care — medication usage, physical assessments, and physiologic changes. However, the nursing students struggled with communication skills. In particular, nursing students had difficulty interacting with caregivers. One participant stated, "The communication aspect was worrisome for me and definitely what I felt least ready for." Another stated, "This experience made me realize how many unanswered questions that patients and families often have and the importance of that information."

In addition, the nursing students felt more comfortable with end-of-life communication after the simulation. One acknowledged that the simulation "took me out of my comfort zone, which always makes you learn in the long run, so I am thankful for that." Interacting with emotional patients and family was particularly challenging for the students. Students noted that the simulation was helpful in this regard specifically because it involved interacting with actual people instead of manikins. "This can more closely

replicate an actual clinical encounter, and allows the student to learn the limits of their knowledge in a safe environment," says Dias.

Undergraduate nursing education needs to offer students more opportunity to practice communicating with patients and caregivers in end-of-life cases, the study's findings suggest. "This will help alleviate the anxiety and stress that students feel, leading them to more effectively communicate sensitive information with patients and their loved ones," concludes Dias. ■

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What's Futile Care? Clinicians, Families Have Different Views

Many ethics consults involve conflicts between clinicians and families about end-of-life care. After speaking with the various parties, ethicists sometimes realize that the root of the issue is differing views of what constitutes "futile" care.

"Most of us, as we journey from our birth — 'Point A' — to our death — 'Point Z' — desire a healthy, fulfilling, meaningful life," says **Abenamar Arrillaga**, MD, FACS, FCCP, associate trauma medical director at Good Samaritan University Hospital in West Islip, NY. However, some people reach a point — which Arrillaga calls "Point Y" — where quality of life is no longer possible. "If we become sick and we are in between point A and Y, most of us want to find a cure, at best, or want to prolong our life with quality as second best. However, as all practitioners of medicine know, there are many times when a person reaches point Y," says Arrillaga.

At that point, continued aggressive care, rather than prolonging life, instead prolongs the dying process, explains Arrillaga. Individuals vary as to when they conclude that this point has been reached. However, clinicians may come to a different conclusion. "There may be a gap between what providers feel is a futile situation vs. what laypeople, who are not in the healthcare field, feel is futile," explains Arrillaga.

Arrillaga and colleagues conducted a research study to explore this gap.[1] Study participants were divided into two groups: 36 physicians (emergency medicine attendings, trauma surgeon attendings, and emergency medicine residents) and 30 non-healthcare workers (patients and their families in a waiting room of an outpatient trauma clinic). The researchers gave participants a questionnaire based on three scenarios involving treatment plan decisions. For two of the scenarios, there were futility gaps. A significantly larger percentage of physicians stated that they would not pursue treatment that was potentially futile compared to non-healthcare workers who were more supportive of continuing treatment.

In the third vignette, there was no significant difference between physicians and laypeople on whether to surgically remove a cancer in an elderly woman with advanced dementia. However, more physicians (91.7%) felt that the patient's advanced dementia was an important factor in the decisions, compared to laypeople (63.3%). "This indicates that for physicians, quality of life is important when making these medical decisions. I would say for laypeople it is true, but not as much," says Arrillaga. Other key findings:

- For both groups, likelihood of recovery was the most important factor in treatment decisions.
- Physicians placed greater importance on the potential for futile treatment to harm patients than non-healthcare workers.
- Non-healthcare workers prioritized patient satisfaction and fulfilling family wishes more than physicians.

For clinicians, the "futility gap" raises some important ethical considerations. "Clinical decision-making is complex, involving many factors — medical, cultural, societal, economic, legal, and humanitarian,"

notes Arrillaga. Clinicians' conclusion that a point of futility has been reached must be communicated to the patient or surrogate. During this conversation, providers can bear in mind that there likely are differences in perceptions of what constitutes futile care. "There is an opportunity for improved communication and more realistic decision-making," offers Arrillaga.

Few healthcare providers are also clinical ethicists. "However, we do get a modicum of ethical training, and throughout our practice are confronted with ethical decisions on a daily basis," says Arrillaga. Thus, clinicians may reach the conclusion that a point of futility has been reached earlier than patients or surrogates do. "All of us, ethicists included, can benefit from increased training and knowledge about ethics as it relates to medical decision-making," asserts Arrillaga.

Most healthcare providers explain treatment recommendations to patients and families in terms of medicine. Ethical principles, such as preservation of life, salvageability, nonmaleficence, autonomy, justice, or societal impact, typically do not come up during those discussions. "By the time the presence of futility is being discussed at the bedside, it is usually too late to apply ethical principles to change mindsets and decisions," says Arrillaga.

A more proactive, comprehensive approach is needed, suggests Arrillaga. That includes policy makers, administrators, insurance providers, members of the judicial system, pharmaceutical manufacturers, the media, and laypeople.

"All of us as a society — as a group of professionals in the medical field, as administrators, as law makers, as family members — can make contributions to decreasing the futility gap," concludes Arrillaga. ■

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Ethicists Find that Empathy, Accurate Information Defuse Conflicts

Edward Dunn, MD, ScD, MBA, MPA, MPH, makes a point of never using the word "futile" with patients or their families. "It is a word that may elicit negative reactions from people and that can be emotionally charged in difficult situations," explains Dunn, an associate professor of palliative medicine at the University of Louisville School of Medicine and medical director of palliative care and Ethics Committee chair at Jewish Hospital of Louisville.

Families may interpret the word "futile" to mean that clinicians are just giving up, that the patient is not important enough to continue the current level of care, or even that clinicians are trying to clear the bed for a more deserving patient. "No one can agree on what the word 'futile' means. In terms of benefit to a patient, does it mean fifty percent chance of recovery? Ten percent? One percent?" asks Dunn.

That kind of probabilistic language also is problematic. "Most people cannot relate to probabilities and will often ask for a more practical interpretation of the numbers," Dunn explains. Families and patients ask, "Is he going to make it?" or "Am I going to die?" When discussing a highly unlikely recovery from a medical illness, clinicians might say there's a 1% chance of survival. To this, many people would say, "I'll take it." "I find this language unhelpful when trying to work with a family of a critically ill patient," says Dunn.

Clinicians must establish a plan of care that is medically indicated. That plan must be acceptable to the patient or family. "Medical indications must be in balance with patient autonomy," says Dunn. If a patient or family requests medical treatment that is not medically indicated, clinicians do not provide that treatment. This scenario came up frequently during the pandemic with patients with pneumonia on prolonged ventilator support. The patients' lung function had been irreparably injured, such that it was incompatible with life without mechanical ventilator support or extracorporeal membrane oxygenation support. "Those were cases in which we knew the critical care support was no longer benefiting the patient, because there was no path to recovery," Dunn explains. Continuing the same level of critical care was no longer beneficial, because it subjected the patient to harm and there was no achievable goal. "It simply prolongs the dying moment," says Dunn.

Conveying respect to families is of the utmost importance. Family members with anticipatory grief may feel as though their loved one no longer has a voice in the discussion. Some make comments like, "The doctor has dismissed us." "This is a very real dynamic — and another

reason to avoid the 'futility' term," says Dunn. Dunn uses the terms "non-beneficial" or "ineffective" to describe treatment that is likely to do more harm than good. Occasionally, family members imply that physicians do not really care about their loved one. Clinicians should respond with empathy and compassion. "Emphasize the wish to mitigate human suffering — and reinforce the poor prognosis, which is an unfortunate reality. We must always return to reality, regardless of how painful it is for the family to accept," advises Dunn.

Dunn routinely talks with medical students, residents, fellows, and the clinical team of nurse practitioners, nurses, social workers, and chaplains about how to communicate with patients and families. Hopefully, this prevents some conflicts over whether end-of-life care should be continued or withdrawn. "But experience is the best teacher. Most of this is simple human communication, and sensing where patients and families are emotionally," offers Dunn.

Clinicians tend to think in terms of "appropriate" or "inappropriate" medical treatment, says **Wayne Shelton**, PhD, MSW, professor of bioethics and medicine at Albany Medical College's Alden March Bioethics Institute. If a family is requesting treatment that is non-beneficial and could likely cause unnecessary harm to a patient, it could be construed to be inappropriate. "Generally, doctors are not required to provide treatment that tends to cause more harm than good for the patient," says Shelton.

For clinicians, it is important to distinguish between qualitative futility and physiological futility. If a patient has reached the point where it is physiologically impossible for medical treatment to be effective, then there is no obligation to provide the treatment. In Shelton's experience, cases where there is disagreement usually involve qualitative futility. For example, a patient in a vegetative state could live for many years with a feeding tube. From a physiological standpoint, the intervention is effective — it provides nutritional support. Whether it is an acceptable quality of life is another matter. "That's the point of qualitative futility — it's value-laden. And we generally provide more flexibility in granting surrogates what they want based on their own values," says Shelton.

Clinicians must empathize with what it is like to be a family member being asked for direction on how to proceed. "Surrogate family members, understandably, aren't rational onlookers in these situations. They don't have that detachment and objectivity that doctors have," says Shelton. Family may think a miracle will happen or that the patient will recover against all odds. The challenge for the care team is to give the family time to acclimate to the facts and get beyond the shock of the situation.

"A lot of decision-making is based on how the doctors interpret the situation medically, how severe the injury or the disease is, and what the reasonable options are for managing it," says Shelton. Shelton says ethicists can guide the family in answering complex questions such as: Is this person going to be bedridden and unconscious or have multiple acute medical problems for the rest of their lives? In short, what kind of lives are they going to have? Will it be a quality of life they would want?

Conflicts are not always about families wanting to continue non-beneficial treatment. Sometimes it is the opposite — the family wants to withdraw treatment, but the care team disagrees. This can happen if a patient has some cognitive impairments immediately following a stroke. The patient may have indicated in the past that they would never want to live with those types of deficits, so the family wants to stop life support. Yet clinicians believe there is a possibility of meaningful recovery, so further discussion continues.

Regardless of the facts of the case, clinicians are obligated to give an accurate picture of the patient's current clinical situation and prognosis. At the same time, clinicians must help families from an emotional perspective. "Console them, support them — and explore if they really believe their loved one would want this, and if continued treatment is in their best interest," says Shelton. ■

Unique Ethical Dilemmas for Mental Healthcare of Infants, Young Children

Infant and early childhood mental health practitioners face complex and unique ethical issues. "But there has been little explicit attention to the ethical dilemmas that emerge when taking care of vulnerable infants and their families," says **Paula Zeanah**, PhD, research director at the Cecil J. Picard Center for Child Development & Lifelong Learning at University of Louisiana at Lafayette. Zeanah and colleagues argue that a code of ethics is urgently needed.[1] "Ethical codes for the involved professional disciplines fail to provide guidance

about when caregivers and infants' needs diverge," according to Zeanah. Currently, ethical guidance in the field is limited to general statements on values, principles, or professional comportment from professional societies and specialty organizations. These do not provide enough detail to guide clinicians' actions, the authors argue.

An infant's needs may conflict with those of the caregiver. "This is a common ethical challenge," says Zeanah. Some caregivers are unable or unwilling to consider the infant's needs over their own. In other cases, the parent's needs require attention before the infant's needs can be addressed. "Thus, there is the dilemma of beneficence for one and potentially maleficence for the other," explains Zeanah.

Laws protect children from abuse and neglect, but situations are often not so clear-cut. Some cases are more of a gray zone, leaving clinicians unclear on whether, when, or how to act. For example, an infant's caregiver may have a substance use problem, or suffer from depression — both treatable conditions. "But the caregiver can choose whether to participate in treatment, or the treatment response may be slow," says Zeanah. The caregiver's symptoms may hinder the ability to recognize and respond to the infant's needs, risking behavioral or developmental delays. The ethical question then becomes: At what point does the infant's need for safe, nurturing care take priority over the caregiver's right to determine their own health?

"Another common challenge is an 'eye of the beholder' question," says Zeanah. A young child with a speech delay initially may be evaluated by a speech therapist, pediatrician, early education provider, or child protection worker. Each of those providers evaluates the child through a specific "lens" — thus, the level of concern can vary considerably. "The ethical concern with this is beneficence and nonmaleficence," says Zeanah. A child in this situation could end up with a missed or wrong diagnosis, inappropriate treatment, or delayed treatment.

Hospital-based professionals encountering these dilemmas can turn to ethics committees and clinical ethicists. Such resources are not available in community-based settings. Zeanah argues that ethicists and clinicians have an obligation to be sure that identified ethical concerns are addressed post-discharge. For example, clinicians can connect families with appropriate community programs. "Ethical issues do not disappear after discharge — and may be exacerbated by the infant and family's experience during the hospitalization," says Zeanah. ■

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Ethical Input Needed for Digital Models and Simulations in Healthcare

Digital models and simulations are a quickly evolving technology that, like artificial intelligence (AI) tools, will change clinical practice and patient care. **Kristin Kostick-Quenet**, PhD, an assistant professor at Baylor College of Medicine's Center for Medical Ethics and Health Policy, was lead author of a recent paper on how ethicists are integrating social determinants of health into digital models and simulations.[1] *Medical Ethics Advisor* (MEA) spoke with Kostick-Quenet about ethical considerations with this technology.

MEA: Where do things stand currently with digital models and simulations in healthcare? What should clinicians and ethicists be aware of regarding this evolving technology?

Kostick-Quenet: Creating these types of virtual models is becoming enabled by a growing variety of data collection devices. These could be wearables or other types of computer perception devices that can detect things about you or your surroundings and translate them into computational representations of your biological processes, behaviors, or — some even argue — your thoughts and feelings.

When you put enough of these relevant data together, along with scientific understandings of biological or psychological processes, you can potentially create virtual models that can predict the likelihood that certain clinical outcomes might happen.

These types of virtual models were first created by NASA in the 1960s to predict how spacecraft would react to the extreme environments of spaceflight. After this pioneering step to create a "digital twin" of these mechanical and physical systems, virtual models progressed and were extrapolated to airplanes, transportation systems, and buildings

in an effort to model how these systems might react to different conditions and physical pressures. Only recently have these models promised to play a role in healthcare and patient outcomes.

In healthcare, virtual models are still in the very early stages and are just beginning to take shape. Building virtual models for healthcare is a little trickier than building a virtual twin of a mechanical system.

We are still a long way from using virtual simulations as a replacement for clinical trials or from being able to use virtual models in clinical care with real patients. But because these are the early stages, we have an opportunity to lay the groundwork for what kinds of standards — both technical and ethical — we expect from these technologies.

MEA: What are unique ethical concerns when digital models and simulations are applied to human health?

Kostick-Quenet: For a physical or mechanical system, with the right kind of tools and background knowledge about causal properties from physics and engineering, you can probably anticipate outcomes pretty well. But health and illness are quite different. All kinds of social phenomena (collectively called "social determinants of health") shape disease, illness states, and health outcomes. These could include anything from eating habits, where you live, exercise habits, cultural and social practices, or treatment-seeking behaviors. If you are building a system where you are trying to capture all the mechanisms that lead to a health outcome, this means you have to computationalize all of those things. And this is something that we still do not do very well at all. Often, we don't even know the full range of health predictors or which are the most important for which types of conditions. Even just capturing a few of them has proven to be notoriously difficult.

For a long time, the idea that sociocultural and politico-economic factors contribute to health was just kind of skirted under the rug. Luckily, there are now a lot of funding mechanisms focused on identifying and addressing social determinants of health.

MEA: What is the central ethical concern with digital models or simulations that you see currently?

Kostick-Quenet: If you create a model that is the prototype model for a given patient or maybe an average patient, it's not going to be generalizable or applicable to all patients. You want a virtual model to be broadly customizable across different demographics, societies, ethnic and cultural subgroups. Otherwise, you will have a model that is prone to error and nonapplicable across diverse patient populations.

This same conversation is being had in the wider context of AI. If you seed models with training data that are not diverse, the model will not be able to accommodate the wide range of heterogeneity that may be relevant to understanding or robustly predicting your outcome of interest.

The same is true for these virtual models. If you're trying to model how a patient's heart might function based on a simulation built from limited and nondiverse data, the model is not likely to perform well for a patient that falls outside the average characteristics of the training data. It would be unethical to use a virtual model in this way, because there is not a lot of wiggle room for inaccuracy in high-stakes health decisions.

I would say that is the main ethical concern: Ensuring diversity in virtual models and simulations, not only in terms of clinical characteristics but also clinical etiologies.

MEA: What about ethicists whose skill set does not include technology? How can those ethicists play a role in ensuring digital models and simulations are ethically developed and implemented?

Kostick-Quenet: There's a growing recognition among developers that you can't wait until the deployment stages to bring in perspectives from clinicians and ethicists. You need to integrate these perspectives from the beginning. Developers are starting to do this in good faith. It's not in their interests to operate with blinders on.

A lot of ethicists come from an interdisciplinary background, with varying levels of training, some minimal, in computational or other technical fields.

Now that AI is such a hot topic, there is a wider range of people who don't have technical backgrounds contributing to the discourse on these topics. But to engage in some of the hairier questions that these virtual models raise, you do have to be willing to dive more into certain literatures that you might not be able to fully understand at first. It is a humbling process. But there has to be a willingness for anyone interested in chiming in from an ethical, regulatory, or philosophical perspective to engage with more of the technical side of things as well. And we see that happening, which is a good sign. ■

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Ethical Responses if Faculty Object to Teaching Physician-Assisted Death

Multiple recent papers focus on the ethics of conscious objection of providers participating in medical aid in dying (MAID).[1-3] "However, we weren't aware of any recommendations or guidelines to conscientious objection to teaching MAID," says **David Wendler**, MA, PhD, head of the section of research ethics at NIH Clinical Center.

Recently, the chief of a palliative care consultation service team that trains fellows from all over the country included training on MAID, which is legal in some form in many jurisdictions. "The challenge was that a number of clinicians on her team were personally skeptical of, or opposed to, MAID," says Wendler. This presented a conflict between the need to ensure that fellows got the necessary training and the need to respect the views of the individuals who objected. Wendler and colleagues examined the ethics of conscientious objection to teaching physician-assisted death to trainees in palliative care programs.[4] "Some may say teaching is different because the individual isn't actively participating, and is just teaching somebody else what's involved. We thought that required a separate analysis on to what extent people should be allowed to opt out to teaching something like MAID," says Wendler.

It probably is not necessary to allow faculty to opt out altogether from teaching MAID, the authors assert. Teaching about the history of MAID and presenting arguments for and against the practice are different from teaching how to do the procedure. If the institution does allow faculty to opt out of teaching some aspects of MAID (or altogether), there's a need to ensure sufficient education for trainees. "Palliative care training already tends to be pretty collaborative in most institutions," notes Wendler. Thus, it probably would be possible for other faculty to step in, even internally or outside the institution, to cover the aspects of MAID to which the faculty member objects.

Some argue that clinicians have a professional obligation to provide whatever medical interventions are legal in the jurisdiction in which they are practicing. "The problem with that is that it seems like it at least potentially doesn't offer sufficient respect for the personal values of clinicians," says Wendler. For academic institutions, it is a similar ethical balancing act. There's an obligation to ensure trainees get a good education. "But it's also important to respect educators' values and work hard to not undermine their clinical, professional, and personal integrity," says Wendler.

Institutions would not necessarily need a formal policy for faculty opting out of teaching MAID, according to the authors. It could take the form of recommendations or a guidance. The important aspect is for institutions to consider the issue ahead of time. "Our hope is that in doing that, it will help institutions to avoid making mistakes — either by undermining education or by putting faculty in a position where they have to do things that go against their values," says Wendler.

MAID remains a controversial issue, both within the medical community and in society more broadly, observes **Jacob M. Appel**, MD, JD, MPH, HEC-C, director of ethics education in psychiatry at Icahn School of Medicine at Mount Sinai and an attending physician at Mount Sinai Health System. Some form of MAID is legal in 10 states and the District of Columbia.[5] "The current legislative landscape suggests the number of jurisdictions that permit MAID will only increase," notes Appel. However, some physicians object to participating, and some medical students and residents wish to be excused from learning about MAID. "Conscientious objection raises ethical challenges for medical schools. It is worth noting that this situation is not novel," adds Appel.

Some trainees object to learning about or engaging in elective pregnancy terminations or elective vasectomies. Abortion and sterilization are covered by specific federal statutes known as the Church Amendments, enacted in the 1970s to protect the conscience rights of healthcare providers. "Society has created legal carve-outs excusing trainees from engaging in these areas, and will likely do so for MAID as well. However, it should be noted that the legal resolution is not the same as the ethical one," says Appel.

Physicians may have a moral duty to serve the public in ways that lawyers, accountants, or barbers do not. As long as a sufficient number of providers offer services in these areas, ethical concerns are minimized.

However, if a practice like MAID or non-therapeutic abortion were legal, but no providers (or very few) are willing to offer it, it would raise ethical concerns about patients' right to access those services. "Balancing the goal of ensuring that people

from all cultural and religious groups can become doctors and the goal of ensuring access to care, even for controversial interventions, is not an easy one," says Appel.

The related ethical issue is whether faculty must teach about controversial procedures. "Even though I am opposed to capital punishment, when I teach a class on constitutional law, I am expected to teach the case law related to the death penalty. That is my job," notes Appel.

Similarly, medical faculty are expected to offer instruction on the subjects which they are hired to teach. "Of course, that does not mean endorsing these practices or demonstrating them in their own clinical work," says Appel. A medical school might choose to allow a faculty member to opt out of teaching a particular subject.

Additionally, The Coats Amendment of 1996 allows an entire program not to teach about abortion. "If the program chooses to do so, they will find someone else to teach the subject. That is the legal rule as it applies to abortion specifically," Appel explains. "But in other areas, such as MAID, this practice is discretionary for the medical school."

Another option is for medical school faculty to add a disclaimer stating that they personally object to the procedure in question before teaching about it. "However, teaching medical students is a privilege, not a right, and it comes with responsibilities," argues Appel. "One of those responsibilities is serving the general public by training future physicians in the skills that society has determined are important for the greater welfare." ■

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Ethical Decision-Making with Deprescribing for Older Adults

Physicians must consider multiple ethical issues when making decisions on deprescribing for older adults with dementia, a recent study found.[1] In 2021, researchers surveyed 689 primary care physicians and asked them to consider situations in which a physician might decide to deprescribe. In one of the hypothetical cases, the medication could result in an adverse drug event; in the other hypothetical case, there was no evidence of benefit. The physicians then ranked factors related to ethical and pragmatic concerns. In both of the hypothetical cases, physicians reported these as the two biggest barriers to deprescribing:

• that the patient or family reported benefit from the medication, so the physicians worried that deprescribing could worsen symptoms;

• that the medication had been prescribed by another doctor.

Patients are taking more prescriptions in large part because of seeing multiple specialists, most of whom are reluctant to discontinue medications prescribed by a different provider, says **J. Russell Teagarden**, DMH, MA, a medical ethicist who has worked in community pharmacy, hospital pharmacy, and in medical affairs in pharmacy benefits administration. From the standpoint of an individual patient, ethical deprescribing "comes down to a straightforward analysis of risk and benefit," says Teagarden. With older patients, the risk/benefit ratio for the same drug can change over time and has to be re-evaluated on a regular basis, adds Teagarden.

Unnecessary prescriptions are ethically concerning because they could harm individual patients. However, the situation also affects healthcare more generally. "What I don't hear mentioned much in this context is, more broadly, the societal element," says Teagarden. Pharmacies are overwhelmed by the sheer number of prescriptions being filled, not all of which are needed. This is happening amid growing concerns about the high prevalence of burnout among pharmacists.[2] "There is an ethical rationale to reduce the volume of prescriptions to take pressure off

the pharmacies, allowing them to serve people in need better," asserts Teagarden.

Ideally, the work of deprescribing would occur mainly in the outpatient setting, says Teagarden. This would require patients to have good relationships with primary care providers (PCPs) and for PCPs to have time for in-depth review of prescriptions. In reality, healthcare providers are pressed for time and might be seeing the patient for the first time. "Where do you get that capacity? The current system of healthcare delivery is set up to work against that," says Teagarden.

At some skilled nursing facilities, pharmacists historically reviewed medications of residents on a regular basis. "Invariably, those populations are going in and out of hospitals, are put on drugs that are very specific to the hospitalization, and are discharged on those drugs," says Teagarden. Some drugs used for the hospitalization get continued at the nursing home. Pharmacy reviews resulted in some of those drugs being discontinued. Similar efforts are made at some hospitals, where pharmacists perform medication reconciliation. The focus is on patient safety and drug interactions — for medications the patient is taking currently, medications that are given at the hospital, and medications the patient will be prescribed on discharge. However, these efforts are not quite the same as having a designated healthcare provider review the patient's medications with a central focus on deprescribing unnecessary medications, says Teagarden.

"On an ethical level, it's easy to get on a high horse and say, 'People are on too many drugs and we need to take them off some of them.' But it requires careful consideration," Teagarden underscores. Some drugs require tapered withdrawal, and it is necessary to carefully consider the patient's history and reason for each prescription. In years past, community pharmacists typically did this to some degree by calling the physician if the patient was taking medications the pharmacists felt might be unnecessary. "Pharmacists would call the doctor, talk it over, and get it fixed," says Teagarden. "But that takes time — and that's the one thing that people in healthcare don't have." ■

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Informed Consent Practices for Acute Stroke Treatment Vary

Currently, the two cornerstones of acute ischemic stroke treatment are intravenous (IV) thrombolysis and, for patients with large vessel occlusions, endovascular thrombectomy. "Both of these interventions play roles in improving outcomes but also carry risks," says **Michael Young**, MD, MPhil, a neurologist and researcher at Massachusetts General Hospital and Harvard Medical School.

For treating clinicians, the question becomes: How do clinicians ensure that patients (or their surrogate decisionmakers) make an informed decision, while avoiding treatment delays that can result in worse outcomes?

"There may be an inherent tension between the traditional norms of informed consent and the clinical imperatives that exist in the context of acute ischemic stroke — and the management decisions that surround this often-devastating condition," suggests Young.

Young and colleagues conducted a literature review on informed consent practices for patients presenting with acute ischemic stroke who were treated with IV thrombolysis or endovascular thrombectomy.[1] Practices varied significantly among physicians and hospitals. Some key findings:

- Among hospitals and physicians, between 21% and 37% always required consent.
- There were discrepancies in the information shared in terms of whether the provider disclosed the stroke diagnosis, benefits, risks, and IV thrombolysis mechanism.
- For endovascular thrombectomy, research on informed consent practices was scarce.
- Consent requirements tended to be stricter for patients presenting within an extended (three- to 4.5-hour) time frame. "The medicine is approved by the FDA for up to three hours. We will often still recommend it up to 4.5 hours based on guidelines and some pretty reasonable data, but it's a little bit of a gray area," notes **Robert Regenhardt**, MD, PhD, another of the study authors and a

neurointerventionalist and stroke scientist at Massachusetts General.

Physicians must weigh ethical principles such as autonomy, beneficence, and nonmaleficence alongside practical and legal considerations. Physicians also must consider the nuances of the individual case. "Every situation is a little bit different," says Regenhardt. If the patient is being transferred for the procedure and physicians are waiting for the patient to arrive, there would be very little downside to calling the family to discuss the risks and benefits of the procedure. Other times, the patient presents directly to the hospital and physicians have to drop everything to make a treatment decision. "In those situations, it's less clear. Would you want to get informed consent knowing it would delay the procedure?" asks Regenhardt.

Some clinicians prioritize completing the procedure as quickly as possible; others place more weight in ensuring a well-considered analysis of the patient's preferences, values, and goals takes place. "Some of us are pretty aggressive about always wanting to get informed consent before the procedure; others don't think it's hugely important given the evidence of the efficacy and safety of the procedure," says Regenhardt.

The researchers are currently surveying physicians on informed consent practices. "We are seeing a lot of variability in the free response comments. People have very strong feelings on either side of this," says Regenhardt.

The researchers expect to see significant variation in terms of regional locations, background specialty, and who gets informed consent. "That can vary from center to center. At one place, it might be the neurology resident; at another, it might be the neurointerventional attending," says Regenhardt.

Since thrombolysis for acute ischemic stroke was approved in 1996, uncertainty has surrounded the informed consent process.[2] "Some clinicians, especially early after the approval of alteplase for acute ischemic stroke treatment in the zero-to-three-hour time window, obtained written consent," observes **Philip B. Gorelick**, MD, MPH, a professor in the Division of Stroke and Neurocritical Care at Northwestern University Feinberg School of Medicine. Other clinicians obtained verbal consent only, or none at all. Clinicians now have the following guidance to clarify consent obligations for stroke treatment:

- The American Heart Association (AHA) issued a 2003 guidance statement recommending that written consent was not necessary but that patients and their families should be informed about the potential benefits and risks of acute thrombolytic therapy.[3]
- In a 2019 guidance statement, the AHA justified administrating IV thrombolysis in an eligible adult patient with an acute ischemic stroke if the patient could not provide consent and a legally authorized representative was not immediately available to provide proxy consent.[4]
- In 2022, the American Academy of Neurology recommended that the patient and surrogate be informed about the stroke diagnosis, the rationale for thrombolytic therapy, the prospects for a good functional outcome with and without treatment, and the risks of therapy (including brain hemorrhage and angioedema.[5]

When physicians are contemplating administration of acute stroke therapies, it is important to consider the patient's preferences, adds Gorelick. This can be done either by directly questioning the patient or through a legally authorized representative if the patient lacks decision-making capacity. In some cases, a surrogate decision-maker is not available. "In such cases, the clinician may provide treatment based on implied consent, which assumes that a reasonable person faced with similar circumstances would agree to treatment," says Gorelick. ■

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It Is Not Just Physicians: Residents also Receive Industry Payments

Drug and device makers publicly report all gifts made to physicians and advanced practice providers, as required by the 2010 Physician Payments Sunshine Act. Residents and other trainees are excluded from this requirement — but that does not mean these providers are not receiving payments. Of the 124,715 residents in all training programs in 2020-2021, 12% received payments totaling $6.4 million, as recorded in the Open Payments Program database.[1]

"This study provides a window into how physician-industry relationships form," says **Sean O. Hogan**, PhD, the study's lead author and director of outcomes research and evaluation at the Accreditation Council for Graduate Medical Education (ACGME). Since reporting for payments made to residents is voluntary, the actual number is likely higher, assert the authors.

The researchers further analyzed of 65,992 residents in six specialties (orthopedics, urology, general surgery, OB/GYN, family medicine, and internal medicine). Some key findings:

- 13.4% of residents received at least one gift from a drug and device company. Most of the gifts were meals. The average resident who accepted a gift received the equivalent of about $65.
- Residents in orthopedics, urology, and OB/GYN had a higher probability of accepting industry payments than residents in internal medicine.
- Of orthopedic surgery residents, 39% took industry gifts with an average value of $526.
- For family medicine residents, the median value of a single gift was $17. In contrast, for an orthopedic surgery resident, the median value of a single gift was $112.

There is no evidence that payments were associated with compromised patient care, the study authors acknowledge. "At least in theory, important innovations can emerge from communication between practitioners and industry representatives," says Hogan.

A 2009 report published by the Institute of Medicine discussed industry-physician trainee interactions and recommended that educators should prepare learners to navigate potential conflicts of interest.[2] "Residents learn from observing what goes on in their learning environments. Efforts made by programs and faculty to model ethical conduct become part of the trainees' formation," says Hogan. The ACGME requires that institutions maintain a policy that addresses interactions between vendor representatives and residents/fellows. "While the ACGME does not stipulate the specifics of those policies, they need to be maintained," says Hogan.

This study draws attention to an ethical concern that has been largely overlooked since the passage of the Sunshine Act, says **Matthew Wynia**, MD, MPH, FACP, director of the Center for Bioethics and Humanities at University of Colorado Anschutz Medical Campus. Wynia was lead author of a commentary on the study.[3] "We don't really know how many residents are getting so-called free lunches from industry. This recent study shows it might be pretty common, especially in certain specialties," says Wynia.

Patients probably do not even consider the fact that a resident physician could have a financial conflict. "To be honest, my hunch is that many members of the public don't know the difference between an intern, a resident, a fellow, or a physician who has completed training. In any event, I think they should expect us all to live up to the same ethical standards," says Wynia.

For all types of providers, this means avoiding direct financial conflicts with drug companies as much as possible. Patients should be able to trust that providers are making decisions without incentives to use one drug or another, no matter what stage of career the healthcare provider is in. "Mistrust in medicine is such a huge issue these days. So much of it is driven by the concern that doctors might be in the pocket of drug companies. We really need to double down on our efforts to show that we are worthy of patient and public trust," emphasizes Wynia.

Ethicists are well-positioned to call attention to the destructive impact of financial conflicts on patient and family trust, says Wynia. Wynia offers these examples of how ethicists can raise this issue:

• Ethicists can help to develop organizational policies on whether to allow drug reps onsite.

"Ethicists are probably more aware of the voluminous research on how incentives like small gifts actually work than are average clinicians or administrators at hospitals," notes Wynia. Small gifts like a lunch are not likely to make doctors overtly biased. "Instead, they work through

gift relationships, which are extremely subtle," Wynia explains. "The person affected doesn't even notice that their prescribing patterns have changed." Multiple studies have shown that small gifts do, in fact, change doctors' prescribing behaviors.[4-6] "This has been proven over and over. Even though most clinicians sincerely believe they aren't affected by small gifts, in the aggregate we know that they are," says Wynia. "After all, if they didn't work, drug companies wouldn't spend so much money buying lunches for doctors."

• Ethicists can share relevant comments made during consults.

"I'll bet every clinical ethicist has examples of patients or family members implying that the doctor or hospital isn't worthy of their trust because they're allied with drug companies and motivated by profit," says Wynia.

• Ethicists can ask organizations to decide how important is it for patients to trust that clinicians are not influenced by industry.

"If that's a high priority — and I think it should be — then they should develop policies and practices to reinforce that priority," asserts Wynia. ■

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Audio Assistance Improves Minorities' Willingness to Participate in Research

Audio-assisted informed consent forms significantly improved the willingness of a sample of primarily African American patients to participate in a mock clinical trial.[1] "Clinical trial informed consent language has become increasingly complex and difficult to understand for prospective subjects, regardless of race and ethnicity," says **Brenda Jamerson**, PharmD, the study's principal investigator and an adjunct assistant professor in the Department of Psychiatry and Behavioral Sciences at Duke University. A lack of understanding of medical and research information drives unwillingness to participate in clinical research studies. At the same time, African American and Hispanic communities only account for approximately 10% and 6% of clinical trial participation, respectively.[2]

Jamerson and colleagues wanted to determine if fostering understanding of informed consent language via audio assistance and teach-back could overcome this disparity. The researchers compared a standard, read-only informed consent form to an audio-assisted approach (both with and without teach-back). The audio assistance software read the informed consent form summary and participants controlled the pace of the text. Audio-assisted presentation of informed consent language improved willingness to participate in clinical trials, but the teach-back component did not. "This might be due to our sample size. Or it could be that audio methods of presenting complex information are effective in themselves," suggests Jamerson.

Clinical trial researchers have an ethical duty to determine whether a prospective subject understands the information presented in informed consent language, underscores Jamerson. "Fostering appreciation and understanding of informed consent language helps assure subject autonomy. It could also improve recruitment of participants from underrepresented communities who

COMING IN FUTURE MONTHS

- Must-have metrics to improve ethics consult quality
- Clinicians have misconceptions about ethics service
- Ethical concerns with fraud in social media research
- Dramatically improve POLST form completion rates

might be prone to distrusting medical research," says Jamerson. ■

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Higher Mortality for Neurosurgery Patients with Pre-Existing DNRs

Neurosurgeons at University of Rochester Medicine observed that patients with pre-existing do-not-resuscitate (DNR) orders receiving cranial neurosurgery tended to have poor outcomes. To see if their clinical observations were reflected in actual data, the neurosurgeons analyzed 30,384 patients who underwent cranial neurosurgery in 2018-2020.[1] Some key findings:

- The 2,505 patients with DNR orders received gastrostomy and tracheostomy less compared to patients without DNR orders.
- Patients undergoing cranial neurosurgery with pre-existing DNRs had higher mortality rates compared to non-DNR patients.
- Half of the patients with DNR orders died during their hospitalization.

Given these findings, there are important ethical implications for clinicians evaluating patients with DNR orders who are also eligible for cranial neurosurgery. "It is important to highlight the potential for poor outcomes with surrogate decision-makers and to discuss the possibility of suspension of a DNR in the perioperative setting," says **Benjamin George**, MD, MPH, one of the study authors and an assistant professor in the Department of Neurology at University of Rochester Medicine.

It is important for neurosurgeons to consider what the patient would want in each scenario. "Ethicists and clinicians can guide surrogates in making decisions that are in keeping with patient autonomy and self-determination," offers George. ■

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CME/CE QUESTIONS

1. **Which did a study find regarding clinical ethicists?**
   a. Physicians followed ethicists' recommendations over the objections of hospital attorneys.
   b. Ethicists struggled to obtain clinicians' buy-in.
   c. Ethicists wanted to be viewed as a compliance entity.
   d. Ethics recommendations superseded physicians' decision-making.
2. **Which did researchers find regarding nursing students and end-of-life care?**
   a. Nurses had significant knowledge gaps with medication usage.
   b. Nurses preferred to interact with caregivers instead of patients.
   c. Nurses' skills improved only if simulations used manikins.
   d. Nurses mainly struggled with communication skills.
3. **Which did researchers find was the most important factor in treatment decisions for both physicians and non-healthcare workers?**

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CME/CE QUESTIONS

a. Likelihood of recovery
b. Quality of life
c. The potential for futile treatment to harm patients
d. Patient satisfaction

4. **What does David Wendler, MA, PhD, advise regarding conscientious objection to teaching medical aid in dying (MAID)?**
a. Institutions are required to have a formal policy on faculty opting out of teaching MAID.
b. If faculty opt out from teaching MAID, institutions must ensure sufficient education for trainees.
c. The issue is becoming less prevalent due to a decreasing number of jurisdictions permitting MAID.
d. There are legal carve-outs excusing faculty from teaching MAID.

5. **Which did researchers find regarding informed consent for acute stroke treatment?**
a. Most hospitals and physicians always required consent.
b. All providers disclosed the stroke diagnosis, benefits, risks, and IV thrombolysis mechanism.
c. Consent requirements were stricter for patients presenting within the extended three- to 4.5-hour timeframe.
d. Hospital policies no longer allow providing treatment based on implied consent.

6. **Which did researchers find regarding industry payments made to residents?**
a. The average resident who accepted a gift received the equivalent of over $1,000.
b. Payments to residents decreased due to mandatory reporting requirements.
c. Residents in orthopedics, urology, and OB/GYN had a higher probability of accepting an industry payment than residents in internal medicine.
d. The median value of a single gift was higher for family medicine residents than orthopedic surgery residents.

7. **Which did researchers find regarding cranial neurosurgery patients?**
a. Patients with DNR orders received gastrostomy and tracheostomy more often than patients without DNR orders.
b. Patients with pre-existing DNRs had lower mortality rates than non-DNR patients.
c. Half of the patients with DNR orders died during their hospitalization.
d. Clinicians overestimated the potential for poor outcomes with surrogate decision-makers.

CME/CE OBJECTIVES

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

- Discuss new developments in clinical ethics and research regulation and their implications in healthcare systems for patient care, healthcare delivery, and research.
- Discuss the implications of developments in clinical ethics for patients, families, physicians, other healthcare professionals, and society.
- Review and apply principles of human subject protection in clinical trial programs, including compliance with mandated regulatory safeguards and educational requirements for human subject research.