

Ethics for Lunch September 2021

Annual Review of the Ethics Consultation Service 2020-2021

Moderator: Mark Hughes

Panelists: Meg Garrett, Allyson Smith-Mitchell, Alison Turnbull

The September Ethics for Lunch (EFL) reviewed themes arising from the ethics consultation service in the 2020-2021 academic year. Characteristics of the patients for whom consults were requested and the members of the health care team who requested the consult were summarized, as well as how the ethics consult service responded to the request.

Key points:

1. The ethics consult service received over 100 requests on 87 patients. Among the patients on whom requests were placed, there were more males than females and more Blacks than Whites. 3% of patients were Asian and 6% Hispanic or LatinX. 93% had English as their primary language. Median age was 57 years old. Over 50% of the patients had been admitted to Johns Hopkins Hospital previously
2. 43% of consults were requested by resident or fellow physicians, 18% by attending physicians, 15% by advanced practice providers, and 12% by nurses. Only 2 consults were requested by a patient or family member.
3. Most consult requests were for adult inpatients: 49% were on adult hospital units, 33% in adult intensive care units or intermediate care units, 8% in pediatric units, and 6% in pediatric or neonatal intensive care units. 5% of cases were for outpatients.
4. 80% of requests were handled with a phone call to the requester. Additional meetings sometimes needed to occur after the initial call: 25% of the requests led to a meeting with the clinical team; 11% involved a phone discussion with the clinical team; 5% involved a meeting with the clinical team and the patient or their authorized decision maker; 4% involved a meeting with the patient or their proxy.
5. When a meeting occurred, the median number of ethics consultants participating was 5 and the maximum was 12. Virtual platforms for meetings facilitated greater participation than in the past.
6. Sometimes the ethics consultant recommended involvement of other services such as the legal department (31%), palliative care (25%), chaplaincy (14%), patient relations (8%), or administration (4%). Sometimes the ethics consultant contacted other support services directly; this was particularly the case when requests also involved a legal issue.
7. Cumulative time spent by the ethics consult team leaders for the year was 155 hours, and the median time per consult request was one hour. When other ethics consult team members were involved, the cumulative time for the year was 108 hours.
8. While many of the consult requests involved a disagreement about the care plan between the patient or authorized decision makers and the clinical team, other concerns were raised:

- a. Help with developing a safe discharge plan
 - b. Medically ineffective or potentially inappropriate treatment
 - c. The patient or proxy deciding to forego or refuse recommended treatment
 - d. The patient having unclear decision-making capacity
 - e. Identifying a surrogate decision maker or pursuing guardianship
 - f. Inability to reach authorized decision makers or the authorized decision maker not making decisions
 - g. Disagreement between authorized decision makers or between the authorized decision maker and the patient
 - h. Discrimination based on characteristics of the patient
 - i. Behavioral challenges, such as an angry or disruptive patient or family member.
 - j. Disclosure of information to a family member
 - k. Caring for a dying patient or a patient meeting neurologic criteria for death
9. Some of the cases involved clinical team members' coping with moral distress.
10. When a consult request is received, the ethics consult team leader tries to gather additional information to determine how best to respond to the request. This includes:
- a. Who is calling and what is their role in the patient's care? Are they calling for themselves or on behalf of the clinical team?
 - b. What have they done up until this point to try to solve the issue that is of concern? Why are they calling now?
 - c. What has been happening to the patient both clinically and ethically?
 - d. Is the issue an ethical concern? Sometimes it may be more of a legal issue. Sometimes it may be more about emotional distress in caring for a dying patient, in which case other support services such as palliative care or the RISE team may be appropriate.
11. The panelists reviewed representative scenarios in which these concerns were raised:
- a. A patient with COVID-19 ARDS who is unlikely to recover from multi-organ system failure and the family does not wish to withdraw treatment. It should be determined:
 - i. Who is the authorized decision maker?
 - ii. What is the family's understanding of the situation?
 - iii. Had the patient previously completed an advance directive?
 - iv. In conversations the team has conducted with family members, are there reasons the family has given for not wanting to withdraw treatment? Do they disagree with the recommendations? Do they not want to be in a position to make a decision to withdraw life-sustaining treatment? Are they holding out hope for a miraculous recovery? Do they have spiritual beliefs informing their decision making?
 - b. An elderly patient lacking capacity and surrogate consent is needed for procedures, but concerns are raised about the appropriateness of the identified surrogate decision maker:
 - i. Work with legal department and social worker to determine who the authorized decision maker is and whether guardianship has previously been pursued. Find out if Adult Protective Services has been involved.

- ii. If concerns are raised about ulterior motives on the part of the surrogate decision maker, is there corroborating information from other family or friends? Is there a need to pursue guardianship to permit the court to weigh in on the appropriateness of the surrogate continuing in their role as decision maker?
 - iii. If the surrogate has been making decisions up until this point, have those decisions been reasonable and consistent with the patient's best interests?
- c. A patient whose behavior toward hospital staff poses a safety concern:
 - i. Social work and legal should work together to develop a plan to ensure safety for the staff, the patient, and other patients on the unit. This might require involvement of the security department.
 - ii. Recognizing that staff distress can impact their ability to provide optimal care to the patient.
 - iii. Differentiate verbal abuse from physical abuse. Workplace violence has to be taken seriously.
 - iv. Determine if there is underlying mental illness that is leading to the behavior.
 - v. Find out why the patient is behaving in such a manner as to make people feel threatened.
 - vi. The team may need to create a behavioral alert and document the instances where there have been the behavioral challenges.
 - vii. Find liaisons who can better relate to the patient to learn their perspective and share that with the team.
- d. A pediatric patient whose parent wants to be in control of daily care
 - i. Differentiate between a parent whose behavior is difficult/obstructionist versus a parent who is advocating for their child.
 - ii. Has the team taken time to explain the rationale for the care plan they are recommending and learn the parent's perspective?
 - iii. The longer a patient is in the hospital with a serious illness, the higher the stress and the more likely it is that conflict may arise.
- e. A patient lacking decision-making capacity is refusing a procedure that their authorized decision maker has consented to
 - i. Did the patient have an advance directive? Did the patient ever state preferences about the procedure when they had capacity?
 - ii. What is the urgency of the procedure?
 - iii. Is the family aware of the patient's refusal? Have they been able to discuss it with the patient even if the patient lacks capacity?
 - iv. Is there a third party (e.g., a consultant) to weigh in on the situation?
 - v. Are there ways to think creatively about finding a solution?
 - vi. How does the procedure fit into the overall, long term goals of care?