Bioethics Newsletter

Ochsner Health System

Fall 2012 Issue

A Message From the CMO
Dr. Joseph Bisordi

As Chief Medical Officer of Ochsner Health System, I encourage you to read our inaugural Bioethics Newsletter. It is designed to bring medical ethics issues to your attention and also includes helpful tools and information to better serve our patients. The last page - *Bioethics Resources for You* - will be in each quarterly edition and kept updated. In this issue, the first few articles by Bourgeois, Tompkins, and Shnaider give helpful advice about difficult conversations and breaking bad news to patients. McFadden highlights the many bioethics articles in *The Ochsner Journal* with hyperlinks so you can go directly to them with a mouse click. Breault outlines some of the Bioethics Committee's history and structure at Ochsner.

The ethical principles of autonomy, beneficence, non-maleficence, and justice are critically important in a world-class institution like Ochsner. We need a strong bioethics program that educates and assists all of us in sorting out how to proceed when these ethical principles appear to clash. I encourage everyone in the Ochsner community to take advantage of learning from the bioethics newsletters and other programs outlined here.

3rd Annual Bioethics Grand Rounds

Nov. 27, 2012 - Noon

Monroe Hall at OMC - Lunch served at OMC

Videoconferenced to Baptist, Kenner, Westbank, St. Anne, OHC - Baton Rouge Bluebonnet Clinic, & OHC - Marrero Clinic

Will be available on streaming media after the event for those who wish to view it on their computers from the Ochsner network.

Title: Approaching Patients and Family Members Who Hope for a Miracle
[Journal of Pain and Symptom Management, 42(1), July 2011, 119-125]

Speaker: Erik K. Fromme, MD, Associate Professor of Medicine in the Division of Hematology & Medical Oncology; Assistant Director, Center for Ethics in Health Care; Oregon Health & Science University.

Dr. Fromme specializes in palliative medicine. He also conducts research on managing the symptoms of cancer. He started the first supportive oncology and palliative medicine clinic in Oregon, where he works with nurses, social workers, and physical therapists to help patients with cancer and their families to control their symptoms and maximize the quality of their lives.

INSIDE

Getting Help with Difficult Conversations Early in Admission

Deborah Bourgeois MN, APRN,ACNS-BC, Lisa Tompkins, Esq.

Every healthcare provider has walked into a patient's room only to discover that the patient and/or the family is angry or in denial about the patient's condition. You have discussed the diagnosis and made your recommendations. You thought it was clear, yet there seems to be no consensus in understanding or how to proceed with the treatment plan. Often, taking additional discussion time to actively listen to patient and family concerns can help resolve the dilemma successfully.

Yet there are those times when, despite your best efforts, time and discussion will not resolve the conflict. Regardless of how hard you try, the situation seems to deteriorate. This happens most often when the physician and the patient/family disagree about the type of treatment or whether treatment is indicated at all. Healthcare providers often resist getting help, thinking, "If I just try harder, it will get better." The Bioethics Committee's case experience has demonstrated that in these circumstances, the situation very often continues to deteriorate. Getting help with these difficult conversations as early as possible in the admission is a good method for successfully communicating with your patient and his/her loved ones.

Gaining mutual trust in a physician/patient relationship is paramount and the foundation of the treatment plan. Once this relationship deteriorates, reestablishing trust is very difficult. To help you maintain the therapeutic relationship, you can present the option of broadening the treatment team to include a consultant as a helpful second opinion. The physician can say, "We seem to be having trouble communicating, and I think asking Dr. Smith to join me may help me better understand what you are trying to say." This approach does not place blame on anyone and can help maintain the relationship by keeping things on track.

In *Fast Facts and Concepts: Conflict Resolution II*, Adam Kendall, MD, MPH and Robert Arnold, MD recommend using principled negotiation as a conflict resolution method to establish a foundation for negotiating mutual goals of care while maintaining trust: "Principled negotiation is an approach to resolving conflict that avoids power struggles and unwanted compromises."

The following is a brief description of the steps that trained consultants use to assist medical teams in this type of discussion:

- **"Separate people from the problem."** Identify the fundamental understanding of the problem and separate the individuals'—on both sides—intentions and concerns.

- **"Focus on interests."** Listen to requests and demands, explore the underlying interests, and express and clarify the intentions and goals of the medical team.

- **"Invent solutions."** Avoid contrasting different philosophies of medical care; instead, propose a care plan that meets the family's expectations but also provides good medical care and aligns the mutual interests of the goals of care.

- **"Outline objective criteria."** Agree, in cases of time-limited trials, on what the success features will be. Provide objective information to back up medical recommendations.

When conversations are difficult, it is human nature to avoid them. Unsuccessful conversations with hostile patients and families are troubling to the medical team and are a source of moral distress for all involved. What often follows is the continuation of care that might not be indicated. Time does not cure this problem and, in fact, often makes these conversations less effective, complicating the treatment course. Having a consultant speak with the family and deliver the same message in a different way can help. It is much better to do it early on. If you would like help with a difficult conversation, you can always call a member of the Palliative Medicine team and/or the Bioethics Committee who will talk with you about the best options to get the assistance you need.

References

Fisher R, Ury W. *Getting to Yes: Negotiating Agreement Without Giving In*. New York, NY: Penguin Books; 1992.

Kendall A, Arnold R. Fast facts and concepts: conflict resolution II: principled negotiation. Medical College of Wisconsin End of Life / Palliative Education Resource Center. July 2007;184. http://www.eperc.mcw.edu/fastfact/ff_184.htm. Accessed July 25, 2012.

King DA, Quill T. Working with families in palliative care: one size does not fit all. *J Pall Med*. 2006;9(3):704-715.

Breaking Bad News

Phyllis Shnaider, LCSW

One of the most challenging tasks facing clinicians is breaking bad news to patients. Whether it's news about their own state of health or that of a loved one, telling someone he or she is facing loss or a poor prognosis raises multiple challenges across all medical disciplines.

Bad news can be a diagnosis affecting the patient's ability to maintain normal function and independence, an unexpected negative event such as an adverse surgical outcome, lack of response to treatment, or the need to face end-of-life issues.

Historically, physicians took an authoritarian or paternalistic role in deciding what was best for patients to know and when they should be protected from bad news. Today, providers are mandated to be increasingly transparent in sharing medical news and records with patients. Providers are challenged to meet the needs of patients regardless of their own personal comfort level with sharing bad news or what they believe is best for the patient. In order to do this well, it is essential to receive information and training about how best to communicate bad news to patients and their families. Equally important is to address personal issues that might interfere with the ability to share bad news in a caring and professional manner.

Skill in breaking bad news is more than a touchy-feely exercise. The relationship between the provider and the patient affects medical outcomes, patient compliance, and patient satisfaction. How the news is presented affects the patient's understanding of what is happening and his/her psychological adjustment.

Some providers are blessed with an easy bedside manner, but for many, breaking bad news is an awkward task. Skills don't necessarily improve with experience, unless one has good role models to learn from. Providers faced with the task of breaking bad news often feel anxious, burdened by this added responsibility, fearful of upsetting an already distressed patient, and reluctant to deal with the messiness of emotional issues.

A key factor in helping patients with difficult news is to be sensitive to their emotional needs. Observe their reactions carefully, giving them time to process. Show concern for both the patient and family or significant other, since any news affects all of them. Offer emotional support, validating that this is challenging for them. And as much as possible, allow patients some hope, if only the hope of keeping them comfortable or continuing to work with them.

Patients are looking for an alliance with the provider—someone who has the courage to offer honesty, openness, and respect, while validating their needs and fears. Remember that each patient is different, in terms of education, culture, faith, level of family support, and emotional resilience. Being aware of these differences can allow the caregiver to tailor the response to the individual patient.

Multiple paradigms can help providers improve their confidence and ability to discuss bad news with patients. Some shared elements are common to all of these techniques and are listed in the sidebar.

PREPARE in advance. Assemble all information and materials. Invite the patient to bring along a significant other. Invite members of the treatment team to attend if possible. Identify any special needs for this patient.

SET the stage. Meet in a quiet, private location. Turn off cell phones and pagers to avoid interruptions. Allow sufficient time (as much as possible).

ASSESS patient knowledge. What does the patient already understand about his/her condition? What previous experience has the patient had with this problem, perhaps with a family member or friend? Open-ended questions—such as "What have you been told about your illness so far?"—can help you know where to start.

MEET the needs of the patient. Ask how much the patient wants to know about the condition and/or about the treatment. Does the patient like detailed information or just the basics? If the patient asks for the prognosis, don't try to spare him/her because of your discomfort.

PROVIDE VERBAL FOREWARNINGS to help set the stage. "I'm afraid I have to tell you…" or "Unfortunately I have some bad news" helps prepare the patient for what is coming. Avoid excessive bluntness that takes away all hope, as in "You have a very bad cancer and there's nothing we can do for you."

DELIVER news carefully; your delivery style is key. Facts are the easy part, but communicating in a way that is useful to the patient takes some effort. Pacing is very important. Patients hearing bad news often stop hearing anything you say after the initial information. Just because the patient is looking at you and nodding does not mean he/she comprehends or is absorbing the information. Stop and give the patient time to regroup. Give information in small chunks. Invite the patient to repeat what he/she heard. Use lay language geared to the patient's level of education and understanding.

ENCOURAGE patients to share their reactions. "How are you feeling about what I just told you?" Help patients identify particular concerns; they could be medical; practical issues around transportation, the ability to continue working, or parenting; or the financial impact on the family. Address concerns about the future as candidly as possible and help patients make realistic choices.

VALIDATE the patient's expressed needs and feelings. "I wish the news were better." "This is hard, I know." Even a simple "I'm so sorry" shows the patient you care about him/her as a human being.

ENSURE understanding. Patients are unlikely to remember specifics of what you said, and even family members serving as another pair of ears may be overwhelmed or confused. Allow for questions from the patient and significant other.

FINISH by discussing the treatment plan and setting a time for follow-up. Patients will inevitably have further questions once the news sinks in and so will their loved ones. Provide a written summary of the information you've given them, information about the illness, and instructions on next steps. Enlist other members of the treatment team to help resolve issues outside your scope of practice. A therapist, nurse, social worker, clergy member, PT, or OT can provide much-needed assistance. Recommend support groups or reading materials.

Bioethics in *The Ochsner Journal*

Kathleen McFadden, MA

Following the extremely positive reviews of the bioethics theme issue of *The Ochsner Journal* in Winter 2011 (see sidebar), the journal's editorial board approved a new quarterly column entitled "Bioethics in Practice" that debuted in spring 2012. In the column, guest authors explore real-life topics in medical ethics, providing thought-provoking and practical insights.

Dr. David Taylor penned the inaugural column, "The Value of Bioethics Consults" (Volume 12, Issue 1). After citing the 5th International Consensus Conference in Critical Care perspective on the role of bioethics in bedside care, Dr. Taylor provides several examples of situations in which bioethics consults are valuable for helping patients, families, and caregivers reach agreement about treatment decisions. He also makes the point that bioethics expertise is necessary to establish best practices and end-of-life care in the ICU.

Dr. Christopher Blais wrote "Assessment of Patients' Capacity to Make Medical Decisions" (Volume 12, Issue 2). In his column, Dr. Blais gives a precise, step-by-step method for determining a patient's decision-making capacity and asserts that such an assessment should not only be part of every medical encounter but must always take place before a physician concludes that an individual cannot speak for himself or herself.

The fall issue of the journal (Volume 12, Issue 3) is a theme issue on pediatric oncology and blood disorders. In keeping with this theme, Dr. Michael White addressed the ethical implications of obtaining consent from children to participate in research studies. In "Can Children Participate in Research?" Dr. White provides an interesting summary of the history of informed consent, particularly with respect to children, and the gaps and inconsistencies in the accepted guidelines that researchers must reconcile in order to enroll children in clinical trials.

In another theme issue, this one devoted to innovations in medical education (Volume 12, Issue 4), Dr. William Pinsky explored "Bioethics Training in Medical Education."

The "Bioethics in Practice" quarterly column will continue to be a feature of *The Ochsner Journal*, and we welcome submissions. To discuss potential topics, contact Dr. Joe Breault at jbreault@ochsner.org.

The Ochsner Journal - Winter 2011

Ochsner's Bioethics Committee

Joseph Breault, MD, ScD, MPH

The Bioethics Committee at Ochsner's Jefferson Highway campus was established as a medical staff committee in the medical staff bylaws. The current bylaws state, "The Bioethics Committee will serve upon request in an advisory capacity to physicians, staff, and family / patients in bioethical situations, be available for an official consult at the request of a physician, staff or family, will organize educational sessions, and will advise the staff of relevant legislation."

The Bioethics Committee at the Jefferson Hwy campus now has 32 members, including physicians, nurses, lawyers, chaplains, social workers, psychologists, and others. The chair is appointed by the medical staff, and I am currently serving in that role. The quarterly meetings are designed to educate members through reviewing ethics consults that have happened since the last meeting, engaging in a brief bioethics consult skills training session, reviewing relevant trends in current bioethics literature, discussing any new relevant legislation, occasionally reviewing policies that the bioethics committee signs off on, and discussing the bioethics education program.

Bioethics Committee members attend the 2nd Saturday morning of May Clinical Ethics Symposium for a more intense training program, and this symposium is open to everyone throughout OHS who is interested. Dr. Michael White spearheaded the development of this training program in the first few years, and it is now an established annual program.

A major role of the Bioethics Committee is to staff bioethics consults when requested, and this aspect has been headed by Dr. David Taylor for many years with coordination by the chaplains. Sometimes, preliminary consults with Palliative Care (headed by Dr. Chris Blais) or Risk Management (Shelley Sullivan, Esq and Ann Koppel, Esq are members of the committee) can resolve issues without requiring a formal bioethics consult.

In 2009, Dr. Bisordi and the Quality Committee requested the formation of a Bioethics Executive Committee to help with OHS-wide bioethics issues, including clarifying Ochsner's end-of-life policy and facilitating high-quality standardization for bioethics consults throughout OHS at all its facilities. Each OMC local bioethics coordinator (see back page for the list) along with a handful of the Jefferson Hwy bioethics leaders meet quarterly to review consults at all locations and to discuss any bioethics policy issues for OHS that arise. All campuses share bioethics consult resources. For example, a Jefferson Hwy consult utilized a nonconflicted specialty physician in Baton Rouge, while staff at the West Bank, Kenner, and Baptist facilities have called on Jefferson Hwy consult teams to assist them.

Role of the Bioethics Committee

"The Bioethics Committee will serve upon request in an advisory capacity to physicians, staff, and family / patients in bioethical situations, be available for an official consult at the request of a physician, staff or family, will organize educational sessions, and will advise the staff of relevant legislation."

Ochsner Clinic Foundation Medical Staff Bylaws

Recently, the Bioethics Committee began an effort to collect better "customer" feedback of whether needs were met, so those asking for a bioethics consult, along with a family member if appropriate, may be contacted a few months after a consult occurs with a request for feedback on how the consult went from their perspective and how we can improve the service.

First and last, the Bioethics Committee is focused on what is best for our patients who find themselves in very difficult circumstances and on how to balance the ethical principles of autonomy, beneficence (do good), nonmalfeasance (do no harm), and justice in real people's lives. As noted in the bylaws, the Bioethics Committee gives nonbinding advice.

Bioethics Resources for You

Bioethics Education Program

- **Annual Bioethics Grand Rounds** - Tuesday, Nov. 27, 2012
- **Annual Clinical Ethics Symposium** - Saturday, May 11, 2013
- **Bioethics Website (consults) -** http://academics.ochsner.org/bioethics.aspx
- **Bioethics Website (resources) -** http://academics.ochsner.org/librarydyn.aspx?id=38008&terms=bioethics
- **Quarterly Bioethics Newsletter**
- ***The Ochsner Journal* Bioethics column -** http://www.ochsnerjournal.org
- **Schwartz Rounds**
- **Palliative & End of Life Care Lectures -** http://academics.ochsner.org/uploadedFiles/Bioethics/2012EPEClectures.pdf

End-of-Life Resources

- **LaPost**
  http://lhcqf.org/lapost-home
- **5 Wishes**
  http://academics.ochsner.org/bioethicsdyn.aspx?id=54656
- **Advance Directives, Living Wills, & Healthcare Power of Attorney**
  http://ochweb/page.cfm?id=3919
  scroll down to Miscellaneous Forms
- **Palliative Care**
  http://ochweb/page.cfm?id=2429
- **State Living Will Declarations**
  http://www.sos.la.gov/tabid/208/default.aspx

How to Request a Bioethics Consult at any Ochsner Facility

- Request a consult online - http://academics.ochsner.org/bioethicsform.aspx
- Call an Ochsner Chaplain 504-842-4629
- Call Risk Management 504-842-4003
- Contact your OMC local bioethics coordinator

Any Clinic	Contact Chaplain's Office
OMC-Eastbank	Contact Chaplain's Office
OMC-Westbank	Joan Rooney, RN
OMC-Kenner	Harold Moore, RN
OMC-Baptist	Gretchen Ulfers, MD
OMC-BR	Ralph Dauterive, MD
OMC-St. Anne's	Kathy Hebert, RN
OMC-Elmwood	Contact Chaplain's Office
OMC-Slidell	James Newcomb, MD

Bioethics Q&A

What is an ethics consult?

- **Medical Ethics Website** http://academics.ochsner.org/bioethics.aspx
- **Bioethics Consultations and Resources** http://www.ochsnerjournal.org/doi/pdf/10.1043/1524-5012-11.4.357

What is sometimes helpful prior to an ethics consult?

- **Asking the chaplain to come visit**
- **Holding a family conference**
  http://ajrccm.atsjournals.org/content/171/8/844.full.pdf
- **Requesting a palliative care consult**
  http://ochweb/page.cfm?id=2429
- **Having a discussion with Risk Management**
  http://ochweb/page.cfm?id=3325