The 4th Annual Clinical Ethics Symposium was held May 10th this year. It was moderated by Dr. Joseph Breault and Deborah Bourgeois who provide a report of the symposium in this issue. Highlights of the symposium included Dr. David Taylor’s presentation on the ethical principles that form the basis for bioethics consultation decision-making and the mock ethics consult panel that considered cases presented by Drs. Michael White and Chris Blais.

The Louisiana State Legislature has provided the citizens and healthcare providers of our state with an important, comprehensive, and legal tool to guide end-of-life care by honoring healthcare choices for those with serious and advanced illness. Louisiana Physician Orders for Scope of Treatment (LaPOST) was passed in 2010 and took effect in 2011. In this issue of the newsletter, Ann Moll and Cathy Green explain the difference between LaPOST and an advance directive and provide information about the LaPOST course that is available on the Ochsner Learning Network.

With the remarkable advances in life support systems and critical care, the perception of “end of life” has become increasingly blurred for patients, families, healthcare providers, and the public. It is increasingly difficult to balance the complexity of life support systems and treatments with the patient’s and family’s preferences and values. In this issue of the newsletter, Deryck Durston outlines an approach for defining a patient’s end-of-life care wishes. An important part of this process is to do a spiritual assessment to clarify a person’s values and beliefs about life and death.

The final page of the newsletter provides a variety of resources. We encourage you to print and post the page for reference. Have a great summer!

Editorial Notes from Patrick Breaux, MD

Upcoming Schwartz Center Rounds®
September 11 - BH Caldwell Room
December 11 - BH Caldwell Room
12:00 pm to 1:00 pm
Lunch will be served at 11:45 am

All members of the healthcare team are encouraged to attend. No RSVP is required.

Schwartz Center Rounds are a multidisciplinary forum where caregivers participate in their own self-care by discussing the difficult emotional and social issues that arise in caring for patients. A case is presented by a panel of healthcare professionals representing multiple disciplines and points of view. The audience is invited to participate in an interactive discussion about the case and reflect on their shared experiences in caring for patients and their families.

The objectives of Schwartz Center Rounds are to
• Improve understanding of the patient as a whole person within his/her unique context and the impact of illness on the patient and family
• Improve the sense of support and decrease the sense of work stress and isolation
• Increase insight into the psychosocial and emotional aspects of care
• Enhance empathy
• Enhance understanding of the perspectives of colleagues within and across disciplines and professions
• Improve teamwork

Sponsored by the Institute for Medicine, Education, and Spirituality at Ochsner and the Schwartz Center for Compassionate Healthcare
Annual Bioethics Symposium Features Bioethics Consults

Joseph Breault, MD
Deborah Bourgeois, APRN, ACNS-BC, ACHPN

The 4th Annual Clinical Ethics Symposium was held at Ochsner on May 10, 2014. Dr. David Taylor opened the conference by providing a historical perspective of clinical bioethics consults and then discussed national trends in reasons for consultation compared to the trends seen by the OHS Bioethics Consultation Committee. He also discussed the ethical principles that are the basis for decision-making and the application of those principles in case-based ethic consultations. Copies of Dr. Taylor’s slides are available on the bioethics website: www.ochsner.org/bioethics.

Dr. Michael White presented the first case. A previously healthy 8-year-old had a syncopal episode that was followed by a complex set of worsening clinical events within a 1-week period. The patient’s final clinical outcome was declaration of brain death. There were no medical or legal questions about the accuracy of the brain death diagnosis. The patient’s parents were of Asian descent and had emigrated from China. They were unable to accept that their only child and firstborn son was dead. The parents wanted ventilator and other ICU life support treatment to continue. Among the consult panel, much discussion exploring the clinical issues, the patient’s cultural needs, and ethical principles took place. At the conclusion of the discussion, the mock committee demonstrated to the audience how a plan is developed to care for the patient’s parents in a dignified, ethical, and realistic way.

Dr. Chris Blais presented the second case. A 76-year-old nursing home patient with cancer and multiple admissions is in the ICU, is ventilator dependent, and is being followed by a multiple consultants. The attending hospitalist does not think further medical interventions are beneficial as they will not change the outcome in a meaningful way. The hospitalist considers continuing ICU care a medical futility. The patient, when she was alert and in better health 6 months ago, signed an advance directive stating she wants everything done. As her healthcare agent and surrogate decision maker, the patient’s son wants “everything done” and is directing the healthcare team to continue all medical interventions. One of the declining patient’s medical issues is worsening renal failure. While the hospitalist staff did not think dialysis would be beneficial, the renal consultant offered dialysis to the family. The patient’s son is agreeable to dialysis and is hopeful that his mom is not dying. Following the discussion, the committee recommended that the members of the patient’s medical team meet and come to consensus on the goals of care so recommendations to the patient’s son could be made. Following this discussion, the medical team concluded that continuing care of this patient is futile care, but the son still wants everything done. As a final step, the mock bioethics committee met with the patient’s son to assist in the resolution of the process.

After the mock ethics panels, the audience participated in the symposium’s concluding discussion and Q&A session related to various aspects of bioethics.

The Annual Clinical Ethics Symposium occurs each year on the second Saturday morning in May in the Brent House Conference Center. The Bioethics Committee, an Ochsner Medical Staff Committee, sponsors the symposium. Continuing medical, nursing, and social work education credits are provided. Ochsner learning credits are also provided. Please consider attending next year on May 9, 2015 and place it on your calendar now.
Nursing Education: LaPOST Awareness

Ann Moll, BS, RN, CNOR, Hospital Education Manager, OMC-WB

Cathryn Green, BSN, RN, CCRN, Palliative Care Nurse Coordinator, OMC-WB

Have you heard about LaPOST? We first became aware of the LaPOST form and state statute via an email last year and used the links to learn more. It soon became apparent that many of our staff—RNs, LPNs, unit ambassadors, and physicians—were unaware of this important new legal document. We were also concerned that nursing staff and others involved in patient care may confuse LaPOST with advance directives.

Louisiana Physician Orders for Scope of Treatment (LaPOST) is a document for patients diagnosed with a life-limiting disease and irreversible condition (the physician expects death to occur within less than 1 year) that informs healthcare providers of what type of treatment they want or do not want. As stated on the LaPOST website, the mission is to improve end-of-life care in Louisiana by honoring healthcare choices for those with serious advanced illness. LA State Statute 1299.64 passed in 2010 and took effect in June 2011. Louisiana is now 1 of 14 states that provides a form for a physician’s order that reflects the patient’s desired level of care and interventions at the end of life when related to a terminal or irreversible illness.

What is the difference between LaPOST and an advance directive? The LaPOST form is an actual physician’s order for code status and scope of treatment options the patient has chosen. It is signed by the physician and the patient or the patient’s representative. In contrast, an advance directive is a guideline for a patient’s code status and treatment options that must then be written as an order by the physician. An advance directive is signed by the patient and 2 witnesses, not by the physician.

To facilitate greater understanding and use of the LaPOST form, Ochsner Learning Network (OLN) education was developed and is now assigned to all nursing staff across the Ochsner Health System in the New Hire and Annual RN/LPN curricula. The OLN course explains the difference between an advance directive and the LaPOST order form and includes the following information:

- LaPOST is a physician’s order that encompasses the wishes of the patient and/or family in the end stages of life. It can be used in conjunction with an advance directive/living will.
- It must be printed on bright gold paper.
- It is transferrable across healthcare settings within the entire state of Louisiana.
- It should be scanned into the patient’s electronic medical record (EPIC). The patient keeps the original.
- The discussion with the family is initiated by the physician. The LaPOST document must be signed by the physician and the patient or patient’s representative.
- Review of the LaPOST form is recommended whenever the patient is transferred from one care setting or level of care to another, a substantial change in the patient’s health status occurs, or the patient’s treatment preferences change. The review history and changes are documented on the back of the form.

Ochsner was well represented at the LaPOST education workshop in Baton Rouge in March 2014. Cathy Green, Ann Moll, Roseann Fondren, Stephanie Anderson, and Katie Bodin attended. Dr. Susan E. Nelson, Chair of the LaPOST Coalition, presented valuable information about the purpose and scope of LaPOST. Toolkits provided to all attendees included the LaPOST document, LaPOST Consumer Handbook, guides for discussion with patients and families, and a DVD for educational use. To learn more about LaPOST and obtain educational materials for staff, patients, and families, visit the LaPOST website: www.la-post.org

The Education Department held a patient, family, and staff LAPOST information day at the West Bank campus in April. Additionally, the OMC-WB Annual Mandatory Employee Skill Fair scheduled for October 2014 will include interactive education for all attendees. Cathy Green will present LaPOST information at the OMC-WB physician meetings over the next few months.

Summer 2014
One of the ironies of the nature of treatment in the ICU, where much aggressive care is provided, is that ADs and durable powers of attorney for healthcare are difficult to attend to even though they may speak to the patient’s wishes about limits to be observed in the type and amount of care given. The complexity of treatment options may also make it hard to honor the patient’s and family’s preferences and values as expressed in an AD that the patient thought covered all the relevant situations. Research suggests that strong community education about ADs can help decrease the prevalence of high-cost, unwarranted, end-of-life care.

Education, reflection, or conversation that raises these issues while a person is not in a critical health situation will lay the groundwork for care that is supportive of the wishes of the patient.

Spiritual assessment is a process that can help to clarify a person’s values and beliefs about life and death that will have implications for a person’s wishes regarding end-of-life care. Many tools are available to help clinicians develop a spiritual assessment. One of them—available for use in Epic—is FICA. This abbreviation does not have anything to do with taxes but stands for Faith, Importance or Influence, Community, and Address. FICA provides a guide for eliciting a person’s sense of meaning.

**Faith**

What is your faith or belief?

What things do you believe in that give meaning to your life?

**Importance/Influence**

Is it important in your life?

What influence does it have on how you take care of yourself?

How have your beliefs influenced your behavior during this illness?

What role do your beliefs play in regaining your health?

**Community**

Are you part of a spiritual or religious community?

Is this a support to you and how?

Is there a person or group of people you really love or who are really important to you?

**Address**

How would you like me, your healthcare provider, to address these issues in your healthcare?

The most important thing to remember about using a tool is that it is just a tool, not an end in itself. The FICA questions are open ended and do not impose a particular set of beliefs on the patient. These questions invite a person to share, which can only be successful if the chaplain, nurse, or physician is open to thinking about his or her own spirituality. Any sense of judgment from the questioner will immediately be noticed and will militate against a sincere reflection happening. So if the questioner has an agenda for the patient, the questioner will likely hear what he or she wants to hear rather than what the person really feels. Obviously such a personal interaction needs to happen in a place...
and at a time when a personal conversation will be uninterrupted as much as possible and genuine interest in what makes the person “tick” is driving the conversation. In other words, questions about spirituality are more likely to be heard and responded to when some trust has been built.

This is not the same as asking someone what faith he or she belongs to. For example, many different answers could be forthcoming from someone answering the question on admission to the hospital: “I am Catholic, but I don’t want to be visited by a priest or Eucharistic minister.” “I am Catholic, but I have my own priest who will visit.” “I would prefer to speak to a chaplain rather than a priest.” “I am an atheist, but I would like to talk with a chaplain.”

When a chaplain is assessing someone’s spiritual needs, what the person says about his/her personal faith is as helpful as stating what his or her faith group is. Most of us have a complicated mixture of influences in our spiritual lives, as we have been exposed to positive and negative experiences along our pathway in life. Most of us have also experienced feeling freer to talk about sacred or serious topics with a stranger that we might not mention to a person with whom we are familiar. These are common experiences for a chaplain, but sometimes, the cleaner in the room hears concerns a chaplain does not hear at all.

Another way to think of spiritual assessment or diagnosis is offered in a classic treatment of psychiatry and spiritual care. Draper uses the analogy of the person as a plant. For the gardener to be successful, he must have an appreciation for the soil (culture), for the climate (family), and for the potential of the seed (genes). It is also important for the chaplain to ask the following questions to gauge the spiritual dynamics at play for the patient: What is the trouble? Why call for me? Why call for me now? The answers to these 3 questions can really focus a conversation.

The different schemes for thinking about the process of spiritual assessment are designed to help the clinician, especially the chaplain, develop a sense of the urgent need in the patient’s life and how the patient imagines he or she will get help. (Draper E. Psychiatry and Pastoral Care. Philadelphia, PA: Fortress Press; 1970.)

Physicians can shape their own interventions by using a patient’s spiritual resources as part of the process of preventive health and well-being. Gowri Anandarajah, MD, and Ellen Hight, MD, MPH, remind us that spiritual concerns and questions often have no clear answers or solutions, yet they can significantly affect the quality of a patient’s suffering. Consequently, it is not answers that serve the patient well, but an empathic presence, understanding, acceptance, and compassion. They also emphasize the importance of incorporating spirituality into preventive healthcare. Patients can be helped to identify and mobilize their own internal spiritual resources as a preventive healthcare measure.

These resources may include prayer, meditation, yoga, t’ai chi, walks in the country, or listening to soothing music. The physician can help patients identify spiritually based measures that can be useful to them in conjunction with standard medical treatment. For example, a patient may choose to say the rosary while taking medication or may listen to music or read scripture before surgery. A patient’s spirituality can also empower him or her to ask for a change in the treatment plan.

The authors write, “Modifications can be made based on better understanding of the patient’s spiritual needs as related to medical education, reflection, or conversation that raises these issues while a person is not in a critical health situation will lay the groundwork for care that is supportive of the wishes of the patient.”

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Spiritual Assessment and Advance Directives

care. This can include such measures as stopping or continuing chemotherapy in a patient with metastatic cancer; referring a patient in spiritual distress or crisis to a clinical chaplain; using community cultural or religious resources; and teaching the relaxation response or other meditation techniques to patients with chronic pain or insomnia." (Anandarajah G, Hight E. Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. *Am Fam Physician*. 2001 Jan 1;63(1):81-89.)

Two aphorisms are helpful here. **Proper treatment depends on proper diagnosis. Physician, treat thyself.** It is important to some patients to believe the physician is spiritual also, not necessarily with the same spirituality, but for some patients, knowing that the physician has a personal spirituality is an assurance that the patient’s spirituality is likely to be respected and taken into account in treatment.

Chaplains are partners, specialist partners, on the healthcare team. They have been trained to bring to their work a spirituality they have reflected on, which helps them listen to the spiritual concerns of the patient and to help interpret these concerns to the team. Chaplains often fulfill requests for copies of a booklet called *Five Wishes*. Five Wishes is a document in 2 parts: a workbook that lists possible medical treatments and forms for the patient and family to specify their wishes for treatment. As they work through the Five Wishes process, the patient or family members may call the chaplain to discuss these questions and decisions further. If you or your patient wants to speak with a chaplain about these issues, have them call **842-WISH** (842-9474). The chaplain is not a medical professional, so any questions of a medical nature will be referred to medical personnel. However, listening carefully and helping the person and his family work through questions of what values are directing the decision-making and what will be most likely to serve those values well are squarely in the field of the chaplain.

It would be good if chaplains could staff outpatient clinics so persons who come for routine checkups could discuss their thoughts about these issues while they are not in the middle of a healthcare crisis. Perhaps as part of the continuous and accelerating evolution of hospitals, the outpatient clinic will become the place where consequential conversations take place that impact acute care options.
Bioethics Resources for You

End-of-Life Resources

- 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/OurOffice/EndOfLifeRegistries/Pages/default.aspx
- UpToDate: Ethical Issues Near the End of Life http://www.uptodate.com/contents/ethical-issues-near-the-end-of-life
- Katy Butler: Slow Medicine http://katybutler.com/site/slow-medicine/
- Dr. Atul Gawande: Letting Go http://www.newyorker.com/reporting/2010/08/02/100802fa_fact_gawande?currentPage=all
- LaPOST: State Website https://lhcfq.org/lapost-home
- LaPOST video: Using the LaPOST Document to Improve Advance Care Planning (intranet only) http://mediasite.ochsner.org/mediasite50/Viewer/?peid=b54700807b474e1e8fe96113ca985e4b
- Respecting Choices Training http://respectingchoices.org/training_certification

Bioethics Q&A

What is a bioethics consult?
- Medical Ethics Website http://academics.ochsner.org/bioethics.aspx

What is sometimes helpful prior to a bioethics consult?
- Asking the chaplain to come visit http://www.atsjournals.org/doi/pdf/10.1164/rccm.2501004
- Requesting a palliative care consult http://ochweb/page.cfm?id=2429
- Having a discussion with Risk Management http://ochweb/page.cfm?id=3325

Bioethics Education Program

- Annual Clinical Ethics Symposium - Saturday, May 9, 2015 http://academics.ochsner.org/bioethicsform.aspx
- Bioethics Website (consults) - http://academics.ochsner.org/bioethics.aspx
- Bioethics Website (resources) - http://ochsner.org/bioethics
- Quarterly Bioethics Newsletter - http://ochsner.org/bioethics
- The Ochsner Journal Bioethics column - http://www.ochsnerjournal.org
- Schwartz Rounds

Bioethics Consult at any Ochsner Facility

- Request a consult online - http://academics.ochsner.org/bioethicsform.aspx
- Call an Ochsner Chaplain 504-842-3286
- 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 Contact Chaplain’s Office
  OMC-Kenner Dawn Puente, MD
  OMC-Baptist Gretchen Ulfers, MD
  OMC-Br Ralph Dauterive, MD
  OMC-St. Anne’s Marsha Arabie, RN
  OMC-Elmwood Contact Chaplain’s Office
  OMC-Slidell James Newcomb, MD

“...most hospitals in the USA provide clinical ethics consultation that is mainly due to the requirement of The Joint Commission for Accreditation of Healthcare Organizations—in 2007 renamed the Joint Commission—that accredited hospitals must have a method for addressing ethical issues that arise.”
  From http://www.iep.utm.edu/bioethic/