Program in Bioethics and Humanities
Carver College of Medicine

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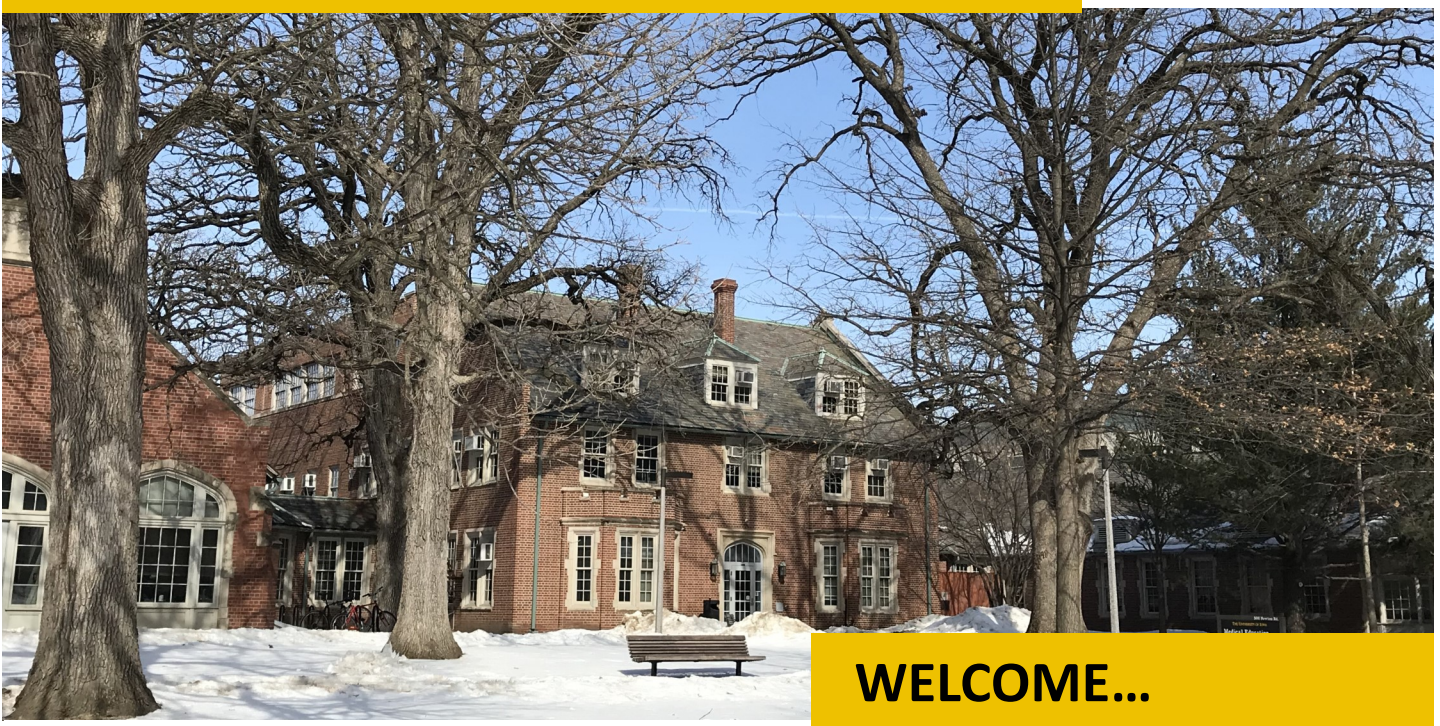
Bioethics & Humanities Newsletter



Inside this issue:

WELCOME…

Welcome to the monthly Bioethics and Humanities Newsletter provided by the Program in Bioethics and Humanities at the University of Iowa Carver College of Medicine.

Program in Bioethics and Humanities:
Our Mission
We are committed to helping healthcare professionals explore and understand the increasingly complex ethical questions that have been brought on by advances in medical technology and the health care system. We achieve this through education, research, and service within the Carver College of Medicine, University of Iowa Health Care, University of Iowa, and the wider Iowa community.

More Details About The Program

ETHICS IN HEALTHCARE 2023 CONFERENCE

Sponsored by the Program in Bioethics and Humanities,
Carver College of Medicine, University of Iowa

Location: 2117 Medical Education Research Facility, Carver College of Medicine, University of Iowa

Date and Time: Friday, May 19, 2023, 8:00 AM – 4:00 PM (check-in opens at 7:30 AM)

Audience: Administrators, Attorneys, Chaplains, Nurses, Nurse Practitioners, Physicians, Physician Assistants, Social Workers, Students, Trainees, and Others

Registration Fee: $100 (includes continuing education credits)

Conference Coordinator: Noel VanDenBosch, BA (contact: 319-335-6706, noel-vandenbosch@uiowa.edu)
Conference Director: Lauris Kaldjian, MD, PhD

Objectives:

SESSION ONE (Speaker: Dr. Erica Carlisle)

- Review the ethical principles that guide the allocation of scarce resources.
- Discuss the ethical challenges of triage.
- Explore the moral distress that may occur during triage.

SESSION TWO (Speaker: Dr. Graeme Pitcher)

- Define burnout in healthcare settings.
- Explore ethically controversial aspects of burnout.
- Relate the roots of burnout to healthcare's ethical foundations.

SESSION THREE (Speaker: Dr. Aaron Kunz)

- Explain the goals, benefits, and harms of social distancing.
- Articulate reasons for or against visitor restrictions using bioethical frameworks.
- Propose ethically-conscious, patient-centered strategies for implementing and removing visitor restrictions.

SESSION FOUR (Speaker: Dr. Rebecca Benson)

- Identify key events and issues that have led to the emergence of contemporary clinical ethics consultation.
- Describe the goals and scope of clinical ethics consultation and distinguish it from the roles of an ethics committee or policy review committee.
- Discuss advantages and disadvantages of individual, small team, and committee models for providing ethics consultation.

Please see our website for full details and information about continuing education accreditation.

CLICK HERE TO REGISTER

PUBLICATION HIGHLIGHT

"Reading the Room:" A Qualitative Analysis of Pediatric Surgeons' Approach to Clinical Counseling

Erica M. Carlisle, Laura A. Shinkunas, Maxwell T. Lieberman, Richard M. Hoffman, Heather S. Reisinger

Journal of Pediatric Surgery

BACKGROUND: In our prior analysis of parental preferences for discussions with pediatric surgeons, we identified that parents prefer more guidance from surgeons when discussing cancer surgery, emergency surgery, or surgery for infants, and they prefer to engage surgeons by asking questions. In this study, we investigate surgeon preferences for decision making discussions in pediatric surgery.

METHODS: We conducted a thematic content analysis of interviews of pediatric surgeons regarding their preferences for discussing surgery with parents. Board certified/board eligible pediatric surgeons who had been in practice for at least one year and spoke English were eligible. Fifteen surgeons were invited, and twelve 30-minute semi-structured interviews were completed (80%). Interviews were recorded and transcribed. Thematic content analysis was performed using deductive and inductive methods.

RESULTS: Data saturation was achieved after 12 interviews [6 women (50%), median years in practice 6.25, 10 in academic practice (83%), 8 from Midwest (67%)]. 5 themes emerged: (1) Collaboration to promote parental engagement; (2) "Cancer is distinct but not unique;" (3) "Read the room:" tailoring discussions to specific parental needs; (4) Perceived role of the surgeon; (5) Limited experience with decision support tools in pediatric surgery.

CONCLUSIONS: Pediatric surgeons prefer a collaborative approach to counseling that engages parents through education. They prioritize tailoring discussions to meet parental needs. Few have utilized decision support tools, however most expressed interest. Insight gained from our work will guide development of a decision support tool that empowers parental participation in counseling for pediatric surgery.

To read the full article, click here.

BIOETHICS TOPIC OF THE MONTH:

THE ETHICS OF NAVIGATING CHALLENGING PATIENT-PROVIDER RELATIONSHIPS

Key Articles and Resources

⇒ Applewhite M, Giordano J. The patient as responsible agent: Ethical constructs important to considering behavioral contracts for "difficult" patients and families. Am J Bioeth. 2023 Jan; 23: 77-79.

⇒ Blackall GF, Green MJ. "Difficult" patients or difficult relationships? Am J Bioeth. 2012; 12: 8-9.

⇒ Blustein J. Doing what the patient orders: Maintaining integrity in the doctor-patient relationship. Bioethics. 1993 Jul; 7: 290-314.

⇒ Eriksen A. Conflicting duties and restitution of the trusting relationship. J Med Ethics. 2018 Nov; 44: 768 -773.

⇒ Fiester A, Yuan C. Ethical issues in using behavior contracts to manage the "difficult" patient and family. Am J Bioeth. 2023 Jan; 23: 50-60.

⇒ Groves JE. Taking care of the hateful patient. N Engl J Med. 1978 Apr 20; 298: 883-887.

⇒ Lieber SR, Kim SY, Volk ML. Power and control: Contracts and the patient-physician relationship. Int J Clin Pract. 2011 Dec; 65: 1214-1217.

⇒ O'Dowd TC. Five years of heartsink patients in general practice. BMJ. 1988 Aug 20-27; 297: 528-530.

⇒ Radlicz CM, Fernandes AK. Physician conscience and patient autonomy: Are they competing interests? Linacre Q. 2019 Feb; 86: 139-141.

⇒ Roberts LW, Dyer AR. Caring for “difficult” patients. Focus. 2003; 1: 453-458.

HUMANITIES CORNER

This month's spotlight is on **Faizan Khawaja, a fourth year medical student.** His creative work is a written reflection. He completed this creative work as part of the *Ethics and Humanities Sub-Internship Seminar*. During this Seminar students are asked to complete a written reflection or creative work that responds to a situation they encountered during their sub-internship that illustrated values in ethics, professionalism, or humanism.

The patient is wheeled into the room. She is matted with dirt, her clothes hang over her loosely, cut in half by the paramedics on site. "One, two, three!" and she is swiftly transferred to the trauma bed. Sheets are rapidly taken off, the team in unison rolls her to her side and strips away her clothing. "A woman in a motor vehicle collision. She has pain in her—" the report goes out to the dozen-or-so people in the room. Most of them are strangers to me. All of them are strangers to the woman on the table.

Airway, breathing, circulation: cleared. Alert and oriented "times-three." The intern donned in the lead jacket yells questions at her. "Does it hurt here?! Ecchymosis over the antero-lateral scalp! Is this tender?! Tenderness over C4, C5!" The patient is now naked. She continues to lay still, held in place by straps and a collar. Her eyes are wide. The patient is rolled over to her side and the intern proceeds to perform a rectal exam. No blood, she moves on to the next system. Over the patient's arm, an IV is placed and blood is unintentionally spilled over her wrist. An ultrasound is brought in, and cold gel is smeared over her bare chest and abdomen; someone hurriedly and poorly wipes it off before getting out of the way of the nurse wheeling the bed to the CT scanner. Despite the clear, loud, and unambiguous communication in the ED trauma room, there is hardly a word said to the patient herself.

There is a dichotomy within the role of a trauma doctor. As outlined in the Physician Charter on Medical Professionalism, doctors provide "expert advice to society on matters of health." The trauma doctor is expected to execute their expert knowledge and skills rapidly, with certainty, and with the intent to save a life hanging in the balance. Yet, doctors are also responsible for protecting the integrity of a patient. Within the trauma bay, to me, it seems that for one of these values to be upheld must come at the expense of another. Jordan Cohen writes about competency and caring, but what is the expectation from physicians in situations where care—for the dignity and autonomy of the patient—seems to be the least important thing in that moment?

I write about this experience because I—as a most-of-time-observer and sometimes-participant in trauma calls—believe my role on the team gives me the perspective of a fly on the wall. Between scribbled notes on labs or exam findings, as this room full of people swirls around me, I am allowed the space to watch the patient and, sometimes in this 3:00AM surreal event, place myself in their shoes. The hospital is a place where people often have the worst day of their life and there is nowhere other than the ED trauma bay that this is made more evident. On top of the embarrassment of their accident, patients are put through a humiliating set of exams where their

HUMANITIES CORNER (CONTINUED)

dignity is defiled. Laid out naked, smeared with cold lube, their rectum probed, their blood spilled. If "professionalism... is a way of *acting*" then the high-velocity stripping of patient autonomy certainly seems unprofessional.

It can be argued that these are necessary sacrifices made to potentially save a patient's life. But what happens once we clear the patient of being in critical condition? Does the trauma of the trauma assessment dissipate? I would argue no. I would argue that after such ordeals, patients remain silent about what they are put through. Silent because they believe they ought to be grateful for having their life saved. Silent because, *surely*, this same experience is what hundreds of people are put through every week in that same room.

In as little as a year from now, I will be that intern in the lead jacket performing the primary and secondary trauma survey. Someday, I may even be the attending physician in such a situation. What will I do differently, and *can* anything be done differently?

Cohen writes "humanism… is a way of *being*" and I acknowledge that this essay takes an aggressive tone towards a situation most do not think twice about. But, I certainly believe that my "deep-seated personal convictions," my obligations to altruism, duty, integrity, and respect for others can nudge my actions and maybe the actions of others in a direction that gives trauma patients back some sense of autonomy and dignity. I think this can be done without sacrificing efficiency, morbidity, or mortality.

I believe this can be achieved, firstly, by simply acknowledging the patient. "Ms. Smith, we are going to move you in... Three, two, one!" Certainly, the concepts taught to the clinician of signposting can be incorporated into a trauma situation to not only the benefit of the patient but to the entire team. Trauma teams should also be trained to practice compassion at the core of every action. While this may seem like an increase in cognitive burden, by incorporating patient-sensitive language and actions into training itself, I think a more humanistic culture can be brought about. Finally, I see a role for debriefing. Using a checklist, we can not only assess the efficiency and effectiveness of the trauma team but also whether the patient was cared for with compassion. Ultimately, while saving a patient's life in a trauma situation is the primary goal of every member of the trauma team, the effort to communicate and care for the patient in these seemingly small ways gives patients a modicum of respect during a period of their life where their control over their life has been suddenly stripped away. Physicians are held to high standards. It is not enough to simply save a life, we should hold ourselves accountable for the mannerisms we employ while doing so.

Particular details of the story have been changed to protect the identity of the patient and the circumstances of the trauma.

BIOETHICS IN THE LITERATURE

⇒ Bernat JL. Clarifying the DDR and DCD. Am J Bioeth. 2023 Feb; 23: 1-3.

⇒ Berwick DM. Salve lucrum: The existential threat of greed in US health care. JAMA. 2023 Jan 30. [Epub ahead of print]

⇒ Blackshaw B. Are heartbeat bills ethically defensible? Bioethics. 2023 Feb; 37: 219-220.

⇒ Buck Z. Fraud, abuse, and financial conflicts of interest. N Eng J Med. 2023; 388: 673-676.

⇒ Chen W, Chung JOK, Lam KKW, et al. End-of-life communication strategies for healthcare professionals: A scoping review. Palliat Med. 2023 Jan; 37: 61-74.

⇒ Dunsford J. Nursing violent patients: Vulnerability and the limits of the duty to provide care. Nurs Inq. 2022 Apr; 29: e12453.

⇒ Ferrario A, Gloeckler S, Biller-Andorno N. Ethics of the algorithmic prediction of goal of care preferences: From theory to practice. J Med Ethics. 2023 Mar; 49: 165-174.

> ***"The integration into clinical practice of algorithms that predict care preferences, particularly when involving advanced AI, is a complex and interdisciplinary exercise that draws on ethicists, computer scientists, designers, clinicians, loved ones and patients."***
>
> (Ferrario et al.)

⇒ Ferrario A, Gloeckler S, Biller-Andorno N. AI knows best? Avoiding the traps of paternalism and other pitfalls of ai-based patient preference prediction. J Med Ethics. 2023 Mar; 49: 185-186.

⇒ Flanagin A, Bibbins-Domingo K, Berkwits M, et al. Nonhuman "authors" and implications for the integrity of scientific publication and medical knowledge. JAMA. 2023 Jan 31. [Epub ahead of print]

⇒ Gaillard AS, Braun E, Vollmann J, et al. The content of psychiatric advance directives: A systematic review. Psychiatr Serv. 2023 Jan 1; 74: 44-55.

⇒ Gamble VN. Dr Herman A. Barnett, black civil rights activists, and the desegregation of the University of Texas medical branch in 1949: "We ought to go in Texas and I don't mean to a segregated medical school". JAMA Int Med. 2023 Feb 6. [Epub ahead of print]

⇒ Grier K, Koch A, Docherty S. Pediatric goals of care communication: A socioecological model to guide conversations. J Hosp Palliat Nurs. 2023 Feb 1; 25: e24-e30.

⇒ Grinberg G. Please look at my baby — when clinicians should say the word "hospice". N Eng J Med. 2023 Feb; 388: 486-487.

⇒ Hem MH, Molewijk B, Weimand B, et al. Patients with severe mental illness and the ethical challenges related to confidentiality during family involvement: A scoping review. Front Public Health. 2022; 10: 960815.

⇒ Hodson N. Commitment devices: Beyond the medical ethics of nudges. J Med Ethics. 2023 Feb; 49: 125 -130.

BIOETHICS IN THE LITERATURE (CONTINUED)

⇒ Keilman L, Jolaei S, Olsen DP. Moral distress and patients who forego care due to cost. Nurs Ethics. 2023 Jan 28. [Epub ahead of print]

⇒ Letson MM, Crichton KG. How should clinicians minimize bias when responding to suspicions about child abuse? AMA J Ethics. 2023 Feb 1; 25: E93-99.

⇒ London AJ, Seymour CW. The ethics of clinical research: Managing persistent uncertainty. JAMA. 2023 Feb 20. [Epub ahead of print]

⇒ Moore B, McDougall R. Exploring the ethics of the parental role in parent-clinician conflict. Hastings Cent Rep. 2022 Nov; 52: 33-43.

⇒ Nielsen Busch EJ, Mjaaland MT. Does controlled donation after circulatory death violate the dead donor rule? Am J Bioeth. 2023 Feb; 23: 4-11.

⇒ Park-Clinton E, Renda S, Wang F. A targeted discharge planning for high-risk readmissions: Focus on patients and caregivers. Prof Case Manag. 2023 Mar-Apr 01; 28: 60-73.

⇒ Quek CWN, Ong RRS, Wong RSM, et al. Systematic scoping review on moral distress among physicians. BMJ Open. 2022 Sep 2; 12: e064029.

⇒ Roest J, Nkosi B, Seeley J, et al. Respecting relational agency in the context of vulnerability: What can research ethics learn from the social sciences? Bioethics. 2023 Jan 29. [Epub ahead of print]

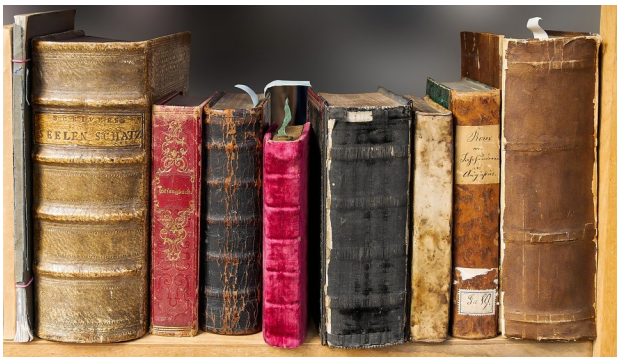
⇒ Schwartz PH, Sachs GA. Rethinking decision quality: Measures, meaning, and bioethics. Hastings Cent Rep. 2022 Nov; 52: 13-22.

⇒ Smajdor A. Reification and assent in research involving those who lack capacity. J Med Ethics. 2023 Jan 23. [Epub ahead of print]

⇒ VanderWeele TJ. Abortion and mental health-context and common ground. JAMA Psychiatry. 2023 Feb 1; 80: 105-106.

⇒ Weaver MS, Sharma S, Walter JK. Pediatric ethics consultation services, scope, and staffing. Pediatrics. 2023 Feb 1. [Epub ahead of print]

⇒ Wentlandt K, Wolofsky KT, Weiss A, et al. Physician perceptions of restrictive visitor policies during the covid-19 pandemic: A qualitative study. CMAJ Open. 2023 Jan-Feb; 11: E110-e117.



BIOETHICS IN THE NEWS

⇒ 60% of Americans would be uncomfortable with provider relying on AI in their own health care. Pew Research Center, February 22, 2023.

⇒ How to fold Indigenous ethics into psychedelics studies. Science, February 23, 2023.

⇒ Improving patient safety shouldn't be a financial calculation. STAT News, February 17, 2023.

⇒ 'It is a balance:' Scientists grapple with ethics of cutting-edge stem cell research. STAT News, February 13, 2023.

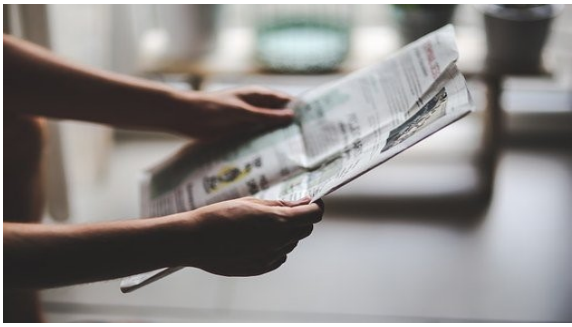
⇒ The ethical dilemmas behind plans for involuntary treatment to target homelessness, mental illness and addiction. The Conversation, February 3, 2023.

⇒ ChatGPT: Five priorities for research. Nature, February 3, 2023.

⇒ A new bill would let Mass. Prisoners donate organs for reduced sentences. Critics call it 'coercive.' The Boston Globe, February 1, 2023.

⇒ Diversity mandate for clinical trials aids review boards' role. Bloomberg Law, February 1, 2023.

⇒ Requiring integrated care plans to offer spiritual care to dually eligible individuals. Health Affairs Forefront, January 31, 2023.



BIOETHICS OPPORTUNITIES

UPCOMING

⇒ The Hastings Center: Upcoming Webinars and Events

⇒ Michigan State University: 2022-2023 Bioethics Public Seminar Series

ONGOING

⇒ The Hastings Center: Recent Webinars and Events

⇒ American Journal of Bioethics: YouTube channel containing previous webinars

⇒ The MacLean Center for Clinical Medical Ethics: YouTube channel containing previous lectures

⇒ Children's Mercy Kansas City: Pediatric Ethics Podcast series and Webinars and Workshops

⇒ Office for Human Research Protections Luminaries Lecture Series

BIOETHICS SERVICES AT THE UIHC

ETHICS CONSULT SERVICE

This service is a clinical resource for UI Health Care personnel who would like help addressing an ethical question or problem related to a patient's care. Consults can be ordered through EPIC or by paging the ethics consultant on call. For more information, click here.

CLINICAL RESEARCH ETHICS SERVICE

We provide free consultation on ethical issues related to research design, tissue banking, genetic research results, informed consent, and working with vulnerable patient populations. In particular, we assist clinical investigators in identifying and addressing the ethical challenges that frequently arise when designing or conducting research with human subjects. These include ethical challenges in sampling design; randomized and placebo-controlled studies; participant recruitment and informed consent; return of individual-level research results; community engagement processes; and more. For more information, click here.