Volume 24.... 2014.... Number 4

BENO

BIO Quarterly

A Publication of
The Bioethics Network of Ohio

From the President

Sharon Darkovich, RN, MA, BSN, CPHQ

First Annual Bioethics Week!

At the Board of Trustees' meeting of the Bioethics Network of Ohio (BENO) on September 30, 2014, the Board voted unanimously to declare the First Annual Ohio Bioethics Week to be held the week of April 27, 2015. Bioethics Week 2015 will culminate on May 1st with BENO's annual conference when BENO will celebrate its 25th anniversary.

Celebrating Bioethics Week within your organization and institution can have multiple purposes. The Board hopes that on a local level at your health care facilities, Bioethics Week will be an opportunity to raise awareness of your organization's clinical ethics resources and to inform your personnel about the functions and services of your ethics committee and its members.

How might you celebrate the First Annual Bioethics Week within your organization during the week of April 27th to May 1st? Here are some suggested ideas and activities:

- An information table near your cafeteria, staffed by ethics committee membrs during high-traffic times. Hand-outs could include:
  - *A one-page flier listing ethics committee members, functions, and how and when to access the ethics consultation service.
  - *A Patient Rights brochure.
  - *The Ohio Advance Directives (Living Will, Health Care Power of Attorney).
  - *Raffle tickets for gift cards.
  - *Bite-size candies!
- Clinical ethics educational events such as a Bioethics Grand Rounds presen-

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Bio Quarterly
is published four times
a year by Bioethics
Network of Ohio,
2653 Ramsay Road
Beachwood, OH 44122
PH 216.397.4445
www.BENOethics.org

Submissions

to Bio Quarterly are encouraged. Manuscripts may be original material or reprint with permission. Appropriate subject/topics include: issue analysis, cases, report of institutional activity or programs, legisative and policy commentary and book reviews. Please submit your article electronically to **smithm24@ccf.org** for consideration. Quarterly deadlines are the 15th of February, May, August and November.

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Sharon Darkovich,
RN, MA, BSN, CPHQ
President

Marty Smith, STD
Editor

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We welcome your Charitable Contributions

Your financial contribution to BENO, a qualified 501(c) (3) organization, is considered tax deductible. We appreciate all contributions to help further our mission and educational efforts. Contributions can be made by check or on our website, www.BENOethics.com. A receipt is available upon request.

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Bioethics Week *continued...*

tion, nursing in-services, brown-bag lunches, and journal club discussions on a journal article or book chapter.

- Information and education about your ethics committee and ethics consultation service distributed through in-house publicity mechanisms such as your newsletter or TV channel.
- A poster or easel display near high foot-traffic areas (e.g., cafeteria) with information about Bioethics Week and the ethics committee, and pictures of ethics committee members.
- Recognition and appreciation of the service provided by your ethics committee members through certificates or plaques for years of service.
- Showcasing any Quality Improvement projects by your ethics committee.
- Promoting attendance at BENO's 25th annual conference, May 1, 2015 in Dublin, OH.

This list of activities, of course, is not exhaustive and I encourage you to think creatively about what will work at your own institution. Most importantly, somehow and in some way, celebrate the First Annual Bioethics Week by raising awareness of your clinical ethics resources and by educating your front-line professionals and administrators about clinical ethics issues.

The BENO Board and I hope that Bioethics Week will be an exciting opportunity for you, your ethics committee and your ethics consultation service and that you can join us for a stimulating 25th annual conference on May 1st.

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BENO Ethics Consultation Course, 2015-2016

What: A twelve-month course with the goal of enhancing core competencies of knowledge and skills necessary for functioning proficiently as a clinical ethics consultation team member.

How: Educational methods include didactics, mentoring, small peer group interactions, reading assignments, and three independent projects due at the full-day sessions in July, October and January.

When: Four full-day sessions: April 30, July 25, and October 3, 2015; and January 30, 2016 (March 19, 2016 as needed in case of snow!).

Where: Offices of Midwest Care Alliance, Dublin, OH.

Faculty: Cynthia Griggins (Course Director), Anne Lovell, Margot Eves, Marty Smith.

Maximum Registrants: 16, with each faculty member mentoring 4 participants.

Registration Fees: Physicians: $525; Non-physicians: $475.

CME/CEUs: To be applied for and offered.

Materials Provided: (costs included in registration fees):
1) *Core Competencies for Healthcare Ethics Consultation*, 2nd Edition; and
2) Hester DM, Schonfeld T. *Guidance for Healthcare Ethics Committees*. Cambridge University Press, 2012.

For Questions and Registration: Contact Anne Lovell (Anne.Lovell@cchmc.org).

Pearls and Pitfalls: Suggested Do's and Don'ts for Healthcare Ethics Consultants (HCECs)

Joseph A. Carrese and the Members of the American Society for Bioethics and Humanities
Clinical Ethics Consultation Affairs (CECA) Standing Committee

Joseph A. Carrese, MD, MPH *is a Professor in the Department of Medicine at Johns Hopkins School of Medicine and a core faculty member of Johns Hopkins Berman Institute of Bioethics.*

For the full text of this article and a list of Contributing Authors, see: Carrese JA, et al. HCEC Pearls and Pitfalls: Suggested Do's and Don't's for Healthcare Ethics Consultants. *The Journal of Clinical Ethics* 2012; 22(3): 234-240.

1. Don't assume that the question you are asked to address is a matter of ethics, or that it is the primary issue or the only issue. Do take the time to clarify for yourself (and your team) the following: What are the relevant concerns, and are they a matter of ethics?

Those requesting an ethics consultation recognize that a problem exists. However, they may not be able to accurately determine whether the problem is truly a matter of ethics or not, and even if they can, they may not be able to correctly articulate the precise nature of the ethical concerns (that is, the values about which there is uncertainty or conflict). Further, requesters may not appreciate that, in addition to the question(s) they have raised, other important ethical concerns may be involved. One important task for HCECs, then, is to determine if the request is appropriate for ethics consultation and, if so, to clarify the ethical concern(s).[1] If the request does not involve an ethics question (that is, what should be done in the face of uncertainty or conflict about values), it should be referred to other resources in the healthcare system that are better equipped to handle such requests. For example, if the requester is seeking a legal opinion, he or she should be referred to legal counsel. Similar to making a diagnosis in clinical medicine, where precision in diagnosis leads to appropriate intervention, clearly and accurately identifying and describing the ethical concerns in an ethics consultation will more likely lead to a correct and helpful analysis and appropriate recommendations. Another parallel to clinical medicine is that, as the case unfolds over time, new issues may emerge. An initial set of questions, even when addressed and resolved, may lead to awareness of new ethical issues as the case evolves. The consultant should be attentive and open to this possibility and revisit the ethics question(s) in the consultation, as needed.

> ***One important task for HCECs, then, is to determine if the request is appropriate for ethics consultation and, if so, to clarify the ethical concern(s).***

2. Don't conduct ethics consultations a different way each time. Do have a standardized and systematic approach for gathering, analyzing, and synthesizing information.

"Excellence is an art won by training and habituation: we do not act rightly because we have virtue or excellence, but we rather have these because we have acted rightly; . . . we are what we repeatedly do. Excellence, then, is not an act but a habit."[2] Excellence in ethics consultation, as in any other pursuit, is not an accident. It is born of commitment, training, and the habit of approaching our work with high standards and rigor, every single time we do a consultation. One strategy for facilitating high quality ethics consultation is to have a standardized process for conducting consultation that is thorough, systematic, and employed every time. Approaching one's work differently each time increases the likelihood of omissions and mistakes. Many strategies for conducting healthcare ethics consultations have been suggested.[3] We do not endorse a particular strategy; rather, we urge HCECs and consultation services to select and use one strategy consistently—that is, to make it a habit, so that quality is enhanced and excellence can be achieved. Another advantage of a consistent approach is that, over time, those who request assistance from HCECs learn what to expect.

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3. Don't come to premature closure about the issues involved and the options available. Do take the time necessary to be thorough in each step of the consultation process.

One basic rule in clinical medicine is resisting the temptation to arrive at a conclusion prematurely.[4] Instead, the preferred approach is to be careful, deliberate, and thorough before arriving at a conclusion. The same applies to HCEC. Thoroughness in all phases of the consultation process may take more time, but this approach is more likely to result in sound recommendations. HCECs should adhere to a systematic approach for gathering information (such as one of those referenced in Pearl 2) that begins with careful chart review (for case consultation), proceeds to interviewing stakeholders, and includes careful reflection along the way. Similarly, a thorough approach should be employed when analyzing the gathered information and when identifying, and, in turn, evaluating, ethically acceptable options. One strategy to contemplate when considering this "Pearl" is to periodically ask oneself and others involved in the consultation the following questions: Have we missed anything? Is there anything we haven't considered or anyone from whom we haven't heard? Have we accounted for all relevant perspectives? Are we aware of our assumptions and have we assessed them? Are there other possible explanations for what is happening? Have any new issues emerged since we started the consultation? Have we challenged ourselves to think creatively to identify additional ethically supportable options?

...be careful, deliberate, and thorough before arriving at a conclusion

4. Don't conduct informal "curbside" consultations when making recommendations about a specific patient. Do conduct formal case consultations that are documented in the patient's medical record.

There are times when physicians and nurses ask HCECs for advice over the phone or in the hallway and there can only be a brief exchange of information and ideas. Staff may desire a quick answer and may want to avoid initiating a consultation process that may take some time to complete. Forces conspiring to truncate the ethics consultation process can, at times, be very significant. A concern related to quick, curbside consultations is the possibility of incomplete appreciation by HCECs of all of the relevant facts and considerations. This in turn could lead to inappropriate or unfounded advice. In contrast, a formal, deliberate approach to gathering information and discussing the issues that have been raised enhances the likelihood that the process and outcome will be of the highest quality. In addition, a telephone or hallway conversation is not captured in the medical record, and is therefore not available for other members of the healthcare team to review and reflect upon. A carefully written formal consultation note placed in the medical record is available to others and serves as evidence that important issues in the case were carefully considered by HCE experts.

However, despite the preference for formal consultation, HCECs should be sensitive to the needs and limitations of those who may desire their services but are not willing or able to engage in a formal case consultation process. Consultants should develop strategies for being responsive, engaged, and helpful, even when a formal case consultation is not being requested.[5] For example, it is acceptable for HCECs to educate and offer generic advice to colleagues. An HCEC might be asked by a colleague to review and explain the key steps in assessing decision-making capacity, as a point of general information. Similarly, an HCEC, before being invited to undertake a formal case consultation, might advise careful communication between key stakeholders (such as a meeting between staff and family members). The key issue here is role clarification. There is an important distinction between providing general education or coaching about communication principles and giving specific advice about a particular patient that may lead to important decisions about that patient's medical care. HCECs need to be aware of this distinction, be clear about their role, and avoid offering specific advice about a particular patient unless it is in the context of a formal case consultation.

5. Don't allow the HCE consultation discussion to be dominated by particular individuals. Do be facilitative, inclusive, and a good listener.

The work of an HCEC, by definition, involves interaction with multiple parties, including patients, family members, and staff. Clearly, either in one's role as a member or as a leader of a consultation team, it is essential to ensure that all perspectives are given voice and that all stakeholders feel included and respected. If one person dominates the conversation, there is a risk that important information will not be communicated. Attention to core dialogue skills such as suspension of judgment, identification of the assumptions being made, skilled listening and inquiry, and reflection helps to create an inclusive, facilitative process.[6] This "ethics facilitation approach"[7] decreases the likelihood of missing crucial information and enhances the probability of arriving at an optimal understanding of the situation. [8]

6. Don't assume your written consultation note will be understood without verbal communication. Do use the consultation as an opportunity to engage healthcare staff in direct conversation to explain and teach.

One basic premise of optimal HCE consultation is optimal communication. Usually this means direct verbal communication with members of the requesting service to review key recommendations and associated reasoning, in addition to generating a written consultation note.[9] Direct verbal communication increases the likelihood that consult participants will understand the specific ethical concerns raised during the consultation, in part by creating an opportunity for questions to be asked and addressed. In this way, direct verbal communication reduces the risk of confusion or misunderstanding. In addition, many HCECs consider teaching and education to be part of their core mission—that is, to help those involved learn to work through ethical uncertainties and disagreements on their own.[10] Engaging members of the requesting service in conversations throughout the consultation process is one way to fulfill the HCEC's teaching mission.

7. Don't assume you are doing a good job. Do invite evaluation of your consultations from those requesting and/or participating in them.

A basic principle of quality improvement is to evaluate what you are doing. One way to evaluate ethics consultation is by getting feedback from end users.[11] While hard work and good intentions are important, they alone don't ensure that HCECs are doing the best job possible. For example, ethics consultants have blind spots like everyone else: interactions may be perceived by others as suboptimal in ways that HCECs cannot appreciate. Inviting feedback about specific aspects of the consultative process from those who requested and participated in the consultation is a useful way to better understand what is going well and what needs attention and improvement. The Department of Veterans Affairs Integrated Ethics initiative has many useful resources, including an evaluation tool that can be used to assess participants' perceptions of consultation performance.[12] Using this tool or a similar evaluation instrument after every consultation, combined with periodic review and discussion of aggregated feedback results, is an important step toward making necessary adjustments and providing better ethics consultation services. Examples of domains about which HCECs might invite feedback include respecting the opinions of the requestor, giving useful information, explaining effectively, clarifying decisions to be made, clarifying appropriate decision makers, identifying and describing ethically supportable options, and being accessible and timely.

One way to evaluate ethics consultation is by getting feedback from end users.

8. Don't assume that everyone who needs an ethics consultation will know that they need one, or even know that a consultation service exists. Do engage in outreach to raise awareness about the existence and role of the HCE consultation service.

Fox and colleagues found that 80 percent of U.S. hospitals and 100 percent of hospitals with 400 or more beds have an ethics consultation service.[13] However, patients, family members, and members of the hospital community who may be involved in patient care and who may be in a position to request an ethics consultation may not be aware that a consultation is needed, or they may not be aware of the existence of the HCE consultation service as a valuable resource. Lack of awareness that an ethics consultation is needed could be addressed by informational and educational outreach in a variety of forums in both the community and in the healthcare facility. The goal of these efforts should be to increase understanding about clinical ethics concerns and raise awareness about the HCE consultation service as a resource for addressing these

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concerns. HCECs should be mindful of how they describe and market the ethics consultation service to avoid the common misconception that requesting an "ethics consultation" means that someone has done something "unethical." In this regard, it may be more useful and less threatening to describe an ethics consultation as a way of protecting a "moral space" for staff to reflect on complex issues.[14]

9. Don't assume that everyone who wants an ethics consultation will feel empowered to ask for one. Do take action to reduce barriers to consultation requests.

Individuals who may be in a position to request an ethics consultation may not feel empowered to request one. Lack of empowerment among healthcare providers to request a consultation may occur for a variety of reasons, including a suboptimal work environment, suboptimal relationships with colleagues, or fear of retribution for "rocking the boat" or "whistle-blowing." Some of these potential reasons may be related to a staff member's location in the organizational hierarchy.[15] An unfortunate consequence of this situation is that moral distress is often suffered by staff members who believe that requesting an ethics consultation is the right thing to do, yet who feel uncomfortable requesting a consultation, either because the risks are too high or they are actively prevented from doing so.[16] Lack of empowerment among patients or family members to request a consultation may relate to fears of offending members of the healthcare team. Strategies for addressing these barriers include clear institutional policies and procedures asserting open access to HCE consultation[17] and ongoing outreach and education by HCECs. Education should be directed toward staff, who may desire an ethics consultation but who are not able or willing to request one over and against resistance by others, and those who are likely to be resisting a consultation request in the first place. Attention should be paid to how the service is described and marketed, as mentioned in Pearl 8.

> ***Education should be directed toward staff, who may desire an ethics consultation but who are not able or willing to request one over and against resistance by others.***

10. Don't confuse legal considerations with HCE consultation. Do recognize the appropriate roles and contributions of legal considerations in HCE consultation.

While legal considerations (including risk management and legal precedent) and ethical concerns related to a particular case may overlap considerably, they are not synonymous. This is not surprising, because their ultimate purposes differ, and the key stakeholders may be different. For example, in risk management, one goal is institutional protection, and the key stakeholder is typically the institution itself. For HCE consultation, the ultimate goal is arriving at healthcare decisions that are ethically optimal and defensible, and the key stakeholder (particularly in a case consultation) is typically a person, such as a patient or a staff member. Similarly, while legal considerations (such as case law or relevant state/federal legislation) may be very germane and inform ethical thinking about a case in important ways, what legal counsel might advise may differ from what the HCEC might recommend. Accordingly, the HCEC must resist the temptation to simply follow the guidance of legal counsel or risk managers, and instead arrive independently at positions and recommendations based on ethical principles and considerations.

11. Don't be too sure of yourself. Do embrace the complexity of each case with a healthy dose of humility.

Humility in an ethics consultant is a desirable, if not necessary, trait. Important features of humility are self-awareness, careful reflection, and a respectful attitude towards others. There are many reasons to embrace humility: the absence of a clear, right answer; the uncertainty often present in clinical medicine that permeates many cases for which HCE consultations are requested; the fact that reasonable people can and often do disagree about how to regard the same set of facts; the reality that consultants' abilities to know and understand are limited and imperfect. In addition, humility may have the added value of positioning a consultant to be open to and even actively seek alternative perspectives, which may lead to a more complete process, and ultimately to better consultations. Finally, humility may help consultants appreciate the boundaries of their role and serve as a check to overstepping their authority during a consultation.[18] Humility, therefore, is the proper disposition of consultants.

Humility in an ethics consultant is a desirable, if not necessary, trait.

12. Don't do it all on a shoestring. Do advocate for adequate resources and support for yourself and your fellow consultants.

In an era when most of us are accountable to someone for how we spend our time, and for how our time is supported, securing adequate resources for the important work we do is essential. Otherwise, the risk is that the time we are able to spend on this work is shortchanged, and the goal of conducting high quality consultations is threatened. There are many aspects of HCECs' work that could benefit from financial support. A partial list includes: continuing education related to ethics consultation, and to clinical ethics more broadly, for members of the consultation team; educational sessions provided by the institution's HCEC(s) for staff and for the greater community; compensation for time spent doing HCE consultations. HCECs should establish effective working relationships with institutional administrators to address the issue of adequate support for their work, broadly defined.

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Revising the American Nurses Code of Ethics

Martha Turner, PhD, RN-BC *is Assistant Director of the American Nurses Association (ANA) Center for Ethics and Human Rights.*

Posted with permission from the Society of Critical Care Medicine. The original material appeared in Critical Connections (Vol. 13; No. 4).

The American Nurses Association (ANA) Code of Ethics for Nurses with Interpretive Statements supports the standards and ideals of nursing service. It is a living document to guide all nurses in all roles and settings. It articulates both the values and the ideals of the profession. This legacy had its beginnings with Florence Nightingale in 1850. The last major revision of the code was published in 2001.

> ***...a call to all nurses in all roles and settings to commit to the values and ideals of the code.***

Upon the recommendation of the Ethics Advisory Board to the ANA Center for Ethics and Human Rights that the code be reviewed every 10 years, an ANA working group was formed in 2012 and charged with the question, “What, if any, changes should be made to the code?” A 123-item survey was posted to query nurses and the public on the need for changes and updates. Data were collected during February and March 2013. Over 2,700 responses were received and analyzed in a detailed report. Survey results revealed that Provisions One through Seven were still relevant and needed only minor changes to update language. Provisions Eight and Nine required major revision due to developments in healthcare delivery, nursing, advocacy, technology, and global health. The working group determined that revision was needed, including an updated preface to serve as a compelling summary of overarching ethical themes with a call to all nurses in all roles and settings to commit to the values and ideals of the code. Following an ANA request to members for participation, a small steering committee and larger advisory group were formed for the revision process.

The revised code was posted for public comment for one month during spring 2014. Over 1,500 comments were considered for changes to the final draft. After the steering committee and the ANA Ethics Advisory Board review these comments and agree on the changes, the revised code will go to the ANA Board of Directors for final approval later this year. Publication is expected in early 2015. When published, the revised code will be indexed to facilitate navigation to key words and will include an introduction, glossary of terms and a resource list.

The ANA thanks all who participated in this review and revision process. For additional information, please contact Martha Turner at martha.turner@ana.org or Director Laurie Badzek at laurie.badzed@ana.org.

MOLST in Ohio: Can We Get it Done?

Jeff Lycan, RN, MS *is the President and CEO of the Midwest Care Alliance, and an ex officio member of BENO's Board of Trustees. He has been a long-standing member of Ohio's "Honoring Wishes Task Force" which was formed to promote the POLST/MOLST paradigm and process in Ohio. In his letter below, Jeff provides an update of potential MOLST legislation in Ohio.*

Dear Colleagues,

In September 2014 the Institute of Medicine (IOM) published a report, *"Dying in America, Improving Quality and Honoring Individual Preferences Near the End of Life".*[1] [See Marty Smith's brief article in this issue of *BIO Quarterly*]. For many of us in the healthcare arena this is not new but having IOM report on the need to improve care at the end of life helps validate the concerns we see daily. In Ohio a broad based discipline and association task force (Honoring Wishes Task Force), meeting over the last eight years, is finally seeing the fruit of its labor with the introduction of HB588 (State Representatives Matt Huffman, and Lynn Wachtmann) and SB347 (State Senator Peggy Lehner). This legislation would establish a uniform physician order document to use with frail individuals and/or those who have a serious progressing illness. The form is called the MOLST, Medical Orders for Life-sustaining Treatment. Midwest Care Alliance has been host to the task force and now we are asking others to reach out to your state representative and senator to ask for their support of this legislation.

In an effort to develop a uniform tool that is transportable from one health setting to another, the task force was driven to develop consensus on broad concepts and then focused on the details to come to agreement or positions of neutrality with all the parties involved. The MOLST process and form have been developed as a balanced nonbiased approach to help patients develop individualized goals of care that can travel with them as they move from one health care setting to another. This patient-centered tool is built upon the POLST paradigm (www.polst.org) and is fully implemented in 16 states already.

Research recently published in the *Journal of the American Geriatrics Society*[2] demonstrated that individuals with serious illness who utilize such a tool have a greater opportunity to have their wishes honored. Depending on the treatment pathway one chooses, many of these individuals avoided unwanted hospital admissions while others, who wanted more aggressive care, utilized more hospital-based services. Thus, supporting the conclusion that the tool is helpful to individuals so they receive the type of care they want in the appropriate setting to give that care.

As forces continue to realign our health care systems, patient-centeredness is consistently identified as an approach to care that would harmonize medical and individual needs to achieve the highest possible quality of life and care for individuals and their families. For individuals nearing end of life, this approach is recommended to ensure an integrated delivery of services for continuity across the health care continuum. This starts with clinician-to-patient communications and advance care planning. Many individuals with serious life-limiting illnesses lack the information or capability of making their own care decisions without adequate and accurate information. As well, clinicians may often choose the wrong care pathways without the knowledge of a person's care preferences and treatment goals.

While advance directives are critical tools to inform others of one's wishes at end of life, they are narrow in scope and used as such. With the aging population and the chronic nature of most illnesses today, along with the developing technology and ability to treat disease, our health care system supports individuals longer on their journey toward death. The MOLST is a tool that meets the criteria we are looking for to help frail patients and individuals with serious progressive illness by promoting communications with health care providers and systems. It also encourages a broader conversation with their families which improves understanding of the disease process and helps those involved make better informed decisions about care and future treatment goals. It is also a tool that informs health care providers about the discussions and decisions that have occurred in the past.

Patient-centered care, coordination of care across the continuum, and increasing quality of life are critical components of MOLST's and the Institute for Healthcare Improvement's (IHI) triple aim - improving outcomes, lowering cost and increasing value. I believe the MOLST process and form help us achieve these goals.

The introduction of these legislative bills noted above signal the time to educate our legislators about the importance of MOLST. Chances are slim, as time slips on, that these bills will pass in 2014 during the current legislative session. However, now is the opportunity to educate our legislature about the importance of the MOLST so that hopefully in 2015 we will have a document in Ohio that helps all of us, at some point in our life's journey, when faced with such critical decisions.

Jeff Lycan, President/CEO Midwest Care Alliance

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2. *Association between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and In-Hospital Death in Oregon* http://www.polst.org/jags2014/

IOM Report and Call to Action to Improve Dying in America

Marty Smith, STD *is the Director of Clinical Ethics at the Cleveland Clinic, a long-standing BENO Board member, and the current Editor of BIO Quarterly.*

On September 17, 2014, the Institute of Medicine (IOM) issued a report titled, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. (1) The 507 page document contains findings and recommendations developed over a two-year period by a 21-member national committee of experts composed of physicians, nurses, geriatricians, bioethicists, legal scholars, insurance/payer representatives, and religious leaders.

In a press release when the report was published, the IOM's president, Victor Dzau, stated: "This is one of the most comprehensive and up-to-date studies that has been performed on end-of-life care for people of all ages who are approaching death. The time is now for our nation to develop a modernized end-of-life care system as envisioned in this report."

The report is structured around five "Key Findings" and five corresponding sets of Recommendations: 1) Delivery of Person-Centered, Family-Centered Care, 2) Clinician-Patient Communication and Advance Care Planning, 3) Professional Education and Development, 4) Policies and Payment Systems, and 5) Public Education and Engagement. A seven-page on-line booklet summarizes these Findings and Recommendations. (2)

One thread woven throughout the report's Findings/Recommendations is an emphasis on Palliative Care. After acknowledging that there have been significant strides in integrating palliative care into various disease trajectories and clinical pathways, this IOM report is clear that significantly more needs to be done. A few semi-quotations:

- Widespread adoption of timely referral to palliative care appears slow.
- There is insufficient attention to palliative care in medical and nursing schools.
- Health professionals are not always adequately prepared to deliver "basic" or "primary" palliative care to patients not currently hospitalized and not requiring specialty palliative care.
- Changes are needed throughout the health care system to incentivize provision of comprehensive palliative care

> ***One thread woven throughout the report's Findings/Recommendations is an emphasis on Palliative Care.***

Not surprisingly, another emphasis within the report is on advance care planning which, the report asserts, "is essential to ensure that patients receive care reflecting their values, goals, and preferences." In this context, clinicians are tasked with the responsibility "to initiate conversations about end-of-life choices and work to ensure that patient and family decision making is based on adequate information and understanding."

The above few paragraphs are hardly adequate to capture the wisdom, insight and calls to action that this IOM report contains, especially regarding the report's specific recommendations. At a minimum, I encourage you and your ethics committee to access and discuss the Findings/Recommendations in the IOM's seven-page summary booklet (2), and discern how your organization and institution can and will contribute to improved care of those near the end of life.

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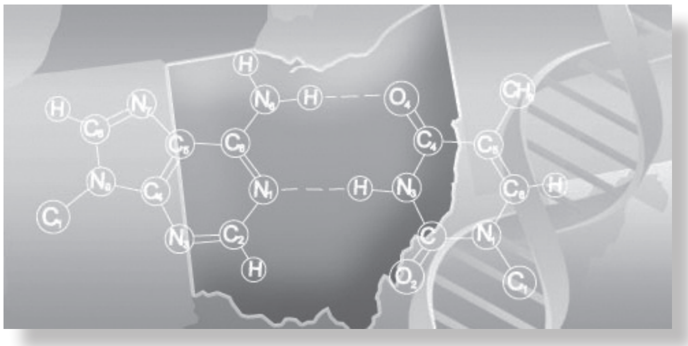
(1) http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx

(2) http://www.iom.edu/~/media/Files/Report%20Files/2014/EOL/Key%20Findings%20and%20Recommendations.pdf



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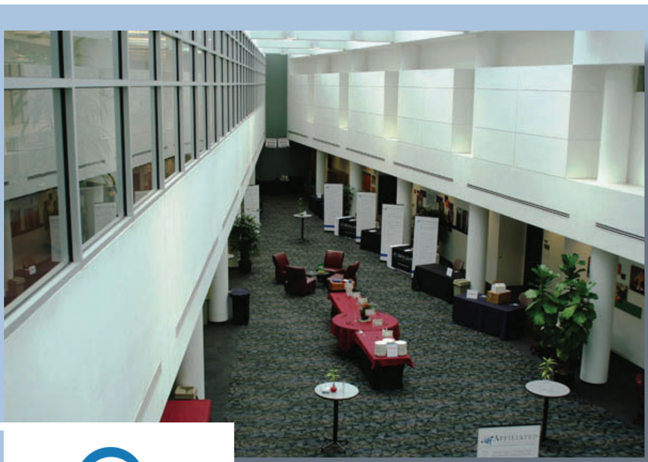

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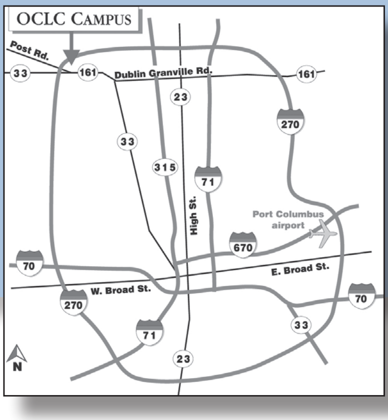

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