

BENO

BIO Quarterly

A Publication of
The Bioethics
Network of Ohio



● Emergency Department Patient Satisfaction: Factors Associated with Satisfaction with Care

Catherine A. Marco, MD, FACEP; Andy Davis, BS; Sylvia Chang, BS; Dennis Mann, MD, PhD; and James E. Olson, PhD.

Dr. Marco is Professor of Emergency Medicine and Surgery at Wright State University Boonshoft School of Medicine. She is a previous BENO President (2001 – 2003) and Board member (1999 – 2003).

Mr. Davis and Ms. Chang are medical students at Wright State University Boonshoft School of Medicine. Dr. Mann is Assistant Professor at Wright State University Boonshoft School of Medicine. Dr. Olson is Director of Research Laboratory and Professor of Emergency Medicine at Wright State University Boonshoft School of Medicine.

This research project was supported in part by grants from the Bioethics Network of Ohio and the Wright State University Boonshoft School of Medicine. The results were presented at the Society for Academic Emergency Medicine Midwest Regional Meeting, (September 2015, Toledo OH), and published in the American Journal of Emergency Medicine in 2015 [33(11):1708-9. PMID: 26364146].



Patient satisfaction is associated with improved patient compliance with therapy, reduced malpractice risk, and improved job satisfaction among the Emergency Department (ED) staff.¹ Previous studies have shown numerous factors to be associated with improved patient satisfaction, including effective pain management, effective communication, timeliness of care, empathy, and technical competence.^{2,3,4,5} This study was undertaken to measure patient satisfaction among ED patients and to assess the relationship between patient and physician demographic factors and patient satisfaction.

continued on page 3...

CONTENTS

MOLST -
Update for Ohio

4

CPR - What Has
History Taught Us?

5

Rule Revisions for
Ohio Guardians

7

Pain Management for
Black Patients

8

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, legislative 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.

Reprint Permission

is granted to BENO members for professional/educational purposes unless otherwise indicated in the article. As a courtesy, please inform the editor of the purpose of volume copying. We are interested in what you are doing.

*Sharon Darkovich,
RN, MA, BSN, CPHQ
President*

*Marty Smith, STD
Editor*

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.org. A receipt is available upon request.



● From the President

Sharon Darkovich, RN, MA, BSN, CPHQ



Hello, Everyone. I hope you are all enjoying the Spring/Summer weather!

For those of you who attended BENO's 2016 annual conference on April 29th, I trust that you found it enjoyable and enlightening. From the feedback we received during the conference, it was a great success. Thanks again to the Program Planning Committee and the faculty presenters for a great conference. The Planning Committee for the 2017 conference is already hard at work! If you have suggestions for topics you would like to see presented, please send them to Henry Blair (HBlair@ccf.org) who will be our conference co-chair for 2017.

My thanks to the faculty of BENO's ethics consultation course who helped almost 50 people during the past three years become more proficient in ethics consultation, thus promoting the practice of high quality clinical ethics in Ohio. The most recent graduates were honored at the 2016 conference and received their certificates of completion. (See photo on back cover) Unfortunately we did not have a sufficient number of registrants for a 2016-2017 course. If you are interested in a future version of the one-year consultation course (to begin in April 2017), contact Anne Lovell (annelovell65@gmail.com).

As we look ahead to the coming months, it is nearly time for elections to BENO's Board of Trustees. My own term of Board service ends this year after the election. Thank you to all the board members both past and present with whom I have had the privilege and pleasure to work over the last several years. Be assured that they will continue BENO's mission.

Because we will have openings for several new Board members, please consider running for the Board. You can contact Cassandra Hirsh for more information if you are interested (chirsh@chma.org). Include your name, contact information, and a brief paragraph regarding your qualifications to serve in this capacity. Please also share this information with others at your respective institutions so they can be considered.

The Board furthers BENO's mission by promoting bioethics education to Ohio's healthcare community. This is done by working to provide high quality educational offerings through the annual conference and the ethics consultation course, and by reviewing applications for educational and research grants.

Finally, thanks to all of you for your dedication to furthering bioethics in Ohio.

Sharon Darkovich, BENO President

Emergency Department Patient Satisfaction

continued from page 1...

This prospective survey study was conducted at an urban ED at Miami Valley Hospital, and was approved by the Wright State University Institutional Review Board. Eligible participants included a convenience sample of adult ED patients age 18 and over from July 2014 through March 2015. Data were analyzed using SAS (Statistical Analysis Software, Copyright (c) 2002-2012 by SAS Institute, Inc., Cary NC, USA).

Among 315 patients who participated in this study, the mean age was 52 (range 18-90+). Approximately half of the patients were female (58%). Patient ethnicities included white (68%), African American (26%), and other (6%). Most patients arrived by walk-in (64%) and some arrived by ambulance (36%). ED disposition included hospital admission (54%) and discharge to home (46%).

On a 0 to 7 Likert Scale, the most frequently chosen overall satisfaction score was 7 (very strongly agree). There were no statistically significant differences in overall satisfaction by patient gender, ethnicity, ED disposition, physician gender, physician ethnicity, or patient-physician gender concordance ($p = \text{NS}$, non-parametric Wilcoxon or Kruskal Wallis tests). A higher percentage of patients who had a female physician selected the highest satisfaction rating for overall satisfaction compared to those who had a male physician ($p\text{-value}=0.04$; Chi square).



The most important factors associated with satisfaction included communication, overall experience, speed of treatment, and quality of care. The most common

factors associated with dissatisfaction included waiting time, treatment of pain, and nursing staff.

In recent years, the Center for Medicare Services (CMS) has added patient experience of care, or patient satisfaction, as a key marker of value in the Value-Based Purchasing programs that are being used for distribution of healthcare resource dollars. In short, HCAPHS (Hospital Consumer Assessment of Healthcare Providers and Systems), a post discharge survey instrument, is used in conjunction with other hospital quality measures as part of a pay-for-performance metric. Outpatient survey instruments used by many hospitals, such as Press Ganey, employ mailed surveys to discharged ED patients. Such surveys may be fraught with statistical unreliability, with low response rate, selection bias, and exclusion of admitted patients.⁶

Previously, factors such as door-to-doctor time, positive physician identification, and perhaps gender have been shown to affect patient satisfaction survey results.^{7,8,9} In the current study, physician-associated factors did not appear to play a significant role in patient satisfaction results.

This study identified, by free text responses, the most important factors associated with satisfaction and included communication, overall experience, speed of treatment, and quality of care. The most common factors associated with dissatisfaction included waiting time, treatment of pain, and nursing staff. These results inform potential areas for improvement in emergency care to enhance patient satisfaction.

These results inform potential areas for improvement in emergency care to enhance patient satisfaction.

This study relies on self-reported data. Because most patients were highly satisfied, small differences between groups may have been difficult to detect.

In conclusion, ED patients were highly satisfied with their care. Patient satisfaction scores did not vary significantly according to patient gender, patient ethnicity, ED disposition, physician gender, physician ethnicity, or patient-physician gender concordance. Patients treated by female physicians were more highly satisfied with ED care.

References

(Endnotes)

- 1 Welch SJ. Twenty years of patient satisfaction research applied to the emergency department: a qualitative review. *Am J Med Qual.* Jan-Feb 2010;25(1):64-72.
- 2 Bhakta HC, Marco CA: Pain Management: Association with Patient Satisfaction among Emergency Department Patients. *J Emerg Med.* 2013 [Epub ahead of print]
- 3 Downey LV, Zun LS. The correlation between patient comprehension of their reason for hospital admission and overall patient satisfaction in the emergency department. *J Natl Med Assoc.* Jul 2010;102(7):637-643.
- 4 Taylor DM1, Wolfe R, Cameron PA. Complaints from emergency department patients largely result from treatment and communication problems. *Emerg Med (Fremantle).* 2002 Mar;14(1):43-9.
- 5 Bongale S1, Young I. Why people complain after attending emergency departments. *Emerg Nurse.* 2013 Oct;21(6):26-30
- 6 Sullivan W, and DeLuca J: 2+2=7? Seven things you may not know about Press Ganey Surveys. Sept. 2010 *Emergency Physicians Monthly.*
- 7 Associations between patient and emergency department operational characteristics and patient satisfaction scores in an adult population. *Ann Emerg Med* 2014 Dec; Vol. 64 (6), pp. 604-8.
- 8 Hall JA, Gulbrandsen P, Dahl FA: Physician gender, physician patient-centered behavior, and patient satisfaction: A study in three practice settings within a hospital. *Patient Education and Counseling* 2014; 95: 313-318
- 9 Siegrist RB: Patient satisfaction: history, myths, and misperceptions. *American Medical Association Journal of Ethics* 2013; 15 (11): 982-987.

● Medical Orders for Life-Sustaining Treatment (MOLST) - Update for Ohio



Jeff Lycan, RN, MS, is Chair of the Honoring Wishes Task Force and President of the Hospice Alliance of Ohio. He has worked over thirty-five years in healthcare, primarily in oncology, hospice and palliative care. For the last 18 years his focus has been on advocating for improving quality of life and care for individuals at the end of life.

End-of-life conversations are often fraught with emotion for both patients and those who care for them. Nevertheless, they are a critical component of providing superior care for the seriously ill and frail seniors who are living with a terminal illness or final stages of life. The conversation that occurs with the Medical Orders for Life-Sustaining Treatment (MOLST) process helps healthcare providers and families understand the patient's perspective, values, and wishes. Together, care providers, the family, and patient can translate this discussion into specific healthcare decisions and medical orders. Often, broaching these topics feels like pointing out the elephant in the room. For some, it is hard to acknowledge, while others feel a sense of relief at having started the conversation and having it out in the open. Too often, the discussion never occurs.

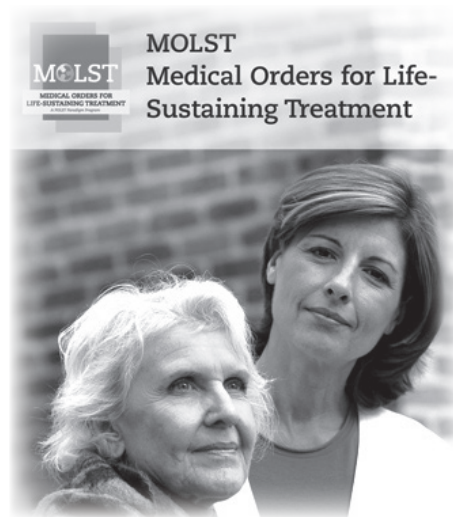
Those of us who interact with individuals at end of life have witnessed too many families who feel forced into making important decisions in the middle of a healthcare crisis. The healthcare system can do better for the individuals we are privileged to serve. Many in healthcare (e.g., physicians, nurses, chaplains, social workers) are well positioned to guide patients with patience and candor through these difficult conversations. This should occur to provide patients with better coordination, planning, and delivery of services as they approach the end of their lives.

Senate Bill 165 is aimed at reforming Ohio's current do-not-resuscitate form (DNR) and replacing it with the MOLST tool. MOLST is voluntary and only designed for patients with advanced illness, or who are frail or elderly,

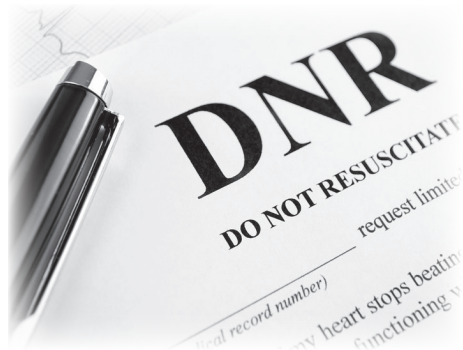
those for whom these conversations are most important. Unlike the DNR order, MOLST will encourage communication about end-of-life decisions and provide

more clarity to patients, their families, and care providers. This Senate Bill passed two major hurdles in May 2016. It was unanimously voted out of the Senate Civil Justice Committee and then passed the full Senate by a vote of 30 - 3. The bill now needs to move to the Ohio House. While difficult, efforts and energy will focus heavily to move this bill after the general elections in November.

MOLST and MOLST-like tools are all developed under the framework of the POLST paradigm (www.polst.org) and have been enacted in 22 states. These states find that patients with a MOLST form are more likely to die in the setting of their choice. MOLST can be utilized by individuals who want to sustain life until their final breath or for those who chose to die a natural death. This means less fear and worry for seriously ill individuals and more time for important things like family, loved ones, or whatever else is most critical to that individual.



The Honoring Wishes Task Force is a statewide coalition of healthcare providers, patient advocates, and religious organizations working hard to make MOLST a reality. Together with bill sponsors, legislators, and stakeholders, this coalition has carefully designed SB165 with special protections in place to prevent it from being abused or used as a vehicle for physician-assisted suicide. We are confident that this legislation can provide improved end-of-life care for those we love and have the privilege of serving. We encourage you to reach out to your state representatives expressing support for SB165.



● CPR - What Has History Taught Us?



Anita Tarzian, PhD, RN, is the Program Coordinator for the Maryland Healthcare Ethics Committee Network (MHECN), which is run out of Maryland Carey Law. She is also Associate Professor at the University of Maryland School of Nursing and does consulting work in clinical and research ethics.

This article was previously published in the Mid-Atlantic Ethics Committee Newsletter (Fall 2015) and is published here with the permission of Dr. Tarzian.

Dr. James Jude, a Johns-Hopkins-trained thoracic surgeon, died in Florida in July 2015. Jude was one of a number of physicians in the Baltimore area who helped develop modern cardiopulmonary resuscitation (CPR) techniques in the late 1950s. Back then, sudden cardiac arrest was often

... The evolution from CPR's innovation to its widespread application offers some lessons for the challenges encountered in its current use.

triggered by medical procedures performed on hospitalized patients, such as anesthesia during surgery. Until that time, the standard method of resuscitating a patient involved direct cardiac massage – something that typically required a thoracic surgeon to cut open the patient's chest (Jude, 2003). CPR offered the opportunity to save many lives. Before that goal could be fully realized, widespread education and training was needed. The evolution from CPR's innovation to its widespread application offers some lessons for the challenges encountered in its current use.

CPR is unique in that it is administered as a default procedure unless a medical order is written that it be withheld. This raises the question of how the decision is – and should be – made to withhold CPR attempts. If a patient's death is imminent and the goals of care thus shift toward preserving dignity and comfort, should CPR even be offered?

For a growing number of individuals, death is preceded by extended stays in intensive care unit (ICU) settings that obfuscate the line drawn where death is deemed "imminent." This is relevant because the imminence of death marks a clear transition from a clinician's duty to preserve life (often at the expense of comfort) to a duty to prioritize comfort and dignity during the dying process. Of course, we should prioritize a patient's comfort and dignity throughout the

disease trajectory. However, as unavoidable death draws nearer, maintaining comfort and dignity becomes a central focus. The burden of a particular life-saving intervention should thus be weighed against its benefits. When death is truly imminent, CPR provides no benefit to the patient. Benefit to the bereaved who may view failed CPR as the ultimate evidence that everything was tried to save their loved one's life raises the question of whether it's appropriate to provide CPR merely for the psychological benefit to survivors – what some have depicted as a modern "death ritual" (Lantos, 1992; Truog, 2010).

Jude and his colleagues foreshadowed this situation. He and his collaborator and coauthor James Elam made it clear that CPR should only be used with patients who experience sudden cardiac arrest who could be successfully defibrillated/revived. In their 1965 book, *Fundamentals of Cardiopulmonary Resuscitation*, Elam and Jude emphasize that CPR is inappropriate to use with dying patients. Consider this exchange between Elam and an attendee of the ad hoc conference on cardiopulmonary resuscitation, convened by the National Research Council of the National Academy of Sciences in 1966.

Q: When do you start or decide not to start CPR?

A: (Elam) "This has been critically reviewed by the committee... You start CPR whenever there is a sudden cardiac arrest. You do not start it on a patient with an incurable or intractable chronic disease. You do not start it when you are sure that the patient has been clinically dead for so long that resuscitation with a viable brain is out of the question. If you are not sure about starting, the patient deserves the benefit of the doubt. If in doubt, start CPR and then determine the pre-arrest time and status of the patient as quickly as possible so that you can decide whether to continue CPR or to stop it." (National Research Council, 1966, p. 195).

There are three critical points here: (1) Whether to attempt CPR is a medical decision; (2) CPR is inappropriate

continued on page 6...

when death is expected and unavoidable; and (3) If valid ambiguity exists among clinicians at the bedside, CPR can be started but should be stopped as soon as it is deemed inappropriate. The first point was less controversial in the 1960s, when physicians routinely made decisions without much input from patients and families about which end-of-life treatments to provide or withhold. In today's legalistic and patient-rights-driven era, clinicians prefer getting permission to withhold CPR attempts. However, this implies that patients or their surrogate decision-makers have the final say. This often doesn't "feel" right when involving patients who won't survive discharge from the ICU – not to the bereaved who feel implicated in the decision to "allow" their loved one to die, nor to clinicians who prefer a more peaceful send-off for a dying patient than "ritualized CPR."

Once again, revisiting CPR's origins may provide some guidance. Several organizations, such as the American Red Cross and the American Heart Association, spent concerted, widespread, long-term efforts at training first responders to do CPR. Initially, training was limited to health care providers, then expanded to emergency medical technicians, and later, directed toward lay persons. Early education and training, such as the ad hoc CPR conference mentioned above (National Research Council, 1966), went into fine detail about all aspects of CPR provision, such as how to outfit ambulances to allow enough physical space to properly perform CPR, and how to address attitudinal barriers. Consider this exchange between Dr. Larry Birch and an attendee:

Q: Will considerable psychologic training be needed? I find that most nurses who have been trained say they would not use CPR because it is a doctor's job.

A: (Birch) "I think nurses who have been reluctant to use CPR are not doing so because of a psychological block. This hesitancy relates to the question of what is nursing practice and what is medical practice." (National Research Council, 1966, p. 190).

With adequate training, nurses overcame their resistance to providing CPR and soon accounted for the largest group of health care professionals to perform the technique. Today, clinicians' moral distress related to CPR relates more to whether or when they can refuse to perform it. Moral concerns about attempting CPR on dying patients is some-



times centered on the unnecessary suffering this causes the patient. This is not a compelling logical argument, as it's unlikely that a patient undergoing chest compressions and cardiac defibrillation is conscious enough to feel pain and discomfort (future suffering if they are successfully revived notwithstanding). More likely, clinicians at the bedside feel that CPR attempts are not the appropriate way to demonstrate care and respect for a dying or dead person's body.

Granted, what constitutes appropriate respect for a dead body depends on context and culture. Methods of attempting to revive the recently deceased have existed for centuries, and include whipping the body with stinging nettles, blowing smoke into an animal bladder and then into the rectum, hanging the body upside down, or over a barrel that is moved back and forth, or over a trotting horse, and burying a body up to the chest and splashing water on the face (National Research Council, 1966). Such indignities were justified if meaningful life was saved. Thus, the burden of the indignity needs to be weighed against its benefit. This weighing process has become more complex in today's healthcare climate. Concerns of patients, bereaved loved ones, and clinicians at the bedside all deserve attention, as well as how to fairly allocate finite healthcare resources. Education and training for when *not* to attempt CPR, and what will be done instead, is multi-layered, complex, and a grand undertaking. It's time to delve into the fine details, as we learned from the CPR pioneers. Clearly this is still a work in progress.

References

- Lantos, JD. (1995). Bethann's death. *Hastings Center Report*, 25(2), 22-3.
- Jude, JR. (2003). Personal reminiscences of the origin and history of cardiopulmonary resuscitation (CPR). *The American Journal of Cardiology*, 92(15), 956-963.
- Jude, JR. and Elam, J. (1965). *Fundamentals of Cardiopulmonary Resuscitation*. Philadelphia, PA: F.A. Davis Co.
- National Research Council (1966). *Cardiopulmonary Resuscitation Conference Proceedings*. Archer S. Gordon (Ed). Washington, D.C.: National Research Council. Publication 1494. (Available using title search at <http://books.google.com>)
- Truog, R. (2010). Is it always wrong to perform futile CPR? *N Eng J Med*, 362(6), 477-9.

● Recent Rule Revisions for Ohio Guardians

Jude Troha, LSW, NCG, BA, is a graduate of Ursuline College (Pepper Pike, OH). He has been employed by Adult Guardianship Services (AGS) in Cuyahoga County for the past 16 years, and currently serves as the AGS Program Director. He has been working on behalf of adults with mental illness for over 20 years, and is endlessly fascinated by the workings of the disordered mind.

The big news for guardianship in Ohio is the adoption of the Amendments to the Supreme Court Rules of Superintendence for the Courts of Ohio, commonly referred to as Rule 66. These amendments, which were several years



in the making, became effective on June 1, 2015, and they affect all guardians in Ohio. As noted by Chief Justice Maureen O'Connor, the rules "...will align Ohio with standards set by the National Guardianship Association in adult guardianship cases and raise the level of professionalism among our guardians. We know this has been a long process, but we have never lost sight that the ultimate goal is to provide our probate courts with effective means to ensure the safety and well-being of people who need our protection."

The amendments address both the responsibilities of the court establishing guardianships and the responsibilities of the guardian. Major highlights include the following:

Courts must make sure that all guardians have a criminal background check. There is an exception for attorneys who are in good standing with the Ohio Supreme Court.

There are two education requirements, one initial and the other ongoing. All guardians, both existing and newly

appointed, must take a six hour guardian fundamentals course. Guardians appointed on or before June 1, 2015 had until June 1, 2016 to complete the training. Guardians appointed after June 1, 2015 must complete the training within six months of appointment. In each succeeding year following the six hour training, a guardian must complete a three hour continuing education course.

An applicant-guardian must meet with the proposed ward at least once prior to appearing before the court for a guardianship appointment.

A guardian is responsible for notifying the court about a ward's change of address and the reason for the change unless impractical. This notification must take place no later than ten days prior to the move.

A guardian is responsible for filing an annual plan with the court, and this plan must state the guardian's goals for meeting the ward's personal and financial needs. There is a strong social services focus to Rule 66, and 66.09D (Person-centered Planning) states, "A guardian shall advocate for services focused on a ward's wishes and needs to reach the ward's full potential. A guardian shall strive to balance a ward's maximum independence and self-reliance with the ward's best interest."

A guardian must meet with the ward at least quarterly, and assess the ward's physical and mental conditions and limitations; appropriateness of current living arrangements; and need for additional services.



AGS has been a proud member of the National Guardianship Association for many years. We applaud the Ohio Supreme Court for working to elevate the practice of guardianship in Ohio.

The entire text of Rule 66 can be found on the Ohio Supreme Court's website, supremecourt.ohio.gov.

The Columbus Dispatch newspaper published a series in 2014 on guardianship problems in Ohio, and the series helps bring some perspective to guardianship reform (available online at Dispatch.com/unguarded).

● Inefficient Pain Management for Black Patients Shows That There is a Fine Line Between “Inhumane” and “Superhuman”



Keisha Ray, PhD, earned her doctorate in philosophy from the University of Utah. She is currently a postdoctoral fellow at the McGovern Center for Humanities and Ethics (Houston). She has been a lecturer at various universities in Texas and Utah, and a postdoctoral fellow at the Center for Bioethics and Humanities at the University of South Carolina. Most of her work focuses on justice questions related to biomedical enhancement, and she has a more general interest in the field of bioethics.

[This article is from Dr. Ray's Blog entry, dated 5-4-16, published on-line by the American Journal of Bioethics. It is re-printed here with her permission].

It is well known that in America there are great disparities in health, access to health care, and health care outcomes between black people and white people, with black people, on average, faring much worse than white people. For example, if you are black in America, you are more likely to die from breast cancer, heart disease, strokes, and giving birth than if you are white in America. According to the National Institute of Medicine (1), health disparities between races exist even when factors such as stage of disease presentation and severity of disease are the same.

Health disparities between races exist even when factors such as stage of disease presentation and severity of disease are the same.

This has led some researchers to believe that there are social causes for some health disparities that are not due to people's lifestyle choices or their noncompliance with medical advice. For example, there are sleep disparities between races, with black Americans more likely to get less sleep and lesser quality of sleep (2) than white Americans. Explanations for sleep disparities include disparities in discrimination (the more discrimination you encounter, the more stressed you become, and the more stressed you become the less likely you are to sleep.). Additionally, researchers at the University of California, San Diego (3) have speculated that there is a correlation between living in lower quality neighborhoods (including high noise levels, lack of safety, and higher rates of crime, which are more likely to be populated by black Americans than white Americans) and a lack of sleep.



Social factors are also thought to be responsible for disparities in adequate pain management (4) between black Americans and white Americans. Black people (5) are less likely to receive adequate pain management and are less likely to be prescribed pain medication, including after experiencing injuries typically thought of as very painful, such as bone fractures. In a study conducted at University of Virginia, in which researchers studied white medical students' views of black patients, they found that many students held false beliefs about the biology of black people, which could explain disparities in pain management. For example, researchers (6) found that some white medical students believed that black people have thicker skin than white people, black people's blood coagulated quicker than white people, black people have stronger immune systems than white people, and that black people's nerve endings were less sensitive than white people's nerve endings. Other than these views being troublesome simply because of their false nature and not being grounded in science, many of the medical students who held these beliefs also had false beliefs about black people's ability to feel pain, believing that they feel less pain than white people. The worry is that these unscientific views could be used to develop treatment recommendations by future physicians and are currently used by some practicing physicians to treat their black patients.

There is a case to be made that basing pain management procedures on the belief that black people experience less pain than white people is inhumane. Diminishing or ignoring people's pain, in general, is cruel because simply pain is typically not thought of as desirable; few people want to be in pain, particularly when it is pain they cannot control.

There is a case to be made that basing pain management procedures on the belief that black people experience less pain than white people is inhumane.

Additionally, pain can greatly diminish autonomy and severely limit opportunities to live the lives that we choose to live. If black people are more likely to have their pain untreated, then individual black people are also more likely to not be able to live the kinds of lives that they desire to live because of pain. One of the great benefits of adequate health care is the autonomy it can confer. But when health care's stewards can manage pain but do not because of racist beliefs, they are acting as barriers to autonomy rather than facilitators of autonomy.

There is also a case to be made that believing that black people feel less pain than white people treats black people as if they are superhuman. Just as comic book superhuman (such as Superman or Spiderman) are superhuman because they have power and skills that ordinary humans do not have, thinking of black people as being able to feel less pain than white people treats them as if they have a power that ordinary humans do not have, a power that separates them from normalcy.



Taking a lesson from comic book superhumans, being thought of as superhuman is not always as desirable as it may seem and is sometimes very hard. In comic books,

because of their abilities, superhumans are viewed as being odd, as if they are from another planet (even when they are not) and then treated by the populous as if they are not human or not normal. They are then ostracized, ridiculed, and condemned for not being one of us (human). In general, they are thought of as being different and because they are different, they can be treated in ways that we would not normally treat humans; they can be poked and prodded, experimented on without consent, or even killed (which is usually the goal of a supervillain). This is the general problem with thinking that black people feel less pain than white people—it treats them as an “other,” and when a group of people is treated as an “other” it spurs lies and falsehoods about their humanity. These lies and falsehoods in turn justify not treating them as human, giving us permission to treat them as we desire, without regard to their health or safety or their wants. This is how historical injustices like genocides and apartheid, racism in and outside of medicine (e.g. Tuskegee Syphilis study), and disparities in health and health care are justified.

Thinking of black people as having a higher tolerance for pain than white people is another method of making some types of lives not available to some black people, namely a life free of pain. It's also another way that health care contributes to the already troublesome disparities in health. But it is difficult to say whether treating black people's pain differently than white people's pain because of racial bias is an instance of inhumane treatment or superhuman treatment. And one is no better than the other. Both require us to look at people as if they do not deserve to be treated like other people. They require us to look at pain as if it is something that only some people are worthy of not experiencing, which is another falsehood perpetrated by racism in health care.

References:

- 1 <http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/Disparitieshcproviders8pgFINAL.pdf>
- 2 http://www.huffingtonpost.com/entry/black-white-sleep-gap_us_56c64123e4b0ec6725e20e4a
- 3 <http://www.theatlantic.com/health/archive/2015/10/the-sleep-gap-and-racial-inequality/412405/>
- 4 <https://www.washingtonpost.com/news/to-your-health/wp/2016/04/04/do-blacks-feel-less-pain-than-whites-their-doctors-may-think-so/>
- 5 <https://news.virginia.edu/content/study-links-disparities-pain-management-racial-bias>
- 6 <https://www.washingtonpost.com/news/to-your-health/wp/2016/04/04/do-blacks-feel-less-pain-than-whites-their-doctors-may-think-so/>

WELCOME

New BENO Members

Institutions

Ohio's Hospice of Dayton
Dayton, Ohio

Individuals

Michael O'Connor, MD
Cleveland Clinic
Cleveland, OH

Joshua Crites, MD
Cleveland Clinic
Cleveland, OH

Jeffery Tuma, MA, JD
Cleveland Clinic,
Cleveland OH

Alan Murphy, PhD
OhioHealth
Columbus, OH



● Ethics Consultation Quality Assessment Tool (ECQAT) Training



The Veterans Administration's National Center for Ethics in Health Care invites ethics consultants to participate in training in the use of the ECQAT, an approach to rating the quality of ethics consultations through written documentation. The ECQAT and its development are described in the March 2016 issue of the *American Journal of Bioethics* (at <http://www.tandfonline.com/doi/pdf/10.1080/15265161.2015.1134704>).

Training sessions using the ECQAT are scheduled between July 12th and 20th. The sessions will involve scoring ethics consultations and then discussing the rationale for each case's score. The training will occur virtually, require five homework assignments (total time = 5 hours), and include six discussion sessions (total time < 6 hours).

An important goal for this training is for participants to use the ECQAT at their facilities to improve their own ethics consultations. If interested, participants may champion the tool at their facilities by promoting its use as a teaching device for discussing the quality of ethics consultations.

If interested in learning more about the training (e.g., the exact timing of the sessions) and/or signing up to participate, contact Lynn Gessner at L.Gessner@va.gov and include your name and role at your institution, and your institution's name and location.

Save the Date



● ASBH 18th Annual Meeting

The American Society for Bioethics and Humanities (ASBH) will hold its 18th annual meeting and conference on **October 6-9, 2016**, at the Hyatt Regency Washington on Capital Hill in Washington, DC. Details about the conference agenda, registration, and hotels are available at asbh.org.

Featured Speakers:



Julie Saba, MD PhD **Doubling Time: Chronicles of a Cancer Insider**

The distance between doctor and patient is as small as the distance between the doctor's mouth uttering a diagnosis and the patient's ears. Empathy is a crucial aspect of doctoring and, being human, doctors will sooner or later seek empathy as patients. As an oncologist and cancer researcher who also has leukemia, the presenter has scrutinized the condition from every angle and will share her alternating perspectives as she moves forwards on all fronts.



Paul S. Appelbaum, MD **Consensual vs. Coercive Mental Health Treatments: New Manifestations of an Old Dilemma**

Coercive approaches date to the very beginnings of organized mental health treatment. Despite the expectation of reformers in the last third of the twentieth century that coercive approaches would wither away, they have not disappeared and may not even have diminished. This presentation looks at the practice of coercive interventions, the justifications offered, and the likely future of nonconsensual approaches to mental health care.



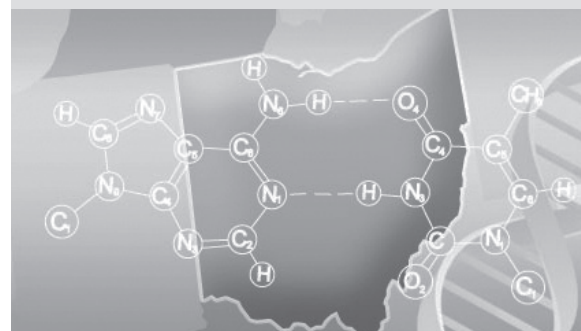
Amy Kuebelbeck **Perinatal Hospice and Palliative Care: Continuing a Pregnancy When a Baby's Life Is Expected to Be Brief**

After receiving a prenatal diagnosis that their baby has a life-limiting condition, some parents wish to continue the pregnancy and embrace whatever time they may have with their child, even if it is only the time before the birth or a few minutes after the birth. This relatively new patient population can be supported through the innovative model of perinatal hospice and palliative care, a compassionate and practical response to one of the most heartbreaking challenges of prenatal testing. The presenter will share her own story and offer insights through the words of many parents who have walked this path.

● Are you or your institution a **BENO** member?

BENO is the only statewide organization serving Ohio as an educational resource in healthcare ethics. If you share this interest, we invite you to become a member and ...

- **Network**
with experienced ethicists statewide.
- **Earn**
continuing education credit.
- **Participate**
in our projects.
- **Better serve**
your organization and community.
- **Polish**
skills and learn new ones.



BENO provides a unique opportunity for continuing education and for networking with colleagues across the state.

BENO

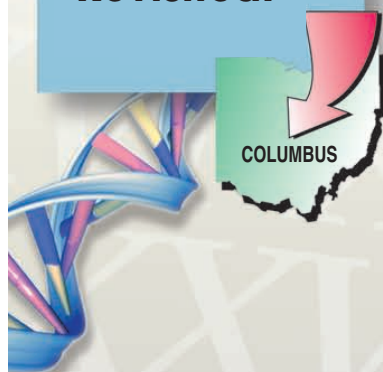
Bioethics Network of Ohio
2653 Ramsay Road
Beachwood, OH 44122

Non-Profit Org
U.S. Postage
PAID
Berea, Ohio
Permit No. 333

Return Service Requested

Serving Ohio as an educational resource in healthcare ethics.

2016 Annual BENO Conference Revisited!



◀ *Brendan Minogue, PhD, honored as a founding board member and first President of BENO, is flanked by current BENO President, Sharon Darkovich, left, and conference Co-Chair, Marty Smith.*

Attendees at Founders' Plenary Session >



◀ *Graduates of the most recent BENO course "Developing and Enhancing Proficiencies for Ethics Consultation" receive their Certificates of Completion"*