Volume 25.... 2015.... Number 4

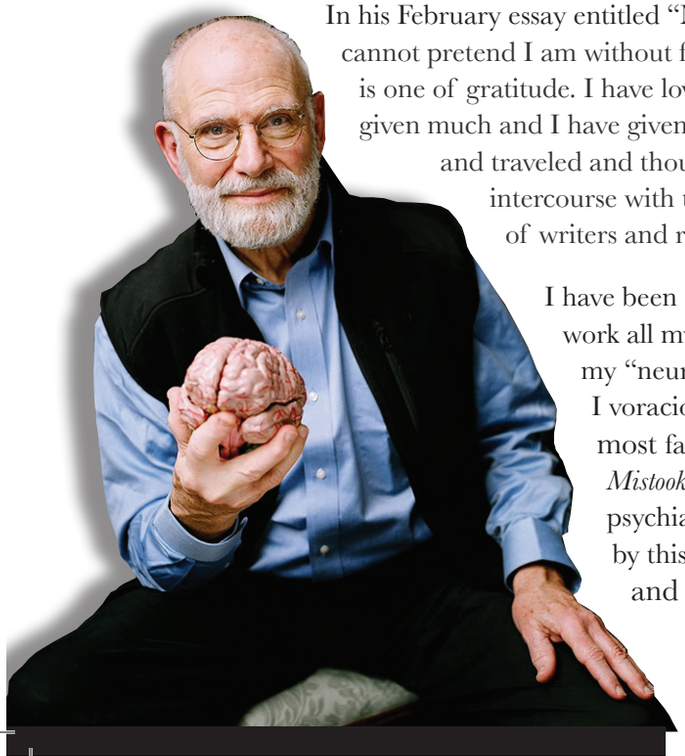
BENQ

BIO Quarterly
A Publication of
The Bioethics Network of Ohio

Remembering Oliver Sachs

Susan Stagno, MD *is the Director of Education for the Department of Psychiatry at University Hospitals Case Medical Center (Cleveland, OH), and Professor of Psychiatry and Bioethics at CWRU School of Medicine. She also holds the Sihler Family Professorship in Psychiatry. Her clinical work is primarily in the area of Psychosomatic Medicine (Consultation Psychiatry), with a special interest in the care of persons with neurologic disorders and cancer. In collaboration with many colleagues, she is developing a Humanities Pathway for medical students at CWRU.*

In February of this year, Oliver Sacks, MD, shared with the world through an essay in *The New Yorker* that he was dying. For those of us (and I suspect there are many) who loved Dr. Sacks – his quick British wit, his amazing writings, his deep care for patients, his remarkable and profound observations – this was indeed a sad day. Sadder yet was the day he died – August 30, 2015 – at the age of 82, in his home, from metastatic melanoma that began in his eye.



In his February essay entitled "My Own Life" he wrote: "I cannot pretend I am without fear. But my predominant feeling is one of gratitude. I have loved and been loved; I have been given much and I have given something in return; I have read and traveled and thought and written. I have had an intercourse with the world, the special intercourse of writers and readers."

I have been reading and enjoying Dr. Sacks' work all my professional life. He has been my "neurologic hero" and an inspiration. I voraciously read his first and probably most famous book, *The Man Who Mistook His Wife for a Hat*, when I was a psychiatry resident. I was quite taken by this physician's observational skills and vowed that I would attempt to

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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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● From the President

Sharon Darkovich, RN, MA, BSN, CPHQ

It is hard to believe that the holidays have already begun and the year will soon be ending. As I reflect over the past year, I think that the Bioethics Network of Ohio has been successful in many ways:

BENO celebrated 25 years as an organization this year. We look forward to many more years of meeting our mission to provide ethics education to those of you on the front lines.

The 25th annual educational conference held in May was a wonderful success with many positive comments expressed on the evaluation forms.

Fourteen participants completed BENO's 2014-2015 Ethics Consultation course and were awarded certificates-of-completion at the annual Conference.

Seventeen new participants are well on their way to completing the 2015-2016 Consultation Course and will likely finish their requirements in March. We hope to have another group of participants ready to begin their journey on April 28th, the day before the 2016 conference.

The planning committee for the 2016 conference has done a great job in arranging for another exciting educational program with an exceptional group of speakers and topics. The conference theme will be, "Bioethics in Ohio: Current Clinical Challenges." Publicity for the conference (to be held on April 29th) has already begun. Check the BENO website (www.BENOethics.org) for "Save the Date" information. The conference agenda and other details will be posted soon on the website.

Two new Board members were welcomed this year: O. Mary Tawose (University Hospitals, Cleveland) and Lynn Maitland (St. John Hospital, Westlake). Anne Lovell (Cincinnati Children's Hospital) was re-elected to the Board as well.

At a recent Board meeting, Board members discussed ways to involve our membership (and you the readers of *BIO Quarterly*) in more of BENO's activities. There is always an open invitation to submit content for our publication. Conference attendees will also be invited to let us know if they have topics of interest for the 2017 Conference and if they would be willing to be a conference presenter or know of good speakers. BENO is also looking for new members for the Board because we have several members rotating off in June of 2016. Look for more information on how to become a Board candidate in an upcoming issue of the *BIO Quarterly*. As always we welcome new members at any time.

I am looking forward to 2016 and another successful year, and I hope you will continue to be part of that success by reading and sharing *BIO Quarterly* with your colleagues, and by attending the annual conference on April 29th.

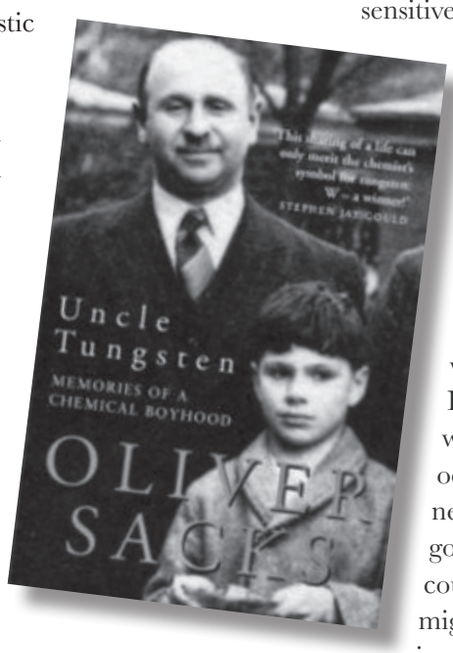
Best wishes for a wonderful holiday season and a healthy new year.

Sharon Darkovich, BENO President
Sharon.Darkovich2@UHhospitals.org

Sacks *continued from page 1...*

do half as well. Just as compelling is his ability to see the positive attributes in individuals, and to care about each person's quality of life – characteristics and behaviors that I regard as truly "professionalism in action."

I had the good fortune to hear Dr. Sacks speak at an event in Cleveland some 15 or so years ago. I anxiously anticipated this event and expected a highly intellectual and very polished speaker. Instead, what I witnessed was a slightly disheveled-looking, somewhat awkward, but very endearing British gentleman. The topic he was talking about, autism, was the diagnostic focus of the stories contained in his book, *An Anthropologist on Mars.* He delivered his presentation with passion and energy, and he wanted to be sure that if any of us had any questions, we could write to him. So he distributed to each of us who wished to have it, a small bit of paper with his home address on it. Not his office, not the hospital address – his personal home address! That slip of paper remains in my address book to this day. I did not write to him although in retrospect I wish I had – maybe he would have answered. But I didn't think I had anything profound enough to ask or say to this amazing and famous writer and doctor. I treasure that bit of paper! And it will live on in my address book forever as a wonderful memento.



Dr. Sacks did not have an easy life. He was born in 1933 in London, and of course World War II broke out 6 years later. His parents, who were both physicians and Orthodox Jews, sent both Oliver and his brother to a boarding school which Sacks described as "a sadistic travesty, rife with bullying and cruelty … made worse for most of us by the sense that we had been abandoned by our families, left to rot in this awful place." He returned to London at age 10, and seemed to find solace and refuge in studying chemistry and the periodic table. His book, *Uncle Tungsten,* is an autobiographical memoir of his early life, and his near obsession with "the elements."

In his later years, Dr. Sacks felt more comfortable discussing his homosexuality – a topic that had resulted in him being rebuffed by his parents. His mother, upon learning of his sexual orientation when he was 18 years old, said to him, "You are an abomination. I wish you had never been born." He attributed her response to his parents' religiosity and a passage in the Torah in Leviticus which uses this language. His mother's reaction caused him to turn away from his Jewish faith, stating that this "made me hate religion's capacity for bigotry and cruelty." After graduating medical school at Queen's College, Oxford, Sacks came to the U.S. to do his neurology training. During his early years in the States, he entered weight lifting competitions, traveled with the Hell's Angels on motorcycle trips, and struggled with drug addiction – activities that likely surprised many of us. As a psychiatrist, I'm guessing that he was "working out some issues" – but I'm quite sure that these experiences made him a more sensitive, empathic and caring clinician.

Oliver Sacks had a very successful career as a neurologist, a teacher, and of course, a writer. Early in his clinical career, he was able to provide a brief respite from the catatonic-like state that engulfed many of the patients whom he cared for with post-influenza encephalitis by treating them with a medication used for Parkinson's Disease. He was fascinated by the workings of the human brain and the oddities that could result from various neurologic insults or developmental issues gone awry. He himself suffered from a couple of these "oddities" – he had ocular migraines and facial blindness. Maybe that is why his writings documenting his careful observations of patients' symptoms and behaviors also include their humanity – something never left out of Sacks' accounts of his patients' predicaments.

I'm quite sure that these experiences made him a more sensitive, empathic and caring clinician.

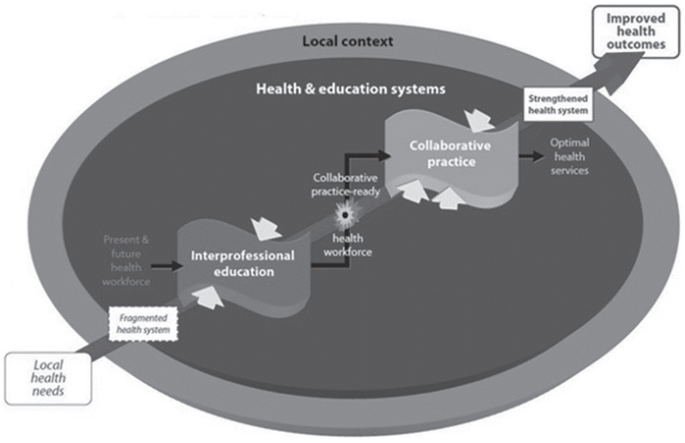
When asked how he would like to be remembered, Oliver Sacks stated: "I would like it to be thought that I had listened carefully to what patients and others have told me," [and] "that I've tried to imagine what it was like for them, and that I tried to convey this. And, to use a biblical term, bore witness."

To bear witness. This is the quintessence of caring that a health professional can offer a patient. You will be remembered by me, Dr. Sacks, in just that way.

● Interprofessonal Education and Collaborative Practice: Revitalizing an Emphasis on "Team"

Donna F. Homenko, PhD *is an Adjunct Professor in Bioethics and Professor Emeritus at Cuyahoga Community College, past President of BENO (2011-2014), and a consultant with the Academy of Academic Leadership (Atlanta) providing webinars for faculty in health education. Recently, Dr. Homenko has been involved with national curriculum revision projects at the American Dental Education Association (ADEA) in Washington, DC.*

The World Health Organization (WHO) has defined interprofessional education "when students from two or more professions learn about, from, and with each other to enable effective collaboration and improved health outcomes." (1) Interprofessional collaborative practice occurs "when multiple health workers from different professional backgrounds work together with patients, families, care-givers, and communities to deliver the highest quality of care." (1) The ultimate goal of deliberately and intentionally working together is to build an improved patient-centered, community-based health care system. The accompanying Figure depicts the movement and dynamic relationship between and among interprofessional education, collaborative practice, and improved health outcomes.



A report from the Institutes of Medicine (IOM) in 2003 highlighted the limitations of the existing educational model, consisting of content delivered in traditional "silos" with little interaction among peers in other professions. To develop core competencies, the national education associations of allopathic medicine, osteopathic medicine, nursing, dentistry, pharmacy and public health have established goals that can be shared across disciplines. (2) The competencies are divided into four major domains: 1) Values and Ethics for Interprofessional Practice, 2) Roles and Responsibilities, 3) Interprofessional Communication, and 4) Teams and Teamwork. Specific criteria for each core competency are detailed in the report from an expert panel of the Interprofessonal Education Collaborative (IPEC). (2)

Too often the concept of ethics is presented as "professionalism" of the individual in lieu of the dynamics for delivering health services as part of a team.

The domain on "Values and Ethics for Interprofessional Practice" focuses on a shared commitment by all health professionals to support the common good in creating a safer, more effective system that promotes wellness and provisions for comprehensive care. Too often the concept of ethics is presented as the "professionalism" of the individual in lieu of the dynamics for delivering health services as part of a team. "Consistent demonstration of core values evidenced by professionals working together, aspiring to and wisely applying principles of altruism, excellence, caring, ethics, respect, communication, [and] accountability to achieve optimal health and wellness in individuals and communities" is referred to as "interpressional professionalism" by the IPEC (3). Educators responsible for training health care professionals need to incorporate not only basic ethical principles and the construct of health care as a right, but also the importance and value of relationships with patients and other members of the health care team. For some disciplines, this may begin with intra-disciplinary experiences in clinical settings where, for example, occupational therapists and occupational therapy assistants, nursing staff and nurse practitioners, physicians and physician assistants, and dentists with dental hygienists are involved in the coordination of care. It is expected that each professional acts in accordance with her or his respective code of ethics; however within interprofeessional collaborative practice, the cohort of values will be expanded to include a team of providers linking professional values. In accordance with the delivery of patient-centered care, working relationships in the form of interprofessional ethics is emerging as a primary component of the competency domain.

The conversation on interprofessional ethics and professionalism needs to occur early in the educational process. Opportunities should be created to gather together trainees and clinicians, and facilitate discussions not only about professional-patient relationships but also about the significance of clinical team member collaborations in the service of improved health outcomes.

To promote and implement interprofessional education and collaboration, several resources are available online through the MedEd Portal from the Association of the American Medical Colleges (AAMC). (4) The MedEd Portal is a free resource that promotes "interprofessional collaboration by facilitating the open exchange of educational resources across the health professions." It also seeks to "equip healthcare professionals across the continuum with effective and efficient educational resources to improve patient care." (4)

A recommended activity suitable for an interprofessional seminar or as part of an orientation for clinical practice is the following: *Got Ethics? Exploring the Value of Interprofessional Collaboration Through a Comparison of Discipline Specific Codes of Ethics*. (5) Learning objectives for this online publication and its activities include to: 1) work with individuals of other professions to maintain a climate of mutual respect and shared values; 2) respect the unique cultures, values, roles and responsibilities, and expertise of other health professions; 3) listen actively, and encourage ideas and opinions of other team members; 4) develop consensus on ethical principles to guide all aspects of patient care and teamwork; and 5) reflect on individual and team performance for individual as well as team performance improvement.

The concept of team dynamics includes developing a consensus on the roles of individuals as part of shared responsibility leading to enhanced team performance.

As noted above, there are three other competency domains addressed by the IPEC; these also have important ethical implications. "Roles and Responsibilities" promotes the role of each health professional to optimize interdependent relationships, advance learning and meet specific patient care needs. "Interprofessional Communication" involves learning to express one's knowledge and thoughts to other members of the health care team, along with communicating information to patients and their families. The fourth competency domain, "Teams and Teamwork," discusses how to be a "team player." The concept of team dynamics includes developing a consensus on the roles of individuals as part of shared responsibility leading to enhanced team performance. This would also include developing "consensus on the ethical principles to guide all aspects of patient care." (2)

In recent years, the role of interprofessional education within existing curricula has been supported by specific accreditation standards. One example states, "Graduates must be competent in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care and practice management." (6). Some clinical training programs may have a white-coat ceremony or a specific oath to recite. Incorporating evidence to further develop interprofessional professionalism could include a journaling activity on one's "Moral Compass," i.e., a reflection of experiences or people that influenced the understanding of right and wrong, or patients who challenged the ethics of being a professional. Another activity could be development of an e-portfolio designed to share patient-related decision-making (within the limits of patient privacy and confidentiality) and treatment protocols with cross-professional exchanges of information. A comprehensive case-based scenario would be when collaboratively a physician, nurse, occupational therapist, dentist and pharmacist provide a detailed history and physical, and an evaluation of activities of daily living, supported by a supplemental oral exam and medication regimens respectively.

Currently, there are barriers to interprofessional education in both academic and clinical settings, revolving around scheduling of core content and patient experiences. Studies to measure the impact of interprofessional education on collaborative practice and patient outcomes are being addressed, given the complexity of the clinical environment. (7) It is anticipated that electronic health records (EHR) combined with the role of informatics will

continued on page 6...

continue to improve patient care alongside interprofessional educational and collaborative initiatives.

Finally, additional resources for interprofessional education include the following:

- Institute of Medicine (2003). Health Professions Education: A bridge to Quality. An Institute of Medicine Report. Washington, DC: National Academies Press.

- National Center for Interprofessional Practice and Education (2012). Available at: http:// www. ahceducation. umn. edu/ prod/ groups/ ahc/ @pub/ @ahc/ @educ/ documents/ asset/ ahc_ asset_ 423392. pdf. [The National Center for Interprofessional Practice and Education serves as a repository of resources and publications for implementing and evaluating interprofessional collaboration and practice].

- Nexus is a Means of Connecting Health Care Practice and Education – Creating a True Partnership and Shared Responsibility, Conversation, Language and Learning. Available at: https://nexusipe.org/informing

- Institute for Healthcare Improvement. The IHI Triple Aim. Available at http:// www. ihi. org/ Engage/ Initiatives/ TripleAim/ Pages/ default. aspx.

- National Research Council. Health Professions Education: A Bridge to Quality (2003). Washington, DC: The National Academies Press.

- Interprofessional Education for Collaboration. Learning How to Improve Health from Interprofessional Models Across the Continuum of Education to Practice. Workshop Summary (2013). Washington, DC: The National Academies Press. Available at: http:// www. nap. edu/ openbook. php? record_ id= 134

- American Interprofessional Health Collaborative. Available at: http://www.aihc-us.org/aihc-interprofessional-webinar/ [The mission of the American Interprofessional Health Collaborative (AIHC) is to improve health outcomes by fostering a learning community with a shared commitment to collaboration across health professions].

- Josiah Macy Jr. Foundation. Available at: http:// macyfoundation.org [The Josiah Macy Jr. Foundation is dedicated to improving the health of the public by advancing the education and training of health professionals].

References:

(1) World Health Organization. Framework for Action on Interprofessional Education and Collaborative Practice, 2010.

(2) Interprofessional Education Collaborative Expert Panel. Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel. Washington, DC: Interprofessional Education Collaborative, 2011.

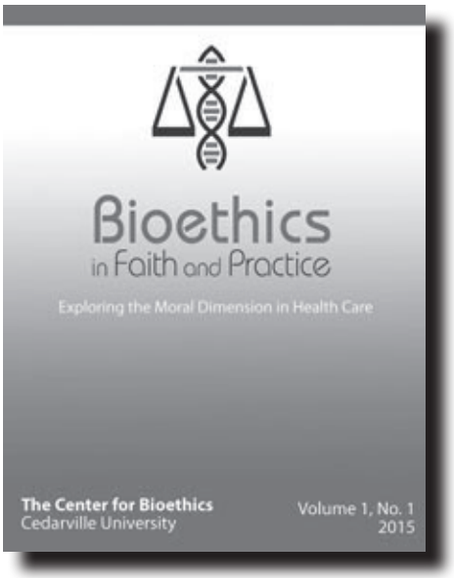
(3) Victoroff K, Demko C, Iannadrea J, et al. Interprofessional Clinical Experiences in Dental Education. Current Oral Health Reports, 2014; 1(3): 161-66.

(4) https://www.mededportal.org

(5) https://www.mededportal.org/publication/9331#sthash.sXpUEKTz.dpuf

(6) Commission on Dental Accreditation, American Dental Association. Accreditation standards for dental education programs, 2013. (ADA 2-22)

(7) Costanza ME. Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes." Journal of Interprofessional Education & Practice, 2015; 1(2): 34-35.



New Journal Launched at Cedarville University

The Center for Bioethics at Cedarville University (Cedarville, OH) is pleased to announce the publication of the first issue of its new journal, *Bioethics in Faith and Practice*. The new issue is available at: http://bit.ly/1Aekert.

Both academic and clinical scholars should consider submitting to the new journal. The focus is on health care ethics, but submissions may also include manuscripts of a more theoretical nature. Though the journal will emphasize Judeo-Christian values, "we are open to a large variety of voices, including secular ones."

Please share this news with others in your sphere of influence.

BENO Ethics Consultation Course, 2016-2017

What: A twelve-month course with the goal of enhancing core competencies necessary for gaining proficiency when functioning as a clinical ethics consultation team member.

How: Educational methods include didactics, mentoring, small peer group interactions, three independent projects, and reading assignments.

When: Five full-day sessions with didactics, mentoring, peer group interactions, and reporting of independent projects. First full-day session will be April 28, 2016. Remaining dates to be determined.

Where: Columbus, OH.

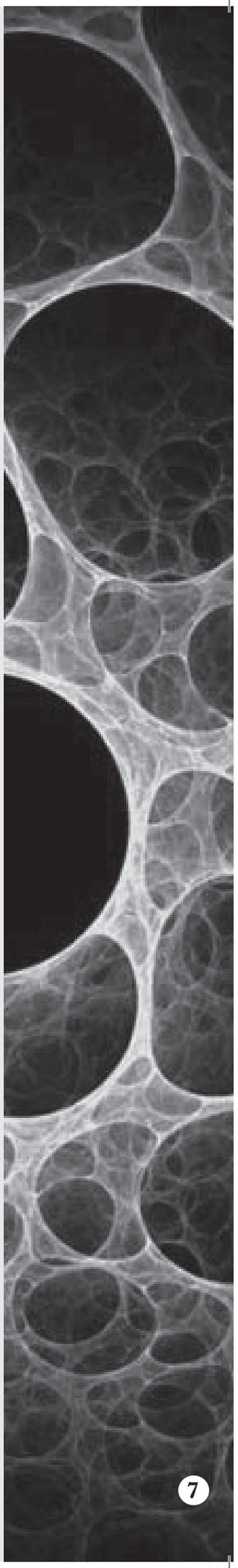
Participants: Maximum of 18.

Registration Fees: Physicians, $675; Non-physicians, $600.

CME/Contact/Clock hours: Applications to be submitted for 20 hours of CME and other CEUs.

Materials provided to participants (costs included in registration fee): (1) *Core Competencies for Healthcare Ethics Consultation*, 2nd Edition, 2011; (2) *Improving Competencies in Clinical Ethics Consultation, An Education Guide*, 2nd Edition, 2015; (3) Hester DM, Schonfeld T. *Guidance for Healthcare Ethics Committees*. Cambridge University Press, 2012; and (4) handouts and power point for each didactic.

Registration: Contact Course Administrator Anne Lovell**:** Annelovell65@gmail.com



● Training Critical Care Fellows to Deliver Bad News: A Pilot Project

Silvia Perez-Protto, MD

Dr. Perez-Protto is currently a General Anesthesia and Critical Care staff member at the Cleveland Clinic. Previously she was a Critical Care Assistant Professor and Organ Procurement Coordinator in Uruguay, South America. She was trained in communication skills in Spain, conducting more than 100 family interviews for organ donation over the years. She is board certified in Anesthesiology and Critical Care.

Patricia A. Mayer, MD

Dr. Mayer is currently the Director of Clinical Ethics at Cleveland Clinic Florida. She participated in this project while a fellow in the Cleveland Fellowship in Advanced Bioethics. She has been a practicing physician for over 20 years and is board certified in Internal Medicine, Rheumatology, and Hospice and Palliative Medicine.

Marc Popovich, MD, FCCM

For nearly 25 years Dr Popovich was a Staff anesthesiologist-intensivist at Cleveland Clinic, serving as Medical Director of the Surgical Intensive Care Unit (ICU) and Program Director of the Anesthesiology Critical Care Fellowship. He is currently the Northern Arc Medical Director, Emory Healthcare Center for Critical Care, and Professor of Anesthesiology and Critical Care Medicine at Emory University (Atlanta).

Most critical care practitioners would agree that honest discussions involving prognosis, brain death, potential organ donation, end-of-life considerations, and Do-Not-Resuscitate (DNR) orders fall under their purview. Such discussions involve a unique knowledge base and skill set (1). For example, intensivists must be familiar with DNR orders allowable by law in the state in which they practice and must also be familiar with hospital policy on the topics listed. Moreover, they must be able to explain complicated concepts to people with varying educational levels. Most of the time intensivists deliver "bad news" not just to individual surrogates but to groups that include relatives, friends, co-workers, or others close to the patient. Managing such meetings is frequently a challenge (2).

they must be able to explain complicated concepts to people with varying educational levels

For these reasons, we believe that formal training on delivering bad news should be incorporated into Critical Care fellowship curricula. We propose that hands-on sessions simulating different scenarios will allow Critical Care fellows to learn to recognize and manage these interactions. Having practice sessions with self-evaluation forms and experienced feedback can help fellows improve their body language and expressions, and also learn which of their behaviors or words may impede delivery of their message. We propose the following initial list of topics for such training efforts: DNR orders (including what is allowable within state law), brain death, organ donation after cardiac death, family meetings, decision-making for patients without surrogates, and surrogate decision-making.

A small pilot project and workshop was conducted at the Cleveland Clinic (Cleveland, OH) with the Critical Care faculty in concert with members of our Bioethics Department. We organized a professional video recording session with three Critical Care fellows who practiced delivering bad news to Critical Care staff, other Critical Care fellows, and a Bioethicist, all "acting" as family members and loved ones of patients. All the cases involved patients with a high risk of dying shortly, with one patient at high risk of being declared dead by neurological criteria. The fellows' job was to deliver to the patient's family members or friends the combined message of the severity of the patient's condition and next steps in the plan of care. The videotapes were then reviewed and discussed in a supportive environment that included the three fellows who were doing the simulations, as well as all the other "actors." The goals of the debriefing sessions were to emphasize good approaches as well as to identify ways to improve.

Of great interest to all involved, none of these senior fellows were able to deliver openly and easily the message that the patient was likely to die or was likely to be declared "brain dead." The fellows were much more comfortable using phrases such as "failing," "not doing well," "may do poorly," "multi-organ failure," "no improvement," or "no

brain activity." This was true even when "actors" directly asked the fellow delivering the bad news, "Do you mean my loved one might die?" This inability to say the word "die" is common and has been noted and criticized in the popular media (3).

Of great interest to all involved, none of these senior fellows were able to deliver openly and easily the message that the patient was likely to die

From the fellows' follow-up evaluations, we learned that all found the workshop useful, and all realized they needed to practice saying difficult words like "death," "likely to die," and "has suffered brain death." All of them also concluded that they need to be more direct, use simpler explanations, and utilize silence more. Additionally, all of them found this specific training activity very helpful because seeing themselves on videotape felt very different from receiving oral feedback following a witnessed interaction. Each fellow experienced some version of, "Do I really do that?"

We found it important to involve a Bioethicist in the training to help emphasize to the fellows the bioethical principles underlying the discussions. These principles included being direct with information (truth-telling), helping families make decisions they believe their loved ones would have wanted (substituted judgment and surrogate decision-making), avoiding harm to patients who could no longer be helped by aggressive interventions (non-maleficence), and recommending shifting to comfort care when this was the patient's best medical option (beneficence).

We believe that Critical Care fellows should undergo formal training during their fellowships to prepare them to be responsible for this type of communication with surrogates. Such training may reduce the likelihood of misstatements that can complicate family members' decision making or negatively impact their emotions. These encounters with physicians are unique experiences for families and may impact situational coping and grieving. Intensivists should use simple terms and concepts to ensure that loved ones understand how the complexities of ICU care impact patients. Learning to explain the negative progress of disease and the concept of "dying" in simple terms is fundamental to Critical Care and can be made easier by controlled, videotaped practice with collegial feedback.

References:

(1) Fields SA, Johnson WM. Physician-patient communication: Breaking bad news**.** W V Med J, 2012; 108(2):32-5.

(2) Weaver JL, Bradley CT, Brasel KJ. Family engagement regarding the critically ill patient**.** Surg Clin North Am, 2012; 92(6):1637-47.

(3) Zamichov N. Op-Ed: The two words most doctors avoid saying: You're dying. LATimes. Feb 13, 2015.

● In the Literature: A Focus on Behavioral Health

Joseph Rinderknecht, D. Min., BCC, *is the Director of Pastoral Care and a full-time chaplain at Marymount Hospital, a Cleveland Clinic hospital (Garfield Heights, OH), which has a 62-bed, inpatient Behavioral Health Unit. He is an active participant in the BENO Ethics Consultation course, 2015-2016. As partial credit for one of his Independent Projects for this course, he compiled an Annotated Bibliography on five journal articles illustrative of significant issues in Behavioral Health ethics. Dr. Rinderknecht shares this annotated bibliography below.*

Lolak S and Sher Y. *Ethical Issues in Psychosomatic Medicine (Consultation-Liaison Psychiatry)*. FOCUS 2013; 11(4):511-15.

The authors note that psychiatrists, although often without formal study in bioethics, are frequently "expected to be expertly versed in . . . medical ethics." They describe and summarize the "Four Topics Method" as a useful framework for ethical analysis of patient-centered cases (Siegler M. *Decision-making Strategy for Clinical-Ethical Problems in Medicine*. Archives of Internal Medicine, 1982). This method ethically approaches case analysis and decision making through a four-step process (also called "the Four Box Method"): 1) analysis of medical indications; 2) understanding patient preferences; 3) quality-of-life considerations; and 4) contextual factors. The authors present three cases, all of which involve determining patient decision-making capacity. By demonstrating the application of the Four Topics Method for each case, the authors successfully argue for its easy application and helpfulness in clinical ethics. They use and presume familiarity with "Principlism" for ethical decision-making (e.g., Respect for Autonomy, Beneficence, Non-maleficence, and Justice).

Kontos N, Freudenreich O, Querques J. *Beyond Capacity: Identifying Ethical Dilemmas Underlying Capacity Evaluation Requests.* Psychosomatics 2013:54:103-110.

The three authors are colleagues in the Department of Psychiatry at Massachusetts General Hospital. They are frustrated by their increasing experience of a "circumscribed, binary moral system" of autonomy versus paternalism which does not do justice to the complexity of ethical issues needing analysis. Facing a growing demand for decision-making capacity evaluations which appropriately seek to protect patient autonomy, they find that nearly "… 40% of such requests are . . . not about capacity at all." The authors describe four typical scenarios in each of which they identify a conflict between autonomy and another ethical principle (e.g., beneficence, non-maleficence, justice, and autonomy versus autonomy). In this way they broaden and inform the reader's ability to see beyond the binary system noted above. The authors exhibit a strong desire to encourage psychiatrists to bring ethical understanding and clarity to such conflicts without claiming a special expertise or role. "The newly revealed ethical dilemma *(in such consults)* itself is a distinctly non-psychiatric concern for all involved in the patient's care."

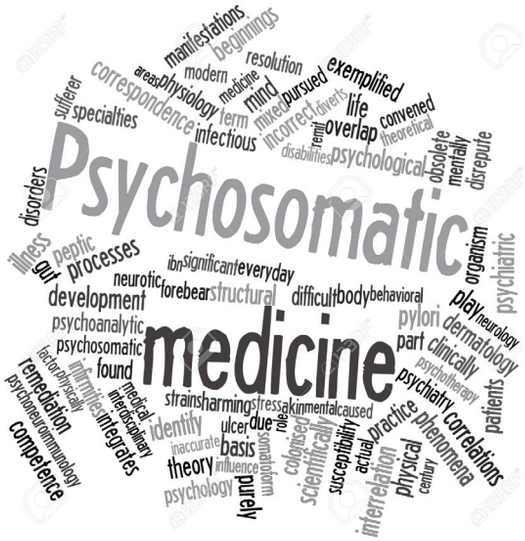
Wright MT and Roberts LW. A *Basic Decision-Making Approach to Common Ethical Issues in Consultation-Liaison Psychiatry.* Psychiatric Clinics of North America 2009; 32:315-28.

Drs. Wright and Roberts are colleagues in the Department of Psychiatry and Behavioral Medicine at the Medical College of Wisconsin. Their article is cited by and foundational to Lolak's and Sher's article (annotated above). Writing primarily for consultation-liaison psychiatrists, but by extension for others as well, they note the

frequency of ethical dilemmas in their work and the paucity of ethical training in psychiatric curricula. Noting that ethical dilemmas "often involve multiple stakeholders," they assert that a focus only on the patient can miss important components of ethical dilemmas. They too recommend Siegler's "Four Topic Method." They illustrate this deliberative approach with four cases, showing how it can lead to different and better outcomes and insight than a more hurried or limited approach.

Brendel RW and Schouten R. *Legal Concerns in Psychosomatic Medicine*. Psychiatric Clinics of North America 2007; 30:663-76.

Drs. Brendel and Schouten are colleagues in the Department of Psychiatry, Massachusetts General Hospital (MGH), and also members of MGH's Law and Psychiatry Services. In this journal article, they review a variety of legal considerations related to clinical ethics. Under "Confidentiality" they discuss the "duty to protect" third parties, which is interpreted differently across the country. (In Ohio, mental health professionals have a duty to warn for "an explicit threat of inflicting imminent and serious physical harm to or causing the death of one or more clearly identifiable potential victims." http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx) In the article, HIPAA is also described as it relates to psychiatric practice and confidentiality. "Consent to and Refusal of Treatment" includes the assessment of decision-making capacity (DMC) as distinct from the judicial determination of competency. In the authors' view, DMC is task-specific (capacity for what?) and can be addressed through a framework that includes patient preferences, factual understanding, appreciation of the significance of facts, and rational manipulation of information. While legal standards for disclosure of information can vary, more information is generally better and should be shared in "a process (of) frank discussion and exchange of information between the doctor and patient." The authors present "Advance Directives and Substitute Decision-making" as an extension of respect for patient autonomy. Surrogate decision makers are charged with using substituted judgment which mirrors what a patient would have chosen. When substituted judgment is not possible, the standard for decision making on behalf of someone else is patient best interests. "Malpractice Claims" require that four elements are met: 1) a doctor-patient relationship existed with a duty of reasonable care; 2) the physician breached that duty; 3) harm was caused to the patient; and 4) the patient suffered harm as a result. Malpractice, as a tort of negligence, does not require proof of intention to harm.



Geller JL. *Patient Centered, Recovery-Oriented Psychiatric Care and Treatment Are Not Always Voluntary*. Psychiatric Services 2012; 63(5): 493-95.

Dr. Geller is affiliated with the Department of Psychiatry at the University of Massachusetts Medical School. One of his goals is to "develop methods for humane, respectful, recovery-oriented involuntary interventions to specifically achieve recovery goals." A significant problem with coerced treatment is that patients often perceive it as dehumanizing. To counter this in an in-patient setting, Dr. Geller argues for "continuous meaningful patient and staff input" to define problems and goals. Simply put, the challenge is to establish a relationship with a behavioral health patient so that the patient enters into an understanding with the doctor that, under certain circumstances, the patient agrees and provides informed consent in advance to the use of involuntary treatment. In practice this means that patients and psychiatrists would discuss in advance what conditions would warrant involuntary hospital admission, what contact patients and psychiatrists would have during an admission, and how they would process the involuntary interventions afterwards. A primary argument for such involuntary treatment is that it is for patients' and others' safety and, as such, it is something patients can be invited to endorse when they are doing well. In addition to an agreed-upon plan and parameters, another important ingredient is a stated commitment on the part of a psychiatrist not to abandon the patient. As one patient is quoted as saying, "Doc, I know you act with me whenever you can and act for me only when you have to. We are in this together, even if you lock me up once in a while." This sense of commitment and collaboration is an important witness to the patient's dignity and value, the very things felt to be transgressed by involuntary treatment.

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