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BEN

BIO QUARTERLY

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Decision Making for Patients in Custody

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Mr. Smith is a 30-year-old man who is brought to the hospital from jail after he was assaulted by another inmate. He has multiple fractures, a suspected closed head injury and is not following commands. The ED staff stabilize Mr. Smith and he is intubated and sedated for airway protection. He will need surgery in the next day or two to repair the fractures. The ortho trauma team wants to contact the patient's highest priority surrogate, his mother, for consent. The guards contact their supervisor, who tells the team that they are not to contact anyone as that would be a security risk and that they should provide whatever care the patient needs without consent. The ortho trauma team is uncomfortable proceeding without consent, but they are also afraid to go against law enforcement to call the family.

Cases like this one are especially challenging at least partly because they introduce duties, principles and power structures that are not commonly considered in medical cases. Law enforcement agencies, for example, have a primary duty to maintain public safety and have special authority to restrict some individual rights to accomplish that task. Clinicians and staff are not accustomed to considering unknown security risks and balancing the physical safety of staff and patients against their fiduciary duty to their patient. There may also be fear and uncertainty about the consequences of pushing back against the supervisor's refusal to allow the team to contact the family. All of

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Bioethics Network of Ohio
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ANNIVERSARY
Serving Ohio Healthcare Ethics

President's Greetings

Welcome to the Winter Issue of BioQuarterly.

Happy Spring! Wait, weren't we supposed to have six more weeks of winter?? For those of you who, like me, love the snow and all things winter, here's to hoping the sudden stratospheric warming drops some flakes. To all, whatever your seasonal preferences, greetings and well wishes.

I want to highlight the two excellent focal pieces in this issue of BioQuarterly, shining light on sometimes-overlooked aspects of clinical ethics: ethical medical care for patients in custody and ethical issues arising in health care provided in the rural setting. We also have a review of Atul Gawande's now classic book, *Being Mortal*—a must read for anyone caring for patients. Thanks to the editorial crew for ensuring other BioQuarterly content, including art commentary, a list of upcoming educational opportunities, and member spotlight. In future issues, we are hoping to introduce a new column that allows readers to request content that may be of interest to others working in clinical ethics. Content experts will be asked to respond in a non-advisory format to these topics. Watch for more information and please consider contributing.

Looking ahead to other BENO activities on the horizon in 2023, we are anticipating re-introducing BENO-sponsored educational offerings periodically throughout the year. A small team of Board members has been endeavoring to re-invigorate our educational profile in ways that are impactful and sustainable. We hope you will benefit from those efforts.

Finally, it is with great enthusiasm that we share additional information about this year's annual conference, occurring virtually April 20-21. The title of this year's conference is "Fostering an Inclusive Ohio: Anti-Racism, Diversity, and Healthcare." A huge thanks to members of the planning committee who have secured an excellent line of up speakers and break-out session facilitators. Please check out the enclosed flyer and share widely. We have continued to try to make the conference financially accessible and convenient. Registration is open, and we hope many are able to participate.

My Best,

Josh

FOLLOW BENO ON:

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this is combined with the experience of many communities-especially communities of color- with law enforcement and the trust deficit that may be present at the outset among clinicians. The result is a difficult, high-tension situation.

In this article, I will sketch an ethical argument in favor of contacting families for consent and describe a process for doing so, including some tips from my experience with this process. However, before getting started, there are two caveats. First, these cases involve significant questions about legal rights, legal custody, etc. and I am not an attorney and will not provide legal analysis or legal advice. My service worked together with the relevant institutional stakeholders to develop the process I describe and follow, but this is not a substitute for consulting your own legal services. Second, the discussion will be limited only to patients who are inmates at a jail or prison. These cases are more situationally uniform and therefore amenable to developing a process. Other patients who present with police may have come straight from a crime scene with undetermined custodial status, or be under arrest, in protective custody, or a person of interest, etc. Teasing out the myriad of very context-dependent situations is beyond the scope of what I can offer here.

But for patients like Mr. Smith who have come from jail or prison, how do we handle decision making and consent? If Mr. Smith had decisional capacity, then he could consent on his own behalf. But since he is incapacitated, who should make decisions and provide consent on his behalf? There are essentially three candidates: no one/the treating team, custodial agency personnel, or the patient's mother [1]. The law enforcement agency suggests that the team should just treat without consent according to their medical judgment. This is at least somewhat plausible. After all, it is highly unlikely that the patient's mother would refuse the surgery and may not even have the authority to refuse it since Mr. Smith is not in a terminal or permanently unconscious condition. And there are certainly cases where this happens when necessary, such as in an emergency or when a patient is unrepresented and needs surgery. However, this is not an immediate emergency and the patient is not unrepresented.

The presumption is that we can fulfill our fiduciary duty to Mr. Smith and patients like him while mitigating the security concerns of the custodial agencies.

Treating informed consent as a pro forma, bureaucratic step misses the point of why the obligation to obtain informed consent exists in the first place: it is an important part of respecting the patient's bodily integrity, authenticity, and agency. Without it, the surgery would be an unauthorized violation of the patient's bodily integrity even if it is for the benefit of the patient. It is an *unnecessary* violation, since the mother's contact information is readily available, and it denies the opportunity to clarify the patient's values, such as preferences regarding the use of blood or non-porcine products. Mr. Smith is an inmate, but he is also a patient to whom the clinicians have a fiduciary duty. In addition, though the 'blessing' from law enforcement feels official, it is not clear that they have the authority to mandate bypassing the requirement for informed consent.

Some custodial agencies have asserted the authority to make decisions on behalf of patient-inmates and even have policies that support this authority in some cases [2]. This represents a substantial conflict of interest, as wardens or jail administrators have obligations to their employers including maintaining security, budgetary pressures, and operational and staffing constraints. They do not have a potentially-mitigating fiduciary duty to the patient-inmate to prioritize their medical interests beyond their obligation to ensure that patients have access to appropriate medical care. Wardens and administrators rarely know the patient and are typically unable to speak to the patient's goals, values or beliefs.

Mr. Smith's mother, on the other hand, generally does not have such conflicts of interest. Of course, family dynamics can be complicated and challenging, but the hope is that Mr. Smith's mother would have personal concerns and ties that would motivate her to act in Mr. Smith's interests or at least be able to speak to his values and preferences. In addition, Ohio law sets out a surrogate hierarchy for decisions regarding withholding and withdrawing life-sustaining treatment that does not contain exceptions for inmates [3]. While the decision about Mr. Smith's surgery is not currently about withholding or withdrawing life-sustaining treatment, it could come to that. I have also yet to be pointed to a statute that grants the custodial agency the same decisional authority.

The concern from the supervisor is not about the mother's decision making, but about the possible security risk that may arise if friends and family (or enemies) learn that the patient is in the hospital, a less secure environment with far fewer law enforcement resources. While Ohio prisons may have a policy of notifying families when an inmate transfers to the hospital, jails do not necessarily have such a policy. Mr. Smith's connections might not know of his hospitalization without the care team's contacting his mother for consent. This is a real tension since patient and staff safety are also a hospital priority. There are some cases I can imagine that would be so sensitive and risky that our consent-related obligations to the patient would be outweighed by the compelling safety considerations of the patient and others. But the presence of a potential security issue does

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The Challenge of Resilience in Rural Health

Alexandra Perry, Ed.D., M.Ed. is the interim Dean of the McDonough Center for Leadership and Business and an Associate Professor of Leadership and Ethics at Marietta College. She is also a clinical ethicist with Ohio-Health. She is currently working on a book that looks at end-of-life care in American Hospitals, and projects surrounding the opioid epidemic, and rural and indigenous healthcare.

Healthcare policy and best clinical practices are undoubtedly informed by the context in which they are developed and refined. Because of the concentration of major healthcare systems in urban and suburban areas, health policy is reasonably informed by these settings more often than more rural healthcare markets. Large university medical systems are sometimes located in rural settings, but they are often large enough that they can bypass some of the challenges that face rural healthcare systems in the United States.

Ethical Challenges in Rural Communities

Ethical issues raised in rural healthcare sometimes differ from ethical issues in other geographic regions. There are several conditions of rural areas, identified by the Vermont Ethics Network, that impact healthcare systems and lead to unique ethical challenges. They are: Limited economic resources, reduced health status, limited availability and access, cultural and personal values, dual and overlapping professional-patient relationships, caregiver stress, and limited rural-focused ethics resources [1].

Rural areas tend to face poverty in a way that is much more punctuated than in urban or suburban areas. While poverty rates in urban and rural areas are similar, rural poverty presents very differently because of a lack of access to resources that exist to mitigate poverty in more urban areas. In fact, public perception is often that rural poverty is more common because the way that it is concentrated makes it so visible, but recent research shows that urban poverty is actually more common. [2]. The challenge might be, then, that urban poverty is sometimes masked through an abundance of resources while rural poverty feels more concentrated because it is left unaddressed.

This is certainly true in healthcare systems. Urban and suburban centers that serve low-income populations often have a greater degree of economic resources available to help address factors that lead to poorer outcomes for patients. Transportation, outpatient options, and the availability of specialists are all economic resources that are more limited in rural environments. This unevenness in available resources creates an ethical disparity.

The second and third factors identified by the Vermont Ethics Network are reduced health status and limited availability of and access to healthcare resources [1]. The FDA confirms that these disparities disproportionately impact the rural communities across the United States. People living in rural communities are at greater risk of death from heart disease, cancer, stroke, respiratory diseases, and opioid overdose [3]. The FDA also identified risk factors that lead to this increased health disparity. This disparity can be attributed to some existing social factors such as low health literacy and the existence of food deserts, but also to systemic challenges posed by having fewer healthcare providers in rural areas which already face challenges in accessing the options that do exist [3]. The fact that health outcomes are correlated with community is an ethical challenge that begs for solutions.

> ***In rural communities where hospitals are some of the largest employers, struggling healthcare systems can lead to higher incidences of mental health disorder, substance abuse, and chronic disease while becoming less capable of handling the demands of these challenges.***

The fourth factor influencing the ethical challenge that arises from rural healthcare is the cultural and personal values of patients who seek healthcare in rural communities. Pesut, Borttorff, and Robinson (2011) conducted a study that identified rural health values that were consistent across various communities. They found that rural communities had three primary values, which are: knowing and being known, being available and present, and maintaining a spirit of community and

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not entail that the risk is always so high as to outweigh the obligation to obtain informed consent or that the risk cannot be mitigated.

For these reasons, the surrogate decision maker for Mr. Smith the inmate should be the same as it would be for any patient who is not an inmate- his mother. So how should the care team respond to the supervisor's refusal? What follow are practical suggestions you might consider together with relevant stakeholders at your institution. The suggestions are, to repeat, *not* legal advice.

1) The first step is to **contact the correct person at the custodial agency** and explain that Mr. Smith lacks decisional capacity and that the team needs to contact his mother. It is important that the team identify the person with authority to manage the situation, which may not be the guard's supervisor. It may be the warden, the captain of the jail, the custodial agency's clinical liaison, or someone else with authority at the custodial agency.

2) The team should then **work with the custodial agency to develop a safety plan** to mitigate security risks. Most clinicians are familiar with the typical restrictions on inmates, such as not communicating the discharge date, visitor and phone restrictions, and other limits placed by the custodial agency. A safety plan might include additional restrictions, such as: not disclosing the patient's location in the hospital; transferring the patient to a locked unit if possible; notifying the guards prior to each contact with family; only speaking to the surrogate and not to anyone else; or other such limits. Custodial agencies do sometimes allow visits; be sure to clarify any rules about visitation. If there are compelling security-based concerns to not contact family, those concerns should be escalated and the decision to not contact family should be reviewed with the institution's ethicists, attorneys and leadership.

3) **Communicate the safety plan to all team members** and **contact Mr. Smith's mother.** Communicating the safety plan reduces missteps that increase safety risks, such as reaching out to a sibling or other family member if the mother is not available. Be sure to follow the safety plan. The safety plan may be revised if new information comes available or changes to his condition necessitate changes.

The effectiveness of this or any process for handling these difficult cases depends substantially on the institutional support for it. Institutional stakeholders including clinical ethics, legal services, risk management and others should be involved in developing the process. This helps ensure that the various institutional stakeholders are in agreement and will support the process when called. The process can be added to existing policy on surrogate decision making or managing patients in custody. These steps- obtaining buy-in from institutional stakeholders and codifying the process in policy- provides support and consistent guidance for frontline staff when they need to escalate situations in which custodial agencies have special safety concerns or push back on the process in general.

It is also important to work with custodial agencies as much as possible. Particularly in end-of- life situations, custodial agencies may be working to get patients released from custody, which facilitates family visitation and communication. They may also need some additional time to ensure proper staffing or determine if specific family members or friends represent significant risks. In Mr. Smith's case, the plan is for surgery in a day or two, so waiting a few hours to accommodate the custodial agency would likely not compromise Mr. Smith's decisional rights provided that other consents are not needed in the meantime.

In addition to working with custodial agencies in specific cases, if there are agencies that bring patients in more frequently, meeting with those agencies' leadership and stakeholders to clarify the institution's surrogate decision making processes for inmates can help make sure everyone is on the same page and knows what to expect. It also helps build a working relationship with the custodial agency's leadership and provides a point of contact for those inevitable cases that are not so easily resolved.

Ultimately, these cases will continue to be challenging and require some moral courage to stand up for patient-inmates' decisional rights. Offering staff a clear and consistent process that is supported by institutional leadership gives them the tools they need to do so. The presumption is that we can fulfill our fiduciary duty to Mr. Smith and patients like him while mitigating the security concerns of the custodial agencies. In less-common cases where security concerns are too compelling and the decision has to be made to not contact family, that decision is well-considered and not the first reaction.

[1] There is a fourth option, which is a judge or court. I have yet to see this raised as a serious suggestion and it would likely be unwieldy for every consent the patient will probably need for the duration of his admission. For those reasons, I do not consider it here, but do acknowledge it as an option as well as the possibility that the court could designate a decision maker.

[2] Ohio Department of Correction and Rehabilitation, Consent to and Refusal of Medical Treatment, Policy 68-MED-24.
Accessed February 18, 2023 *https://drc.ohio.gov/Portals/0/Policies/DRC%20Policies/68-MED-24%20(8-2021).pdf*

[3] Consenting to withholding or withdrawing life sustaining treatment from patient, Ohio Revised Code, Section 2133.08.
Accessed February 18, 2023 *https://codes.ohio.gov/ohio-revised-code/section-2133.08*

***Rural Health**...continued from page 4*

mutuality [4]. These values build a strong case for strong primary care efforts being effective in rural communities, but as healthcare models move away from family physicians in private practices in favor of more cost-effective healthcare systems, rural healthcare is seeing a tension between values and financial realities.

Dual and overlapping relationships can also post a challenge in rural healthcare. While the study above focused on rural health consumers valuing knowing and being known, this can also pose challenges. Mullin and Stenger (2013) point out that resources in rural settings are often so short in supply, that providers cannot entirely avoid situations that threaten their ability to be competent, or to promote confidentiality [5]. They write, "Although the issues of multiple relationships are not unique to rural practice, they are common there. Practice in a small community will increase the probability that individuals will come into contact with each other in a variety of settings and in a variety of professional roles." This can cause a cascade of ethical issues around confidentiality and competence. Rural communities also see challenges around treating stigmatizing illnesses and disorders because patients often have concerns around privacy [6].

The penultimate factor influencing rural healthcare is the fact that caregiver stress is much more heightened in rural communities, likely because of the lack of resources outside of metropolitan areas to offset the burden of caretaking on caregivers. This stress on caregivers exposes the fragility of rural healthcare, and often leads to chronic ethical issues around discharge planning, follow up care, and more.

Finally, the lack of rural-focused clinical ethics resources is a challenge for healthcare systems that look to address the challenges of rural populations. Many tools, policies, and guidelines are developed with urban or suburban environments in mind, and they offer solutions that cannot be translated into the rural setting. Quilliam, et.al. argue that rural healthcare calls for "rich micro-level healthcare user relationships," and point out that this approach is "largely missing from the dominant rural healthcare access conceptual frameworks." [7] This echoes the idea that a core value in rural communities, "knowing and being known" [4] is not central in the delivery of rural healthcare. Clinical ethics simply has not comprehensively addressed the unique context of rural health.

Resilience in Rural Healthcare

Collectively, the ethical issues that arise from these rural health stressors also pose a threat to the resilience of rural healthcare systems overall. According to a report by the Center for Healthcare Quality and Payment Reform, nearly 800 U.S. rural hospitals are at high risk of immediate closure. Almost all states have at least one rural hospital at risk of closure, and 22 states have more than 25% of all rural hospitals at immediate risk of closure. In Ohio, 27% of all rural hospitals are at risk of closure [8]. Rural healthcare is challenged by overall weaknesses in all five domains of the social determinants of health: economic stability, education, health and healthcare access, built environment, and social and community context [9].

The stress on rural healthcare system manifests in many practical ways. Among them are poor retention of nursing staff, ineffective surge capacities, a lack of local resources for post-acute care stays, and higher incidences of chronic health conditions. Additionally, rural communities historically have had more challenges staffing specialty services and offering higher level acute care without transporting patients to other regions. Regional barriers to care such as a lack of public transportation and lower than average health literacy can further destabilize situations that involve high levels of stress [10]. These stressors often create feedback loops. In rural communities where hospitals are some of the largest employers, struggling healthcare systems can lead to higher incidences of mental health disorder, substance abuse, and chronic disease while becoming less capable of handling the demands of these challenges.

During COVID-19 the delicacy of rural healthcare systems was exposed. Nursing shortages strained already cash-strapped systems and made it impossible in some cases to keep all hospital units open. Critical care resources such as beds, ventilators, and ECMO circuits were scarcer in rural communities than in their urban counterparts which often have networks of nearby hospitals that can share resources in the worst case scenarios. Many complex cases needed to be transferred to higher acuity hospital facilities, which meant that for many providers there was no closure on the outcome of a case, leading to poor morale. Rural EMS services were strained and often EMS personnel had to wait with patients in overburdened emergency rooms. In some cases, the biggest challenge to rural healthcare systems was the misfit of state guidelines to the rural health context [11].

Strategies

What are strategies for bridging the gap between healthcare ethics resources and rural health? To start, healthcare systems can build on the existing strengths of rural communities. Often these communities have strong support for the organizations that call them home, and are willing to engage in finding creative ways to support them. Available resources are often known and well-utilized. Data also shows that recruiting of qualified providers is often successful in rural communities through recruiting incentives, though of course this also means that there is a high resource allocation to recruiting, and that turnover is often high.

The value placed on primary care and having a medical "homebase" is aspirational in many healthcare contexts, but in rural health it is a common approach. Rural healthcare systems are also used to having to be adaptable under surge conditions, and put emphasis on unit- preparedness, adaptable operations, and even flexible construction. This can be an asset when a crisis like COVID-19 emerges.

Other strategies that might be implemented to help address ethical challenges in rural healthcare are more innovative. Telehealth has the potential to expand access to healthcare in rural communities. Many large hospital systems are also bringing specialty clinics to rural communities on a rotating basis. For example, a large flagship hospital might have a cardiology clinic in rented space at a rural hospital once every week. Rural hospitals can also consider forming coalitions that share or pool resources for administrative, legal, or supervisory support. It is also critical to integrate rural health considerations into medical school and residency programs and training [13].

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MEMBER SPOTLIGHT

Elizabeth Lanphier, PhD, MS, HEC-C
Assistant Professor, Ethics Center, Cincinnati Children's Hospital Medical Center
BENO Member since 2021 (after moving to Ohio in 2020)

It took me a while to find my way into clinical ethics, but I am so glad I did. It was really the combination of being curious combined with a good dose of chance combined with luck that got me here. My first professional experiences were working in global health, starting with an internship in my senior year in college that I got because I was interested in non-profit work and happened to speak French. I was fortunate to grow my career there and then move to another organization doing global health work at Columbia University, where I was also able to enroll part time in a master's degree program in Narrative Medicine – a field I thought would allow me to combine my interests from college in literature with my work related to health. It definitely combined these interests, but also helped me discover that I loved reading and writing poetry, and was also intrigued by philosophy as a discipline to ask – and potentially answer – the kinds of questions I found most motivating.

To make a long and rambling story not too much longer, after 10 years in the global health sector I decided my next move was either going to be an MFA in poetry or a PhD in philosophy. Craig Irvine, a philosopher at Columbia, was an invaluable mentor in helping me see philosophy as a realistic goal I could pursue. Thanks to a chance encounter with two physician poets at a medical humanities conference, they connected me to another key mentor, Larry Churchill, who had the kind of career I didn't even know was possible but that I now feel so lucky to have: doing philosophical bioethics research *and* being involved in patient care through clinical ethics consultation. The poetry has fallen to the wayside, for now, but hopefully not forever.

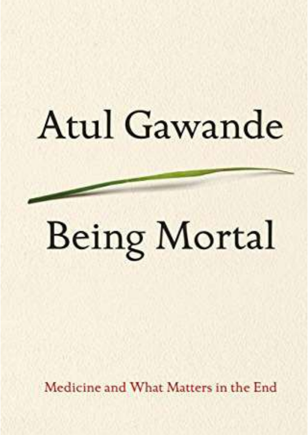
The current work I am doing that most combines my clinical ethics and scholarly interests is related to trauma informed care and ethics consultation. It also started as a chance exchange several years ago with Uchenna Anani, an ethicist and neonatologist, noticing how – for both patients and care teams - trauma experiences potentially contributed to or resulted from the kinds of situations that lead to ethics consultations. This conversation launched a new path in our research both together and individually on trauma informed ethics consultation, which we have published on and continue to grow and integrate into our practices and looking forward are especially interested in the connection between trauma informed care and social justice.

Before moving to Ohio, I grew up on the West Coast, moved to the East Coast for college and work, then to the South for graduate school, and now am in the Midwest. In another twist of chance, my spouse, who I met in Nashville, grew up in Cleveland and now our kids are growing up in Ohio just like he did. The parks and playground are probably the parts of Cincinnati I have gotten to know best in the last few years!

HUMOR

"Frankly, I'm surprised you've lasted this long."

BOOK REVIEW



Being Mortal: Medicine and What Matters in the End by Atul Gawande
Year of Publication: 2014 | Genre: Humanities and Social Sciences
No. of pages: 277

Reviewed by Kathy Grannan, RN-C, MSN

Being Mortal is an eloquently written, in-depth exploration of the role of Medicine in end-of-life care. Atul Gawande balances poignant story telling and research data to illuminate the dynamics of human understanding of mortality. He captures the perspectives of patients, family members and health care professionals in a variety of difficult health crises, relating their hopes, fears, and concerns, and how those factors take patients and their caregivers down paths of treatment that may or may not match their true goals.

The book's eight chapters walk the reader through the physical, intellectual, emotional and spiritual aspects of this arduous journey, from cultural and personal perceptions of independence and autonomy, through physiological changes beyond our control, into dependence, forms of assistance needed and the choices we must make as the journey progresses. Each story weaves together hopes and fears with the expectations of patients and their caregivers, professional and familial, including the impact of cultural norms and previous life experience. Gawande acknowledges the gap in medical education for end of life care, both in understanding the patient's true priorities along this journey and developing communication skills about the choices to be made. He describes multiple creative approaches for reviving or enhancing patients' sense of purpose or reason to live; his account of integrating many forms of life (dogs, cats, plants and hundreds of birds!) into a depressed nursing home setting brings both a smile and an awakening to new care possibilities.

Gawande, with the help of philosopher Ronald Dworkin, artfully weaves together the concepts of personal freedom, autonomy and end-of-life choices into the broader concept of being the author of our own lives, shaped according to unique character, conviction and interest. He characterizes the importance of maintaining our integrity in the face of end-of-life changes, a frame of reference that allows the reader to see the health care professional role through new eyes. He discusses the delicate balance of nurturing hope and making a plan for the most probable outcome, helping patients with both information and guidance in death, a kind of surrender they will only make once.

The author explains the interpretive role of health care professionals, giving examples of its value over a patriarchal or strictly informational stance. He provides examples of insightful listening and conversational tools to allow for preservation of integrity and a meaningful end. Stories describe helping patients navigate through the "ODTAA syndrome" (One Damn Thing After Another) toward achieving a personal understanding of finitude, which can be a gift in making choices that suit the individual. He uses Socratic wisdom to understand the kinds of courage required to decide whether end of life choices are guided by patients' fears or hopes. He applies research regarding perception of life as a whole and meaningful story rather than a series of peaks and valleys, which influences decision making about managing suffering.

Gawande acknowledges the current failure of medicine in treating the sick and aged. He offers insight and tools for health care professionals to help patients express and live out their priorities beyond being safe and living longer, transforming the last chapter of their lives.

Helping patients face the end of their lives is one of the most challenging parts of any health care professional's role. *Being Mortal* provides profound understanding of what both the patient and the caregiver are facing. Gawande challenges us to develop the skills and take the time to make this journey as meaningful as possible. The fruits of this investment are not limited to one patient's experience, but result in cumulative wisdom and a greater peace about the life we live and the work we do. I found this book to be a moving experience and I hope many health care professionals will read it and take its messages to heart. In the light of its wisdom, we can transform end-of-life care.

UPCOMING EDUCATIONAL OPPORTUNITIES

1. Conference on Medicine and Religion
March 12-14, 2023
"At the Limits of Medicine: Caring for Body and Soul"
http://www.medicineandreligion.com/

2. Bioethics Grand Rounds: Ohio State University Medical Center
April 12, 2023 from 12:00-1:00pm EST
"Free Britney! Capacity, Competence, and Consent for those with Diminished Decision-making Abilities"
Abraham Graber, PhD

In person location:
Prior Health Library room 400 A and B @ OSU

Webinar Link:
https://osu.zoom.us/j/97936042993?pwd=M1kyelFuQjR0RmE3VGY2UGFGWlNMdz09
Password: 550522

3. Bioethics: The Law, Medicine, and Ethics of Reproductive Technologies and Genetics
An introduction to the study of bioethics and the application of legal and ethical reasoning.
Harvard University Course (10 weeks online) Free.
https://pll.harvard.edu/course/bioethics-law-medicine-and-ethics-reproductive-technologies-and-genetics?delta=2

4. AMA Journal of Ethics article for CE Credit: Ethics Talk: is VIP Care Really Better? A discussion of pressures to fundraise.
https://journalofethics.ama-assn.org/podcast/ethics-talk-vip-care-really-better

5. AMA ED Hub:
This website has articles, podcasts and interviews with quizzes for CE at completion. Topics are diverse including sections on ethics and healthcare disparities.
https://edhub.ama-assn.org/

6. Bioethics Nursing CEU Courses:
A variety of online options for a fee.
https://www.nurse.com/ce/bioethics?p=1

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Healthcare ethics needs to define a rural healthcare agenda in order to frame potential strategies and assess their effectiveness. Nelson, et al. propose the following agenda:

- Develop an understanding of the concept and scope of rural healthcare ethics.
- Increase awareness and understanding of issues on rural healthcare ethics as perceived by rural residents and healthcare professionals, including the contextual influence on ethical issues and how the issues are different from non-rural settings.
- Increase awareness and understanding of rural healthcare ethics decision making, including how living and working in regionally diverse rural communities affects the response to ethical issues.
- Collaborate with rural healthcare professionals to draft guidelines for dealing with common, recurring ethical conflicts.
- Explore, assess and propose models for "doing ethics" in small rural health facilities.
- Develop and implement ethics training curriculums and other educational resources for and with rural clinicians, administrators and policy makers.
- Provide an ethics perspective to administrators and policy makers charged with allocating healthcare resources, supported by empirical data on potential urban–rural healthcare disparities.
- Foster a dialogue with the general healthcare ethics community regarding the unique nature of rural ethical issues. [12]

Whether this is the agenda that is accepted or not, having clear steps to address the ethical challenges in rural healthcare can help to shape better outcomes for patients in rural communities.

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ART SPOTLIGHT

Lucien Falize, "Design for Enameled Clock," 1882. Metropolitan Museum of Art.
https://www.metmuseum.org/art/collection/search/337366

Three years out from the initial shock of COVID-19, US healthcare is not remotely the same but has seemingly settled into an ambiguous time defined more by what's behind us than by anything inherent to itself. The federal public health emergency will reportedly end on May 11, 2023 [1], but this clearly formalizes not the end of the disease but its routinization. Many of us have spent years hoping for a time when things would seem normal; told that now *is* normal, we may be feeling all different ways, or no particular way at all.

The pen, ink, and watercolor design reproduced here renders the design for the front face of a spectacular clock covered in precious metals and jewels in the collection of the Metropolitan Museum of Art [2]. The bland quartz clocks that efficiently report the time in countless hospital units and clinics are much more accurate, at least as long as someone has remembered to replace the batteries. Bare precision, though, clearly was never the point of Falize's clock design, which reminds us that a time as normal as 12:22 on an indeterminate day is beautiful with the right embellishment. And I have to hope for all of us that we can surround our new, putatively "normal" times with the people, activities, and things that make any time meaningful.

[1] US Department of Health and Human Services, *"Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap,"* February 9, 2023. https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html

[2] Various artists, *"Table clock with calendar,"* 1881. Metropolitan Museum of Art. https://www.metmuseum.org/art/collection/search/207968