WHAT’S NEW IN THE LITERATURE? 2017

CHEF Conference, June 2017

Jean Abbott, MD, MH
Katie Fulton, MS
CHEF Theme: Conscience, Professionalism

- Dealing with patients who have mental health problems
- How to respond to racist patients?
- Partial codes and other EOL challenges
- Worldwide statistics on dying
  + + + + +
- Moral resilience (Rushton)
- Conscientious objection in health care (Stahl, Emanuel)
- Penalties for not honoring Advance Directives and DNAR order (Pope)
- Proper use of MOST forms (Geripal and NHPCO)
Moral Distress:
A Catalyst in Building Moral Resilience

Rushton C. AJN, 2016; 116:40-48
Moral distress as....

• Consequential:
  – Burnout
  – Demoralization
  – Blaming
  – Frustration, anger, guilt
• Opportunity for growth, empowerment
• Opportunity to build community
• You are in charge of positive effort, not outcome
Liberty vs. Need – Our struggle to care for people with serious mental illness

3-part series
Systemic Problems: Undertreatment

- Deinstitutionalization without community based care
- In-patient psychiatric beds:
  - 1955: 337 /100,000 population
  - 2016: 11.7/100,000 (Colorado 10.0 – ranking 34th among states)
  - 4.1:1 = ratio of inmates with SMI vs. psych hospitalization
- Lack of good anti-psychosis medications
Pervasiveness and fallout of undertreatment

- ¼ of homeless have serious mental illness
- 40% of 9.8 mill people with serious mental illness –
  - No treatment in a given year
- Consequences....

- Medical + Serious mental illness:
  - Mortality gap of 18-30 years
Factors in mortality gap

• Provider bias: diagnostic overshadowing
• Superficial capacity assessment
  – Why is it impaired?
• Fear of force vs. negligence for failing to provide necessary treatment
• Anosognosia – 40-50% of people with SMI deny disability
Where is ethics in this?

• We pursue protected environments for people with physical causes of lack of DMC and lack of insight (e.g. Alzheimer's, drug toxicity...)

• Early treatment improves outcomes

• Why do we allow mentally impaired patients liberty to refuse interventions?

• Why does autonomy trump....?
The “thank you” theory of paternalistic intervention
Stone, 1970s lawyer

• Need can trump liberty if, once stabilized, person likely to be grateful?
• Vs. only with “imminent danger” can civil liberties be violated.
• Words are important in behavioral health:
  – “Patient” vs. “survivor,” “client,” “consumer.”
  – “Recovery” mission
Unlearning our helplessness

– Coordinating care
– Intensive work to establish trust
– Maintaining the connection:

“supporting the patient through infinite moments when treatment demands intact cognition.”
Some suggested practical solutions:

• One-time autonomy violation and “forced” treatment
• Controversial “Ulysses contract”
• Assisted outpatient treatment (i.e. court ordered)

• What do you think: need vs. liberty?
Dealing with Racist Patients:

When a Family Requests a White Doctor:
Reynolds, Pediatrics, 2015
• Physician sees 3-year-old in ED. On mom’s lap. Starts exam.
• Father says “I’m sorry. Please don’t touch my daughter. We would prefer a different doctor.”
• Pause…… “May I ask why?”
• Very politely: “We want a white doctor.”
Should that request be honored?

• Arguments for acquiescing to family:
  – Better understanding (language barrier)
  – Relieves tense dynamic, turns down the heat
  – Right of patient against unwanted touching
  – Better patient satisfaction
  – Better medical compliance, therapeutic alliance
  – Cultural sensitivity (Muslim women…)
  – Part of professionalism, respect for autonomy, informed consent
Should that request be honored?

• Arguments against:
  – Push-back and displays of competent, confident care can dispel some myths, increase respect.
  – Recognition of historical legacy
  – Ethical statement about values of the institution.
  – Keeps respect of physician, provider, nurse…..
  – In non-emergent situation, can seek healthcare elsewhere
Your thoughts?
ZITS

WON'T IT BE GREAT IF EVERYBODY IN THE WORLD JUST LIGHTENED UP?

WHY CAN'T WE GET ALONG...

...AND LET LICE...

...LET BYGONES BE BYGONES...

...IGNORE THE OCCASIONAL CALCULUS QUIZ SCORE...

ALWAYS WAIT FOR THE CONTEXT.
PARTIAL CODES

Rousseau P: Partial Codes – When “Less” may not be “More”

Zapata JA: Partial Codes – A Symptom of a Larger Problem
A Case:

- 77 year old man with widely metastatic colon cancer
- Code called.
- “Partial code, no intubation” says the nurse.
- What to do?
  - Bag, CPR, central line, meds
  - 30 minutes to restoration of pulse, resp.
  - 2 weeks later to ward, on dialysis, neurologically devastated
- Staff debrief......
Staff debrief 2 weeks later

- Was there true informed consent?
- Who is responsible?
- Who is responsible for his care afterwards?
  - The “ethical, moral and financial debris of a partial code”
- “We did something rather than nothing!”
  - Was this a variation on a “slow code”?
  - Symbolic gesture, the ritual of death in our society?
• “A partial code likely represents a partial understanding by a patient or a partial assessment of their priorities by their provider.”

• “…the ever-increasing use of life-prolonging medical technology that complicates the acceptance of death..”
“I eat right, I exercise, I don’t drink or smoke...but I’m still going to die someday? That changes everything!”
Last orders

Thinking about your own death, how important is:
2016, % replying extremely or very important

- family not burdened financially
- being comfortable/without pain
- being at peace spiritually
- family not burdened by decisions
- having loved ones around you
- having your wishes for care followed
- living as long as possible

Source: Kaiser Family Foundation/The Economist
Where would you prefer to die?
Deathly silence
2016, % replying yes

Have you thought about your own wishes for medical treatment if you were to become seriously ill?*

0 20 40 60 80

Have you ever had a serious conversation about your wishes for end-of-life medical care: with a family member or other loved one?

0 20 40 60 80

with a doctor or other health-care provider?

0 20 40 60 80

Do you have your end-of-life wishes for medical treatment in a written document?

0 20 40 60 80

Source: Kaiser Family Foundation/The Economist
*Those replying “a great deal” or “some”
“Let the healing begin.”
Legal Briefing: New Penalties for Disregarding Advance Directives and Do-Not-Resuscitate Orders

Thaddeus Mason Pope

The Patients Were Saved. That’s Why the Families Are Suing.

Paula Span
THE NEW OLD AGE   APRIL 10, 2017
So what are courts saying?

• “....will of patient/agent, not will of provider, that controls.”
• Patient/agent may feel differently about allowing death vs. “pulling plug.”
• Providers can’t claim “immunity.”
• Institutions can be fined.
  – Janesville WI (DNR, with CPR, 911 instituted)
“....unless health care providers...face consequences for ignoring or failing to follow a patient’s directives, the public policy favoring these directives stands to be undermined.”
Physicians, Not Conscripts – Conscientious Objection in Health Care


• CO in military service:
  – Quakers in Civil War, 1917 – alternative service
  – WWII: objectors take non-combat military role

• CO in Medicine:
  – Starting 1970s, abortion legalization, Church amendment – states, individuals with federally funded research
  – 1990s – abortion training optional, insurance Co denial of coverage
    • Boama – constraint; Trump sees to expand conscience regulations
Health Care Organizations:

• Patient well-being is primary
• Most accept conscientious object of varying types
• AMA: may not discriminate against classes of patients: (gender, race, HIV, etc…..)
  – Physician Exercise of Conscience– articulates latitude
• Pharmacists: individual right to conscientious refusal
• Ob-Gyn: abortion refusal “only if the primary duty to the patient can be fulfilled” (directly or through referral)
Premise of authors:

• Professional role is a voluntary, individual choice
• Professional obligation assumed:
  – Well-being and rights of patient at center
• Cannot separate medical conditions from “lifestyle choices”
• CO: limited recourse for “professionally contested interventions” – i.e. MAID (abortion is not medically controversial)
• Alternative service: accurate information, timely referral, emergency response
Your thoughts?

• Your professional society?
• Are you/should you be bound to your society’s "reflective equilibrium" – decisions on what is medically appropriate?
• Other thoughts?