Latest developments in Practical Professional Ethics in Headache Medicine

Morris Levin, MD

UCSF

Outline

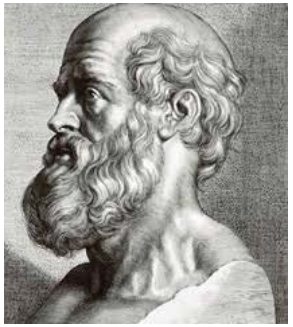
1. Terms and concepts
2. Why ethics?
3. Conflicts of Interest
4. Burnout and self-compassion
5. Equality - Gender equality, Underserved populations
6. Reporting & Managing errors
7. Cases for consideration - Audience participation

Ethics is not new

- Philosophers have been searching for guides to behavior since ancient Greek times and before
- Medical Ethics was discussed by Hippocrates and Maimonides
- Modern Medical Ethics is relatively new – starting in the mid 1940s after WW2, later Tuskegee experiments, and other ‘lapses’

…the Art is great, but the human mind presses on…

The physician should be: well-kempt, honest, calm, understanding, and serious



Modern Medical Ethics

- As patients' rights and and a focus on patient safety achieved impetus, Medical Ethics began to flower:
- 4 major areas: hospital ethics, ethics at private practices, clinical research ethics, and ethics in public health.
- **Hospital Ethics** – end of life issues
- **Clinical research ethics** – informed consent, placebo
- **Medical Practice ethics** – COI, confidentiality, boundaries
- **Public Health ethics** – Legal issues (abortion, vaccinations), distribution of costly tests and treatments, MUPs, public health insurance

AMA Principles of Medical Ethics

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the law.

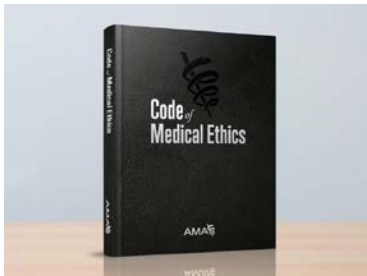
V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.



Common Medical Ethics Issues

- Physician assisted suicide, end of life comfort
- Patient confidentiality
- Informed consent
- Abortion
- Healthcare rationing
- Stem cell use and genetic engineering
- Clinicians' and Researchers' COIs
- Burnout and Self-care
- Issues of Equality for practitioners and patients
- Approach to medical errors

Common Medical Ethics Issues

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- **Clinicians' and Researchers' COIs**
- **Burnout and Self-care**
- **Issues of Equality for practitioners and patients**
- **Approach to medical errors**

Words

- **Ethics** refer to rules/guidelines/principles that are intended to guide behavior, provided by an external source, e.g., codes of conduct in workplaces
- **Morals** refer to an individual's own principles regarding right and wrong.
- **Professionalism –** Following the conduct, aims, or qualities that characterize or mark a profession or a professional person, over and above the expected normal behavior of a non-professional person
- **Practical Professional Ethics** – Rehearsed or planned behavior in certain professional situations.

Biomedical Ethics principles

"Four principles" approach postulated by Tom Beauchamp and James Childress in their textbook *Principles of biomedical ethics*.

- Respect for autonomy – the patient has the right to refuse or choose their treatment. (*Voluntas aegroti suprema lex*.)
- Beneficence – a practitioner should act in the best interest of the patient. (*Salus aegroti suprema lex*.)
- Non-maleficence – to not be the cause of harm (Primum non necere) Also, "Utility" - to promote more good than harm
- Justice – Fariness - concerns the distribution of scarce health resources, and the decision of who gets what treatment (fairness and equality). (*Iustitia*.)

Sometimes the 4 areas conflict – Which is more important?

Biomedical Ethics principles

Might want to add 2 more

- Respect for autonomy
- Beneficence
- Non-maleficence
- Justice
- Honesty
- Confidentiality

Sometimes the 4 areas conflict – Which is more important?

Words

- **Conflict of interest** - the clash between one's self interest and one's professional obligations, such as the public/patients' interest. E.g.: being paid to promote one over another treatment option; selling remedies, profiting from testing. These are mostly financial but we will talk later about time conflicts of interest in Professionalism and Burnout.
- **Appearance of COI** is generally COI –Speaking at an industry program; publishing only positive results in a pharma-sponsored study; Being paid to give promotional lectures
- **COI is universal**. It is a problem in that it poses a risk of bias and resulting harm, not a situation in which bias or harm necessarily happens
- However – Significant COI (even without true bias) tends to lead to a reduction in trust – a very important issue in personal medical practice and organizational activity.

Words

- Corruption – dishonest or illegal behavior by ones in power
- Nepotism – granting special privileges (time, positions, access) to friends and family
- Medically underserved populations (MUPs, MUAs) – Traditionally groups or areas with sparse PCPs. But should extend to all important services. Might pertain to ethnic, cultural, socioeconomic, regional differences.
- Gender inequality - A legal, social and cultural situation in which sex and/or gender determine different rights and dignity for women and men, which are reflected in their unequal access to or enjoyment of rights
- Sexual harassment - the making of unwelcome and inappropriate sexual remarks or physical advances in a workplace or other professional or social situation.

Why is Ethics important for physicians?

- Some ethical standards are also the law – we want to avoid legal problems
- We want our patients to trust us (come to see us, follow our recommendations, pay us)
- We want to have the credibility to pursue important political activities (for government funding of research, changes in our medical system, etc)

Why is it important for medical associations?

- We as a professional organization want to avoid legal problems
- We want the community (other professionals, patients and families) to trust us – so they will see us as sources of information.
- We want to have the credibility to pursue important political activities (for government funding of research, changes in our medical system, etc)

Conflicts of Interest

- True or false: We need to eliminate conflicts of interest

- True or false: the appearance of conflict of interest is not as important and true conflict of interest.

Vendor relationships can lead to COI which impacts Beneficence and Justice

- Studies show that doctors can be influenced by drug company inducements, including gifts and food*
- Industry-sponsored CME programs influence prescribing patterns**
- Many patients surveyed in one study agreed that physician gifts from drug companies influence prescribing practices***

*Güldal D, Semin S (2000). "The influences of drug companies' advertising programs on physicians". Int J Health Serv. **30** (3): 585–95.
Wazana A (2000). "Physicians and the pharmaceutical industry: is a gift ever just a gift?". JAMA. **283 (3): 373–80
***Blake R, Early E (1995). "Patients' attitudes about gifts to physicians from pharmaceutical companies". J Am Board Fam Pract. **8** (6): 457–64.

Rationalizing conflict of interest

- 1) The good we will do outweighs the small amount of corruption that creeps in when COI is unmanaged
- 2) We are so aware of the conflict and so morally committed to not letting bias creep in that it will just not happen.

- Both are fallacious - #1 because it leads down a path, #2 proven to be impossible

Current trend in Medical Societies: Ethics committee

- What should it look like?
- What should it do?
- How should it operate?
- How to monitor/enforce?

Headache Professional Societies: Ethical Challenges and Suggested Solutions

David Borsook, MD, PhD; James L. Bernat, MD

Codes of professional conduct continue to be an essential component of maintaining the integrity of individuals, academic institutions, and medical societies. We review ethical issues of professional conduct focusing on conflicts of interest (COI). We explain how to manage or mitigate COI in the context of professionals involved in headache medicine and its medical specialty societies. We identify the roles of institutional, medical society, and governmental regulation in the protection of patients and maintaining the integrity of physicians and others involved in patient care.

Key words: conflict of interest, ethical misconduct, financial disclosure, Sunshine Act, COI mitigation

(*Headache* 2017;57:1273-1283)

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Public Trust in Physicians — U.S. Medicine in International Perspective

Robert J. Blendon, Sc.D., John M. Benson, M.A., and Joachim O. Hero, M.P.H.

N Engl J Med 2014; 371:1570-1572 | October 23, 2014 | DOI: 10.1056/NEJMp1407373

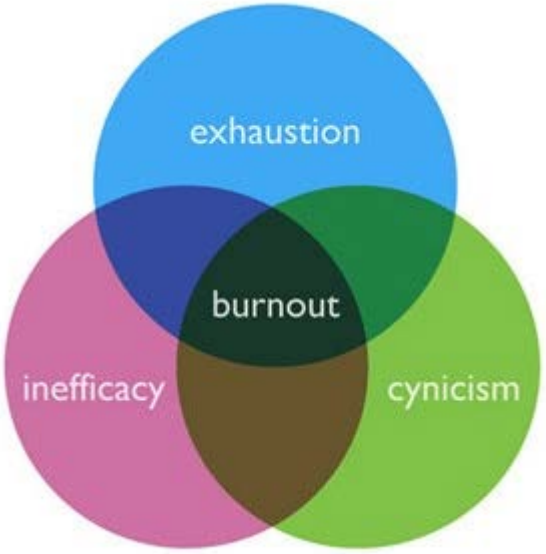
Doctors can be trusted in your country; Agree?

Attitudes about Doctors, by Country.*

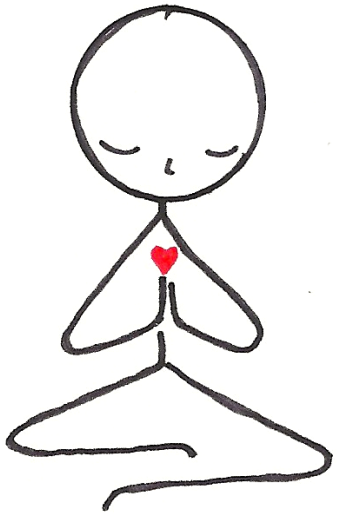
Country	All Things Considered, Doctors in Your Country Can Be Trusted (Strongly Agree or Agree)		Satisfaction with the Treatment You Received When You Last Visited a Doctor (Completely or Very Satisfied)	
	rank	*% (95% CI)*	*rank*	*% (95% CI)*
Switzerland	1	83 (81–85)	1	64 (61–67)
Denmark	2	79 (77–81)	2	61 (59–64)
Netherlands	3	78 (75–80)	11	47 (44–50)
Britain	4	76 (73–79)	7	51 (48–55)
Finland	5	75 (73–78)	9	49 (46–52)
France	5	75 (73–77)	18	38 (36–40)
Turkey	5	75 (73–77)	15	41 (38–43)
Belgium	8	74 (73–76)	5	54 (52–56)
Sweden	8	74 (71–76)	10	48 (45–51)
Australia	10	73 (71–76)	4	55 (52–58)
Czech Republic	10	73 (71–75)	16	39 (36–41)
Norway	12	72 (70–74)	5	54 (51–56)
Slovakia	20	62 (59–66)		
South Korea	20	62 (60–65)		
Lithuania	22	61 (58–64)		
Japan	23	60 (57–63)		
Croatia	24	58 (56–61)		
United States	24	58 (55–61)		
Bulgaria	27	46 (43–49)	20	30 (27–33)
Russia	28	45 (42–48)	29	11 (9–13)
Poland	29	43 (40–46)	25	23 (21–26)

Personal COI policy

- Avoid creating obligations to commercial interests that do not entirely share your missions – accept only educational tools as gifts, and only if no strings attached; accept appropriate honoraria; live within your income.
- Avoid profiting from treatments, tests
- For research that is supported, insist on writing up results and freedom to publish any or all results.
- Disclose all conflicts which pose any potential risk of unprofessional behavior
- AAN Code of Professional Conduct
- AMA Code of Professional Ethics

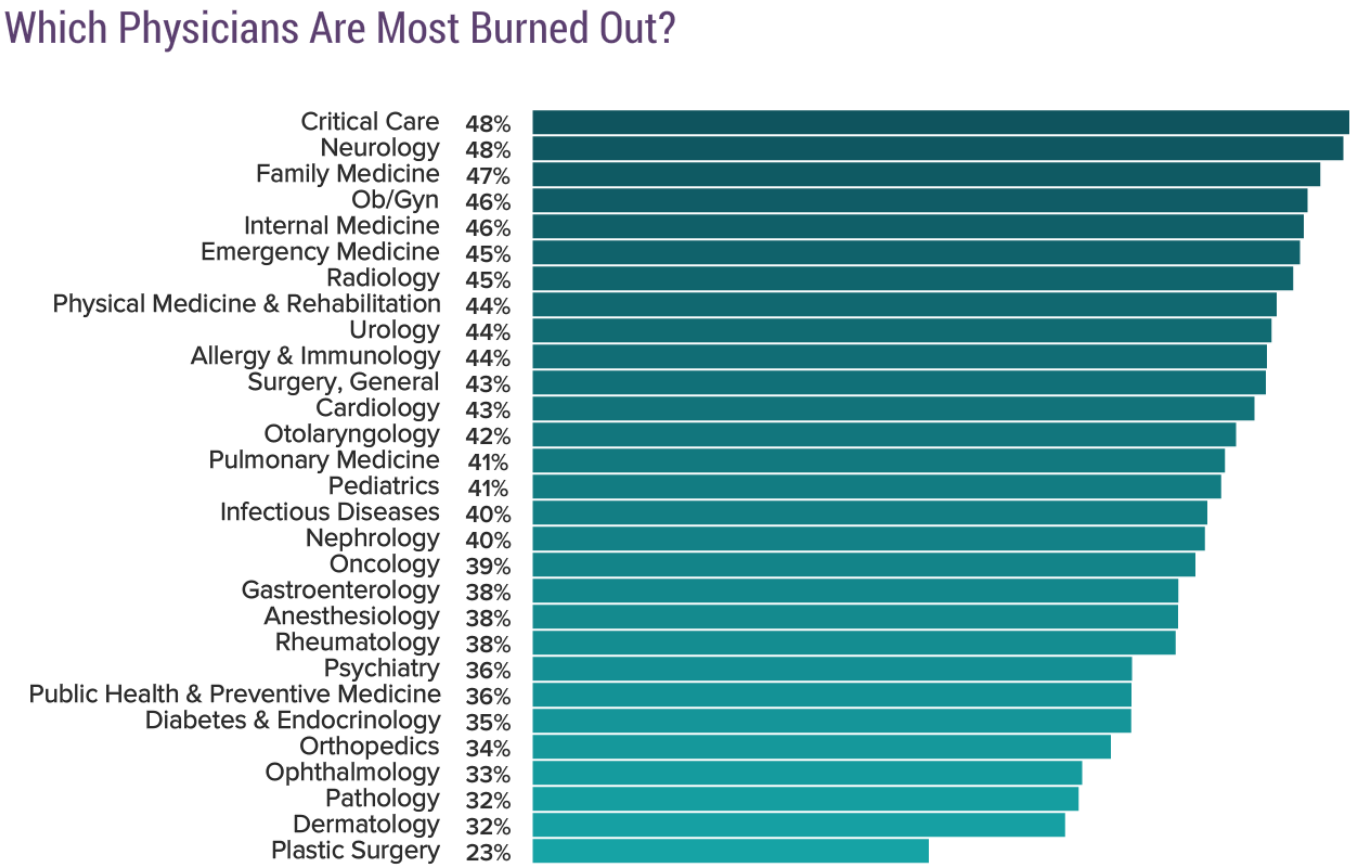


Burnout, and self-care



- Def = state of emotional, physical, and mental exhaustion caused by excessive and prolonged stress. It occurs when you feel overwhelmed, emotionally drained, and unable to meet constant demands
- Self-compassion - extending compassion to one's self in instances of perceived inadequacy, failure, or general suffering

Who is most burnt out?



https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056#21

HA Medicine specialists have a very high rate of burnout

- In a sample of 127 headache medicine specialists, 57.4% physicians reported symptoms of professional burnout reflected by high Emotional Exhaustion and/or high Depersonalization.
- Issues - dissatisfaction with work schedules, government regulations, implementation of the Affordable Care Act, insurance company policies, malpractice concerns, patient telephone calls, and compensation. Sixty-two percent of respondents concur that headache medicine is becoming more complicated without improving patient benefit, 86% felt that headache medicine specialists are not fairly compensated, and only 59% would go into headache medicine again if they were fourth year medical students; 33.9% concur that they will accelerate their retirement plans.
- Headache medicine specialists have one of the highest rates of burnout compared to other physician specialists, which is twice the rate of working adults

Evans RW, Ghosh K. A survey of headache medicine specialists on career satisfaction and burnout. Headache, 2015 55, Issue: 10:1448-

Causes of burnout

Burnout tends to revolve around

1. EMR/charting explosion
2. Downloading of previously non-physician tasks to physicians
3. Lack of time to conscientiously evaluate and treat our patients
4. Difficulty navigating insurance compensation but also arranging testing and treatment for pts
5. Reduced income expectations, leading to longer hours, less personal time
6. Impersonal working conditions (corporate)
7. Benchmarks in productivity and patient evaluations

Annals of Internal Medicine

Estimating the Attributable Cost of Physician Burnout in the United States

Shasha Han, MS; Tait D. Shanafelt, MD; Christine A. Sinsky, MD; Karim M. Awad, MD; Liselotte N. Dyrbye, MD, MHPE; Lynne C. Fiscus, MD, MPH; Mickey Trockel, MD; and Joel Goh, PhD

Background: Although physician burnout is associated with negative clinical and organizational outcomes, its economic costs are poorly understood. As a result, leaders in health care cannot properly assess the financial benefits of initiatives to remediate physician burnout.

Objective: To estimate burnout-associated costs related to physician turnover and physicians reducing their clinical hours at the national (U.S.) and organizational levels.

Design: Cost-consequence analysis using a decision-analytic model.

Setting: United States.

Participants: Simulated population of U.S. physicians.

Measurements: Model inputs were estimated by using the results of contemporary published research findings and industry reports.

Results: On a national scale, the conservative base-case model estimates that approximately $4.6 billion in costs related to physician turnover and reduced clinical hours is attributable to burnout each year in the United States. This estimate ranged from $2.6 billion to $6.3 billion in multivariate probabilistic sensitivity analyses. At an organizational level, the annual economic cost associated with burnout related to turnover and reduced clinical hours is approximately $7600 per employed physician each

...ossibility of nonresponse bias and incomplete ...nders in source data. Some parameters were ...ata and had to be extrapolated.

...ether with previous evidence that burnout can ...educed with moderate levels of investment, these ...ggest substantial economic value for policy and organizational expenditures for burnout reduction programs for physicians.

$4.6 billion in costs

Ann Intern Med. 2019;170:784-790. doi:10.7326/M18-1422 **Annals.org**
For author affiliations, see end of text.
This article was published at Annals.org on 28 May 2019.

ANNALS OF MEDICINE NOVEMBER 12, 2018 ISSUE

WHY DOCTORS HATE THEIR COMPUTERS

Digitization promises to make medical care easier and more efficient. But are screens coming between doctors and patients?

By Atul Gawande

Solving burnout

- Not by giving clinicians ‘opportunities’ for improving their efficiency or resiliency,
- But by making systemic changes that give them back the time and empowerment to listen carefully to their patients, and thoughtfully plan with them their testing and treatment which then actually happens
- How?

Solutions – Big picture

- Reduce (eliminate) non-medical tasks placed on MDs
- Assign medical tasks capable of being done by non-MDs to others
- Improve EMR toward a seamless, user-friendly system, universally used in all medical centers

Solutions – Granular Big picture

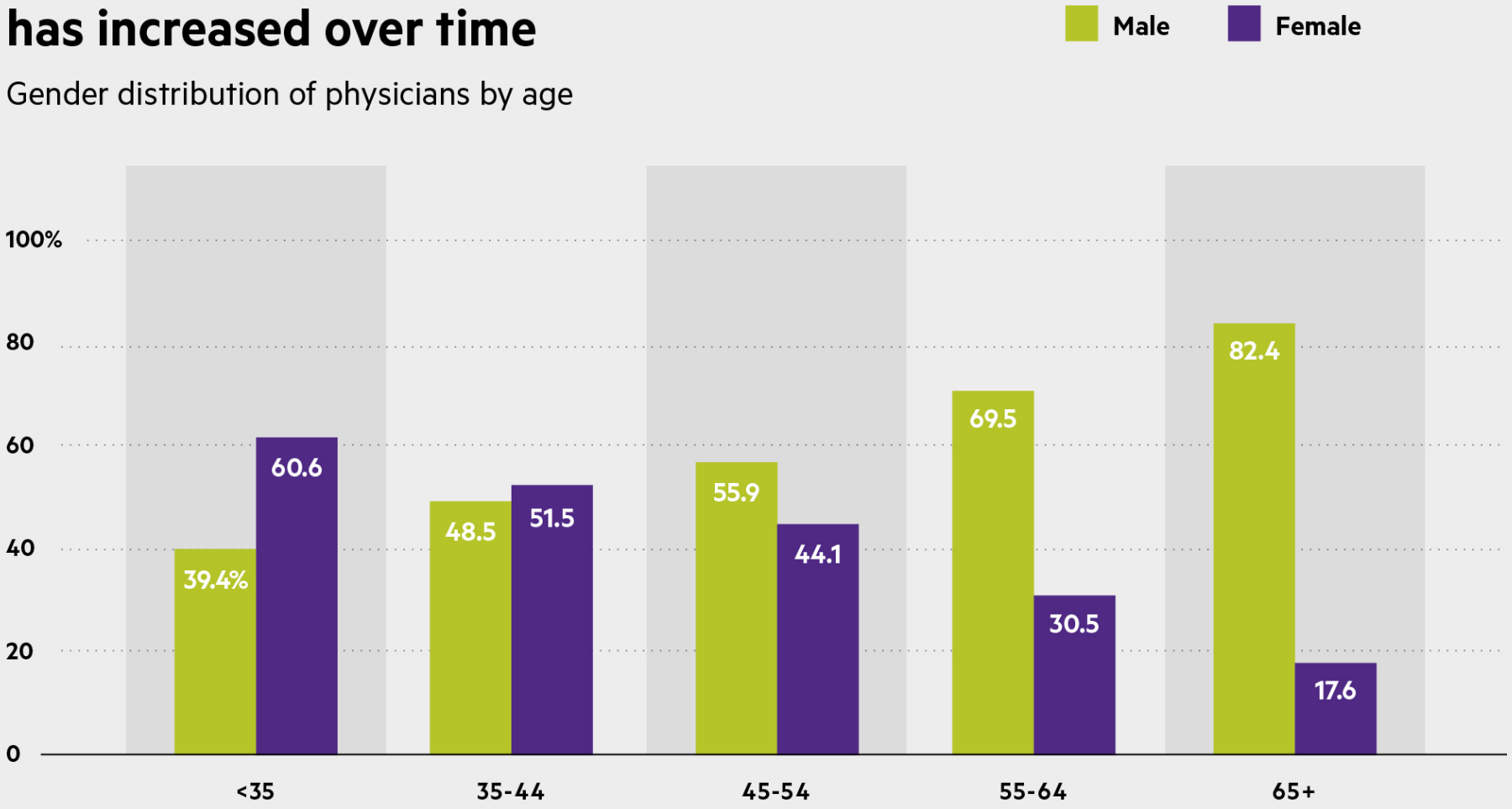
- Reduce (eliminate) non-medical tasks placed on MDs – obtaining/showing data, coding, billing

- Assign medical tasks capable of being done by non-MDs to others – med lists, problem lists, creating updated notes by patient-entered data

- Improve EMR toward a seamless, user-friendly system, universally used in all medical centers
  - MD never touches a keyboard – all is voice recognition with multiple HUD screens

The proportion of female physicians has increased over time

Gender distribution of physicians by age

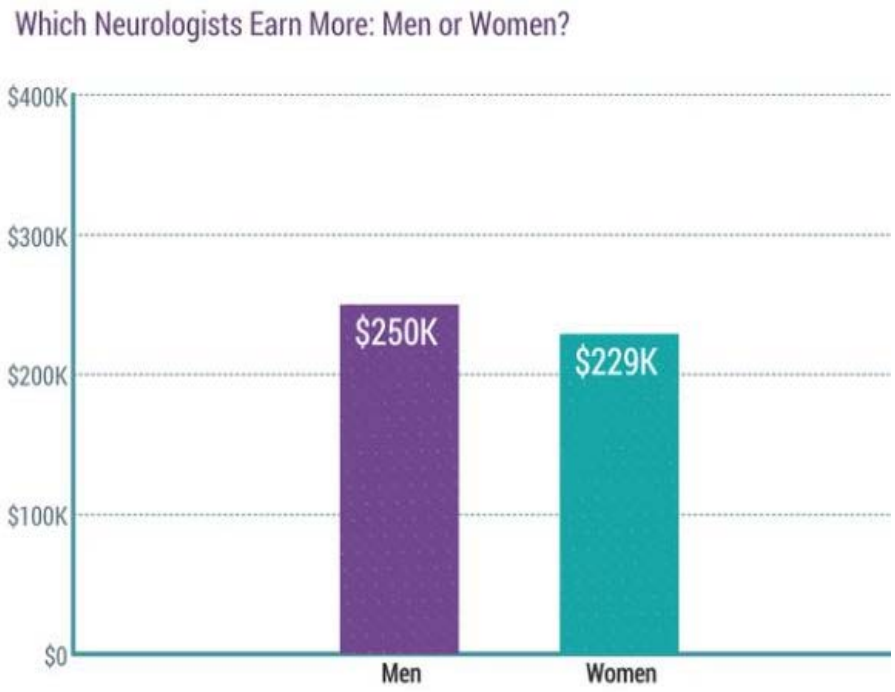


Source: athenahealth

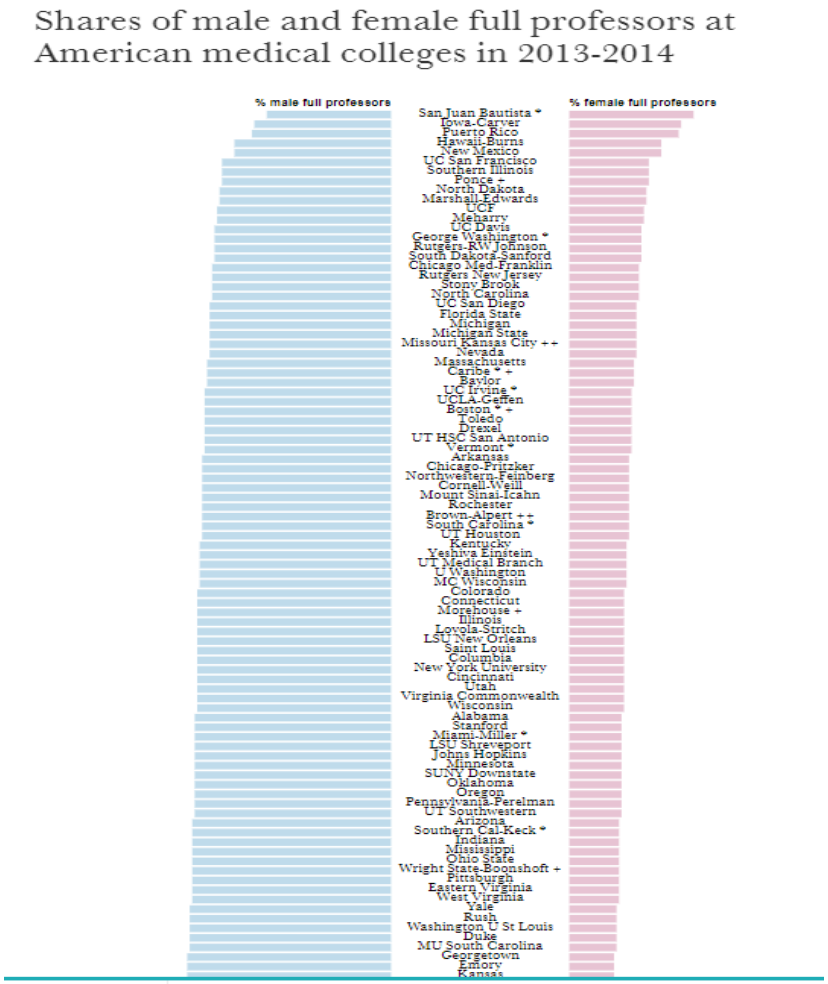
Sample: 18,000+ physicians at approximately 3,500 practices on the athenahealth network from January to June, 2017

Slide borrowed rom E Loder

Gender inequality in Medicine & Neurology



Medscape Neurologist Compensation Report 2018



AAMC Report The State of Women in Academic Medicine
https://www.aamc.org/members/gwims/statistics/

Gender discrimination

- AKA Sexual Discrimination = denial of opportunities, privileges, or rewards to a person (or a group) because of gender.
- Violates the Federal Civil Rights Act of 1964
- No different than discrimination on the basis of race or religion

Sexual harassment

Verbal and nonverbal behaviors that convey unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature which either

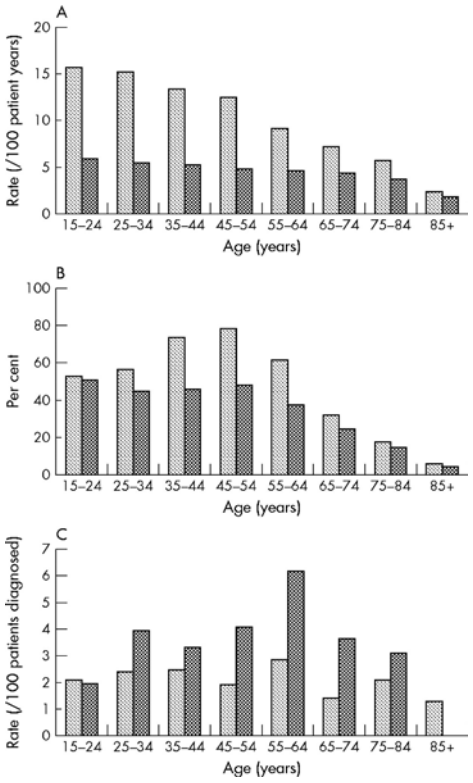
1. Constitutes sexual coercion (when favorable professional or educational treatment is conditioned on sexual activity) or
2. unreasonably impacts an individual's employment or academic performance or creates an intimidating, hostile or offensive environment for that individual's employmen

Harassing behavior can be either direct (targeted at an individual) or ambient (a general level of sexual harassment in an environment).

SH Extremely common in Medicine, especially in academic medicine: 30 to 70% of female physicians, Approx half of female medical students

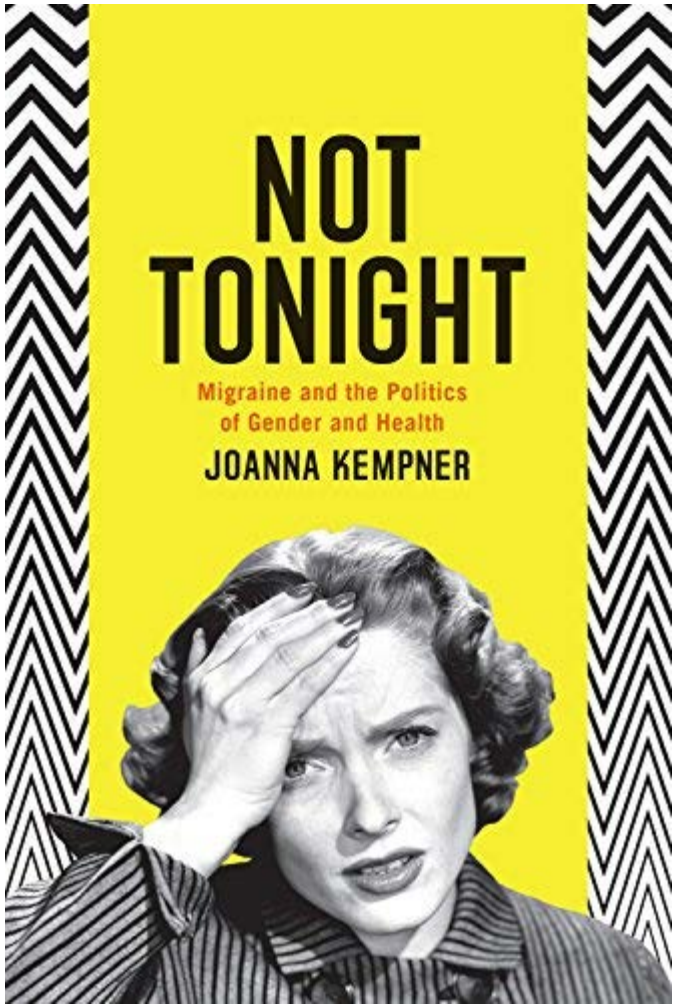
Van Dis, Stadum, Choo. https://hbr.org/2018/11/sexual-harassment-is-rampant-in-health-care-heres-how-to-stop-it

Age and sex specific rates for year 2000 data.



Latinovic R et al. J Neurol Neurosurg Psychiatry 2006;77:385-387

- Women have higher consultation rates
- More likely to be prescribed antimigraine drugs
- Less likely to be sent for additional testing and evaluation



The general dismissal of migraine can in part be due to the gendered social values embedded in the way we talk about, understand, and make policies for people in pain.

Migraine Personality described in the 1940s –
(women with) migraine were described as uptight neurotics

Prescribing high cost medications and other treatments

- Why should we care – Drug prices are at least 2x as costly as anywhere else; directly hurting people and families. And this affects certain populations dramatically.
- Why are they so expensive? – recouping investment costs, companies are under pressure to post profits; generics are hard to make and do not satisfy FDA requirements
- What is our role in prescribing?

MUPs and you

- Often you are insulated from this issue or think you are
- Often there are competing imperatives, or you are led to believe there are
- Concept: *ethical distress*, which occurs when the provider knows what the right course of action is but cannot act on it. This occurs frequently in the care of the underserved. For example, when lack of resources makes it difficult or impossible to pursue the right course of action.
- What can we do? – Generics?
- NIH is required to promote meds that are available and they could put pressure.
- Unbiased individuals should be involved in clinical trials.
- We need to talk to pts about therapies in a balanced way including AEs, cost benefit ratios.

Medical Errors - Why is it important to identify and report medical errors

- Can identify systemic areas for improvement which will improve pt outcomes
- Can identify individual or team areas for improvement which will improve pt outcomes
- Identification leads to improvement
- It is the right thing to do – and patients expect it
- Improves the public trust
- Reduces malpractice suits and awards

Facts

- Medical errors will happen, and they happen frequently
- Though most are not lethal or even dangerous, some may lead to bad outcomes
- There is a significant “second victim” problem*
- Reported errors = approx 1% of total errors
- Most preventable bad outcomes are the result of multiple errors – not just yours

*Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too. BMJ. 2000;320:726-727

Common causes of medical errors

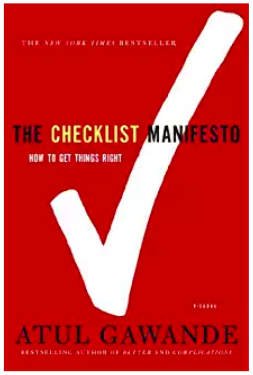
- Knowledge / inexperience
- Poor judgement
- Hesitation
- Fatigue
- Overload
- Faulty communication
- Faulty monitoring
- System flaws

Common types medical errors

- Missed/wrong dx (e.g. failed to do a dx test)
- Poor decision (e.g. premature discharge)
- Missed tx (e.g. waiting on treatment)
- Medication error
- Faulty communication
- Procedural error

How to avoid identifying and learning from errors

- Expect perfection and establish zero tolerance for making errors (infallibility myth)
- See mistakes as an individual problem
- Find the person(s) to blame and punish
- Don’t look for system fixes like checklists, flowsheets, tickler systems, or better electronic communication



The Checklist Manifesto: How to Get Things Right
by Atul Gawande

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To Err is Human

Kohn LT, Corrigan JM, Donaldson M. *To Err Is Human: Building a Safer Health System*. Washington, DC: Institute of Medicine; 1999

- Results: mortality figure estimates that range from 44,000 to 98,000 hospital deaths each year from medical errors.

Makary MA, Daniel M. Medical error-the third leading cause of death in the US. BMJ: British Medical Journal. 2016 May 3;353.

- "…over 400 000 deaths a year, more than four times the IOM estimate"

Adverse events and Medical Errors

- Levinson DR. Adverse events in hospitals: national incidence among Medicare beneficiaries. U.S. Department of Health and Human Services' Office of Inspector General website.
- 13% of all pts have an adverse event
- 44% AEs preventable
- 6/7 errors go unreported

Reporting

- Kaldjian LC, et al. Reporting medical errors to improve patient safety: a survey of physicians in teaching hospitals. Archives of internal medicine. 2008;168(1):40-6.
- Most respondents agreed that reporting errors improves the quality of care for future patients (84.3%) and would likely report a hypothetical error resulting in minor (73%) or major (92%) harm to a patient.
- However, only 17.8% of respondents had reported an actual minor error (resulting in prolonged treatment or discomfort), and only 3.8% had reported an actual major error (resulting in disability or death).
- 16.9% acknowledged not reporting an actual minor error, and 3.8% acknowledged not reporting an actual major error. Only 54.8% of respondents knew how to report errors, and only 39.5% knew what kind of errors to report.

Reporting

- Taylor et al. Use of Incident Reports by Physicians and Nurses to Document Medical Errors in Pediatric Patients. Pediatrics 2004, 114:729-735

- Surveys were sent randomly to 200 physicians and nurses at a pediatric hospital
- 74 docs and 64 nurses responded
- Significant underreporting
- Nurses report more that physicians (OR 2.8)
- Type of error important in whether report or not (more "severe" errors were more often reported).

Reasons why errors go unreported

- Not recognized as an error
- Fear of retribution – Lack of a culture of safety
- Fear of harming/betraying a colleague
- A sense of disbelief – “That doesn’t happen here
- Competing forces – e.g. Productivity demands for volume – “This is bound to happen”

Maximizing/optimizing reporting of medical errors and near misses

1. First step: Belief that reporting errors is fundamental to error prevention
2. Making the reporting system easy
3. Deleting blame – Creating a “Just Culture”
4. Showing benefits to both patients and clinicians

“Disclosure”

- Disclosure = presenting errors to pt/fam
- Traditionally not done – malpractice suit, embarrassment, lack of training in the practice
- Surveys of patients revealed what matters most:
  - Disclosure of HARMFUL errors
  - Why the error occurred
  - How the effects of the error will be minimized
  - Steps that will be taken to minimize this from recurring (for pt and for others)

“Disclosure”

- Partial disclosure v. full disclosure
- Admissions of fault can be used as evidence in court in most states (expressions of sympathy – not)
- Patients are less likely to file suit when physicians apologize and fully disclose errors
- Univ of Mich Full Disclosure policy which included disclosure, investigations, implementation of systems to prevent reoccurrence, apology and financial compensation when care is deemed unreasonable – resulted in fewer malpractice suits and lower litigation costs.

Resources for Ethics

- Ethics in Neurology – Bernat
- AMA Journal of Medical Ethics
- Journal of Medical Ethics (BMJ)
- Practical Ethics - Singer
- A Practical Companion to Ethics – Weston
- Ethics committees at hospitals and professional societies (AAN, AHS, IHS)