Leon Morgenstern, "Proactive Bioethics Screening: A Prelude to Bioethics Consultation," *The Journal of Clinical Ethics* 16, no. 2 (Summer 2005): 151-5.

Proactive Bioethics Screening: A Prelude to Bioethics Consultation

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The scenario is all too familiar. A fragile octogenarian with advanced dementia and a host of co-morbid conditions is now unresponsive, ventilator dependent, in renal failure, and suffering grade-four decubitus ulcers. Death is expected in the near but undeterminable future. There is no advance directive. Of her remaining kin, her daughter insists that "everything be done"; the time has come to consider tracheostomy and feeding gastrostomy.

The hapless doctor knows that further treatment is futile, but feels he has no choice but to accede to the wishes of the daughter, however much he disagrees. The nurses, immersed in the total care and treatment of the patient, suffer moral distress, not related to the care, but to the futile treatment and diagnostic interventions to which the patient is being subjected. The frustrated social worker shuttles between the usual parade of multiple consultants[1] and the family, whose hopes rise and fall as each organ rallies or falters. The variations on this theme are infinite.

Is there a need for bioethics intervention or screening? Arguably so. Out of recognition of this need grew the proposal for proactive bioethics screening. Our concern was not with the consultation requests that were forthcoming, but with those that were never requested, or were requested too late.

Our premise is that many patients in end-of-life situations are "ethically vulnerable." By "ethically vulnerable," we mean that they are subjected to a surfeit of futile diagnostic and therapeutic measures that very likely would be against the patient's wishes, if choice were possible. Vulnerability imposed by surrogates is often times associated with guilt, fear, religious belief, belief in "miracles," denial, uncertainty, and other miscellaneous motives. At the very least, a full and open discussion of the goals, values, and expressed wishes of the patient is strongly indicated.

THE SETTING

The Cedars-Sinai Medical Center is an 876-bed tertiary care facility in a large metropolitan area. It is a teaching hospital with more than 245 interns, residents, and fellows; and more than 1,700 physicians. It has a large geriatric population who have diverse ethnic and religious affiliations. Among the most active services are general medicine and surgery, oncology, trauma, organ transplantation, neurosurgery, obstetrics,

and neonatal pediatrics. There are 127 critical care unit beds, in medicine, surgery, coronary care, cardiothoracic surgery, respiratory care, pediatrics, and neonatal intensive care, all providing ample instances of end-of-life situations.

There is an active structured bioethics program, part of which is a 45-member bioethics committee. It was a task force of the latter that drew up the criteria denoting "ethical vulnerability" and the steps to be taken to initiate a proactive screening process.

The following proposal was made to be added to the rules and regulations of the administrative manual of the hospital.

THE SCREENING PROCESS

1. The ethically vulnerable patient is defined as one who fits the following profile and who is being subjected to a number of futile treatments and/or diagnostic procedures without evidence of a discussion about the patient's goals or preferences, and about the burdens and benefits of the plan of care and treatment.
2. Typically, the patient is of advanced age, suffering severe organic dementia, accompanied by one or more of the following conditions:
   - Intensive care unit stay > 15 days
   - Ventilator dependent > 10 days
   - Profound neurologic deficit, for example, Glascow Coma Score < 7 for 7 > days
   - Multiple decubitus ulcers, usually advanced
   - Acute renal failure complicating existing conditions
   - Terminal illness
   - Recurrent aspiration pneumonia
   - Multiple re-admissions to the hospital
   - Intractable pain, typically due to neoplasm
   - Profound paralysis, post-cerebrovascular accident (CVA)
3. Next steps:
   A. In intensive care units (ICUs) and other areas where there are a high incidence of ethically vulnerable patients who meet the listed criteria, nurses, physicians, and social workers will provide a list of potential bioethics patients to the Bioethics Office on a periodic basis.
   B. Bioethics consultants will screen lists provided by patient care centers to determine who might benefit from a proactive bioethics consultation conference.
   C. If a proactive bioethics consultation is felt to be warranted, a bioethics note for the attending physician will be attached to the patient's chart suggesting the advisability of a bioethics consultation conference. This form is *not* part of the official medical record. Preferably, the bioethics conference should take place in a timely way, within the next few days.
   D. The purpose of such a consultation conference with the family, surrogates, and caregivers would be to define goals, discuss outcomes, and weigh the burdens versus the benefits of diagnostic and treatment options.
   E. It is to be emphasized that in no way will care and comfort of any patient be compromised. Religious and cultural factors will be respected. When necessary, the involvement and advice of chaplaincy, legal affairs, and risk management will be sought.
   F. Bioethics consultation conferences should be of assistance and support to attending staff, families and surrogates, caregivers, and, most importantly, to the patient. For the latter, alleviation of suffering and care, in keeping with the highest ideals of medicine and nursing, will always be the prime motivation of the activity.

4. A note will be attached to the patient's chart suggesting consultation (a sample note is provided in figure 1).
   This proposal was unanimously approved by the Medical Executive Committee of the medical center and was implemented in September 2000.
5. The form used to request a proactive bioethics screening is shown in figure 2.
   The notice shown in figure 3 is e-mailed biweekly to nurse managers of all nursing and critical care units as well as to the social service workers of all units.
   Finally, daily rounds on nursing units and critical care areas, made by the director of the bioethics program and his assistant, provide advice and encouragement to the healthcare team in requesting appropriate screening requests.

RESULTS AND DISCUSSIONS

Since the initiation of the program, there have been 160 requests for proactive bioethics screenings. Each request was investigated by a visit to the patient's bedside, a review of the medical record, and, in most cases, a conversation with the nursing and social service staff. After screening, approximately one-third were deemed unsuitable for a formal consultation, one-third elicited no direct response from the attending physician or a consultation request, and, in the remaining one-third, a formal consultation request was made, resulting in a family-physician conference with bioethics consultants. The numbers of proactive screening requests have been increasing steadily, as have the number of cases that eventuate in full consultations.

One occult factor that is not immediately apparent in the above statistics is the influence exerted by the note suggesting a bioethics consultation. This often initiates a more intense and effective communication between physicians and patients' surrogates, obviating the necessity for bioethics involvement. Also, since a bioethics consultation can be requested by any member of the healthcare team (nurses, social workers, house staff), there have been an increasing number of consultation requests by individuals other than the attending physician. Although it is immensely preferable that the attending physician concur in the necessity for the consultation, requests by other team members are honored. No consultations are held, however, without the knowledge of the attending physician, who is fully informed of the reasons given for the consultation request and the unit staff or group that requested the consultation. Identification of the requestor by unit or service, rather than a specific individual, is done to avoid any unnecessary conflict that might be engendered by the request. As the program has developed and the role of bioethical consults has become better known, instances of animosity or ill-feeling displayed by attending physicians have been negligible.

The major objective of the proactive screening process is to transform the process of requesting bioethical consultation from a completely passive process to one in which the bioethics program is *actively* involved. A component of this objective is to encourage more timely bioethics intervention in cases in which the surrogates are unclear about treatment decisions. When physicians feel obligated to provide questionably indicated treatment, when nurses suffer moral distress in providing such treatment, and, above all, when the "ethically vulnerable" patient suffers needlessly from futile interventions, a bioethics consultation is strongly indicated.

The barriers to timely bioethics consultation are legion. They have been well summarized by Davies

Figure 1.
Sample Note to the Attending Physician

This patient has a clinical condition for which a bioethical consultation might be helpful. The purpose of such a consultation would be to facilitate a dialogue with the patient or surrogate and the healthcare team regarding the goals of therapy, the burdens and benefits of such therapy, and the guarding of the best interests of the patient.

No decisions will be rendered nor will any issues be forced. The goal of the consultation is consensus, based on ethical, cultural, medical, and humanistic concerns.

Feel free to call the Bioethics Office at: [number] or fax to: [number].

[Signature] Director, Bioethics Program
Approved: Medical Executive Committee

and Hudson.[2] Fletcher[3] discussed how more-timely interventions might be facilitated, and DuVal[4] suggested practical steps toward earlier consultation. Often it is only the momentum of treatment that has already been initiated, without consideration of goals and values, that relentlessly drives a treatment plan, without proper thought of the ethical implications. On the part of physicians, it can be a mistaken sense of unwanted intrusion, usurpation of responsibility, or even criticism of their professional ability. On the part of the nurses and other healthcare workers, it may be a fear of retribution for suggesting ethical intervention. On the part of the family or surrogate, it may be unawareness of the availability of a bioethics consultation or a misunderstanding of its purpose. Some families mistakenly feel that a bioethics consultation is tantamount to a verdict for death over life, or, occasionally, vice versa. Education and increasing experience should lower these barriers on the part of all concerned, if bioethics consultation is provided in a timely and effective manner. The consultation standards issued by the American Society for Bioethics and Humanities provide a valuable guide toward this end.[5]

A study by Dowdy and colleagues suggested process-oriented, proactive ethics consultation for critically and terminally ill patients with extended lengths of stay.[6] It involved a small cohort of patients in the setting of an ICU. In commenting on this study, Schroeter and colleagues emphasized the usefulness of such proactive ethics consultations from the point of view of nurses,[7] and Danis recommended the merits of the proactive approach for more general use.[8] Our program extends and defines a process for encouraging timely bioethics consultation, hospital wide, as a valuable adjunct to decision making for critically ill patients. It is a screening process that is designed to lead to consultations that should be requested, but for various reasons are not.

Figure 2.
Bioethics Proactive Screening Data Sheet

Date: _____

Patient's Information

Name: _____

☐ Mr. ☐ Mrs. ☐ Ms

Age: _____

Location/room: _____

Phone: _____

MRN no.: _____

Date entered hospital: _____

Diagnosis: _____

_____

Referral Information

Who requested consultation?

☐ Attending
☐ Family member
☐ Nurse
☐ Resident
☐ Social worker

Name(s) of requestor(s): _____

_____

Phone: _____

Attending: _____

Phone: _____

Other Dr.: _____

Phone: _____

Social worker: _____

Phone: _____

Subject

_____

_____

Description of Bioethical Concerns

(For Bioethics Office use only) _____

_____

File #: _____

Disposition

_____

_____

Figure 3.
Sample E-Mail Notice

Dr. [name] would like to hear from you regarding possible candidates for proactive bioethics screenings. Please forward to Dr. [name] via e-mail [e-mail address] the names and location of any appropriate patient candidates.

Thank you for your cooperation and participation.

Bioethics Office phone number: [number]

_____

[Signature]

In summary, this process helps to identify patients who might benefit from a bioethical consultation and outlines the steps leading to such consultations. As of the present, it has been modestly successful in increasing the number of consultations leading to an ethical benefit for the patient, family, and healthcare team. As experience of the positive attributes of this method grows, it should provide a new dimension in encouraging bioethics consultations.

NOTES

1. L. Morgenstern, "A Piece of My Mind: Will the Real Doctor Please Stand Up?" *Journal of the American Medical Association* 289, no. 1 (January 2003): 18.

2. L. Davies and L.D. Hudson, "Why Don't Physicians Use Ethics Consultation?" *The Journal of Clinical Ethics* 10, no. 2 (Summer 1999): 116-25.

3. J.C. Fletcher, "Ethics Consultants and Surrogates: Can We Do Better?" *The Journal of Clinical Ethics* 8, no. 1 (Spring 1997): 50-9.

4. G. DuVal et al., "What Triggers Requests for Ethics Consultations?" *Journal of Medical Ethics* 27 (2001): 124-9.

5. Society for Health and Human Values—Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation, *Core Competencies for Health Care Ethics Consultation* (Glenview, Ill.: American Society for Bioethics and Humanities, 1998).

6. M.D. Dowdy, C. Robertson, and J.A. Bander, "A Study of Proactive Ethics Consultation for Critically and Terminally Ill Patients with Extended Lengths of Stay," *Critical Care Medicine* 26, no. 2 (February 1998): 252-9.

7. K. Schroeter, "A Study of Proactive Ethics Consultation for Critically and Terminally Ill Patients with Extended Lengths of Stay," *AORN Journal* 71, no. 4 (April 2000): 902, 904.

8. M. Danis, "The Promise of Proactive Ethics Consultation," *Critical Care Medicine* 26, no. 2 (February 1998): 203-4.