West Virginia Network of Ethics Committees
Newsletter

SPRING 2022 Edition

New Feature: Focus on a WVNEC Member Institution

Ethics in Rural Hospitals: The Experience of Davis Medical Center

Interview with Arvela J. Koerner, BSN, RN, ACM, Ethics Committee Co-Chair

Arvela J. Koerner, BSN, RN, ACM, chairs the hospital ethics committee with Davis Medical Center (DMC) board member, Danny Franke, PhD, ThM. The committee meets quarterly, and according to Arvela, formal ethics consults are "pretty rare." At the committee meetings, they usually discuss a case or two in the hospital or in the literature. Several members of the ethics committee may also attend a WVNEC webinar or a West Virginia Rural Emergency Trauma Institute Project ECHO Health Ethics monthly presentation together and then discuss it for their own ethics education. Ethics committee members who attend these educational sessions share information from them at their quarterly meetings. At DMC, in earlier years the ethics committee had to address a lack of staff understanding of ethics, train personnel about what an ethics consult is and when to call one, and deal with the perception that the role of ethics is "to pull the plug."

Although not formally consulted often, Arvela is frequently asked about patient care ethical issues, and she teams with the hospital lead chaplain and spiritual care coordinator, Dina Andrews, MDiv, MACM, BCC, to be proactive in having family meetings to avoid conflict. For example, it is not uncommon for a patient to tell her nurse, early in her stay, that she does not want to be on a ventilator, but she may change her mind when she talks with her family or when her condition changes. After the patient is intubated, nursing staff feels conflicted because they feel like this is not the patient's wishes. Arvela and Dina will meet with the staff and help them understand that the patient has the ethical and legal right to have her preferences respected, even last minutes changes. In addition, they encourage family meetings to address goals of care while providing family support and validation of the nurses' feelings as well as advocating for the patient.

In This Issue

What often makes ethical issues in patient care challenging at DMC is the dual relationships, also called overlapping relationships. Arvela says that frequently everyone on the Ethics Committee knows the patient and/or patient's family on whom they are consulted or asked to provide informal input.

Arvela also notes that the staff frequently deal with moral distress in patient care, particularly during the recent pandemic. DMC has a Resilience Committee to help staff. They have seen great results with family meetings for staff and families alike. The concerns of the staff are recognized, and they have the opportunity to advocate for the patient which in turn decreases their frustrations. Additionally, it assists staff in understanding family dynamics and identifying barriers (educational, religious, fears).

When asked about an ethics consultation that sticks in her mind, Arvela recalled one of an older man who was clear in his wishes that he did not want intubation and mechanical ventilation. He said he had lived a good life, and he was ready to go. His wife was not happy with his decision and talked him into going on a breathing machine. The patient lost decision-making capacity, and the wife continued to request all aggressive care. The staff was troubled because they did not believe that is what the patient would have wanted. At a family meeting, it became clear that the wife was unable to make decisions. She actually seemed frozen, unable to converse, and tearful; she did not appear to comprehend verbal communication. Another family member agreed to serve as his health care surrogate, made the decision to discontinue aggressive care, and a few days later the patient passed peacefully.

Arvela reports that she is grateful for WVNEC as a resource for difficult cases to avoid moral injury in the DMC staff. Although Arvela would like to undertake training to become a clinical ethicist, she does not have the luxury to do that at this time; however she continues to actively engage in as many educational opportunities as she can.

Commentators writing on rural healthcare ethics have identified the contribution that partnerships and collaborative relationships with larger academic institutions with trained bioethicists can make to patient care in rural areas. Such partnerships have been described in which ethics consultation for complex cases is available through telemedicine (videoconferencing) so that the bioethicist can see the non-verbal communication of all participants in the family meeting as well as see and hear the discussion.

With the increasing availability of telemedicine, WVNEC is pleased to offer this service to WVNEC members subject to the availability of a consultant. There will be more information on this topic in a future newsletter.

If you would be willing to be interviewed about your ethics committee for a future WVNEC Newsletter, please email or call Linda McMillen to let WVNEC know at lmcmillen@hsc.wvu.edu or 304.293.7618.

WVNEC announces the launch of a new initiative in clinical healthcare ethics. Watch for more details in the coming months in all WVNEC educational venues!

- The goal is to improve the quality of patient care by identifying, analyzing, and contributing to the resolution of ethical problems that arise in the routine practice of clinical medicine.
- Clinical healthcare ethics is a central component of clinical care that must be practiced by and applied by licensed clinicians in their ordinary encounters with patients.
- It includes informed consent, truth-telling, surrogate decision-making when the patient lacks capacity, and confidentiality.
- It encourages personal, humane, compassionate, respectful, and fair interactions between clinician and patient.
- While few US physicians, advanced practice registered nurses, and physician assistants today are formally trained as ethicists, all are expected to routinely apply clinical healthcare ethics in their regular, daily practice.

West Virginia Health Care Decisions Act Undergoes Major Revisions for the First Time in 20 Years: New Advance Directives and More

Alvin H. Moss, MD
Executive Director
WV Network of Ethics Committees

Danielle Funk Sollenberger, MS
Program Manager
WV Center for End-of-Life Care

For the first time in 20 years, the West Virginia Health Care Decisions has undergone a major revision. Originally passed in 2000, in 2002 the West Virginia Health Care Decisions Act was revised to amend the Physician Orders for Scope of Treatment ("POST") into the law. Since then, both advanced practice registered nurses (§30-7-15d) and physician assistants (§30-3E-12a) were given the authority to sign POST forms when their scope of practice was expanded in 2016 and 2017, respectively.

Passed during the 2022 Regular Session of the West Virginia Legislature, SB 470 not only clearly incorporates the changes in the Practice Acts for these health care professionals into the West Virginia Health Care Decisions Act found at §16-30-1 *et seq*, but also improves so much more (see box on page 4). SB 470 becomes effective June 7, 2022, 90 days after its passage. However, it provides for the use of the new advance directives "on or before January 1, 2023" and stipulates that advance directives completed pursuant to §16-30-3 and §16-30-4 of the West Virginia code before the bill's passage remain in full force and effect. **The new law requires that "all health care facilities and health care providers using a living will, medical power of attorney, or combined medical power of attorney and living will form referenced in §16-30-4 of this code shall update their forms on or before January 1, 2023."**

The biggest changes for the amended advance directives are in the wording of the Living Will and the revised Special Directives and Limitations in the Combined Medical Power of Attorney and Living Will. In the text across for the Living Will, the new wording is underlined, and removed words are indicated by strikethroughs.

If I am very sick and ~~not able~~ unable to communicate my wishes for myself and I am certified by one physician, who has personally examined me, to have a terminal condition, o~~r to be in a persistent vegetative state (I am unconscious and am neither aware of my environment nor able to interact with others)~~ I direct that life-prolonging ~~medical~~ intervention that would serve solely to prolong the dying process ~~or maintain me in a persistent vegetative state~~ be withheld or withdrawn. I understand that by signing this document I am agreeing to the REMOVAL or REFUSAL of cardiopulmonary resuscitation (CPR), breathing machine (ventilator), dialysis, and medically administered food and fluids, such as might be provided intravenously or by feeding tube. I want to be allowed to die naturally and only be given medications or other medical procedures necessary to keep me comfortable. I want to receive as much medication as is necessary to alleviate my pain. Nevertheless, oral food and fluids, such as may be provided by spoon or by straw, shall be offered as desired and can be tolerated.

The new three conditions for Special Directives and Limitations in the Combined Medical Power of Attorney and Living Will are indicated below.

1. IN A TERMINAL CONDITION: If I am very sick and not unable to communicate my wishes for myself and I am certified by one physician, who has personally examined me, to have a terminal condition, ~~to be in a persistent vegetative state (I am unconscious and am neither aware of my environment nor able to interact with others,)~~ I direct that life-prolonging ~~medical~~ intervention that would serve solely to prolong the dying process ~~or maintain me in a persistent vegetative state~~ be withheld or withdrawn.

Thus, if a physician has determined that I am in a terminal condition, I understand that completing this form would mean that I refuse cardiopulmonary resuscitation (CPR). It also means that I refuse or request the removal of a breathing machine (ventilator), dialysis, and medically administered food and fluids, such as might be provided intravenously or by feeding tube. I want to be allowed to die naturally and only be given medications or other medical procedures necessary to keep me comfortable. I want to receive as much medication as is necessary to alleviate my pain. Nevertheless, oral food and fluids, such as may be provided by spoon or by straw, shall be offered as desired and can be tolerated.

2. ~~OTHER DIRECTIVES:~~ OTHER LIVING WILL SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: (Comments about mental health treatment, funeral arrangements, autopsy, and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.)

In exercising the authority under this medical power of attorney, my representative shall act consistently with my special directives or limitations as stated in this advance directive.

3. NOT IN A TERMINAL CONDITION: MEDICAL POWER OF ATTORNEY SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: (Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, mental health treatment, funeral arrangements, autopsy and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.)

For more information about the amendments to the West Virginia Health Care Decisions Act and to obtain the new advance directive forms, go to the West Virginia Center for End-of-Life Care website, www.wvendoflife.org and download them. There will be a session devoted to presenting the changes in the laws and asking for comments and questions at the West Virginia Network of Ethics Committees 34th Annual Symposium, May 6th, at the Stonewall Resort. For the schedule for the symposium, click here, and to register, click here.

Box. Changes in the West Virginia Health Care Decisions Act with Passage of SB 470

- Changes the Living Will, Medical Power of Attorney, and Combined Living Will/Medical Power of Attorney advance directive forms
- Requires health care facilities to update the advance directive forms they provide on or before January 1, 2023
- Removes persistent vegetative state from the Living Will as a condition making it effective
- Renames the POST form—Portable Orders for Scope of Treatment
- Amends the definition for a life-prolonging intervention
- Indicates that advanced practice registered nurses and physician assistants can sign the POST form
- Provides reciprocity for POST forms from other states
- Adds new Special Directives and Limitations format for the Combined Medical Power of Attorney and Living Will
- Adds user-friendly language explaining the implications of signing a living will
- Stipulates in the living will that food and fluids must be provided as desired and tolerated

Discharge against Medical Advice: Potentially Fraught with Ethical and Legal Issues

Alvin Moss, MD
WVNEC Executive Director

The case below will be the focus of the WVNEC June 15, 2022 webinar. Patients who want to sign out against medical advice (AMA) (leave the hospital when the treating physician does not recommend it) are a relatively common occurrence in medical practice. It has been estimated that discharge AMA occurs in 1-2% of all hospital admissions. The risk of readmission has been found to be 12 times more in patients who leave AMA when compared to those who do not. Researchers have also found that those who leave AMA have a significantly increased 12-month all-cause mortality. In the following case, sharpen your skills on what you would recommend to the treating physician if asked for a recommendation.

Case

Mr. A is a 52 y.o. male with history of COPD and cirrhosis from severe alcohol use disorder complicated by ascites, esophageal varices, and a history of GI bleeding. He was admitted to the hospital for complaints of shortness of breath, abdominal swelling, and pain. He has been hospitalized many times in the past for similar symptoms. He was most recently admitted one month before for an opioid overdose and pneumonia. After 3 days, he left against medical advice. He had agreed to finish a course of oral antibiotics for the pneumonia, but he never picked up the prescription at the pharmacy.

It has been estimated that discharge AMA occurs in 1-2% of all hospital admissions.

He is alert and oriented to time, place, person, and situation. He agreed to a paracentesis, had a large volume of fluid removed, and was being treated for spontaneous bacterial peritonitis. He was able to say he was in the hospital because his liver was bad. He reports living by himself in a house. He walks to the grocery store to get his groceries. However, when asked who helps him at home or how he plans to get to his doctor appointments, he states he has nobody at home. His only family is his father from whom he is estranged. He complied with a request to work with physical therapy (PT) to be sure he was able to walk far enough to meet his self-care needs once discharged, and he walked with PT around the entire wing of the hospital three times without difficulty.

The risk of readmission has been found to be 12 times more in patients who leave AMA when compared to those who do not.

He was scheduled to receive 4 more days of IV antibiotics for the peritonitis when he abruptly told the nurse he wanted to sign AMA papers and leave the hospital. He was advised to complete the course of antibiotics. He refused to stay, but he did say he would be willing to take the remainder of his antibiotic course for peritonitis by mouth. Remembering that he said the same thing last time and did not pick up the prescription, the treating physician is worried that the patient will become very sick without full treatment and wonders whether he should let the patient sign out AMA. He requests an ethics consultation.

Should the patient be allowed to sign out AMA?

Test Your Knowledge:
Reducing Moral Distress in Patient Care

West Virginia ethics committees are reporting that moral distress is at an all-time high in their institutions. It is directly or indirectly one of the most common reasons for ethics consultation. Moral distress occurs when a health care clinician knows the ethically correct action to take but is prevented because of constraints from taking that action. Because there is so much concern about this topic, the West Virginia Network of Ethics Committees has launched an initiative to educate its members on it.

"Approaching Moral Distress in Patient Care" will be the keynote address by Laurel Lyckholm, MD, at the WVNEC 34th Annual Symposium, "Moral Distress, COVID Ethical Challenges, and the New Urgency of Clinical Ethics in Patient Care," May 6th at Stonewall Resort in Roanoke, WV. The symposium brochure is here and registration information is here.

To give insight into one of the scenarios that can trigger moral distress and prepare WVNEC members for the healthcare ethics certification examination, WVNEC provides below a discussion of a sample multiple-choice question from the American Society of Bioethics and Humanity. https://heccertification.org/preparation/sample-questions

Q: Moral distress is common when a patient's family members appear to compel providers to deliver treatment upon an incapacitated patient for whom providers assess that treatment to be potentially inappropriate. Which of the following options is the recommended approach for avoiding these "futility disputes"?

Possible Answers

A. Help providers recognize that they are free to discontinue intervention that they judge to be potentially inappropriate regardless of the family's demands.

B. Facilitate awareness among providers that a futility dispute should trigger a call to legal affairs, who will likely recommend that the hospital petition the court.

C. Promote advance directives because a very clear living will overrides the family's right to compel interventions.

D. Encourage providers to explain to family members that their duty is to offer and then provide care that is medically indicated for the patient, not just any care that is available.

Promoting professional integrity enables clinicians to practice according to the highest values of their profession. Please see its relevance to the answer for this question.

Please notice the wording of the question. What is the "recommended" approach? A is not the recommended approach because it is preferable to work with the family so that they understand that a treatment is inappropriate and agree to its discontinuation. B is not the recommended approach because recourse to the courts should be the last resort after all interventions to interact with the family and reach consensus have failed. C is not the recommended approach because living wills only direct care in very limited situations when the patient has been determined to be terminally ill and lack decision-making capacity. Often patients can be very sick, but not clearly terminally ill. The patient's living will is not in effect under those circumstances.

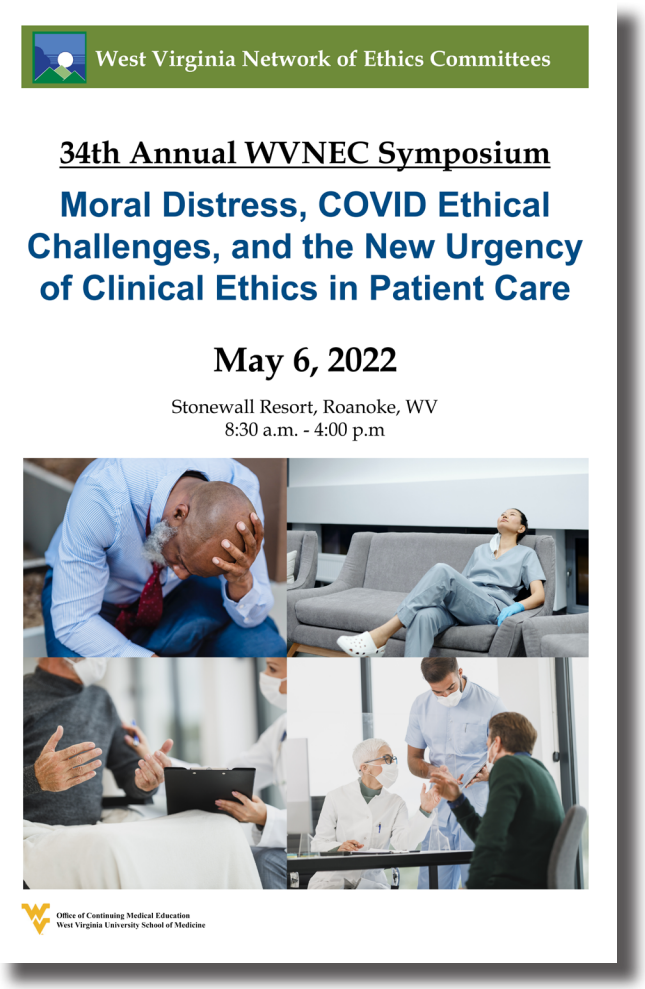
D is the correct answer. It promotes good communication between the physician and family and respects professional integrity and the ethical principles of beneficence and nonmaleficence. It uses the term "medically indicated." To maintain their integrity and respect their Hippocratic Oath, physicians should only offer treatment that is medically indicated, that is, treatment in which the expected medical

benefits justify the risks. The question also uses the words "potentially inappropriate." In an oft-cited article in the critical care literature (Bosslet GT. *Am J Respir Crit Care Med* 2015; 1318–1330), the authors state, "'potentially inappropriate'" should be used, rather than "futile," to describe treatments that have at least some chance of accomplishing the effect sought by the patient, but clinicians believe that competing ethical considerations justify not providing them. Clinicians should communicate and advocate for the treatment plan they believe is appropriate. Requests for potentially inappropriate treatment that remain intractable despite intensive communication and negotiation should be managed by a fair process of dispute resolution [such as an ethics consultation]."

For more information about WVNEC and its educational offerings, please contact Linda McMillen at lmcmillen@hsc.wvu.edu or 304.293.7618.

Be Better Prepared to Answer the Ethical Questions in Your Healthcare Setting!

More than doing ethics consults, research indicates that ethics committee members address questions about ethical issues in patient care in their institutions that do not rise to the level of needing formal consultation. This year's symposium will provide case-based, experiential learning that will help you to think through ethical questions your colleagues are likely to ask you. Don't miss out! Join us on May 6 at Stonewall Resort!



Schedule

8:30 am	Registration and Check-in
9:00 am	**Ethics Consultation in Action, Case 1: The Patient Who Refuses Surgery for a Life-Threatening Condition But Wants CPR** Panelists: Rev Jennifer Johnson, Laurel Lyckholm, MD, Suzanne Messenger, JD, Daniel Miller, PhD and Matthew Smith, MD
10:15 am	**Keynote Talk: Approaching Moral Distress in Patient Care** Laurel Lyckholm, MD
11:00 am	**Q & A**
11:15 am	**20th Anniversary of the West Virginia Health Care Decisions Act: Where Do We Stand?** Alvin Moss, MD
11:30 am	Lunch
12:30 pm	**New Research on Ethics Committees: Doing More Ethics Consults Should Not Be Our Top Priority!** Alvin Moss, MD
1:30 pm	**Ethics Consultation in Action, Case 2: Mrs. T's Nurse Daughter Wants Life Support Stopped Immediately** Panelists: Rev Jennifer Johnson, Laurel Lyckholm, MD, Suzanne Messenger, JD, Daniel Miller, PhD and Matthew Smith, MD
2:30 pm	Break
2:45 pm	**Healthcare Ethical Challenges from the COVID-19 Pandemic: Lessons Learned** Alvin Moss, MD and Symposium Faculty
3:30 pm	**Annual WVNEC Business Meeting**
3:45 pm	**Wrap-Up and Evaluation**
4:00 pm	Adjourn

CALENDAR OF EVENTS

May 6, 2022 - *34th Annual WVNEC Symposium: Moral Distress, COVID Ethical Challenges, and the New Urgency of Clinical Ethic* - Stonewall Resort - This year's symposium will update participants on the ever-increasing importance of clinical ethics in patient care, and the research that suggests ethics education of their colleagues should be the first priority of ethics committees in all settings—hospital, nursing home, hospice, and home health. Speakers will present the profound role of moral distress in today's healthcare, role model how to analyze and contribute to the resolution of ethical issues in patient care, and describe the changes in West Virginia advance directives and the POST medical order set resulting from passage of SB 470 in the 2022 legislative session.

June 15, 2022 - WVNEC Noon Webinar: *Discharge against Medical Advice: Potentially Fraught with Ethical and Legal Issues.* This webinar will address Discharge Against Medical Advice (DAMA) which has been found to occur with 1-2% of hospital admissions. The traditional focus with DAMA has been to get patients to sign a form acknowledging that they are leaving the hospital against medical advice. It turns out that the preferred approach is to use shared decision-making and an Ask-Tell-Ask method to explore the patient's understanding of his/her condition, the reason for hospitalization, and to ensure that leaving the hospital is really consistent with the patient's values, preferences, and goals. Research has shown that when patients feel heard and understood, their satisfaction with care increases. Registration will open soon!

Visit our website at www.wvnec.org for the latest information on future events.

Thespians Wanted for Role-Playing!

Role-playing is a useful technique to prepare ethics consultants for a variety of challenging and difficult situations. It is widely recognized as an approach to improve communication skills. By acting scenarios out, the less experienced ethics consultant can explore how other people are likely to respond to different approaches, get a feel for approaches that are likely to work, and for those that might be counterproductive. The ethics consultant can also get a sense of what other people are likely to be thinking and feeling in the situation and what they might say.

By preparing for case consultations using role-play, the learner can build up experience and self-confidence with handling consults in real life and develop quick and intuitively correct reactions to comments that might be made by patients or family members.

WVNEC would like to incorporate role-playing into its webinars and symposium presentations. If you enjoy acting and would relish the opportunity to role-play challenging ethics consultation dynamics, please contact Linda McMillen, lmcmillen@hsc.wvu.edu. Thank you for considering!

Mission Statement: The West Virginia Network of Ethics Committees assists hospitals, nursing homes, hospices, and home health care agencies to strengthen ethics committees; provides education regarding ethical and legal issues in health care to promote ethically sound decision-making; and helps patients and families to make their end-of-life wishes known.

This is a quarterly publication of the Center for Health Ethics and Law, Health Sciences Center of WVU, for the West Virginia Network of Ethics Committees. Questions, comments, and ideas should be submitted to:

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For more information on these and other future programs, please take a look at "Upcoming Conferences" on our website, www.wvnec.org, or call Linda at 1-304-293-7618.