

Frequency of Ethical Issues on a Hospitalist Teaching Service at an Urban, Tertiary Care Center

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Little is known about the daily ethical conflicts encountered by hospitalists that do not prompt a formal clinical ethics consultation. We describe the frequencies of ethical issues identified during daily rounds on hospitalist teaching services at a metropolitan, tertiary-care, teaching hospital. Data were collected from September 2017 through May 2018 by two attending hospitalists from the ethics committee who were embedded on rounds. A total of 270 patients were evaluated and 113 ethical issues were identified in 77 of those patients. These issues most frequently involved discussions about

goals of care, treatment refusals, decision-making capacity, discharge planning, cardiopulmonary resuscitation status, and pain management. Only five formal consults were brought to the Hospital Ethics Committee for these 270 patients. Our data are the first prospective description of ethical issues arising on academic hospitalist teaching services and are an important step in the development of a targeted ethics curriculum for hospitalists. *Journal of Hospital Medicine* 2019;14:290-293. Published online first March 20, 2019. © 2019 Society of Hospital Medicine

Much has been written about the sources of the hidden curriculum in clerkships and postgraduate medical education.¹⁻³ However, these descriptions do not adequately account for the critical role that hospitalists play in the development of trainees when they encounter ethical challenges on teaching services.⁴ As a role model, teacher, and the attending of record, a hospitalist's response to ethical issues in practice can have a pivotal influence on the life and work of trainees, either instilling positive virtues or perpetuating the negative impact of the hidden curriculum.⁵⁻⁸ Understanding the epidemiology of ethical issues arising on academic hospitalist services has important implications for medical education, clinical ethics, and professionalism, as well as for patient care.

METHODS

Study Setting and Design

We conducted a mixed-method observational study at New York–Presbyterian–Weill Cornell Medical Center, an 862-bed, tertiary-care, academic institution located in New York, New York. We performed a prospective description of the frequency of all consecutively identified ethical and contextual issues pertinent to clinical decision-making by observing

morning rounds with housestaff hospitalist services. Ethical issues were categorized using a comprehensive standardized instrument previously developed and published by the Division of Medical Ethics.⁹

The Division of Hospital Medicine employs 79 physicians, 30 of whom are dedicated full-time to daytime care on housestaff (or teaching) or physician assistant services. Of these 30 physicians, two (7%) were coinvestigators in this project and were excluded from participation to avoid bias. Between September 2017 and May 2018, the attending physicians of record of all available housestaff services were invited to participate with their teams in our research study on a weekly basis. We observed 10 different Hospital Medicine attending physicians (10/28, 36% of the available physician sample) over 19 sessions. Before rounds, a brief introduction to the nature of the study was provided to each team. It was explicitly stated that the observers were present to identify and document possible ethical issues that may arise while discussing the patients on rounds, and that the purpose of the study was neither an evaluation of the team members or their decisions nor a critique or quality improvement exercise. Observing researchers were not allowed to participate in the discussion of any case.

To avoid potential case duplication, we allowed for a minimum two-week interval before rounding twice on any particular team. To control for interobserver variability, we observed in pairs during these sessions. Discrepancies between observers were resolved by *post hoc* discussion and application of the definitions of the standardized instrument used to identify and catalog ethical and contextual issues.

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Study Variables and Definitions

The following variables were collected in all cases: observation date, name of reviewers, demographic characteristics of the patient (age, gender, race, ethnicity, marital status, religion, preferred language, insurance type, and living situation before the admission), patient's location during the admission (emergency room, regular nursing floor, step-down unit, or other), and ethical and contextual issues. "Ethical issues" were defined as those situations involving a conflict of values or preferences among different stakeholders, including, but not limited to, providers, patients, and/or families. Explicit definitions of each issue were generated, and additional standard rules for completion were provided.

Statistical Analysis

Results are presented as n (%) or mean \pm standard deviation. Percentages were rounded to the closest integer. Interobserver variability between the observers in relation to evaluating the presence or absence of ethical or contextual issues was assessed by the kappa statistic. All *P* values are two-sided, with statistical significance evaluated at the 0.05 alpha level. A 95% confidence interval (95% CI) for the kappa statistic (ie, for assessing interobserver variability) was calculated to assess the precision of the obtained kappa estimate. All analyses were performed in SAS Version 9.4 (SAS Institute, Inc., Cary, NC) and Stata Version 14.0 (StataCorp, College Station, TX).

RESULTS

General Characteristics of the Study Sample

In total, 270 patients were evaluated from the teaching hospitalist services during the observation period. Ethical issues were identified in 86 of these patients (31.8%). Observer ethicists disagreed in their initial evaluation of 17 cases (6.3%). After review of and adjudication, both observers agreed that nine of these 17 cases (3.3%) should be excluded from the final analysis, as none reached the necessary threshold to be considered as a true ethical issue. Hence, we report the results of 77 patients (28.5%). These cases comprised the Hospitalist group and involved 113 ethical issues (1.48 \pm 0.5 ethical issues/case). Only five patients in the Hospitalist group had a formal clinical ethics consult before our observation (5/270 patients [1.9%] vs 77/270 patients [28.5%] with an ethical issue, respectively, *P* < .001). Although the majority of ethical issues were noted by members of the primary team (84%), 12 of the 77 cases in the Hospitalist group (16%) were identified only by the observing ethicists. The kappa statistic for interobserver variability between the observing ethicists was 0.85 (95% CI = 0.76-0.92). The major demographic characteristics are summarized in Table 1.

Ethical Challenges

The most common ethical issues hospitalists encountered involved discussions about goals of care (including decisions to pursue aggressive treatment versus hospice care, or debates about the team's ambivalence about the benefits and risks of pursuing investigational chemotherapy), treatment refusals (in-

TABLE 1. Demographic Characteristics of Patients with Ethical Issues^a

Variable	Patients
Sample size (n)	77
Age (years)	63.3 \pm 18.8
Gender (male)	40 (52%)
Race	
White	39 (51%)
Non-white ^b	26 (34%)
Unknown	12 (15%)
Ethnicity (Hispanic)	7 (9%)
Marital status	
Married / Domestic partner	34 (44%)
Single	23 (30%)
Widowed / Divorced	12 (16%)
Unknown	8 (10%)
Religion	
Christian	25 (32%)
Jewish	9 (12%)
Other	8 (10%)
Unknown	35 (45%)
Non-English speakers	9 (12%)
Primary insurance	
Private	22 (29%)
Medicare	23 (30%)
Medicaid	5 (6%)
Managed care	10 (13%)
Uninsured / Undocumented	17 (22%)
Hospital unit	
Emergency room	13 (17%)
Regular nursing floor	40 (52%)
Step-down unit	24 (31%)
Living situation	
Home	60 (78%)
Nursing facility (incl. rehab)	11 (14%)
Undomiciled or homeless shelter	1 (1%)
Other	5 (6%)

^aResults are presented as n (%) or mean \pm standard deviation.

^bNon-white includes Black or African American and Asian racial categories (study subjects did not identify with any other racial categories).

cluding the decision to forgo biopsy of a suspected malignancy), or decision-making capacity (Table 2). Less common were issues pertaining to resource allocation (specially related to pressures to discharge patients), pain management (some patients were suspected of drug-seeking behavior), or surrogate decision making (when alternative decision makers were suspected to lack decision-making capacity). Discussions about forgoing life-sustaining treatments occurred only in four cases (5%). These involved considerations of withdrawing Bilevel Positive Airway Pressure (BiPAP), artificial nutrition and hydration, and/or stopping antibiotic treatment.

TABLE 2. **Characteristics of Ethical Issues Identified in Table 1**

Ethical Issues ^a	113
Ethical issues per case	1.48 ± 0.5
Goals of care	29 (26%)
Refusal of treatment	12 (11%)
Capacity	10 (9%)
Discharge planning	9 (8%)
Resuscitation status	6 (5%)
Pain management	6 (5%)
Surrogate decision-making	5 (4%)
Substance abuse	5 (4%)
Forgoing LSTs	4 (4%)
Resource allocation	3 (3%)
Utilization review / length of stay	3 (3%)
Other	21 (19%)

Results are presented as n (%).

^aNumber of ethical issues was used as denominator to calculate frequencies of observed topics.

LSTs: Life-sustaining treatments (including, but not limited to, mechanical ventilation, BiPAP, vasopressors, ECMO, pacemaker/ICD, dialysis, transfusions, and/or artificial nutrition and hydration).

DISCUSSION

Our data are the first prospective description of ethical issues arising on an academic hospitalist teaching service. These results indicate that there is an ethics epidemiology in the routine practice of Hospital Medicine that has heretofore not been characterized. By this, we mean a discreet incidence and prevalence of ethical challenges in Hospital Medicine that is distinct from that which is encountered by clinical ethics consultation (CEC) services. Although most practitioners recognize the utility of a traditional ethics consultation, there is a surprising paucity of data about the sources of ethical conflict encountered by academic hospitalists at the bedside, particularly those addressed *without* CEC. This suggests that the criteria for requesting a formal ethics consult could be limited and restrictive, which is both undersensitive and overspecific.¹⁰ Because of these limitations, viewing traditional ethics consultation as a proxy for ethical issues arising in daily hospitalist practice would lead to an underestimation of the true prevalence, as our data indicate.

More than one-fourth of the patients admitted to hospitalist teaching services pose ethical conflicts. Some of these are addressed on rounds, some are not, and only a handful of these cases will ever be referred to an ethicist. CEC services are made aware of the “tip of the iceberg,” which accounts for a vanishing small percentage of ethical issues that arise on daily rounds. Some hospitalists may not involve CEC simply because they be-

lieve that the services are not helpful. However, the failure to obtain consultation may also reflect an inability to recognize a “problematic situation” and formulate a referral that might benefit from the assistance of an ethics consultation.¹¹

Our study faces several potential limitations. We are presenting a single-center experience that focuses on the perspective of physicians and trainees. Some ethical issues might have been underestimated because the perspectives of patients, families, nurses, social workers, or other ancillary staff were not directly included. Furthermore, since any ethical challenge could have been discussed on any moment other than on morning rounds, our results may underestimate the prevalence of ethical issues arising from the hospital floors. Moreover, medical teams participating in the study could have been subject to the Hawthorne effect and could have tried to identify a greater number of ethical issues on rounds, which would not reflect actual practice.

CONCLUSION

Almost two decades ago, Coulehan and Williams wrote about the positive impact that ethics and humanities could have if these disciplines could be embedded in the daily practice of medicine, which is as follows:

...ethics and humanities curricula are irrelevant unless they can produce a substantive and continuing impact on hospital culture (...) The idea, of course, is to infiltrate the culture by coopting residents and attending physicians(...) If an ethics program can somehow achieve a critical mass of “value-sensitive” clinical faculty, it may begin to influence the institution’s ethos.¹²

Coulehan and Williams wrote of a need to bring ethics to the bedside. Our data suggest that an ethics epidemiology is deeply embedded in hospitalist services and is waiting to be fully characterized to better inform the care of patients and guide the professional formation and education of students and trainees. Hospitalists frequently confront ethical problems in daily practice that do not come to the attention of the CEC services or the institutional ethics committee. Understanding this emerging epidemiology presents an unrealized opportunity to improve bedside teaching, reinforce normative reasoning, and enhance patient care.

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