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Clinical Ethics and Risk Management:

Patient Well-Being Wins the Day

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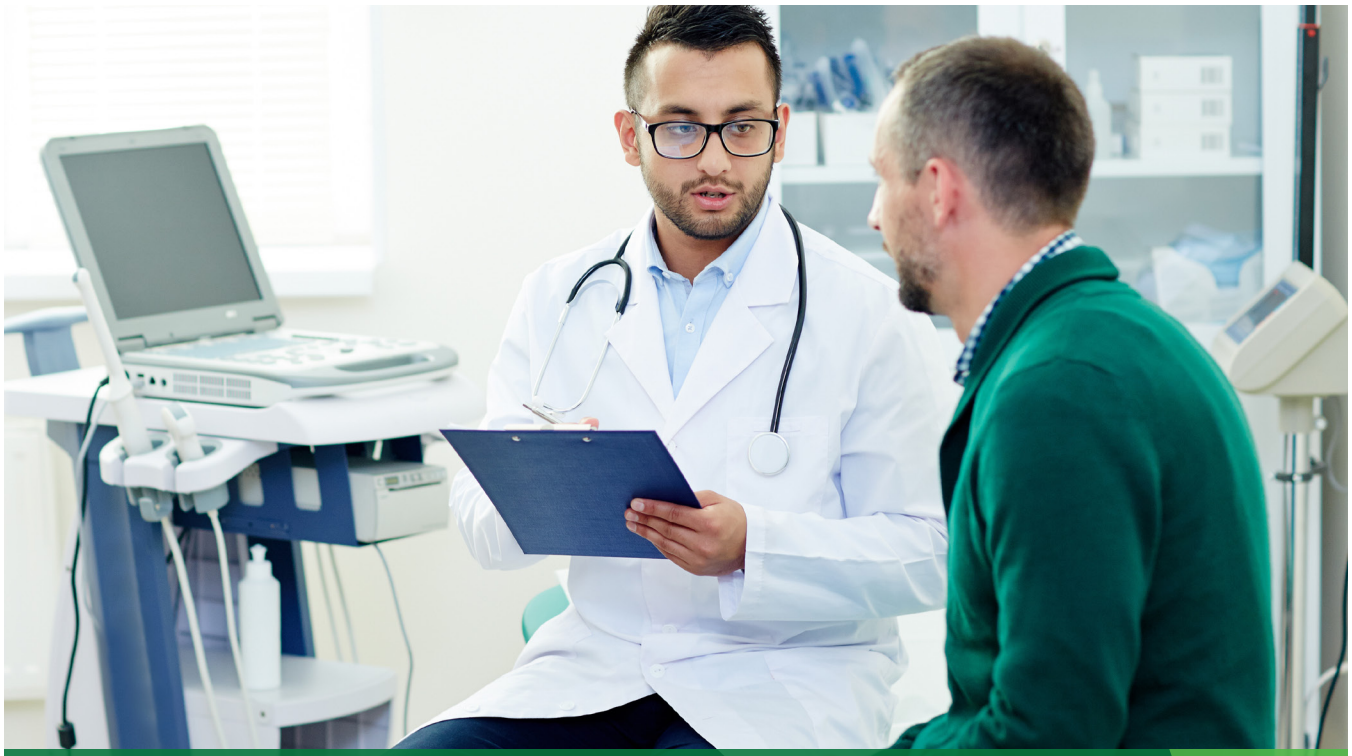

Clinical Ethics and Risk Management:
Patient Well-Being Wins the Day

INTRODUCTION

"Ethicists remind us to be fair, while risk managers remind us to be prepared to be fair,"[1] according to bioethicist David Sine. The two fields are inextricably linked relative to promoting patient well-being.

A primary focus of healthcare risk management is improving patient outcomes and mitigating patient harm. Doing so can reduce liability risk. Although there are many different healthcare ethics frameworks, this article primarily references Beauchamp and Childress' four principles of bioethics (beneficence, nonmaleficence, respect for autonomy, and justice). These principles can be found within many risk management objectives. For example, beneficence (acting for the patient's good) and nonmaleficence (doing no harm) align with meeting the standard of care, and respecting autonomy (a patient's right to make their healthcare decisions) underlies informed consent. The ethical concept of justice (equitably distributing healthcare resources among patients and otherwise treating them fairly) comes up less frequently in liability claims but is useful when problem-solving in situations of healthcare rationing and discrimination.[2,3] According to Beauchamp and Childress, individuals delivering healthcare should follow the four principles in equal measure.[2] In the case of conflict, the respective weights of the competing obligations should be balanced in a deliberate manner to avoid being overly influenced by "gut feelings."[4] Ethical principles are relevant because they provide a structure for analyzing a problem. However, "knowing principles doesn't necessarily correlate with an ethical response in the real world," states Lea Brandt, Director of the University of Missouri Center for Health Ethics. "A sensemaking approach can improve ethical reasoning and response in cases of moral ambiguity."[5]

We interviewed Dr. Brandt for this article. Her views on the ethical issues within the case studies presented are woven throughout this article and support the risk reduction strategies offered.

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WHEN AN ETHICIST ISN'T AVAILABLE: TOOLS YOU CAN USE

We asked Dr. Brandt what physicians' offices and small organizations that may not have access to an ethicist can do when ethical issues arise. To optimize ethical response, she suggests sitting down with trusted colleagues to discuss the issue using sensemaking strategies, such as STICC (Situation, Task, Intent, Concern, Calibrate).[5] For example, the physician bringing the issue to the group might say:

- This is the **situation** that I'm facing…
- I believe I should do … (the **task**).
- I think we should take these steps because … (my **intent**).
- These are the **concerns** I have about my plan…

Calibration in the STICC strategy is asking for reasoning input from the group of colleagues, which is meant to uncover a more complete picture. Prompts to use include:

- What am I missing?
- What did I skip over?
- What might we need to change later?

Dr. Brandt believes that sensemaking strategies allow physicians to address ethics issues with the knowledge and the humility to say, "I don't have all of the answers. Let's reason through this together." These strategies can close gaps in understanding, with each new piece of information gathered during the process providing a springboard for action for the next step. A sensemaking approach like STICC can result in decision-making that is thoughtful and prudent, which is more likely to result in an optimized ethical and clinical response. Alternatively, individuals who rely solely on ethical principles when working through an issue can believe they have all the knowledge needed to solve the problem. In Dr. Brandt's experience, this approach can result in poor ethical outcomes as it does not account for cognitive bias.[5]

Another issue that can get in the way of ethical healthcare delivery, according to Dr. Brandt, is framing an issue in a way that puts the potential liability outcome before patient well-being. She explains, "when considering an ethical issue from a liability risk standpoint, you become physician- or entity-centered, instead of patient-centered." In her experience, "if you as the clinician first ask, 'what's in the medical best interest of this patient?' 'What are my barriers to providing clinically appropriate care?' 'What are my perceived barriers of risk?' and 'How can we navigate those things to still act in the best interest of the patient?' you reduce your legal jeopardy substantially." Her advice for achieving an outcome that is both ethical and low risk is to first focus on what is in the medical best interest of the patient, and then navigate the perceived barriers.[5]

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CASE ONE:
Healthcare Resource Rationing[6]

The COVID-19 pandemic brought attention to various healthcare ethics issues, including healthcare resource allocation—also referred to as rationing. Even in a pandemic, basic healthcare expectations should be met to the greatest extent possible,[7] particularly for liability purposes. The following case study is based on a Connecticut wrongful death case.

> Consider what the cardiologists could have done to reduce the patient's risk of injury.

In a nutshell, a patient who had symptoms of both ST Elevation Myocardial Infarction (STEMI) and COVID-19 was denied admission into a catheterization lab (cath lab), pursuant to the hospital's COVID-19 protocol. The patient was to be denied admission until her COVID-19 test came back negative. She died—never having been admitted to the cath lab—one day after her COVID-19 test came back negative. The patient's family brought a wrongful death action alleging failure to diagnose and treat the patient's STEMI was negligent and caused the patient's death. The defense team argued that the hospital and members of the decedent's healthcare team were immune from liability due to a state COVID-19 executive order in place at the time. The issue of whether liability protections in the executive order applied to the patient's entire hospitalization was appealed to the Connecticut Supreme Court, which determined that the executive order did not apply to the patient's care and treatment that occurred after her COVID-19 test came back negative. Consequently the plaintiffs were entitled to proceed with their lawsuit.

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DISCUSSION

In this case the ethical and liability issues were tightly intertwined. The primary ethical issue presented was whether compliance with policies and protocols created to allocate limited medical resources and control potential spread of COVID-19 should have been prioritized over the decedent's well-being. The underlying liability issue was the failure of the hospital's cardiac team to recognize that the patient was suffering from a critical condition. Complicating the liability issue further, the cath lab COVID-19 policy had a caveat that allowed emergency treatment without a negative COVID-19 test result. The patient's family highlighted the failure to rule out STEMI in their wrongful death lawsuit against the defendant cardiologists. They argued, "but for the misdiagnosis, [the decedent's] COVID-19 status would have been considered irrelevant, and the fact that she was experiencing a STEMI would have compelled the defendants to get her into the [cath] lab quickly."[5]

The cardiologists' decision-making was likely affected by the dearth of information about spread during the early days of COVID-19. Fear of COVID-19 contagion likely influenced the decision to rule out COVID-19 before addressing the STEMI symptoms. One could also argue that two common cognitive biases negatively impacted diagnostic decision-making in this case: premature closure bias and availability bias. The former involves a failure to consider reasonable alternatives once a preliminary diagnosis has been reached. Availability bias can make it more likely that diagnosis is based on what is top of mind, e.g., COVID-19.[8] It is important to keep cognitive bias in mind and use debiasing strategies when it may affect the diagnostic process.

This case also highlights how healthcare rationing can put clinicians in the uncomfortable position of denying care to patients who otherwise would receive those rationed resources. One can argue that physicians have a greater responsibility to serve the patient before them than the broader community. (Plaintiffs in medical liability lawsuits involving rationing would argue this.) From an ethical perspective Dr. Brandt remarks that the physicians in this case likely were not ethically remiss if they were following hospital policy. She explains a utilitarian framework (not the patient-centered Beauchamp and Childress framework) was used during the pandemic to determine how limited resources would be distributed among patients. This resulted in altered standards of care. In a utilitarian framework the objective is obtaining the greatest benefit for the greatest number of people. Problematically, a utilitarian framework was not generally consistent with patient understanding during the pandemic: patients expected to be prioritized over the community. This case also indicates that determinations of the standard of care during the pandemic may conflict with a utilitarian approach to healthcare delivery. (In general, the healthcare provider's duty is to the individual patient in medical professional liability determinations.) Dr. Brandt sees this case and others like it as instructive for hospital and practice administrators: when contemplating future rationing policies and procedures, the standard of care must be carefully considered.[5] Without a clear ethical framework and an understanding of the decision-making process, a rationing policy may not be accepted either by healthcare workers or by patients.[9] Erosion of trust in either group can increase liability risk.

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RISK REDUCTION STRATEGIES

Consider the following strategies:

ADMINISTRATORS

- Have an appeal mechanism in place when implementing rationing policies.
- Make appealing as easy for patients as possible.
- Ensure patients and their families are aware of the appeal process.
- To safeguard fairness, populate the appeals committee with objective third parties.

CLINICIANS

- Understand how to comply with a rationing protocol, including its caveats (e.g., that it does not apply when faced with a medical emergency).
- Carefully consider actions that, though pursuant to a rationing protocol, do not in your opinion comply with the standard of care. Advocate for your patient's use of resources when you believe it is appropriate.
- Be transparent with the patient. Explain the policy and how treatment choices are impacted.
- Do not allow knowledge of a liability waiver contained in policy/legislative documents to affect diagnosis or treatment. Focus on providing clinically appropriate care.
- Interrogate whether your diagnostic process has been affected by cognitive bias arising from a rationing protocol, and take steps to mitigate the risk of misdiagnosis or delayed treatment.

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CASE TWO:
Conscientious Objection

Whether physicians can decline to provide treatment based on conscientious objection without abandoning their professional responsibilities is unsettled. Refusing to provide gender-affirming care and abortions are currently hot topics in the media, courts, legislature, and administrative agencies. In the following case a physician refused to artificially inseminate a patient who was a lesbian because he believed it was against his religion. There is support for physician conscientious objection as a means of maintaining their own moral well-being in both law and medical ethics. However, as this case shows, defending a discriminatory refusal of care is challenging. Dr. Brandt cautions additionally, "You have to use what is medically indicated to guide response. You shouldn't do a procedure that is considered standard of care for one patient and not for another patient because you disagree with that patient's values."[5]

Consider how the physician group practice and physician could have managed the physician's religious objection to providing fertility treatment to women in same-sex relationships. Determine if another approach was less likely to expose the physician to discrimination claims.

In an OB/GYN group practice, fertility services were offered to patients. However, the patient's long-term OB/GYN belonged to a religion that he believed prohibited him from performing artificial insemination for a lesbian, a class that included the patient. There were other physicians in the practice who had no moral objection to providing fertility treatment to lesbians, but they lacked the appropriate license to perform fresh semen artificial insemination, which was the preferred course for this patient. Although there were other physicians in the community who could and would perform the fresh semen artificial insemination, the patient's insurance only covered fertility treatment through this group. Consequently the patient's only option for fresh semen artificial insemination was to pay out of pocket at another practice.

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The patient filed a sexual orientation discrimination case against the physician, who defended his refusal of care with constitutional guarantees of religious liberty. The case ultimately settled.

DISCUSSION

The physician defended his refusal of care based on two different legal theories. He argued that according to the state law, lesbians are not members of a protected class and can therefore be discriminated against. And alternatively he argued that even if lesbians were part of a protected class, the antidiscrimination laws conferring that protection were an unallowable burden on his right to practice religion.

All states have antidiscrimination laws. Some protect individuals against discrimination based on sexual orientation, others do not. Where the state law does not have sexual orientation discrimination protections, however, section 1557 of the Affordable Care Act (ACA) may confer it in a healthcare context. The ACA provides protection against discrimination "on the basis of…sex."[10] The Department of Health and Human Services (HHS) has stated that the ACA prohibits discrimination based on sexual orientation[11] and further, there is no religious exemption to the nondiscrimination provisions of the ACA.[12] However, whether "on the basis of… sex" includes discrimination based on sexual orientation and whether constitutional guarantees of religious liberties trump antidiscrimination laws remains unsettled.[13]

The American College of Obstetricians and Gynecologists (ACOG) provides a framework for "defining the ethically appropriate limits of conscientious refusal in reproductive health contexts." The framework includes four criteria: 1) the potential for imposition of the physician's beliefs on patients, 2) the effect on patient health, 3) the scientific integrity of the facts supporting the physician's claim, and 4) the potential for discrimination.[14] Regarding the first point, which is based in patient autonomy, the physician's choice not to provide artificial insemination arguably imposed his religious beliefs on this patient. This resulted in the patient's inability to obtain covered treatment that was consistent with the standard of care. The second point highlights the ethical principle of nonmaleficence. Often, according to Dr. Brandt, it can be confusing to equate the duty of nonmaleficence with negative action. In this case, however, even though the defendant physician did not cause direct physical harm to the patient, it could be argued that he violated the duty of nonmaleficence by causing the patient emotional and financial harm, and loss of trust.[5] Concerning scientific integrity (point 3), the ACOG guideline notes that physicians who refuse fertility treatment to same-sex couples do so based on the scientifically unfounded grounds that sexual orientation controls fitness to parent.[14] Certainly the fourth point (based on the ethical concept of justice), weighs in favor of the patient in this case. In fact, in its committee opinion on the issue, ACOG uses the example of refusal to provide infertility services to same-sex couples due to conscientious objection, describing it as "oppression."[14]

Dr. Brandt also notes a problem with fidelity in this case. "Physicians make a promise when they enter the profession to put the patient's needs above their own. A physician cannot abandon a patient because they find the patient's life choices repugnant." She sees an ethics case for the physician informing the patient he could not do his best clinical job due to moral conflict, and arranging for a different physician in the practice to take over care. But the fact that the patient could not obtain treatment in this practice made that option ethically untenable.[5]

It would have been preferable for all parties if the defendant physician never had been put in a position where he felt the need to consciously object to providing care. In other words, it is likely the entire conflict could have been avoided if the OB/GYN group had included a physician who was licensed to provide fresh semen artificial insemination and had no objection to providing the service to lesbian patients.

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RISK REDUCTION STRATEGIES

Consider the following strategies:[14, 15, 16]

ADMINISTRATORS

- Discover whether conscientious objection will limit care to patients in a manner that can be interpreted as discriminatory. If this is the case, reconfigure staffing in a way that services are equally available to patients.
- Minimize the circumstances under which members of the healthcare team would be required to act in opposition to their religious beliefs.
  - ► When assigning new patients, be mindful of the likelihood of a particular physician's conscientious objection to that patient's future healthcare.
- If, despite reasonable efforts, chances are high that you will be unable to provide care to patients due to conscientious objection, have reliable referral arrangements. Utilize nearby practices that are willing to take on affected patients within a reasonable time frame and in a manner that is not financially burdensome.

CLINICIANS

- If you have moral or religious objections that limit your ability to provide services to a class of patients, inform administrators. Work to ensure patients have equal access to services through a different clinician within the practice.
- If your moral integrity limits the patients you will serve or the procedures you will perform, be aware of the effects that federal and state antidiscrimination laws could have on your treatment refusals.
- When telling a patient about your conscientious objection, make it about yourself, not about their circumstances. For example, consider: "Based on my own faith tradition I am not able to help you with that. What I can do is answer any medical questions you might have about the procedure and give you information about its availability."[16]

RESOURCES

- ACOG, "The Limits of Conscientious Refusal in Reproductive Medicine."[14]
- Ethics Committee of the American Society for Reproductive Medicine, "Access to Fertility Treatment Irrespective of Marital Status, Sexual Orientation, or Gender Identity: An Ethics Committee opinion."[15]

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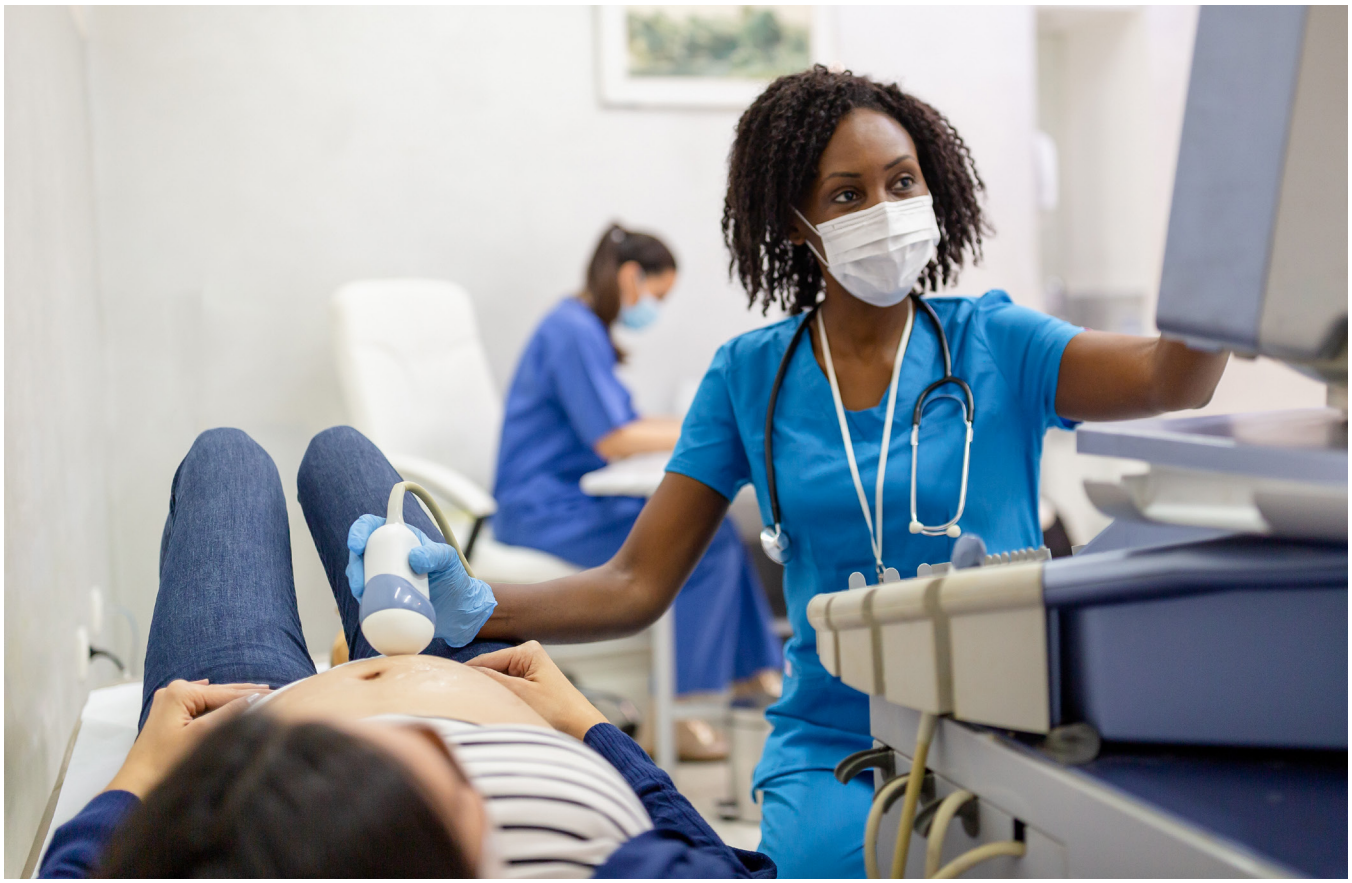

CASE THREE:
C-Section Refusal

One of the most challenging patient autonomy vs. nonmaleficence conflicts arises when a patient refuses a medically indicated C-section for fetal well-being. Luckily this is rare. When told that the fetal heart monitor indicates the need for a C-section, most women consent when advised of the potential consequences of continuing labor.[17] In this case, however, the patient simply would not consent.

> Consider what the obstetrician could have done during the prenatal period to reduce the risk of patient resistance to a medically indicated C-section.

A patient had meticulously planned for a natural childbirth, which she laid out in a birth plan. Within the birth plan she made it clear that she did not want a C-section. She shared her birth plan document with her obstetrician (OB) early in her pregnancy. He put it in her medical record and they never discussed it again. After an uncomplicated pregnancy the patient was admitted to the labor and delivery department in active labor at 1:20 a.m. She gave a copy of her birth plan to a labor and delivery nurse when she was roomed. The OB who followed her during the prenatal period was the attending physician during labor and delivery.

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1:20 a.m.	The patient was 4 cm dilated, 80% effaced, and at -2 station. The fetal heart rate (FHR) tracing was Category I.
10:30 a.m.	The OB noted minimal variability and recurrent lengthy variable decelerations. The patient had not progressed after an hour of pushing. Based on these factors, he recommended C-section. The patient refused, citing her desire for a vaginal delivery. Over the next two hours, the OB continued trying to obtain consent.
12:12 p.m.	The OB called for an emergency C-section.
12:20 p.m.	The OB obtained consent for a C-section.
12:58 p.m.	The infant was delivered with Apgar scores of 0/4/7.

The infant was later diagnosed with cerebral palsy, motor delays, and spasticity. She would require full-time attendant care for the rest of her life. Her parents sued the hospital and all members of the labor and delivery team, alleging the delayed delivery caused the brain injuries. The mother denied being informed that continuing labor could result in her child's brain injury.

This case was settled for a variety of reasons, including negative standard of care reviews. Other reasons included no documentation of the patient's C-section refusal, the physician's efforts to obtain informed consent, or the risks of continued labor he communicated. Additionally, there was high likelihood that the jury would be influenced by the grieving parents and a young child with significant birth injuries.

DISCUSSION

In terms of ethical principles, this scenario presents conflict between the principles of respect for patient autonomy and nonmaleficence (doing no harm to a viable fetus).[18] Considering the potential endpoint of this labor if the team prioritizes nonmaleficence towards the fetus (forcibly performing surgery on a competent patient), or prioritizes patient autonomy (the fetus dies or suffers significant injures), the objective should be to avoid a situation like this entirely.

Women refuse recommended C-sections for various reasons including fear, cost, cultural or religious beliefs, and—as in this case—failure to understand the gravity of the situation coupled with a strong desire for natural childbirth.[17] In Dr. Brandt's experience as a clinical ethics consultant, in the large majority of cases involving patients who are refusing an emergency C-section, the team has not uncovered the reason for refusal. When Dr. Brandt facilitates the discussion between the patient and team after exploring why the patient is refusing, she advises team members to explain how serious the situation is, and then why the team so strongly recommends a C-section. Dr. Brandt recommends that physicians clearly state their discomfort with the possibility that the patient and baby could die—using unequivocal language. But in addition to clearly stating the risks associated with a refusal of treatment, Dr. Brandt believes it is important to ensure patients feel cared about. Using language like, "I want to do what's best for you. I care about you," can reduce a patient's assumption of negative intent and lead to better conversations.[5]

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Ideally, this C-section refusal would have been prevented. Birth plans provide an excellent patient safety and risk management opportunity. With a birth plan and multiple appointments during which the risks, benefits, and alternatives associated with the patient's documented choices can be discussed, OBs have a unique opportunity for shared decision-making. The defendant OB could have used the patient's birth plan to prepare the patient for the various circumstances when continued labor poses too much risk to fetal well-being. Had these discussions taken place during the prenatal period the patient might not have been as resistant, the delivery might have occurred earlier, and the fetal injury might not have occurred. Taking a proactive approach to patient education can lay the groundwork for obtaining an informed consent when a C-section becomes necessary.

RISK REDUCTION STRATEGIES

Consider the following strategies:[17, 19]

BEFORE LABOR AND DELIVERY

- Discover whether the patient has a birth plan.
- Over as many appointments as necessary, negotiate appropriate revision(s) of the birth plan.
- Discuss the potential for complications during the birth process and how C-section may be required to safeguard the well-being of patient and/or fetus.
- Document informed refusal and continue to educate the patient about the potential for fetal/maternal injuries if the birth plan is followed.
- Ensure the birth plan is delivered to the hospital where the patient will give birth. Flag birth plan issues that may impact emergency response during labor and delivery.

DURING LABOR AND DELIVERY

- Try to understand the rationale and motivation behind a patient's refusal. Dr. Brandt suggests introducing a dialogue with something like this: "We talked about how first and foremost; you want a healthy baby. I know you want to have a healthy baby, and to help us ensure that happens, in my medical opinion we need to move forward with a C-section. So, let's talk through what your concerns still might be."[5]
- Ensure that the patient understands the potential consequences of delaying delivery with a Category III tracing.
  - ► Have the patient talk to a neonatologist.
  - ► Suggest consultation for a second opinion with a different OB.
- Bring others (e.g., husband or partner, social worker, cultural/religious liaison) into the decision-making process when appropriate.
- Document all aspects of the conversation thoroughly, including the time conversations took place.

RESOURCE

ACOG, "Refusal of Medically Recommended Treatment During Pregnancy."[19]

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CASE FOUR:
Resuscitation of a Patient with a DNR

In a perfect world, patients' wishes about life-sustaining treatment would be abundantly clear to their families, close friends, medical providers, and whoever else becomes responsible for their end-of-life care. In our imperfect world, family and members of the healthcare team may have different understandings about the patient's end-of-life wishes, and documentation in the medical record is often unclear.

> Consider how the outcome may have been different if the healthcare team had a better system in place to ensure the patient's end-of-life wishes were honored.

The patient, a 40-year-old woman with several chronic conditions, was a long-term resident of a skilled nursing facility (SNF). Her file at the SNF contained a Provider Orders for Life-Sustaining Treatment (POLST) form, which indicated the patient should not be resuscitated (DNR) if she went into cardiopulmonary arrest.

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On a Monday the patient was admitted to the hospital. She brought the POLST form with her, and it was scanned into the EHR. She was competent until Thursday when she suffered a cardiac arrest. She was resuscitated and intubated. Her prognosis was poor. When her father (her healthcare agent) was notified, he was upset that she had been resuscitated because his understanding was that his daughter did not want to be resuscitated. He was informed that his daughter had changed her status to full code at hospital admission. A week later the father consented to the removal of his daughter's life support, and she died shortly thereafter. He filed a lawsuit against the hospital and healthcare team. The lawsuit alleged negligent infliction of emotional distress related to the period following the resuscitation, particularly when he was put in the position of having to consent to the removal of life support.

DISCUSSION

Various issues complicated the defense of this case. There was no evidence in the medical record of a DNR change—the admitting nurse's testimony would be the only evidence. The failure to document the change of the code status was a violation of hospital policy. And finally the hospital never contacted the patient's healthcare agent to inform him of the alleged change.

This case highlights legal, ethical, and emotional differences between withholding and withdrawing life-sustaining treatment. The father in this case argued he never intended to make a withdrawal of treatment decision because there was a DNR order. He believed he deserved compensation for the emotional injury he suffered from the hospital's alleged negligence in failing to comply with his daughter's DNR. (He alleged the hospital's claim that his daughter changed her DNR to full code was fraudulent.)

In Dr. Brandt's opinion, if CPR was not clinically indicated for this patient based on her goals of care and/or limitations of treatment, then the resuscitation attempt was ethically problematic. Because code status often defaults to full code even when CPR is futile, there is often tension between autonomy and beneficence/nonmaleficence. In other words, competent patients have a right to choose not to be resuscitated, and when limitations of CPR and the risk for harm is not clearly explained to patients, resuscitation attempts can violate the duty of nonmaleficence. If the patient requested a change to her code status at admission, one of her physicians should have had a discussion to "make sense" of the change in her directive. Communication strategies should include an overview of the clinical situation and reasonable expectations for CPR success as well as an exploration of patient values, intent, and fears. These types of conversations can minimize risk for subjecting the patient to burdensome, ineffective interventions. The objective should be closing gaps in understanding to determine what is in the patient's medical best interest. "It's our job as healthcare providers to make sure we're matching what's clinically indicated with what treatment patients are receiving. We don't do that well with regard to CPR," says Dr. Brandt. "If we had better processes for code status conversations, there is lower likelihood these types of cases will occur."[5]

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RISK REDUCTION STRATEGIES

Consider the following strategies:[20]

CLINICIANS/STAFF

- When first encountering a patient with documented end-of-life preferences, ascertain whether they accurately reflect their current end-of-life intervention preferences. Document necessary changes.
- Advise healthcare agents about changes a patient makes to end-of-life preferences as they occur.
- Be particularly vigilant about checking for DNR/POLST orders when a nursing home or SNF patient with a preexisting, life-limiting medical condition has been transferred, especially during a healthcare emergency.

ADMINISTRATORS

- Make sure through policy and protocol that the patient's DNR status is prominently displayed and easily located.
- Ensure there is a standard protocol for documenting changes to end-of-life treatment choices in the patient record. Also ensure that all members of the patient's healthcare team will have access to the updated information.
- Train clinicians and staff to handle tasks that involve ethical decision-making.

RESOURCE

American Medical Association, Code of Medical Ethics—Opinion 5.4: Orders Not to Attempt Resuscitation (DNAR)[21]

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CONCLUSION

The fields of healthcare ethics and risk management are intertwined, both aiming to promote patient well-being and autonomy. Bioethicists Beauchamp and Childress propose a framework of four principles for healthcare delivery: beneficence, nonmaleficence, respect for autonomy, and justice. When these principles conflict, they are weighed against each other to suggest an appropriate course of action. Dr. Brandt believes ethical principles provide a framework for ethical analysis, but that knowing and applying the principles to a given clinical scenario do not necessarily correlate with an ethical response. She recommends a sensemaking approach to improve ethical reasoning and response in cases of moral ambiguity.[5] This article has explored the intersection of healthcare ethics and risk management through case study analysis to provide strategies that mitigate liability risk and achieve ethical results.

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ENDNOTES

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1. David Sine, "Risk Management Ethics," *AMA Journal of Ethics* 22, no. 11 (2020): E909-910. https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2020-11/joe-2011.pdf.
2. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 7th ed. (New York: Oxford University Press, 2012), 99-288.
3. Alber R. Jonsen, Mark Siegler, and William J. Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, 7th ed. (New York: McGraw Hill, 2010), chap. 1.
4. Rosalind McDougall, Cade Shadbolt, and Lynn Gillam, "The Practice of Balancing in Clinical Ethics Case Consultation," *Clinical Ethics* 15, no. 1 (2020): 49-55. https://doi.org/10.1177/1477750919897377.
5. Lea C. Brandt, PhD, OTD, MA (Director, University of Missouri Center for Health Ethics), interviewed by Mary-Lynn Ryan, November 15, 2023.
6. Mills v. Hartford Healthcare, 2021 WL 4895676, https://jud.ct.gov/external/supapp/Cases/AROcr/CR347/347CR68.pdf.
7. Kasper Raus, Eric Mortier, and Kristof Eeckloo, "Ethical Issues in Managing the COVID-19 Pandemic," *Bioethics* 35, no. 6 (2021): 581–588, https://doi.org/10.1111/bioe.12877.
8. Christina N. DiMaria et al., "Cognitive Bias in the COVID-19 Pandemic," *Cureus* 12, no. 7 (2020): e9019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7405980/.
9. G. Srinivas et al., "Ethical Rationing of Healthcare Resources During COVID-19 Outbreak: Review," *Ethics, Medicine and Public Health* 16 (2021): 100633, https://doi.org/10.1016/j.jemep.2021.100633.
10. Rachel Kogan, Katherine L. Kraschel, and Claudia E. Haupt, "Which Legal Approaches Help Limit Harms to Patients From Clinicians' Conscience-Based Refusals?" *AMA Journal of Ethics* 22, no. 3 (2020): E209-216, https://doi.org/10.1001/amajethics.2020.209.
11. "Court Sets Aside HHS Interpretation That ACA Section 1557 Prohibits Discrimination on the Basis of Sexual Orientation or Gender Identity," Thomson Reuters, November 23, 2022, https://tax.thomsonreuters.com/blog/court-sets-aside-hhs-interpretation-that-aca-section-1557-prohibits-discrimination-on-the-basis-of-sexual-orientation-or-gender-identity/.
12. "Section 1557: Frequently Asked Questions," U.S. Department of Health and Human Services, last reviewed May 18, 2017, https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html#:~:text=Section%201557%20makes%20it%20unlawful,%2C%20sex%2C%20age%20or%20disability.
13. Eric Heisig, "Obamacare LGBTQ+ Discrimination Clause Could Cause Circuit Split," Bloomberg Law, December 6, 2023, https://news.bloomberglaw.com/litigation/obamacare-lgbtq-discrimination-clause-could-cause-circuit-split.
14. "The Limits of Conscientious Refusal in Reproductive Medicine," Committee Opinion Number 385, reaffirmed 2019, ACOG, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2007/11/the-limits-of-conscientious-refusal-in-reproductive-medicine.
15. Sigal Klipstein et al., "Access to Fertility Treatment Irrespective of Marital Status, Sexual Orientation, or Gender Identity: An Ethics Committee Opinion," *Fertility and Sterility* 116, no. 2 (2021): 326-330, https://doi.org/10.1016/j.fertnstert.2021.03.034.
16. Margaret Little and Anne Drapkin Lyerly, "The Limits of Conscientious Refusal: A Duty to Ensure Access," Virtual Mentor, *AMA Journal of Ethics,* 15, no. 3 (2013): 257-262, https://doi.org/10.1001/virtualmentor.2013.15.3.oped1-1303.
17. Neha A. Deshpande and Corrina M. Oxford, "Management of Pregnant Patients Who Refuse Medically Indicated Cesarean Delivery," *Reviews in Obstetrics & Gynecology* 5, nos. 3-4 (2012): e144-e150, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3594862/.
18. Bernard Lo, *Resolving Ethical Dilemmas: A Guide for Clinicians*, 6th ed. (Pennsylvania: Wolters Kluwer 2020), 80.
19. "Refusal of Medically Recommended Treatment During Pregnancy," Committee Opinion Number 664, reaffirmed 2019, ACOG, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2016/06/refusal-of-medically-recommended-treatment-during-pregnancy.
20. "Do-Not-Resuscitate Orders," ECRI, February 12, 2018, https://www.ecri.org/components/HRC/Pages/Eth3.aspx (membership required for access).
21. "Opinion 5.4: Orders Not To Attempt Resuscitation (DNAR)," American Medical Association Code of Medical Ethics (website), accessed November 9, 2023, https://code-medical-ethics.ama-assn.org/ethics-opinions/orders-not-attempt-resuscitation-dnar.

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