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The mission of the Center for Ethics at MedStar Washington Hospital Center is to help clinicians and other hospital professionals meet a standard of excellence in the care of our patients through education, training, consultation, policy development, and research in clinical ethics. Additionally, when appropriate, we address the ethical concerns of our patients and families directly.

The Washington Hospital Center bioethics program began in 1982. The Center for Ethics, subsequently established, is involved in over 250 clinical ethics consultations a year, as well as the development of internationally recognized bioethics conferences and education programming.

The Clinical Ethics Immersion (CEI) program is the original experiential and simulation-based education program in clinical bioethics. The CEI is held biannually and is hosted and directed by the faculty and staff of the Center for Ethics. This 4-day course focuses on the institutional development of bioethics programming and practical reasoning in clinical ethics consultation. Participants round with senior clinical ethicists in intensive care units, respond to case consultation requests, and engage in discussions with resident and guest faculty to include topics such as intensive and emergent care, law, moral philosophy, psychiatry, and other subjects essential to the practice of clinical ethics. In addition, participants engage in simulated consultations with trained actors in bioethics consultation, policy development, and research in clinical ethics. Additionally, when appropriate, we address the ethical concerns of our patients and families directly.

The John J. Lynch, MD Moral Courage Awards, named after the founder and Medical Director of the Center for Ethics, is a biennial, virtue theory-based program in recognition of individuals who have exemplified courage when acting against difficult and ethically challenging circumstances. These awards are given in 7 categories (Advanced Practice Clinician, Attending Physician, Fellow Physician, Non-clinical Associate, Nurse, Resident Physician, and Social Worker/Case Manager), and are selected from nominations by hospital associates. Established at the Center for Ethics in 2010, these awards have become a way in which hospital leaders can communicate about values they consider central to creating and sustaining an ethically sound climate in the hospital.
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Dear Reader,

Welcome to the first issue of our fourth volume. We do apologize for the delay between this and our last. We thank you for your continued patience.

The problem of not having enough time to do everything well is at least a problem with which I know our readers are familiar. When it comes to this issue’s focus, it is critical in a hospital that we communicate well while we’re often running low on time. Fortunately, lack of time need not be the enemy of good, and often healing, communication. Whether we are talking with patients, their family and friends, or our colleagues, we can communicate in ways that advance healing in our patients and are soothing to everyone else.

I have come to believe, after 35 years of observing physicians, that the most relevant skill here is to know how to be fully present. We know that physicians can establish rapport with patients in the briefest of encounters. In my work as a clinical ethicist, I have found the same to be true; if I am fully present to a patient, a surrogate, or a clinician, I can create a trusting relationship. This remains true even when our conversation is on the fly. One can tell if another is present or not, and it’s a skill we can all learn, as well as improve.

I was talking to one of our star transplant cardiologists, George Ruiz (Director, Pulmonary Hypertension Unit, MedStar Heart Institute), about how to train our residents to be fully present to our patients. He’s one of the busiest guys I know, but he always makes you feel like you can stop him and have a substantive conversation, even for a few short minutes. When I asked him how he thought best to approach teaching this skill to the residents, he replied, “This might sound a bit Buddhist, but I work to be here now.” He’s not a practicing Buddhist. But I know him to be someone who definitely works at being in the moment. I’ve seen him silent and close to tears with a grieving family and then as soon as he’s out the door, he’s back to his happy, talkative self. And it’s not faked. George won our hospital’s Moral Courage Award (Attending Physician, more on that below). He is one of the most decent, genuine physicians I know. He’s just an all-around wonderful human and a wonderful doc. Granted, he was seemingly born with the happiness gene, but I don’t think

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Communication: Toward Better Understanding

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that’s all there is to it. Rather, he has just taught himself to be here now so that no matter with whom he is speaking, he is totally present.

To learn this skill, there are some obvious requirements, such as habituating oneself to having one’s electronic devices on silent and disciplining oneself not to respond to our electronic leashes the minute they go off. But I think the really hard part of the be here now skill set is emotional focus. Being present requires being emotionally open to and focused on the patient, the patient’s family or friend, or one’s colleague.

For hospital clinicians, be they physicians, nurses, social workers, respiratory therapists, or others, each has the Aristotelian virtue problem, similar to the porridge selection problem in the fable of Goldilocks and the Three Bears. One has to discern which is too hot and which is too cold, and pick the one that is just right. That is, depending on the acuity and severity of the relevant patient population, one needs to learn how not to expend so much emotional capital that one is left rung out. At the same time, one ought not to become so armored as to create too hard a shell. Instead, one wants to find the degree of emotional openness and focus that is just right.

And so, as I now turn to introducing you to our issue on communication, I encourage us all to work on improving our skills to be here now. Perfecting the skill of being present to patients and their families, as well as to our friends and our colleagues, is central to creating a hospital environment conducive to healing communication. But before moving into the issue’s contents, I’ll briefly explain our Moral Courage Awards and how they fit into our communication theme.

Named after the Medical Director of the Center for Ethics at MedStar Washington Hospital Center, who also serves as Medical Editor for JOHE, the John J. Lynch, MD Moral Courage Awards are given in 7 categories: Advanced Practice Clinician, Attending Physician, Fellow Physician, Non-clinical Associate, Nurse, Resident Physician, and Social Worker/Case Manager.

Hospital associates can vote for every category, nominating whomever and however many one believes deserving. The only requirement is that each nomination be accompanied by a narrative illustrating why the nominee is worthy in relation to our definition of moral courage: physicians, nurses, social workers, non-clinical, and other staff throughout the hospital who have exemplified the virtue of courage and acted against difficult and ethically challenging circumstances.

These awards were created to honor Jack’s more than 50 years of being unflaggingly courageous, the physician champion of ethics in our hospital and at the MedStar corporate board level, and the epitome of the virtuous physician. Since we started this award program in 2010, running it every other year, what it has become is a way by which our hospital’s leadership can communicate about values they consider central to creating and sustaining an ethically sound climate in the hospital. The generation of pride occurring within the various departments and units when they produce Moral Courage Award winners has been deeply gratifying to watch. We have encouraged others in the field to start similar programs within their institutions. For anyone so inclined, we’re happy to assist with more details. Here it should suffice that the kind of communication encouraged by these awards is just one way to improve. The several articles and cases of this issue illuminate various others.
This issue begins with Jason Batten’s critical piece on moving away from proposed concepts that attempt to distinguish (and meet) ethical standards in clinical practice, and instead focusing on communication as a better source for the possibility of assessing and improving the quality of ethics consultation processes.

Following that is an important piece by Amanda Anderson addressing the US press’s handling of nurse involvement in the Ebola crisis as an exemplar of how invisible nurses can be within a hospital, making a cogent argument for devoting resources to training bedside nurses to be prepared to be called on to speak to the public media by their hospitals. As we inevitably face the kinds of infectious outbreaks that garner national attention, it is bedside nurses who will be witnesses, and perhaps victims, to patient care. Their voices are important and need to be heard in fully articulated and personalized ways.

We then present Josh Hyatt’s timely piece on the ethical importance of having clinicians become more sensitized to the specialized communication needs of the LGBT community. Also, our first case analysis is about perception and communication surrounding the care of a homosexual patient. Little did we know (or even think) when we started talking to Josh and our Consult Corner guest editor, Lauren Edelstein, about developing these pieces how timely they would be. But with the landmark US Supreme Court decision on same-sex marriage, the increased well-being of the LGBT community is in the forefront of everyone’s mind. We are especially appreciative for the opportunity to spotlight improved communication skills for caring for members of this community in hospitals where JOHE is read across the country.

Finally, I took the opportunity to write on a topic that is dear to my heart—physician leadership communication. We’re all familiar with the old adage that a physician can often have the ability to get a patient to do just about anything he or she wants. Certainly, like any old maxim, it’s only true part of the time. What is important may be to contemplate the ways in which it is true and when its manifestation is for good or ill. Taking the topic from an organizational ethics viewpoint, I have tried to speak frankly but respectfully about the power of the physician leader to advance the ethical climate of a hospital.

Abuse of physician power is not a well-explored topic. In fact, unprofessional physician communication has lacked accountability for too long. Fortunately, that practiced lack of accountability seems to be coming to an end; the data on how it makes for an unsafe hospital are mounting too high to ignore. The natural leadership position of the physician allows her or him a distinct and uniquely powerful opportunity to elevate the ethical quality of the hospital’s general tenor. Everyone appreciates that physicians are natural leaders within their teams and groups. Certainly, there are some knowledge, responsibility, as well as liability-based reasons for that. However, the real reason, I think, that even the meanest physicians may remain the natural leaders of their teams and groups is the healing relationship that is unique to the patient/doctor encounter. Indeed, the power differential of that dyad, and the profound need of the patient to be able to trust in the good will of the physician, places the physician in an irreconcilable power position. And so, from this assumption, I hope I have mounted a useful argument that this privileged position gives the physician the possibility

And so, as I now turn to introducing you to our issue on communication, I encourage us all to work on improving our skills to be here now.
for setting a high standard for respectful communication. Taking this possibility seriously enough to do the hard self-reflective work for improvement is bound to reap significant rewards.

Turning to the other sections of our issue, we want to thank Lauren Edelstein for serving as Guest Editor for The Consult Corner. She worked with us patiently and helped shape our case scenarios while contributing to the reasoning of the communication-relevant aspects of our analyses. Lastly, Jack Sava, Director of Trauma here at the hospital and a member of JOHE’s Editorial Advisory Board, has demonstrated unflagging support to this journal, for which we are very grateful. Because we consider JOHE a way to meet the educational mission of the Center, we consider training residents one of the most important things we do. Jack’s contribution for this issue’s Residents’ Corner precisely addresses the educational needs of our surgical resident readers and their mentors, for which we thank him.

So that is pretty much that. Hoping what is written is why you continue to subscribe.

Take care,

Evan DeRenzo, PhD
Editor-in-Chief
Assessing Communication to Improve the Quality of Clinical Ethics Consultation

Jason Batten, MA

Leaders in the field of clinical ethics maintain that the goal of clinical ethics is “to improve the quality of patient care by identifying, analyzing, and attempting to resolve the ethical problems that arise in practice.” One service that aims to do this is clinical ethics consultation (CEC), in which an ethics consultant or committee attempts to resolve an ethical problem in patient care by providing recommendation(s) and/or facilitating a resolution to the problem. Given that one of the goals of clinical ethics programs is to improve the quality of care, and given the widespread focus on quality improvement in the US healthcare system more generally, it is not surprising that significant discussion has taken place in recent decades about how we might assess the quality of CEC. In particular, some have considered ways to evaluate “how ethical” the results of CEC are—that is, whether the recommendations and resolutions generated by the service, and the resulting clinical decisions and actions are, in fact, ethically appropriate.

The most concrete proposal for evaluating CEC in this manner is ethicality. Ethicality was proposed in a 1996 issue of the Journal of Clinical Ethics, and has since been incorporated into the second edition of the Core Competencies for Health Care Ethics Consultation. In the Core Competencies, ethicality is defined as “the degree to which clinical practices conform to established ethical standards,” although the report notes, “It is often more practical to examine…whether ethics consultants’ recommendations were consistent with ethical standards.” Examples of such standards include: “obtaining informed consent for medical interventions,
assessing patients’ decision-making capacity, withdrawing life-sustaining interventions from a dying patient, and respecting patients’ Advance Directives.” While these are undoubtedly important considerations in CEC, ethicality faces several limitations in practice. I discuss 3 of these limitations here.

First, there are design concerns: What form could a set of ethical standards possibly take? If ethicality evaluates the degree to which CEC resolutions and recommendations conform to a set of established ethical standards, then we must be able to create a set of such standards that is practically useful. However, both the structure and implementation of the suggested standards are unclear. In considering the structure of the standards, the Core Competencies suggests conflicting ideas. On the one hand, the report suggests that the standards should be used to evaluate recommendations in a binary manner: “One would have to determine whether ethics consultation resulted in decisions or actions that are consistent with established ethical standards.” Hence, the standards would function like a checklist where each standard could be identified as met or not met. On the other hand, ethicality is a matter of degree according to its definition. In this case, a standard might be described as one end of a spectrum, indicating an ethical ideal. CEC recommendations could then be assigned a place along the spectrum depending on their degree of conformance to the standard in question.

While this issue is surmountable, it is not a trivial matter, since standard design is intimately connected to standard use and relevance. In addition, whatever their structure, it is unclear how the standards might be implemented in actual cases. Would the set of ethical standards be one-size-fits-all, or would there be a master list of standards from which we would invoke and specify the most relevant on a case-by-case basis? Ethicality has not yet been sufficiently described in order to allow us to move forward with the creation of useful ethical standards.

Second, and more troubling than design hurdles, is the reality that CEC is practiced in a context of moral pluralism. The care team, patient, surrogate, family, and institution are all stakeholders, each of whom has a set of moral values, beliefs, or policies that are likely to differ from one another. These differences in moral viewpoint and worldview often make it difficult for stakeholders to agree on what the most ethically appropriate course of action is in any particular case. Ethicality, however, requires the creation of ethical standards, which are, in essence, statements of what is believed to be ethically appropriate. Aside from the fact that it is unclear who ought to create these standards, how can we expect the morally diverse stakeholders of CEC to agree to them? Rasmussen states the problem more directly: “The idea that consensus exists regarding what constitutes an ‘ethically acceptable’ choice in a clinical ethics consultation outcome is patently absurd.” The diverse moral judgments of stakeholders in clinical cases make it extremely difficult, if not impossible, to agree upon a single set of ethical standards.

Third, even in cases where all stakeholders might agree on a relevant ethical standard, CEC often deals with situations of conflict, confusion, ambivalence, and uncertainty. These situations trigger a consultation precisely because the application of shared ethical standards is unclear or problematic. As an example, consider one of

In considering the structure of the standards, the Core Competencies suggests conflicting ideas.
the proposed standards for ethicality: respecting patients’ Advance Directives. While this standard does not often engender disagreement among stakeholders in principle, adhering to it in practice is not so simple. For example, Smith, Lo, and Sudore observe that when patients lack decision-making capacity, physicians and surrogates often have to discuss situations that are not directly addressed in a patient’s Advance Directive. In these discussions, our respect for the patient’s Advance Directive is rightly tempered by our consideration of the patient’s best interests; there is a clear interplay (and sometimes conflict) between 2 ethical principles. In such cases, Smith et al note, “There are no absolute right answers that apply to all patients.” To provide guidance in reaching an ethical resolution in these cases, the authors propose a framework of 5 questions that “ensure that key issues are considered” (eg, How well does the Advance Directive fit the situation at hand?). Significantly, this approach “is not meant to reduce complex decisions into a simplistic algorithm.” It is difficult to see how any set of ethical standards, no matter how carefully constructed they are, can avoid this reduction. To create ethical standards is to pre-define what is ethically appropriate and what is not, which will likely fail to accommodate the true
cation and moral deliberation. Agich argues that “quality in ethics consultation can and should be meaningfully addressed...by focusing on the actual processes by which ethics consultants respond to consultation requests.”

CEC is, by nature, a deliberative endeavor; assessing communication, therefore, focuses on the central processes by which consultations arrive at recommendations. Furthermore, I argue elsewhere that, in general, assessment of process captures the quality of CEC more directly than assessment of outcomes. It follows that assessing communication may be more indicative of CEC quality than assessing the resulting recommendations.

The advantages of assessing the quality of communication in CEC, rather than evaluating the ethicality of recommendations, are several. First, assessing communication does not require us to resolve the difficulties posed by moral pluralism. As noted by Crigger and Wynia, “[t]here might be no substantive agreement on how a particular ethical issue should be settled, but there is likely to be broad agreement on who should be at the table and the issues that need to be discussed.” We can agree to a discussion, and probably certain features of that discussion (eg, who the decision maker should be), even if we do not ultimately agree on the most ethi-

The work of clinical ethics is to critically reflect and deliberate upon the most ethically appropriate course of action in each case; ethical standards cannot do this work for us.
Due to the lack of consensus on CEC approach and the lack of national procedural standards, those interested in evaluating CEC communication will have to clearly describe their own processes of interest. Target communication processes can be described by an ethicist or ethics committee, or obtained by referencing educational guides to CEC.\textsuperscript{15,16} For example, the physician(s) involved in the case ought to clearly communicate a comprehensive picture of the clinical situation, including diagnosis, prognosis, available treatment options, and level(s) of certainty. The patient or surrogate (if available) ought to describe the values and preferences of the patient, as well as clearly communicate acceptance of any recommendations. Any involved clinicians or healthcare staff ought to clearly communicate if providing the chosen treatment option poses a threat to their personal integrity or induces a sense of moral distress. The clinical ethicist ought to clearly explain the decision-making process and all ethically permissible options and their reasoning. These communication processes are intended as illustrative examples only and not as representative of all of the communication processes that may occur in CEC. Communication processes can also be defined and tailored to fit one’s institutional environment and chosen method of CEC.

Notably, defining and attending to good communication helps to clarify the role of each individual in the moral deliberation process. For example, it is easy for physicians to assume that they should argue for whatever treatment option they see as most appropriate. Defining relevant communication processes helps to clarify that their role, especially in situations of disagreement, is to communicate the clinical situation, offer recommendations based on the patient’s values and interests, and express their willingness, or lack thereof, to provide any chosen treatment.

After specifying relevant target processes, the current quality of communication can be assessed. This is relatively straightforward, at least conceptually. For example, several studies have been published analyzing the quality of communication in ICU and PICU family conferences based on meeting transcripts.\textsuperscript{17,18} Similar approaches might be used to assess CEC communication. There are also less-rigorous means of gathering data that are appropriate for routine quality monitoring: post-consultation interviews or surveys, analysis of recordings or observation notes, feedback from external observers, or retrospective self-assessment against a checklist. These methods can provide a snapshot assessment of overall CEC communication quality, or can be used to focus extensively on a particular aspect of communication.

In closing, I respond to a probable objection to this approach. It might be claimed that by focusing on communication, we are no longer assessing the ethics of CEC recommendations per se and instead reach for “lower-hanging fruit.” While it is true that we are no longer assessing whether CEC recommendations conform to any predefined notion of what is ethically appropriate, we are not taking the easy way out by assessing communication. Given the reality of moral pluralism and the nature of moral decision-making, it is more appropriate to assess the quality of relevant communication processes than the degree to which ethics recommendations conform to set ethical standards. It seems unlikely that anyone will, in the near future, design a feasible, reliable, and agreed-upon method of assessing how ethically appropriate CEC recommendations are. That being said, since we are interested in improving the quality of CEC now, a feasible and helpful evaluative approach is needed. Assessment of relevant communication processes is a strong candidate.

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References
Connecting Nurses’ Voices at the Bedside and in the Public Media:

The Need for Communication Training and Recognition

Amanda Anderson RN, BSN, CCRN

INTRODUCTION

Although the American Nurses Association explicitly calls for nurses to speak up,\(^1\) often they do not. There are likely so many factors contributing to this phenomenon that they are too numerous to offer a full account here. Instead, this article focuses on just one possible contributor—the need for greater communication training for nurses—and touches on an increasing need for education about the breadth and scope of nursing practice in order to help engender an appropriate public recognition of its distinct insight and contribution.

Focusing on the need for nurse communication training may seem odd to many clinicians because many likely believe that nurses are pretty good at speaking up. Certainly many nurses are more forthcoming today than in the past. With nurse independence growing in all sorts of care areas, one may assume that there are commensurate moves towards independence in nurse communication. The data, however, do not bear out this hunch. Rather, and despite that a large portion of a nurse’s job is communication, many nurses consistently report lacking confidence in bedside communication skills. Poor communication skills and failures in recognizing the invaluable work of nurses lead to failed nurse/physician relationships, are a source of job dissatisfaction, and contribute to nurses’ moral distress.\(^2\)

Patient outcomes are also negatively affected when nurses lack confidence around good communication skills.\(^3\) These bedside communication problems have been reflected in recent media coverage of the first Ebola patients treated in the United States. The need for more communication training for staff nurses is illu-
minated by how the public media involved nurses, compared to other clinicians. That is, while other clinician categories are usually named when quoted, most notably physicians, nurses are not. This phenomenon is as yet not well understood but it appears to mirror the kind of invisibility some nurses feel about their ability to be heard at the bedside. Thus, scrutinizing how nurses were identified, or not, in media coverage during the recent US Ebola crisis can provide insights into nurses’ problems of not speaking up at the bedside.

**HOW MEDIA COVERAGE OF THE EBOLA CRISIS EXEMPLIFIES NEEDED IMPROVEMENT**

In the fall of 2014, American medical workers with Ebola were brought stateside for treatment in specialized infectious disease hospital units. Producing more copy than the 2008 Swine Flu outbreak, the Ebola media coverage rose with each passing day, peaking after the first in-country transmission was confirmed in Dallas in early October. Despite nurses comprising the majority of the country’s transmission population, showing their proximity to the forefront of Ebola care, few bedside nurse narratives surfaced apart from that of whistleblowers.

Except for one nurse who spoke out against government-forced quarantine, nurses who spoke directly to journalists were not named; they were labeled only generically as nurses.

Nurse invisibility is illustrated in the following snippets from a *New York Times* article written at the height of the Ebola craze. In it, the authors present instances of Bellevue Hospital staff discussing the treatment of New York’s sole Ebola patient through various interviews with hospital workers and members of the public. Note here the comprehensive labeling of sources, with pairing of name and/or title, except when it comes to nurse sources.

*For six years, Mayra Martinez had been going to the same beautician in Queens, and considered her a friend. On Saturday, while getting her hair done, Ms. Martinez, 45, mentioned she had just gotten a new job.*

“Where?” the beautician asked.

“She just froze and asked, ‘Are you anywhere near him?’” Ms. Martinez recalled. Then the beautician asked her to please find someone else to do her hair.

This piece does not introduce its source (Martinez) by title or experience. Later on, even though Martinez speaks of her subway commute to work with ID badge and tan scrubs, the reporters do not distinguish her professional role. The sourcing of Martinez left as unidentified is inconsistent with further copy that clearly identifies others’ professional roles.

*Bellevue’s medical director, Dr. Nate Link, said more than a dozen employees—not limited to those taking care of Dr. Spencer—had reported being discriminated against, including not being welcome at a business or social event.*

The physician, a member of hospital administration, is clearly titled and named, a courtesy omitted for the nurses referenced in the next section.
Some nurses who moonlight at other jobs have been told they are not needed there, according to the New York State Nurses Association. One nurse said her child was not allowed to go to day care.

For the remainder of the New York Times piece, although nurses are interviewed, none are named or titled. This is particularly noticeable because ancillary hospital employees, uninvolved doctors, and even street vendors are named and titled. Nurses—the professionals responsible for the majority of the direct care—are simply aggregated as “some nurses.”

Lack of attribution lumps all nurses together into a sea of fungible workers, rather than highlighting the special professional contributions to patient care they make. Excluding nurses’ individual titles and names can make nurses reading such a newspaper report feel that their patient care contributions are diminished.

POSSIBLE CAUSES BEHIND THE ABSENCE OF THE NURSE VOICE
In their seminal work, From Silence to Voice, authors Buresh and Gordon present their quest to understand nursing’s individuated absence from the media. Healthcare journalists themselves, they settled on the surprising realization that journalists are actually not opposed to the idea of nurses as sources, as much as nurses are opposed to the act of talking. Finding nurses more naturally reserved than purposely excluded, the book centers around the problem that nurses have with identity, contributive to a seeming insecurity about their place at the bedside. Further, nurses’ self conceptions often differ drastically from the ways in which the public sees them. For instance, while many nurses see much of their professional identity coming from their engagement in research,³ the public seems almost unfamiliar with this aspect of the profession. Such discrepancy in self and public identities calls for more thought and study.⁶,¹⁰

In some cases, nurses may simply not be allowed to talk to the media without hospital permission. On a strictly practical level, in acute care hospitals and hospital systems, it is common for public relations departments to control to whom the media are given access. Functionally, more often than not, this means that access is given to physicians and hospital administrators, rather than bedside nurses. When there are questions about nursing issues specifically, nurse administrators will be the ones to talk to the media rather than those at the bedside.

...it is not unreasonable for healthcare journalists to believe that bedside nurses avoid talking to the press, even with permission, out of fear of saying something that the hospital may not want said.

These access constraints may merely reflect the traditional hierarchies of medicine and nursing. But some lack of media access to nurses, especially bedside nurses, may also be attributable to concerns that most nurses simply do not have the communication training a hospital requires for those to whom they give the media access. Hospitals are appropriately alert to avoiding situations that can put a hospital at risk of harm to their reputation. Inexperience in talking with media could result in unconscious slips that would put a hospital inadvertently in a bad light.

Because nurses understand the inside perspective, however, it is not unreasonable for healthcare journalists to believe that bedside nurses avoid talking to the press, even with permission, out of fear of saying something that the hospital may not want said. Such an explanation
is given credence in that even when nurses are released to speak with the media, they just are not good sources—they don’t call back, they don’t want to be quoted. Systemically, it may just be easier and safer for bedside nurses to remain untrained and unprepared (or even discouraged) to talk to the media.

Physicians do not seem so inhibited. In the example of the New York Times piece about Bellevue, a physician with no relation to the care of the Ebola patient was quoted. He seemed to have no problems sharing his opinion, no fear of retribution. This physician, a dermatologist, engaged in what a nurse might see as risky media behavior. He not only identified himself as a Bellevue employee, he gave his name and title. With today’s technologies, he could simply have given his name and all this information and more would have been readily available to any journalist.

Today, a physician of any specialty can be searched on the Internet, without requiring location or licensure. S/he can be located, analyzed, and researched for a patient’s interests or a reporter’s questioning. A bedside nurse, however, often has no means for access unless s/he is listed on the hospital website or maintains a presence in higher-level administration. Some hospitals don’t even assign e-mail addresses to bedside nurses, and thus reporters are without direct access to the professionals who provide direct care, as are patients and families. Media databases of staff nurse sources remain almost impossible to find, leaving reporters to depend largely on nurses listed amongst academia and administration. Without context, the average staff nurse, who may have years of experience and knowledge, stands mum to the microphone of the reporter, unreachable by media outlets, patients, and families.

TOWARD IMPROVED COMMUNICATION SKILLS AND RECOGNITION FOR BEDSIDE NURSES

Although the American Nurses Association’s Code of Ethics clearly states that nurses must initiate and take an active role in the communication of care, few hospitals provide documented training or supportive policies for nurses in their communication with patients, physicians, or the media, regarding sensitive issues such as those raised by the care of Ebola patients. Those who oppose bedside nurses obtaining a level of communication skills warranting having named, titled presence in the public media miss the critical connection between such skills in the public arena and within their clinical role.

Communication skills comprise one of the most salient aspects of professionalism and thus are central to quality nursing. Effective communication across professionals is necessary in order to successfully manage patients in today’s complex hospital systems, and can be expected to positively influence nurses’ self-confidence. Self-confidence not only helps nurses be willing to talk to the media if approached, but in turn can also improve staff nurses’ care of patients and their families within their everyday relations at the bedside.

Moreover, and perhaps critical to the capacity for nurses to exercise and effectively implement increased communication skills, is the imperative to develop ways in which the broad spectrum of invaluable work performed by them is more fully recognized. Improved recognition holds the ability to both reinforce confidence in nurses’ own work and to promulgate a better public understanding of their tremendous scope and influence. In turn, there may be an increase, in some cases, where media entities begin to understand the role of a nurse “behind the veil” as possibly having the most comprehensive and/or relevant knowledge surrounding a case of interest to the public. Then they will be more inclined to source him or her as the best material authority and likely provisional of meaningful insight.

Author

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References


Improving LGBT Healthcare Communication

Josh Hyatt, DHS, MHL, CPHRM, FASHRM

According to a 2013 Pew Research study, 92% of lesbian, gay, bisexual, and transgender (LGBT) individuals believe that society has become more accepting of their community throughout the past decade. Some of the differences are understood as the result of generational variations in cultural norms linked to a societal increase in exposure to LGBT individuals. But even with these changes, approximately 33% of LGBT individuals indicate they still face harassment and violence, and more than 70% state they received poor service in a business (including healthcare), rejection by family and friends, or discrimination in their place of employment, in relation to their LGBT identity. If only transgender individuals are considered, these percentages are significantly higher.¹

An important ethical implication of these data for care of hospitalized LGBT patients is that care can be improved by development of strategies for better communications with and about patients from the LGBT community. This article presents concrete suggestions for improving these hospital communications. Examples include developing scripts to structure patient encounters, reviewing language on hospital websites, scrutinizing advertisements for balanced portrayals of visualized hospitalized patients and their spouses/partners, and creating policies that protect against discriminatory communications.

Whenever LGBT patients are hospitalized, it is an opportunity to provide members of this specialized population medical findings that are relevant to them, as well as available resources from which they can benefit. Lack of information and failures in communication have been shown to cause LGBT individuals to delay even seeking healthcare.² One of the most significant problems in healthcare for the LGBT community is that individuals do not appear to seek out medical attention at the same rate as heterosexual individuals, and preventative care is not practiced as frequently in their demographic. For example, studies have shown that lesbians do not seek gynecological screenings as routinely, which may place them at higher risk for cervical cancer.³ It is possible that taking the opportunity to provide these patients with useful information might increase the prospect that they seek out healthcare more swiftly when needed thereafter.
Also, communicating essential information about health issues that are particularly relevant to the LGBT community can help patients make better informed medical decisions. Though distinctions in this regard between LGBT individuals and heterosexuals certainly exist, LGBT individuals should not necessarily be grouped together and assumed to be similar. Indeed, there are subgroups among LGBT patients influenced by race, environmental, and other demographic factors, which are associated with differences affecting the appropriate care of LGBT individuals, just as these characteristics are relevant to the care and treatment of other groups.4

Some research has helped shed light on certain correlations and health trends among particular subgroups within the LGBT community. For instance, lesbians are more likely than individuals of any other sexual group to be overweight and suffer from obesity.5 Women in sexual relationships with women have also been shown to be more likely to develop breast cancer than those in sexual relationships with men.6 Bisexual and transgender individuals also demonstrate certain trends, such as being more likely than others to suffer from eating disorders.6,4 Compared to heterosexuals, they are, in addition, more likely to attempt suicide, be diagnosed with depression, experience a violent encounter with a sexual partner, be obese, or to suffer from asthma. Transgender persons are less likely than all other sexual groups to have health insurance, though both men and women in same-sex relationships generally show more disparities in relation to having appropriate health insurance than those in opposite-sex relationships.7

Clinicians who are up-to-date on such data are likely to be more inclined to ask relevant questions during a history and physical when LGBT patients come into the hospital. Obtaining such information may not only be practically useful for diagnosis and treatment; asking relevant questions can help build trust between the LGBT patient and the clinician. Behaviors and risk factors among different demographics, including sexual minorities, are often associated with different success rates for distinct treatments. For instance, research on smoking habits of LGBT individuals has determined that LGBT smokers may benefit from treatments that are psychologically tailored specifically to promote cessation in LGBT people.8

### PROVIDER KNOWLEDGE AND ATTITUDES

Just as communicating medical realities for LGBT individuals can improve healthcare outcomes, so too can making healthcare professionals well informed. At present, healthcare professionals are not specifically trained, and thus do not have a deep understanding of how LGBT health may differ from the health of non-LGBT individuals. Further, when some form of information regarding LGBT health is learned, it can sometimes be generalized, and physicians and other healthcare providers might fail to recognize the diversity that exists among the LGBT population itself. As research helps clarify specific health risks endured by LGBT individuals, healthcare staff should be equipped with this information so as to more effectively communicate regarding the concerns of their patients.

As healthcare information about the LGBT community accumulates, focused training for hospital clinicians is needed. A recent study on medical education illustrated that medical schools do not cover LGBT topics extensively, though the tendency varies amongst teaching institutions.9 Educators and public health professionals have generated interventional strategies to help reduce the negative impact of LGBT stigma on relevant individuals.10 Though the adoption of these interventions is not
limited to medical education, adopting these measures in medical education specifically could help healthcare providers improve their communications around LGBT issues and, ultimately, the quality of the care they provide. Without students gaining the experience needed to comfortably talk with LGBT patients, it is unlikely that any improvements in hospital clinicians’ communication skills around the care of these patients will be sustainable.

The National Health Interview Survey (NHIS) is beginning to collect data on patients according to sexual orientation. It has been suggested that these data can contribute to goals for Healthy People 2020, including several goals specific to the health of LGBT individuals. As these data grow, their analysis should help inform the healthcare community on how to best communicate with LGBT patients. It is likely that as physicians, nurses, and other healthcare staff incorporate new guidelines into their practices, they will become more comfortable and confident talking with and treating patients of different sexual orientations. Further, these patients will likely feel more comfortable seeking medical attention and be more confident that such attention can effectively address their specific healthcare concerns.

Several issues exist among healthcare providers that contribute to an improper or lack of care for LGBT patients and an inability to communicate effectively with them. To start with, a significant number of healthcare providers simply do not feel comfortable and might experience degrees of anxiety when treating LGBT individuals. It is important to reduce homophobia and discomfort that can be perceived by patients and thereby negatively affect proper communication between a patient and a doctor. A healthcare resource that can be useful in this context is the LGBT Bill of Rights. This document endows LGBT individuals with the right to be treated with respect and with equality. These rights include the right to not be denied care or provided with inferior service on the basis of sexual orientation, the right to be referred to by pronouns of choice, and the right to have any visitors one wants. The Bill of Rights also explicitly gives the LGBT patient the right to privacy through the Healthcare Insurance Portability and Accountability Act (HIPAA).

**COMMUNICATION GUIDELINES: AFFECTING INSTITUTIONAL CULTURE**

There are many ways in which hospitals and clinicians communicate. For example, the expression of heteronormative behaviors and culture is linked with micro-messages to LGBT individuals. Micro-messages are subtle, often unconsciously processed, nuanced messages that are experienced through environment, behavior (eye contact, tone of voice, body language), within language found on administrative forms, or in policy. For the LGBT community, micro-messages include: use of incorrect gender pronouns, brochures and posters that only reflect heteronormative messages, stereotypes, and an overall sense of censure or penalty from a lack of options. All materials should contain appropriate and consistent language and information. Employer-sponsored LGBT employee groups could also help facilitate the development of a more appropriate culture with open dialogues on anti-discrimination policies that could help harness anti-discriminatory sentiments in institutions. Educating people on how to minimize heteronormative messages can create a more nurturing, healthy environment for LGBT individuals.

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Though third-party payers like Medicare have been criticized for excluding care that is specific to transgender people, such as relevant surgeries and long-term hormone
treatments, the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission have been the principle voices in promoting operational changes in healthcare institutions by enacting accreditation and regulatory standards that include an appropriate oversight of LGBT concerns. The Joint Commission has made specific recommendations for best practices for hospitals, including those that support a patient’s right to not be discriminated against and those who will be involved in his or her direct care. The Affordable Care Act addresses the problem with discrimination on the basis of sex and bans this practice. The respective legislation includes a memorandum that allows patient visitation by visitors of any sexual orientation at hospitals receiving Medicaid or Medicare funding. Ridding particular systems of these more obvious forms of discrimination, however, still leaves much work to be done to erase discriminatory hospital communications, while simultaneously improving the level of clinician knowledge.

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To help LGBT patients find organizations that support relevant policies of equality in the healthcare setting, the Human Rights Campaign has developed a screening tool and scoring system called the Healthcare Equality Index (HEI), which can be downloaded from the Human Rights Campaign website. The HEI scores and ranks facilities based on 4 criteria: patient non-discrimination policies, visitation policies, employment non-discrimination policies, and training in LGBT patient-centered care. There were 507 healthcare facilities that were surveyed, of which 427 (87%), met all 4 conditions. There were many healthcare facilities, however, that did not respond or participate, making it difficult for LGBT individuals in rural areas to find facilities that support them and their healthcare needs.

Maintaining an open culture and open dialogues with staff, non-discrimination policies, and employer-sponsored LGBT employee groups can facilitate an institutional culture of fairness and equality. The following are practical recommendations in the form of guidelines related to the many institutional communication-based problems experienced by LGBT persons:

- Don’t conflate sex and gender in the transgender community or overemphasize sexual orientation in the LGB community. If someone’s transgender status and/or sexual orientation are irrelevant, don’t focus on them. Don’t dwell on the anatomical and legal details.
- Take the time to find out a transgender person’s preferred pronoun and address he or she as such.
- Don’t focus on a person’s anatomy, past or present. Belaboring someone’s assigned sex at birth or his or her surgical procedures since then misses the point.
- Never “out” an LGBT person without their permission. This can be viewed as a significant breach of privacy and negatively impact the provider-patient relationship.
- Evaluate your policies and procedures for heteronormative language and points of view. Evaluate the posters, websites, marketing materials, advertising, and brochures in the facility to determine if they are heteronormative in design and could be considered offensive or exclusionary to an LGBT patient.
- Consider the use of scripts to structure patient encounters.
- Provide training on LGBT sensitivity to staff and providers that encourages an open and safe culture, as well as reflects the Joint Commission and CMS requirements.
• Recommend your institution use the Healthcare Bill of Rights, which supports the inclusion of LGBT rights.
• Contact the Human Rights Campaign to learn about the Healthcare Equality Initiative.
• Support staff in identifying and addressing issues related to LGBT care that cause them moral distress and could possibly lead to a moral disengagement or negative patient interaction.
• Provide a safe and welcoming environment for your LGBT employees.

In summary, there are many ways in which clinicians, hospital administrators, and other providers can begin to assure that they are improving LGBT patient communication and the general non-discriminatory climate of an institution. Institutions can also develop research programs that enable them to understand how to best communicate with LGBT individuals to promote favorable health outcomes, using the knowledge to train staff and develop standards for education and specific communication protocols that contribute to care that is ethically appropriate. As these programs are implemented, institutions can monitor their success and modify them accordingly. Through this type of awareness and evidence-based approach to building better LGBT communication, better outcomes for LGBT patients can be anticipated.

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References
Encouraging Others to Speak Up: Physician Leadership in the 21st Century

Evan G. DeRenzo, PhD

INTRODUCTION

Physicians are natural leaders. This is not only because physicians presumably have higher levels of medical knowledge than others, nor because they are the most liable in practice, or even that they are often the highest paid members of any given care team. Their natural leadership, instead, is likely because of the special qualities inherent in and required of the physician/patient relationship. Regardless of how many individuals make up the care team or how many teams are involved in a particular patient’s care, when a patient or a patient’s surrogate is speaking with a physician, there is something special about that communication that is distinctly manifest in the unique nature of the patient/physician relationship. It is the physician, through this special communication, who can incline the patient to trust.

This unique nature creates the capacity that distinguishes the patient/physician relationship from all other relationships in medicine and has arguably continued intact through many changes in the field over the last 50-plus years. True, in the 1960s the United States saw the authority of the physician (like that of many figures) challenged. Since that time, the traditional model of ironclad authority has evolved to where many today think that patients and physicians are indeed partners. Although some think the model of partnership has gone too far, most accept that a patient—and, where appropriate, his or her family—should be involved in care planning to the greatest degree, so long as that involvement is seen as conducive to the provision of excellent care and deemed clinically reasonable. But even when
a patient is fully partnered, the physician appropriately remains in the leadership position.

Because patients must trust that their physicians will not hurt them and that their physicians will protect them from others causing them harm, physicians end up as the leader of those who care for and protect patients. And from here on out, we take this as a given. We shall accept, also, that hospital care has evolved from the pre-1960s single-practitioner model to a predominance of hospital care delivered through a team care model. Whether by design or default, the data show that physician-led teams excel or fail depending on the physician’s leadership style. Further, these same sources convincingly demonstrate that a successful leadership style calls for physicians to shift from a 20th century paternal authoritarianism to a more democratized approach, accommodating what could be described as more appropriate to 21st century hospital culture. Democratization of leadership does not mean, however, that physicians have to yield their natural position. It is just the opposite. Physicians who master 21st century models of democratized leadership can expect the rewards of even greater trust, respect, and cooperation from everyone on the team.

Mastering a democratized physician leadership style means, at the very least, that the physician team leader creates an environment in which everyone, regardless of discipline or seniority, feels safe enough to speak up. Anyone working in a hospital who has been subject to “culture of safety” training knows that everyone on the team, anywhere in the hospital, needs to feel safe enough to speak up. Safety here means that a hospital’s practices assure that those who speak up about actual harms or near misses related to harms to patients and/or staff will be appreciated, rather than having to fear that there will be negative consequences. Physician leaders are central to creating and nourishing or inhibiting such safety practices.

It seems, however, that the creation of environments that make those lower on the ladder feel safe enough to speak up is not occurring uniformly across the country’s hospitals. And it is the determined opinion of this author that one of the reasons many hospitals have not yet evolved into such safe environments is because physicians mistakenly believe that to develop a democratized leadership style means that they will lose their authority. Evidence of this misconception includes when some physician leaders only appear to encourage team-oriented decision-making, when in fact there is none. Too often, teams lack the cooperative spirit necessary to build a truly democratized team with a physician whose leadership style fosters open communication. No matter how excellent the team members may be as individual care professionals, and though the negative aspects of such a culture may be more subtle today than they perhaps were 50 years ago, many team members remain too inhibited to speak up because they sense the possibility of retribution and censure by the team’s lead physician. This bad behavior is then copied, consciously or not, by other physicians on the team.

Developing this misconception can be seen as a natural response; individuals often manifest psychological defenses that can be triggered at the prospect of losing power. This is, of course, neither reasonable nor practical in light of the greater goal of providing excellent care. It is more likely that the physician leader’s position on the team will be strengthened by modeling communications that encourage others to speak up. Because we are

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Creating an Environment in Which It Is Safe to Speak Up

If most can presently agree that everyone in a hospital has the right to expect to be safe, then everyone has the responsibility to speak up when there is a situation that one fears is unsafe. Where the challenge lies is figuring out how to design and implement incentives to create leaders whose style helps people feel safe enough to do this.

If this author had a free hand in designing a program to achieve just cultures in hospitals across the United States, the first step would be to make the financial commitment at the highest levels of a hospital and/or hospital system to improve physician leadership styles. Of course, it is important to work to improve all managers’ styles; we all know how those lower on the power hierarchy can make things difficult for team members, even other physician team members, often in ways in which physician leaders typically are not even aware. But there needs to be a further commitment to bringing physician leadership styles up to 21st century professional culture standards. This emphasis on training physicians is a practical matter.

Those of us involved in resident training can appreciate the phenomenon to which this author has referred for years, half jokingly, as the “cult of the attending.” That is, being in a teaching hospital and charged with teaching residents and fellows about clinical ethics, this author has learned that the first person on the team whose trust and respect must be won is that of the attending physician. She or he holds the natural authority and is the designated team leader, and without the explicit and outward respect of the team leader, the clinical ethicist will be unable to teach anyone anything. But if the clinical ethicist is fortunate and skilled enough to build a trusting and respectful relationship with the physician leader, free of the notion of possibly or actually being co-opted, that clinical ethicist can go on to become a successful model and teacher for others in establishing and nourishing a just culture in a hospital.

The physician leader of every team, unit, and department sets the tone for the group. If the physician leader respects everyone on the team and masters any disinclination to be questioned or challenged, that physician will win the loyalty and dedication of everyone with whom she or he works.

Conclusion and Next Steps

Learning a democratized leadership style requires the ability to be self-reflective. Without the ability for self-reflection and self-awareness, physician leadership styles will get stuck where some are: exhibiting mere lip service to respectfulness, lacking genuine openness to others’ speaking up, and maintaining a clandestine threat of punitive and retributive action. But even for those who find taking on a more democratized leadership style the most tasking, a hospital’s commitment to physician education and retraining can provide significant help.

When the administrative leadership of a hospital starts modeling democratized leadership and creates systems that reward physicians who lead in ways that reward others for speaking up, the expected benefits of the just culture movement are bound to emerge. Then, when patient outcome statistics begin to reflect these benefits, improved patient outcomes will have their own reinforcing effects.

In short, the goal of creating a hospital environment in which everyone feels safe enough to speak up can only be achieved through physician leadership that sets speaking up as a team expectation and means it. Once physician leaders can take this necessity to heart and routinely

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act on this knowledge, establishing a practice of openness and respectfulness, their leadership position on the team can only be strengthened. Learning to listen to the concerns of others about safety problems for patients may be difficult, especially if the physician leader is the person about whom the safety concern has been raised, but it is absolutely necessary, and the well-being of staff and patients depends on it.

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References
Getting the Full Story: Communication Relies on Perception

The Editorial Group of the Center for Ethics at MedStar Washington Hospital Center

PRESENTATION

Mr R is a 29-year-old male with HIV/AIDS. The patient presented to the hospital with nausea and vomiting. He was being evaluated for these problems in a medical unit when he had a massive stroke. Code Blue (cardiopulmonary arrest) was called; he was intubated by the code team and moved to the medical intensive care unit (MICU). After 72 hours in the MICU, Mr R opened his eyes and began following simple commands. Ten days later, these remained the only notable improvements to his neurological function.

Mr R and his sister live in downtown Pierre, South Dakota and are very close. She’s reported that he had been losing weight over the last 3 weeks. Mr R’s mother, who had been visiting from Iowa where she lives with the children’s father, reports that over the last 4 days prior to this admission the patient had been experiencing flu-like symptoms. She also reports that she convinced him to visit a hospital near his apartment, where he was seen in the Emergency Room, given antibiotics, and sent home. Mr R continued to decline, however, so his sister convinced him to come here (Pierre Regional Medical Center). Mr R’s mother has been at his bedside throughout the hospitalization, hardly leaving to sleep or even change her clothing.

Amongst his many friends and other family, the one person who has not visited Mr R is his father. Mr R had remained in contact with his parents, but had not an opportunity to return home for a visit since he moved away from Iowa several years ago.

During daily rounds, the clinical team discussed the patient while the door to his room was open and his mother sat at his bedside. As usual, she did not come out to listen or ask any questions. The attending reports to the rounding ethicist that he has attempted to explain to the mother that the patient is profoundly neurologically injured and is unlikely to return to a state that will allow him to care for himself or communicate with others in any meaningful way. He reports that, “She just isn’t processing the information, despite my numerous attempts over many days to communicate the gravity of the situation to her. She’s obviously an intelligent woman, but she just...
isn’t getting it. I guess I’ll try again.” The attending then goes into the patient’s room, checks on him, and from the bedside begins to try and explain to the mother once again Mr R’s neurological problems.

The clinical ethicist watches from outside the room. She watches the attending physician make a valiant attempt at explaining how damaged the patient’s brain is and framing his prognosis both respectfully and compassionately with courageous detail about the things the patient will never be able to do again. What the clinical ethicist observes, however, is not quite the usual picture of a family member so stung by grief as to not be able to process what is being said. Rather than observing a patient’s family member struggling to understand but failing because of anxiety and grief, there is something different about this mother’s lack of engagement. The more the attending delves into the details, the more distant the mother looks. When the attending comes out he says to the ethicist, “See? I tried but she just doesn’t understand.” The ethicist then requests an opportunity to speak with the mother directly, and the attending readily agrees.

After a short while, the ethicist gets the whole story. The mother explains that Mr R is gay. Mr R comes from a deeply religious family in which homosexuality is considered a sin. The mother emotionally states that she forgives her son and that she didn’t really know but had suspected that he was gay for years and does not care. She clearly understands the extent of her son’s medical problems and is determined to take him home, but his father will be unforgiving of his homosexuality and she doesn’t know what to do. Although she suspects that her husband, Mr R’s father, knows that their son is homosexual, she has not told her husband either that their son is homosexual or that he has HIV/AIDS. Once she is able to express this information to the ethicist, she simply puts her head in her hands and sobs.

**CHART NOTE AND RECOMMENDATIONS**

Call a spiritual care/pastoral care consult, regardless of whether the mother has previously declined. Let the hospital chaplain services arrive and allow them to decide for themselves directly whether spiritual care/pastoral care services may be of value.

**REASONING**

In this case, the team had asked the mother if she would like spiritual care/pastoral care and she declined because she has her own pastor. However, even when patients have their own pastors (or imam, rabbi, or other spiritual leader), those persons are usually community-based and not trained specifically for hospital work. Also, patients and/or family members may respond negatively simply because they are overwhelmed at the thought of having to talk to 1 more person. It may be more than they can handle.

Hospital chaplains are specifically trained for hospital work and, just like any other consultation, can, when deemed appropriate, be called directly. Sometimes it may be best to let the chaplain show up and, if the patient and/or family do not wish to speak to them, let them ask the chaplain to leave. The hospital chaplain won’t be insulted and may be able to provide a kind of insight to the clinical team that will assist in having the communication process go more smoothly. If this assistance is all that comes out of a spiritual care/pastoral care consultation, much will have been gained.

In the case of Mr R, the treating team was so focused on strictly delivering the medical facts that they missed the ability to communicate in a way that connected with this mother. Their misperception that she was either in denial or
did not understand the medical information prevented them from discovering the real problem. The mother understood fully the medical circumstances; her mind was just elsewhere. Mr R had escaped to the city to avoid the negativity that would likely have come from becoming known as homosexual in his previous and largely anti-homosexual religious community. Now Mr R’s mother was faced with her own determination to take him home where the young man’s father resides and is not yet aware of the full story surrounding his son’s circumstance. Had the attending been prepared to allow Mr R’s mother the space to voice her real concerns, much wasted time and uncertainty might have been prevented.

Communication relies on perception. The attending had been kind and attentive, not condescending; he was simply focused on what he thought was most relevant and important. As a result of a somewhat narrowed clinical perception, it did not occur to him that the information being communicated was outside the scope of the mother’s most immediate concerns related to the social implications of her son’s condition.
For now, she is being managed with the hope of saving the hand. Surgery reports that the longer they try and save the hand, the greater her risk of developing drug-resistant infections. If the hand is amputated, surgery predicts the patient could be discharged to rehab within a week. Ms J is on a ventilator and is receiving high levels of pain medication. The medication cannot be reduced without causing the patient intolerable pain. She is intermittently conscious, but is not able to respond coherently, if at all, when addressed by the team, and has therefore been determined as lacking decisional capacity. The patient does not have an Advance Directive (AD), so her family is working to make decisions together. Her family is divided over how long efforts should continue to attempt to save the hand.

Family meetings have been taking place consistently since the patient’s admission. The surgeons report that they have built trusting relationships with all members of the family. The surgeons report, also, that family meetings have been focusing on whether or not the family members think Ms J would consent to amputation. Although mostly quiet during the meetings, Ms J’s older sister is among those who have already voiced reservations about the procedure. One afternoon, one of the nurses spots her on the phone crying, expressing her despair over “not being heard.” A bioethics consultation is requested by the nurse.

The next day, the clinical ethicist joins the family meeting. She notices that the surgeon members of the clinical team sit closer to the family members who have already expressed agreement. Further, these family members nudge the surgeons to chime in when they are trying to convince the resistant family members that it is safer for the patient’s general recovery to amputate sooner rather than later. The clinical team is not
able to assign a main surrogate because the family insists they want to work together in a democratized manner.

**CHART NOTE AND RECOMMENDATIONS**

It is recommended that at the next family meeting:

1. The surgeons open the meeting by explicitly communicating that they and the nurses understand that although some family members may be more comfortable than others speaking up, it is important that everyone is heard.

2. The surgical team pays particular attention to those who have already voiced resistance. Making certain that the surgical team is seated evenly throughout the family members will assist in helping everyone feel they are being equally heard.

3. Make explicit that the conversation needs to shift to focusing on what might be in the patient’s best interest, since understanding the patient’s wishes is not possible now.

4. Set time trials for specific measures of improvements or setbacks that should guide sound clinical decision-making for the patient, and assist family members to come to a best-interests decision, guided by the surgeons and surgical nurses.

**REASONING**

No matter how many times one has experienced a family meeting, the dynamics are always going to be different. Because the clinicians in a hospital setting are often thrown into situations in which they cannot know the patient well, if at all, and do not have time to get to know the family well either, communication is going to be difficult.

What is well identified in the medical communication literature is that there are 2 major elements of the interpersonal kind: information processing and relationship building. Further, a number of respected physician associations and societies have come to recommend taking a shared decision-making model, which we support in this case. A shared decision-making model doesn’t mean that physicians turn over their responsibilities. It just calls on the physician to be particularly mindful to learning how to observe quickly what is the patient’s and/or family’s preferred style of decision-making. Here, the whole family wants to work together.

Clinicians have become used to having a single family decision-maker. This practice is most likely a combination of the patient-centered Advance Directive (AD) movement and the legalities of informed consent. The AD movement has worked to have patients identify an agent. More formalized than family surrogates, an agent is someone who the patient appoints to speak for him or her when the patient is unable to speak for him- or herself in a medical setting. This agent is presumed to know what the patient would want.

The legalities of signed informed consents in medicine have intersected with the rise of the AD movement. The clinicians, needing signed consents, now work hard to identify who in the family is most likely to know the patient well enough to enact his or her preferences.

Having such a person is both a benefit to a patient and a convenience for the clinicians. But where a patient has not assigned an agent and has no ADs, if a family wants to work together, it is necessary to support the family in this regard. In such a situation, it will be especially important for the physician and all others on the healthcare team who communicate directly with the family to be self-monitoring of their verbal and non-verbal messaging so as not to favor one or some of the family over others. Because patients and family are often hyper-attentive to physician communications, not favoring one over another takes practice and skill.

Ms J’s family is trying to make decisions together. Once the clinical team has ascertained
that they cannot make decisions at the level of substituted judgment, we recommend switching immediately to working together to make best-interests standard judgments. To do this, we suggest that during the admission of a not-capacitated patient into a hospital and/or arriving at an ICU or other unit in a hospital, ask the “yes/no” question: “Have you ever had a conversation with your family member about what he or she might have wanted if found in this situation?” If you receive a “no,” immediately start partnering with the surrogate(s) to work together to figure out what is going to be, step by step, in the best interest of the patient.

In the case of Ms J, without an Advance Directive giving her preferences, it is necessary to put an end to further explorations of what she might have wanted. The family has now shown that they are divided and that neither side knows. Because there are good data showing that when guessing for someone else, neither physicians nor family members guess better than chance, shifting the conversation towards working together to figure out what will be the best steps can begin developing a consensus that will resolve an impasse.

Finally, having begun equalizing communication across family members overtly and shifting the goals of the family meetings to figuring out what may be best steps together, setting short time trials for observation of improvement or decline that can help family members come to agreement about what is in the patient’s best interest can assist in the process. These time trials not only allow family members to become partners with the clinical team in deciding what will be best for the patient, they also give family members time to process the alternatives and their possible harms and benefits, perhaps improving communication so that consensus can be reached.

References
CASE 3

When Physicians Lose Their Tempers: Apologizing and Moving Forward in the Care of a Dying Patient

The Editorial Group of the Center for Ethics at MedStar Washington Hospital Center

PRESENTATION

Mrs C is a 76-year-old woman brought to the hospital’s Emergency Department (ED) after a sudden, unwitnessed cardiac arrest. EMS was called after she was found by her neighbors and they were unclear as to how long she had been down. Mrs C received extensive cardio-pulmonary resuscitation lasting over 40 minutes in the ED before establishing a stable cardiac rhythm sufficient for transfer to the cardiac intensive care unit (CICU).

After her admission to the CICU, the neurology team assessed the patient, concluding that she had suffered significant and likely irreversible neurological damage caused by her cardiac arrest. Both neurology and the CICU teams have determined that the patient has very little chance at any meaningful neurologic recovery and that her general prognosis is poor.

Mrs C has 4 adult children and a very involved son-in-law, but does not have an Advance Directive of any kind. Her family and the CICU team have been meeting regularly to discuss her circumstances and determine appropriate goals of care. These discussions have gone on for more than a week. The CICU attending physician has explained at each meeting that the patient’s neurological condition has not changed, that she is hemodynamically stable, and so it will be up to the children whether or not they want the patient to receive a tracheostomy and percutaneous endoscopic gastrostomy (trach and peg) and be moved to a nursing home, or whether they want to shift to comfort measures only.

As the patient’s care moves into the second week, Dr W, the CICU attending physician who has been present at several of the previous family meetings, has grown increasingly frustrated as a result of the children’s inability to decide what direction they want to take with their mother. It has been Dr W’s training that he is to lay out the options and let the family decide. But he has grown frustrated with their indecision and walks out of the next meeting throwing his hands in the air, declaring, “I don’t care what they want, as long as they make a decision!” Both family and medical team members who witnessed the display are left in various degrees of shock, confusion, and anger. Ethics is consulted in order to address the resulting tensions and distress.
CHART NOTE AND RECOMMENDATIONS

1. Dr W and the clinical ethicist should meet with the family so that Dr W can offer an apology for his frustration.

2. Dr W should make a clear recommendation about what he thinks would be best for Mrs C and why he thinks this would be the best approach to her future care.

REASONING

The attending physician has demonstrated an impulsive lack of appropriate professional demeanor and regard for the sensitive nature of the matters under discussion. His voiced frustration has resulted in additional distress to the family and the rest of the clinical team. After calming down and reflecting, Dr W tells the ethics consultant he regrets having blown up. He tells the consultant that his frustration comes not only from the family’s indecision, but from the way in which he feels he has been trained and professionally conditioned to refrain in such circumstances from offering his own recommendation; that he’s just to lay out the options and let the family choose.

Frustration is no excuse when an emotional reaction gets the better of a clinician’s behavior. When this happens, however, clinicians need to acknowledge that they’ve lost their temper and be sure to genuinely apologize. We’ve learned that a sincerely felt and given apology from a physician for a medical error goes a long way to reduce the distress physician mistakes cause to patients and families. There is no reason to think that an honest apology for losing one’s temper can’t have the same beneficial effects. One particular potential outcome, the building of trust, is particularly important here.

Combining renewed trust and having the physician give a clear recommendation may help move the family forward. Separating Dr W’s frustrated outburst from the content of his remarks indicates that he has come to these meetings with an appropriate impartiality towards the outcome. When a patient is unstable and imminently dying, physicians should only offer indicated interventions. If patients or families ask for interventions that are not indicated on the basis of well-established standards of practice, ordinarily physicians should not provide such interventions. Where conflicts continue, transfer should be facilitated to the greatest degree medically feasible.

But where a hospitalized patient, even a dying hospitalized patient, can be made stable to discharge, Dr W appears to be rightly coming to the decision-making from a position impartial towards the outcome. That does not mean, however, that a physician ought not give a recommendation. Although this is a controversial point, we take the position that after presenting all medical options within reason, it remains the physician’s responsibility to make a recommendation. Often this can help a family come to their own decision, whether in agreement with the physician or not.

If, under these conditions, the family cannot come to a decision, it is incumbent on the physician to move to sustain the patient’s life and ready the patient for discharge. If the physician and other clinicians can do this in a supportive rather than frustrated manner, whatever the decision, the hospital experience is likely to be less distressing for everyone.

References

Communicating With Patients and Families: Fundamental Skills and Special Challenges

Jack A. Sava, MD, FACS

Talking to patients is at the core of every physician’s practice. Not only will your reputation depend on your communication skills (perhaps even more than on your clinical acumen), but your ability to impact patients’ lives will rest on talking and listening well. Before you even open your mouth, you will bring many things to your patient discussions. Your personality, your listening skills, your cultural background, your clinical confidence, and—perhaps most importantly—your empathy will all be evident. Empathy is the root of all effective patient communication; it is hard to teach and difficult to fake. You will often need a reservoir of empathy to know what your patient needs to know, what they are too afraid to understand, and how to guide them to a realistic yet gentle understanding of a difficult truth.

That is not to say, though, that you can’t greatly improve your communication skills through consideration and practice. Some of the basics, like setting the stage appropriately, can be learned by rote, just like taking a history or draping a surgical patient. Other tasks, like delivering bad news or managing angry families, are lifelong challenges. But by knowing yourself, cultivating empathy, and watching communicators you admire, you can grow better each year of your career.

SETTING THE STAGE—WHEN, WHO, WHERE, HOW?

You’ll talk to patients in many settings: in their room, in the hallways, maybe in the cafeteria. Some of these conversations may be brief and casual, especially when you know them well. However, the first task at hand is to recognize when you are having a significant clinical conversation. What counts as an important conversation? Any time you are relaying a diagnosis, making or changing a plan, or telling them something that is likely to have a physical, emotional, lifestyle, or financial impact (How do you know? Use your empathy; pretend you are in their position.). If it’s going to be one of these talks, then you need to take the time to do it right.

The next step is deciding who should be there. If the patient is alert, ask them what would make them most comfortable. If their mentation is clouded by illness or medication, you’ll have to start with their next of kin, and ask them who should attend. Often you will have to decide whether to talk about a confused patient in their room, or away from them. If they are conversant, they probably deserve at least a condensed summary of the discussion, but it may not be fair to have them listen in to a complex analysis of risks and possibilities if they are unable to discriminate between current facts and theoretical risks.

Next, you need to pick where you are going to talk. This usually requires a balance of respect and practicality. Your choice of venue will be much easier in the office than with a critically ill inpatient. Nonetheless, you should start by seeking out quiet and privacy. Even when these goals can’t be completely obtained, the efforts you make will be noted and appreciated. Always sit, even if you have to clear belongings from the bed. Try to remove objects between you and the patient. You may notice that if the news is difficult—a complication, for instance, or a bad pathology report—you will find yourself trying to distance yourself from the patient, sitting far away, at an angle, with a table or chairs between you. This distance serves your needs, but not your patient’s.

Finally, how you communicate is critically important. The beginning and the end of your clinical conversations should be pretty predictable. Hopefully you are already in the habit of introducing yourself—not just by name, but also where you fit in the picture. Are you the attending, the intern, the consulting nephrologist? If your role is limited, it’s good to make it clear from the beginning that you won’t be
answering some of the big questions. Ask the patient how they would like to be addressed. Don’t presume to use diminutive nicknames like “Dear” or “Sweetie” unless you have reason to think they will be appreciated. At the end, before leaving, you should always give everyone an opportunity to ask questions, and tell them what to do if they have more questions later.

Another important goal for the beginning of your conversation is to gain an understanding of what the patient or family knows now. Sometimes it will be clear, especially if the illness is new and you are the sole caregiver. In contrast, patients treated for weeks or months by multiple disciplines will likely have had their illness framed many different ways. Some of the team will have told them that the glass is half full, others that it is half empty.

▶ “Mr Robbins, before we start, could you give me any idea of what you’ve been told so far and where you think we stand?”

Throughout your conversation, you should tailor your speech to their level of understanding and education. Many trainees, especially junior ones, find it very difficult to avoid medical jargon. The reasons are not clear, but some have theorized that early learners lack confidence in their own knowledge and use medical terminology to make themselves feel smarter. Some find themselves unable to muster the empathy to make an accurate guess about what their patient understands. Others may spend so much time in the medical workplace that they have trouble remembering what lay speech is. Whatever the reason, complicated medical jargon drives a wedge between you and your patient. If they felt sick and scared before, they will now also feel ignorant, especially if they are sensitive about their level of education.

WHAT SHOULD YOU SAY?
Even well-intentioned, forthright communicators will still find themselves facing a number of difficult decisions in talking to patients and families.

Simplicity vs detail
No matter what crystalline clarity you bring to your description of clinical circumstances, you are eventually going to have to decide how much to say. Once you’ve disclosed the possibility of common bile duct injury, should you talk about all the different ways that complication could play out? When you start your patient on heparin after a DVT, should you tell them about all the different places they could bleed? How much is too much?

There are no simple answers, but in deciding whether to dive into further detail, consider the following:
- Will the patient be able to absorb it, given their level of intellect, education, and fear?
- Does it make a difference? Do they need to base a decision on it?
- Have you already saturated them with all they can take in at one time?
- Is there a way they can learn more later (patient education materials, a second conversation, etc)?
- Can details be bundled together and summarized?

▶ “This medication can sometimes cause bleeding in different parts of the body, which sometimes can be dangerous.”

Bluntness vs kindness
Died, or passed on?
Pain, or discomfort?
Choosing your words is tricky, and you’ll see a wide variety of styles. In the first example, there is wide agreement that relying on a euphemism for death—like “passed away”—can set family up for a dysfunctional grieving process by reinforcing denial. With respect to hurting patients, we’ve all heard pain described as discomfort. Some have argued that using a less harsh word can affect a patient’s perception of a sensation, making it more tolerable. However, the bigger risk is that you will lose credibility with your patient, and will appear to be minimizing their suffering. Also, a euphemism that is clear to you may be misunderstood by the patient, especially if the truth is hard to accept. Most great medical communicators stick to plain, easy-to-understand language.

Optimism vs pessimism
Many of your clinical conversations will be based on a likelihood that things will go well, with a possibility that they won’t. How should your patient feel about, say, a 5% chance that a lump will turn out to be cancer? Beyond whatever numbers or statistics your patients hear, they will look to you for basic human reassurance that things will be okay. Often, after a nuanced and detailed conversation about outcomes, they will simply ask if they are going to be all right. Should you give them this assurance? Is 95% enough? What if it’s 75%, or 99%?
While this question can’t really be answered with a number, there are some situations where you can safely say that things will be fine: a minor procedure, say, with few foreseeable major complications. Some physicians push this quite far, though, assuring even very ill patients that they will be okay. This has the effect of making the doctor seem heroic and omnipotent when things do in fact go well. But when they don’t, it leaves the patient feeling cheated and unprepared.

Often, the patient will be asking for something you can’t offer without a crystal ball. In these cases, you need to find some way of reassuring the patient without sacrificing the truth. If the odds are good, you can stress that. Alternatively, you can emphasize the care and comfort that will be provided.

▶ “I think it’s always important to discuss complications, but most of the time patients do very well after this procedure and are very happy.”

▶ “We’re all going to have to wait for the pathology results to come back, but in the meantime the whole team is committed to making sure you are comfortable and you heal from the biopsy.”

If the medical facts are unpleasant, leave your patient with something to feel optimistic and hopeful about, without encouraging denial.

**CHALLENGES AND PITFALLS**

**The Angry Patient**

Patient and family anger comes in many varieties. They may be mad at you or someone else: at doctors, nurses, the whole team, or the last hospital they visited. Sometimes, the anger is justified, as after a medical error, but other times it is displaced fear or rage at the disease process itself. Fortunately, the steps to managing it are fairly similar regardless of where the anger comes from.

1) **Acknowledge the patient’s feelings.** You don’t have to agree, or even pretend to agree. But until they know that you understand how they feel, they are going to feel compelled to persist in telling you.

▶ “I need to talk to last night’s nurse to hear her side of things, but I can certainly understand that it must have been miserable sitting here in a puddle of urine for hours. I’m so sorry that happened to you.”

2) **Apologize.** In the old days, apologies were thought to be legally important admissions of guilt that led to lawsuits. Now we know that the opposite is true—not only are they kind and just, but they also decrease the likelihood of legal action.

3) **Create a clear separation between the past and the future.** This is critical. You have to assure the patient that their concerns about what happened need not be forgotten. You can help them speak to a patient advocate or a charge nurse. You can even tell them that they have every right to speak to a lawyer. But try to get them to understand that the task at hand is to bring them the best comfort and care possible. Even the most upset patients will usually be willing to call a truce and move forward constructively, if you acknowledge their frustrations, apologize for what you can, and reassure them that they can continue to prosecute the past if they feel they must.

**Bad News**

Communicating unfortunate news is among the most unpleasant parts of a life in medicine. All of the steps above are especially important: choosing a setting, sitting and introducing yourself, using clear language without jargon, apologizing, etc. Bad news delivery (and its most virulent form, notification of sudden, unexpected death) has some unique challenges.

1) **You might think that the way you say something would be relatively trivial, in the face of life-changing new information.** In fact, the opposite is true. When you deliver critical bad news to a patient or family, you are recording a tape that will be replayed in the patient’s mind hundreds or thousands of times per day. Your choice of words has a measurable, long-term psychological impact.

2) **Bad news is best digested in stepwise chunks.** In a chronic setting, this means you are best off using multiple conversations, allowing the patient to absorb one level of news before proceeding to the next. A new cancer diagnosis, details of a complicated operation, and a poor prognosis might be too much for one sitting, and can often be spread out over several conversations. In acute death notification, the stepwise approach takes place over a few sentences, rather than a few days. In this situation, don’t drag on for hours, but plan to use your first 3 to 5 sentences describing the illness or injury, and the treatment, before gently but clearly saying that the patient died.

3) **Don’t let yourself off easy.** When the news is bad, you will have several tricks at your disposal to help you avoid sharing in the suffering. You can use physical distance or barriers, planting chairs between you and your patient or family member. You can retreat into medical jargon—“succumbed” is, after all, easier to say than “died.” You can avoid eye contact and read your lines like a script. You can dodge the question (“Will I ever walk again?”) that you know anyone would want
answered. All of these forms of cowardice will be intuitively available, but you need to replace them with empathy and human connection. All too often, this moment of empathy will be the only healing you have to offer.

4) Don’t seek absolution. Sometimes, especially in the early hours after a complication or death, you will feel shame. This is your burden. It can be crushing, but it should not be passed along to the patient in the form of fishing for reassurance.

▶ “I don’t know...part of me thinks I should have waited to operate...it was a tough choice, because I haven’t seen many cases like this...I hope I did the right thing.”

Apologies and tears both have their place, but they should be focused on healing the family, not on manipulating them into saying what you need to hear. After you take care of the patient, you and your team should find a way to take care of yourself. Your feelings of shame and sadness are important and need to be addressed; they just can’t be ladled onto an already overwhelmed family to fix.

SELF DISCLOSURE
Few of us set out to deceive our patients, or to dupe them into trusting us where they shouldn’t. But the path of disclosure is a slippery one, and we may be justified in wondering how far along it we need to wander. Traditionally, the power gap in the physician-patient relationship prevented any uncomfortable questions about the surgeon’s ability. Recently, though, patients have become emboldened to ask all manner of questions:

▶ “How many of these have you done?”
▶ “How much sleep did you get last night?”
▶ “Will residents assist in the case?”
▶ “Do you believe in God?”

Surgeons face 2 questions: First, what questions should they answer? Second, if an answer is necessary, does that mean that the information should be routinely volunteered?

These answers are in evolution, with a trend towards an increasing obligation of disclosure. Residents’ participation should be discussed in all consent discussions, even if not asked. It is reasonable for a patient to ask what your experience is in a given procedure, but if you are well-qualified, credentialed, and confident, it is probably not necessary to volunteer case numbers. Disclosure of surgeon fatigue is a hot-button issue, arising from regulation of physician resident work hours, research on fatigue and medical errors, and scrutiny of sleep in aviation, nuclear power, mining, and other industries. Surgeons—even those with a healthy appreciation for fatigue and its consequences—have been reluctant to discuss their sleep with patients. They often feel capable of operating when tired, and cite the lack of evidence showing worse outcomes with under-rested surgeons. Also, the alternative to an operation by a tired surgeon may have significant downsides, such as a handoff to a rested colleague with less knowledge of the patient, or postponing the case to a different time with a less familiar operating team.

Patients can be forgiven for bringing their faith to something as important as surgery. But surgeons needn’t feel obligated to discuss their own beliefs. In the elective setting, patients have the right to find a surgeon whose beliefs match their own, but in an emergency this may pose a logistical challenge. Typically, this comes up when a patient is looking for a reason to trust. They’re telling you they want someone to be on their team. Usually they will decide to fold you into their worldview if you underscore some shared values.

▶ “I prefer not to discuss my faith with patients. I treat patients of every faith exactly the same. But you should know that I consider it a sacred duty to do everything I can to make you better.”

EMPATHY AND THE REFLECTIVE SURGEON
Great surgeons cultivate their empathy throughout their careers. Physicians who personally experience the fear and helplessness of illness are often forever changed as doctors and communicators. Those fortunate enough to avoid these lessons can still find ways to put themselves in patients’ shoes. What’s it like to deal with an annoying bureaucrat who responds only in canned answers? Why did that auto mechanic inspire such confidence? How does it feel to talk to someone who always seems to be trying to get out of the room? The best physicians constantly build their empathic reserves, and draw on them to know what to say to patients, even when there are no other rules to guide them.

▶ “People don’t care how much you know, until they know how much you care.” —Theodore Roosevelt

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