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Ethics Consultation on a Gynecologic Oncology Service: An Opportunity for Physician Education

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Introduction

For the last 30 years, ethics consultation has become an increasingly important part of clinical medicine. Beyond simply enhancing the impact of patient preferences in medical decision-making, ethics consults protect patient rights, help resolve conflicts between parties involved in patient care, and provide moral support to both patient and staff [1, 2].

Additionally, ethics consults have been shown to reduce hospital and intensive care unit stays, as well as promote the withdrawal of non-beneficial life-sustaining measures when such measures are futile [3]. Because of the success of ethics consultation services, it is now estimated this resource exists in 81% or more of hospitals in the United States and that more than 314,000 hours are dedicated to ethics consults annually [2].

Cancer medicine provides a unique opportunity for patient interactions that involve ethical matters. Issues surrounding quality of life, medical futility, and palliative care are quite frequently encountered [4–6]. This is particularly true in the subspecialty of gynecologic oncology, where physicians build long-term relationships with the women they care for both medically and surgically. The treatment of these patients truly involves the full spectrum of care, from the diagnosis of disease through, in many cases, the transition to end-of-life. As such, the ability to confidently approach ethical dilemmas in this field is crucial to maintaining continuity with patients, and is an essential skill to be acquired by trainees. Unfortunately, in an era where duty hour restrictions preclude extensive ethics education in deference to other clinically pertinent topics, trainees may not have sufficient opportunities to develop these skills in a supervised manner. The resulting problem faced by program directors, then, is how to provide adequate ethics instruction when it competes with other, equally important, aspects of post-graduate physician training.

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Conflict of Interest

The authors declare that they have no conflict of interest.

Streamlining ethics education is one potential approach. In 2006, Goold & Stern [7] reported on a survey which asked medical residents and a group composed of ethics committee members, patient advocates, practicing physicians, and program directors, to select ethical themes upon which to develop a focused curriculum. Interestingly, the authors noted discordance between how trainees and non-trainees prioritized these themes. For example, trainees selected “family interactions” as the top theme for education, whereas the non-trainee group identified “informed consent” as the most important theme. Goold & Stern therefore argued that opinion or anecdotal experience alone may not provide a strong enough foundation for an educational initiative. Subsequent authors have suggested that ethics consults themselves be the basis for an initiative, since they reflect the actual experiences of physicians and patients, and empirically demonstrate the types and frequencies of contemporary ethical dilemmas [8]. Utilizing such an approach would provide a foundation for directed, succinct, and relevant ethics instruction.

Our institution created an Ethics Consultation Service in 1993, and since that time medical ethicists have worked closely with health care teams who treat patients with a number of cancer diagnoses. The cumulative experience of the medical ethicists at our institution affords us the opportunity to identify the ethical themes prevalent in a population of cancer patients, which can subsequently be used for postgraduate teaching. In this study, we aim to describe the demographic features of gynecologic oncology patients who have received ethics consults, to elucidate the most common clinical case types encountered, and to describe the underlying issues affecting these women. Determining such information may facilitate enhanced collaboration between gynecologic oncologists and medical ethicists and identify areas for directed physician education in clinically pertinent ethical principles.

Methods

After approval by both the IRB and the Institutional Clinical Ethics Databank Committee, all cases of clinical ethics consultation completed for gynecologic oncology patients between September 1, 1993 and December 31, 2008 were identified. A total of 41 consults were performed. Ethics consults were conducted by formally-trained clinical ethicists, all of whom who had graduate- or post-graduate level degrees. At the time of each ethics consultation, the clinical ethicist completed a pre-coded data collection instrument which outlined the reason for the consult, patient-specific demographic information, patient-specific clinical data, and an overall consult assessment which included identification of the predominant clinical case types and common underlying issues. Clinical case types and underlying issues were classified as primary, secondary, or tertiary in order of importance and applicability in each case as judged by the clinical ethicist. Coded data from the collection instruments were entered into a separate electronic database for further analysis.

Clinical information on each patient, including age at diagnosis, stage, pathologic diagnosis, and pre-existing or concurrent psychiatric diagnosis, was abstracted from the institutional electronic medical record. Demographic information was also abstracted, including race, marital status, religion, and insurance status. To establish a baseline population for comparison against the ethics consult cohort, aggregate data regarding race, insurance status, and pathologic diagnosis were collected for all gynecologic oncology patients treated at our

institution between September 1, 1993 and December 31, 2008 using the Clinical Informatics Database. Analysis was performed using summary statistics and chi-square. A p -value < 0.05 was considered statistically significant.

Results

The demographic features of patients receiving consults are shown in Table 1. The mean age at the time of consult was 49.9 years (range 17–79 years), about 2.5 years after the mean age of diagnosis. The majority of patients were either Caucasian or African American, and only 25.6% were married. Approximately 85% of patients were United States citizens, and Christianity was the predominant religious background. Less than 30% of patients had medical insurance through a PPO, HMO, or Blue Cross/Blue Shield; the remaining patients were either subsidized federally or by the county, or were self-pay. Self-pay patients were those women capable of paying for health care services out of pocket, or who did not qualify for funding assistance in Harris County, Texas. Half of all consults were performed at the request of the attending physician, but consults were also requested by nurses (22%), patients or patient advocates (17%), and social workers/case managers (7%). In all cases the recommendations provided by the ethics service were followed.

Consults were performed for patients with cancer of the cervix, vagina, or vulva in 46.2% of cases, with gestational trophoblastic neoplasia (GTN), uterus/endometrium, and ovary/fallopian tube/peritoneum/pelvic mass representing 7.8%, 15.4%, and 30.6% of the remaining cases, respectively. One consult was requested preoperatively to discuss surrogacy on a patient with a pelvic mass suspected to be malignant, but was histologically benign. In 35.9% of cases, the clinical or surgical stage of the patient was either unknown to the ethicist or not applicable. At the time of the consult, seventeen patients had previously undergone surgery, 25 had received chemotherapy, and 22 had been treated with radiation. One-third of the patients had a concurrent psychiatric diagnosis for which they were seen and treated by a mental health professional during their disease course. In 48.7% of cases, the ethicist deemed the patient unable to make her own health care decisions; however, the patient's decision-making ability was called into question by the health care team in only 28.2% of cases. Seven patients (17.9%) had a living will, and only six (15.4%) had established durable medical power or attorney. In 30.1% of cases, the patient had an active do not resuscitate (DNR) order.

Demographic differences were observed between the consult population and the general gynecologic oncology population during the study period. A significantly greater proportion of patients receiving consults had GTN compared to the general population (7.9% vs. 0.8%, $p<0.0001$). No significant differences were seen for any other disease site. Fewer Caucasian patients received consults compared to the baseline population (48.7% vs. 70%, $p=0.0037$), whereas there was greater representation of African American patients (33.3% vs. 10.9%, $p<0.0001$). A disparate proportion of patients with Medicaid or who were self-pay was present in the consultation group (15.4% vs. 4.8%, $p=0.002$; and 15.4% vs. 5.4%, $p=0.009$, respectively). Patients with PPO insurance, however, were underrepresented in the consult cohort (7.7% vs. 20.7%, $p=0.045$).

The most common primary and overall clinical case types are shown in Table 2. Overall clinical case types represent the tally of all identified case types, regardless of their prioritization by the ethicist. *Level of Appropriate Treatment-Code Status* was the most frequently encountered case type, followed by cases of withholding or withdrawing procedures, surrogacy and futility issues, and shift towards palliative care. The most common primary case type was also identifying the level of appropriate care with regards to code status; however, obligations to noncompliant patients and issues surrounding discharge were also recognized as primary themes.

The most frequently encountered underlying issue among all of the consults was a need to provide ethical support for decisions made by the health care team. Other common underlying issues included disagreements between the patient and the physician, language barriers, and complex family dynamics. When primary underlying issues were examined by race, in both Caucasian and African American patients, coping mechanisms were found to be at issue, as was disagreement between the patient/surrogate and the health care team. Family dynamics and spiritual struggles were key considerations for one-third of African American patients. Interactions between family members were also contributing factors in ethical dilemmas involving both Hispanic and Asian women; in fact, all ethicists who provided consults for women of these backgrounds cited family dynamics as the primary issue at hand.

Discussion

Medical ethics education is a crucial component in the training of all physicians. It has been acknowledged by the Accreditation Council on Graduate Medical Education as a core competency in the area of professionalism [9], and is incorporated into both undergraduate and graduate medical training. The American Board of Obstetrics and Gynecology requires that gynecologic oncology fellows graduating from accredited programs be proficient in the implementation of ethics into daily clinical practice, and specifically should “understand the principles of medical ethics including the proper professional conduct concerning the rights and duties of the physician, patients, and fellow practitioners, as well as the physician’s actions in the care of patients and in the relations with their families” [10]. Because of the emphasis placed on mastery of ethical principles during medical training, one would expect extensive didactic and interactive educational programs to facilitate acquisition of such skills. While this occurs in some programs [11], duty hour restrictions for medical trainees and demands on attending staff to be clinically productive often supersede implementation of comprehensive ethics curricula [12]. A review of obstetrics and gynecology training programs by Cain *et al* [13] revealed that on average, residents receive only four hours of ethics education combined over the course of their residencies, while post-residency graduates receive only two hours.

Despite the paucity of time dedicated to ethics education, it has been reported that many surgical programs support the idea of formal ethics training. Downing *et al* [14] published the results of a survey of general surgery residency program directors, which demonstrated that 85% of them favored a standardized curriculum in ethics with content in end-of-life decision-making, managing conflict, and informed consent. Interestingly, these program

directors reported that time constraints of the residents and lack of support by the faculty were two main reasons for the failure of previous ethics programs. Other independent studies examining the success of such standardized programs at teaching institutions suggest that instruction on how to approach ethical dilemmas results in increased trainee confidence in the management of such dilemmas, and ultimately may result in improvements in patient care [15].

Given the importance of clinical ethics in daily medical practice, and the high prevalence and utilization of ethics consultations nationwide, knowledge about the reasons for consults and the issues identified from them provide a unique opportunity to integrate clinical ethics and graduate medical education. In this study, we present the first ever description of ethics consultations in a population of gynecologic oncology patients. While the number of patients is relatively small, we were able to identify issues that should be included in educational efforts, including an understanding of social disparities, an appreciation of family dynamics, and a need to improve patients' awareness and understanding of surrogacy. Our results provide a framework through which gynecologic oncology trainees may become familiar with the most frequently encountered ethical case types and underlying issues in this unique subset of patients. In an era when there is increasing emphasis on personalized care, it is crucial to be aware of the specific needs of the population being served. Such awareness increases the physician's ability to effectively care for patients by anticipating potential ethics-related concerns and identifying situations in which a formal ethics consultation may be beneficial.

In 1985, Culver *et al* [16] proposed an outline for the basic content which should be included in any medical ethics curriculum, and suggested that such a curriculum be presented not only at the undergraduate medical level, but at the residency level, as well. Key topics recommended for discussion include how to proceed when a patient refuses treatment, caring for patients with poor prognoses or who are terminally ill, and understanding factors which may lead to the inequitable distribution of health care [16]. Importantly, the authors state that medical ethics training with the aforementioned topics at the *post-graduate* level should be more intensive and focused on the ethical issues that commonly arise in the particular field of training. These sentiments have been more recently echoed, with encouragement to expand ethical education programs to include fully-licensed professionals, as well [17].

At our institution, the Department of Gynecologic Oncology in conjunction with the Clinical Ethics service has initiated a series of sessions for gynecologic oncology and obstetrics & gynecology trainees based on our findings, with an emphasis on the suggested features recommended by Culver *et al* [16]. These sessions consist of quarterly lectures and interactive seminars aimed to increase familiarity with the basic principles of medical ethics, as well as pertinent issues impacting patient care. Table 3 details the outline of seminars scheduled for presentation in the first year of this program. The topics represent several of the most common clinical case types, as well as a discussion about decision-making capacity since in our study there was a discrepancy between physician assessments and clinical ethicist assessments of patient decision-making capacity. Didactic sessions are introduced by a trained ethicist as a case presentation, and subsequently discussed in an interactive format

with both residents and fellows. Emphasis is placed not only on resolution of the case, but also the core ethical principles applied to each situation. Future topics currently under consideration include conflict management and resolution, understanding patient coping mechanisms, and health care disparities. It is our aspiration that our curriculum can be further developed for use in other training programs as a tool to encourage increased understanding of ethical principles and ultimately establish a foundation for medical trainees to adopt a comprehensive approach to patient care.

Medical ethics is an important part of every physician's practice, and as Lakhan *et al* [17] note, education in ethics is a lifelong process that occurs over the entire course of a doctor's career. Initiating ethics training in medical school and continuing to reinforce basic ethical tenets throughout the entirety of medical training is an educational strategy which can produce physicians who are competent to address the many difficult situations they will encounter. Ongoing collaboration between ethicists and physicians should be encouraged and utilized as a means to facilitate the integration of ethics into day-to-day patient interactions.

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Table 1

Demographic characteristics of Gynecologic Oncology patients receiving consults

Mean Age at Time of Consult	49.9 years
Range	17–79 years
Mean Age at Diagnosis	47.5 years
Range	16–79 years
Race	
White	19 (48.7%)
Black	13 (33.3%)
Hispanic/Asian/Other	7 (18%)
Marital Status	
Married	10 (25.6%)
Divorced/Separated	10 (25.6%)
Single	15 (38.5%)
Widowed	4 (10.3%)
Religion	
Christian-Catholic	9 (23.1%)
Christian-Protestant	21 (53.8%)
Other	5 (12.8%)
Not specified	4 (10.3%)
Country of Residence	
USA	33 (84.6%)
Other	6 (15.4%)
Insurance Status	
HMO	4 (10.2%)
PPO	3 (7.8%)
Blue Cross/Blue Shield	4 (10.2%)
Free Care/County Subsidized	6 (15.4%)
Medicare	10 (25.6%)
Medicaid	6 (15.4%)
Self-pay	6 (15.4%)

Table 2

Clinical case types encountered in Gynecologic Oncology patients

Most Common Clinical Case Types – Overall	
1	Level of Appropriate Treatment – Code Status
2	Withhold or withdraw procedure from incompetent patient – Life-sustaining
3	Surrogacy
4	Medical Futility – Patient/surrogate requests futile treatment
5	Level of Appropriate Treatment – Shift from curative to palliative
Most Common Clinical Case Types – Primary	
1	Level of Appropriate Treatment – Code Status
2	Level of Appropriate Treatment – Shift from curative to palliative
3	Withhold or withdraw procedure from incompetent patient – Life-sustaining
4	Obligations to noncompliant patient
5	Discharge planning

Table 3

Outline of Gynecologic Oncology Ethics Curriculum – Year One

Quarter 1: Medical Futility	
•	Approaching the patient or surrogate decision-maker who wants to pursue treatments that will not change overall patient outcome
•	Addressing sociocultural factors behind patient or surrogate desires for futile medical intervention
Quarter 2: Level of Appropriate Care	
•	Deciding when Do Not Resuscitate is appropriate
•	Assessing when the transition should be made from curative treatments to treatments intended to control symptoms
Quarter 3: Competing Autonomies and Patient Noncompliance	
•	Determining the obligations to the patient non-compliant with prescribed or recommended medical care
•	Recognizing situational cues which may elucidate reasons for non-compliance
Quarter 4: Decision-Making Capacity	
•	Determining what constitutes full decision-making capacity in a patient
•	Identifying when a surrogate decision-maker should be utilized