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Practice

Ethics Pocket Cards: An Educational Tool for Busy Clinicians

Rebecca L. Volpe, Benjamin H. Levi, George F. Blackall, and Michael J. Green

ABSTRACT

The adage "an ounce of prevention is worth a pound of cure" is widely used in healthcare settings and can be applied to the work of institutional clinical ethics committees. The model of clinical ethics consultation, however, is inherently reactive: a crisis or question emerges, and ethics experts are called to help. In an effort to employ a proactive component to the model of clinical ethics consultation (as well as to standardize our educational interventions), we developed ethics pocket cards. The purpose of this article is to: (1) describe the rationale for using ethics pocket cards, (2) provide examples of our cards, and (3) begin a dialogue about the potential uses of ethics pocket cards. In doing so, we

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hope to explore how such portable, economical devices can advance the goals of ethics consultation as well as the educational aims of ethics committees.

INTRODUCTION

Ethics committees have become ubiquitous in U.S. hospitals. These committees help healthcare providers deal with challenging ethical problems and provide ethics education throughout their institutions.¹

The range of ethics case consultations varies by institution, but generally revolves around patients' autonomy, decision-making capacity, and communication.² In one large study, the five most common reasons for requesting an ethics consultation were (1) questions about patients' decision-making capacity, (2) conflict among hospital staff, (3) concerns about quality of life, (4) inquiries about fertility/goals of care, and (5) appeals regarding withholding or withdrawing treatment.³ As with other studies,⁴ in our own institution, ethics consultation requests over the past 18 months reflect similar trends: in 42 percent of cases, the primary ethics issue concerned respect for patients' autonomy, and in 32 percent of consultations, the primary concern was the goal of care. These consultations often occur in the setting of end-of-life care, and frequently involve conflict

between careproviders and family members, or amongst members of the treating team.

Because ethics involves helping to provide a clearer understanding of the meaning and implications of various points of view and/or proposals for action, it is natural that education emerges as a primary role for ethics committees in their service to clinicians and other healthcare professionals. While such education is often delivered proactively in classrooms, small group settings, or “ethics rounds,” the charged environment that often surrounds clinical ethics consultations can provide prime opportunities for direct experiential learning.

Like many teachers who find themselves responding to the same questions over and over, the ethics consultation service at our institution has developed tools to standardize the education it provides, including teaching files, a repository of articles, and, more recently, ethics pocket cards. Although other institutions use similar pocket cards,⁵ to our knowledge, no standards or best practice guidelines exist for their content or format. The purpose of this article is to briefly describe our ethics pocket cards and to begin a dialogue about how such portable, economical devices can be used to advance the goals of ethics consultation, as well as the educational aims of ethics committees more generally.

THE ROLE OF ETHICS POCKET CARDS

Algorithms and decision aids have been used by health professionals for many years to promote better clinical care. Long before practice guidelines were issued by panels of experts and national committees, clinicians developed and shared personalized notecards—some so esteemed that they evolved into publications such as *The Washington Manual of Medical Therapeutics* or the *Harriet Lane Handbook*.⁶ Busy clinicians appreciate these personalized notecards, or pocket cards, for their portability and simplicity, and there is evidence that they are preferred over other educational modalities such as handouts, seminars, workshops, or online tutorials.⁷ Because clinicians *like* pocket cards, they actually *use* them,⁸ and pocket cards have been shown to increase clinicians’ knowledge,⁹ as well as change clinical behavior.¹⁰

Like other pocket cards, ethics pocket cards can help busy clinicians sort through challenging cases. At our institution, the main purpose of these cards is to summarize core knowledge about clinical ethics for clinicians, and to present it in a systematic and accessible manner. The cards can remind clinicians of what they already know, prompt them to

think differently about areas in which they are uncertain, and promote dialogue and further investigation when necessary. We have thus far created ethics pocket cards addressing seven topics: advance care planning, assessing decision-making capacity, advance directives and surrogate decision making, state law related to surrogate decision making, informed consent, medical futility, and an overview of the clinical ethics consultation service. We distribute these cards at educational sessions, during and after ethics consultations, at orientations, and as quick reference tools to facilitate conversations. The cards help members of the ethics committee educate healthcare providers, and also help careproviders educate patients’ family members.

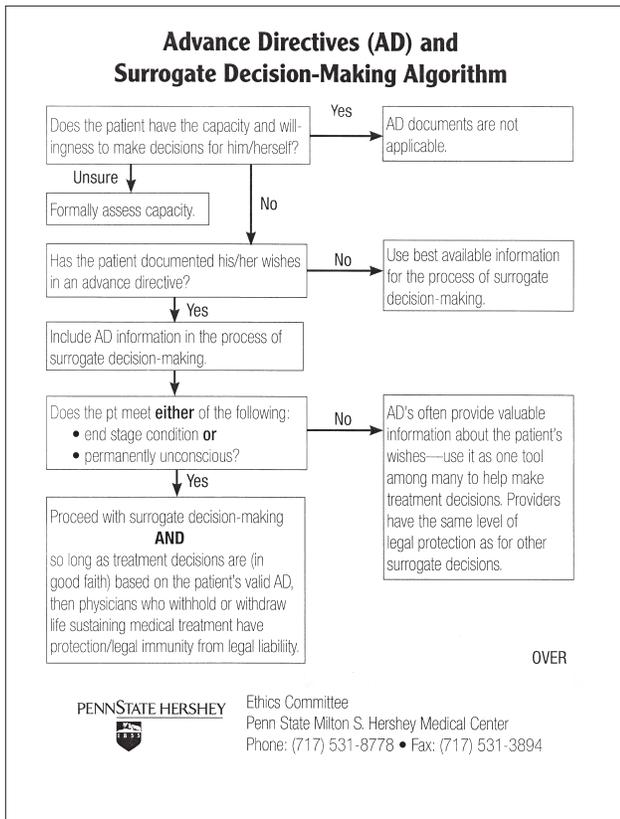
LIMITATIONS OF POCKET CARDS

Pocket cards are not a panacea, and it’s important to guard against over relying on such resources or making them overly simplistic. We have been careful to use ethics pocket cards as an adjunct to comprehensive ethics education, as a ready resource and reminder of the salient points that have been discussed in other fora (formal ethics education, clinical ethics consultations, et cetera), and that reflect general ethical consensus. An educational tool need not be exhaustive to have utility, and our experience has been that ethics pocket cards can be a useful resource when used appropriately.

We also acknowledge that despite our best efforts, no pocket card can be free of cultural context or other sources of bias. For example, our Western perspective on the primacy of respect for patients’ autonomy is reflected in a number of the cards. Further, the authors’ ideas about the best way to *do* clinical ethics are also built into the cards. But so long as such assumptions remain open to question, and the tools are not viewed as a comprehensive response, they can serve a useful purpose for busy clinicians who are seeking guidance about ethical issues.

SUCCESS OF ETHICS POCKET CARDS

Although we began distributing these pocket cards only over the past year, they have become popular with students, residents, nurses, attending physicians, and others. We have received overwhelmingly positive feedback on the pocket cards from clinical directors of medical units and surgical services, hospital administrators, and even nonclinical entities such as the offices for medical education and diversity. While we have not yet formally evaluated the impact of the ethics pocket



A *surrogate decision-maker* is the individual legally authorized to make decisions on behalf of the patient. The goal of surrogate decision-making is to reflect what the individual **would have decided**, if able to speak for him/herself. This **substitute judgment** is used when the patient has previously expressed preferences, or when the surrogate can reasonably infer what the patient would want. When the patient's preferences are unknown or unclear, then the surrogate decision-maker should make decisions based on their determination of the patient's **best interests**.

When the patient has not formally authorized a surrogate decision-maker, Pennsylvania Act 169 outlines the following **priority list for who should serve as the patient's surrogate**:

- Spouse (unless divorce proceedings are underway)
- Adult child
- Parent
- Adult sibling
- Adult grandchild
- Close friend (i.e., individual who is knowledgeable of the pt's preferences)

Studies indicate that patients vary in how much flexibility they would give surrogates to **override their advance directive**: 33% of patients want their AD followed exactly, 33% of patients want their surrogate to have complete authority to override their AD, and the final 33% fall somewhere in-between.¹

Want more information?
Check HMC Policy: Guide to Advance Directives, PC-13 HAM.
Search "Surrogate Decision-Making" @ www.ama-assn.org/ to see Code of Medical Ethics of the American Medical Association policy E-8.081

Questions?
Call the operator (ext. 8521) and ask for the ethicist on-call.

¹Sehgal, A et al (1992). How strictly to dialysis patients want their advance directives followed? *JAMA*, 267: 59-63.

Figure 1. Pocket card, "Advance Directives and Surrogate Decision-Making Algorithm," front and back.

Assessing Decision Making Capacity (DMC)

For adult patients, most routine decisions about Decision Making Capacity (DMC) can be made by any fully-trained physician. Psychiatrists, ethicists, and/or the courts are only needed in problematic cases. Ideally, providers should assess DMC any time they engage patients in discussion about a treatment, not just when a patient disagrees with the treatment plan. Fast facts about DMC:

- 1) Patients who have DMC have an **absolute and fundamental right to make their own medical decisions**, whether or not others agree with their decisions, **even if** the decisions lead to bad outcomes (including death).
- 2) That said, health care providers have a duty to help patients make informed decisions, which includes understanding consequences and options.
- 3) "**Capacity**" refers to a patient's mental ability to participate in decision-making, can wax and wane, and is determined by healthcare providers at the bedside. "**Competency**" is a legal term, refers to a long-standing, global condition, and is determined by a judge (usually with advice from physicians).
- 4) The reason to assess DMC is to answer the question: "**should we allow this patient to make this medical decision, under these circumstances?**" The focus is NOT global capacity, but the patient's ability to decide about a particular proposed intervention or treatment under particular conditions and circumstances.
- 5) There is no one way to assess DMC. In general however, we say a patient has DMC if:
 - a) he or she understands the situation and the consequences of the decision, *and*
 - b) the person's reasoning is consistent with his/her values and preferences

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Four Questions to Assess Decision Making Capacity:

- 1) **Can the patient demonstrate the ability to communicate a choice?**
"Have you decided whether to go along with your doctor's suggestions?"
- 2) **Does the patient understand his or her medical condition and the relevant facts?**
"Please tell me in your own words what your doctor told you about your condition, his or her recommendation, the risks and benefits of the proposed intervention, and the alternatives."
- 3) **Does the patient understand the available options and the consequences of his or her decision?**
"What do you think will happen to you if you are not treated? What do you think will happen if you are treated? Why do you think your doctor has recommend (x) to you?"
- 4) **Is the decision based on reasoning consistent with the patient's values/ preferences?**
"How did you reach your decision? What factors were important to you in reaching the decision?" Make sure the conclusions follow logically from the premises.

Recognize that specific physical or mental diagnoses, e.g., schizophrenia, stroke, depression, or Alzheimer's do **not necessarily** mean that a patient lacks DMC to make a specific decision.

The greater the risk of the intervention, the more important to ensure that patients have DMC before accepting their decision.

Want more information?
Check HMC policy: *Informed Consent, L-07 HAM*.
See Appelbaum & Grisso (1988). Assessing patients' capacity to consent to treatment. *NEJM*, 319: 1635-1638.

Questions? Call the operator (ext.8521) and ask for the ethicist on-call.

Figure 2. Pocket card, "Assessing Decision Making Capacity," front and back.

cards, their enthusiastic acceptance has prompted us to share our experience, along with the pocket cards themselves, with others who may wish to develop (and evaluate) similar interventions. In addition to providing the full text of our two most frequently used pocket cards (see figures 1 and 2), interested readers can go to the Penn State University College of Medicine Department of Humanities website (www.pennstatehershey.org/humanities) to access .pdf files of all the pocket cards we have developed to date. In the future, we plan to examine the effect of ethics pocket cards on clinicians' knowledge, attitudes, and behaviors, as well as their influence on the frequency and nature of ethics consultations. In the meantime, we welcome feedback on our tools, and invite others to contact us to either share their own ethics pocket cards or work with us to develop a repository of such practical educational tools for clinical ethics consultations.

CONCLUSIONS

Ethics pocket cards are a useful way to efficiently deliver basic ethics information to busy clinicians. As clinical medicine becomes increasingly complex, we need more, not less, tools for teaching ethics, and more, not less, creative approaches to help those who need assistance navigating the turbulent waters of modern medicine. Our experience with ethics pocket cards suggests that these cards can provide such support, and we encourage others to adapt our tools or to develop their own resources for helping clinicians in need.

NOTES

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