

## **Sound Ethics in Health Care: Managing Conflicts Between Clinicians and Surrogates**

### **Part 1: Managing Conflicts with Surrogates Related to Life-Sustaining Treatment Decisions**

#### **Narrator**

**Welcome to *Sound Ethics In Health Care*, from the Department of Veterans Affairs National Center for Ethics in Health Care. The topic of this edition is preventing, mitigating, and managing conflicts between clinicians and surrogates. This program features staff from the Ethics Center, as well as perspectives from the VHA Workplace Violence Prevention Program and clinical staff working in local VA medical centers. Barbara Chanko, a Medical Ethicist with the National Center for Ethics in Health Care, emphasizes that for a patient without decision-making capacity, surrogates generally assume the same rights and authorities as the patient with respect to decisions about treatments and procedures.**

#### **Chanko**

When a patient loses capacity, the requirement to conduct shared decision-making on the part of the provider and the team doesn't cease. In VA and in general, we rely on a surrogate to participate in that shared decision-making process. All the same principles and procedures that would apply to holding a conversation with the patient about the treatment options, explaining the risks and the benefits and burdens, should be held with the identified surrogate.

#### **Narrator**

**Dr. Ken Berkowitz, Chief of Ethics Consultation at the National Center for Ethics in Health Care, says that the role of the provider is to lead the shared decision-making process.**

#### **Berkowitz**

During that decision-making process, the provider needs to be professional and empathetic and work hard to form a relationship with the surrogate. They need to communicate effectively so that the surrogate has the appropriate information on which to base their thinking and their decisions. And they also need to guide the surrogate so that the surrogate understands their responsibilities.

#### **Narrator**

**Dr. Ellen Fox is VA's Chief Officer for Ethics in Health Care.**



Fox

Surrogates are *not* supposed to tell you what *they* want. They're supposed to tell you what the *patient* would want. So you need to say to them something like, "You are here because you know your dad better than anyone else in the world. You know what was important to him, and you know him as a person. So that's why I need you to help me figure out what he would want, because he can't speak for himself anymore. And if you don't know exactly what he would want, well, think about who he is as a person and what he values — maybe some of the decisions he made in the past. And together, we'll figure out what's best for him."

**Narrator**

**Dr. Jefferson Rogers is a clinical psychologist and the Ethics Consultation Coordinator at VA Gulf Coast Veterans Health Care System in Biloxi, Mississippi. Dr. Rogers recounts the case of a patient with advanced dementia and multiple comorbidities who was admitted to the intensive care unit with no advance directive. The health care team did not believe there was evidence that the patient would have wanted life-sustaining treatment. The patient's wife disagreed.**

Rogers

The wife believed that what he wanted was to have any type of care that could keep him alive for as long as possible. She wanted him to be full code. And he coded a few times, they were able to bring him back, and he continued to get more and more edema. The nurses, after a period of time, they felt like they were torturing the gentleman. The wife would still come every day and just sit in his room, so it was something that was very painful to her. We tried to help her out, we got chaplains very much involved. We continued to let her know that she was in control of his code status.

**Narrator**

**In such situations, it is important to remember that different patients have different goals of care. While some patients do not want interventions to attempt to prolong their lives, others do. Prolonging the patient's life, even for a short time, can be a legitimate goal of care when it is consistent with the patient's values and preferences, or, if those are unknown, the patient's best interests. Dr. David Alfandre is a Medical Ethicist with the National Center for Ethics in Health Care.**

Alfandre

If prolonging life is an identified goal of care on behalf of the patient, then interventions should be directed at trying to prolong life. I think where providers get stuck is that there are ethically acceptable limits to surrogates' requests for particular treatments. So if there's no chance that an intervention will meet an identified goal of care, then that certainly doesn't need to be offered to the patient.

**Narrator**

**Dr. Jefferson Rogers.**

Rogers

At one point, we clarified that while it was the wife's role as the decision-maker related to code status, it was the physicians' role to decide what treatments were clinically indicated, and that they did not have to provide treatments that they did not feel could meet goals and could even result in harm to the Veteran.

**Narrator**

**It is important to note that having a small chance of achieving a goal of care is not the same as having no chance. Treatments that have some chance of helping to achieve a goal of care, even if that chance is small, should be offered. Providers sometimes make personal judgments about the value of treatments with only a small chance of achieving a goal of care, deciding that some are not worth pursuing, given their burden to the patient and the low likelihood of their success. However, the provider's role is not to determine whether those trade-offs would be acceptable to the patient, but rather, to explain them to the surrogate. If there is no clear indication of the patient's preferences, the provider should help the surrogate explore the best interests of the patient, given what is known about the patient's values. This can require multiple discussions over a period of time. Dr. Rogers.**

Rogers

So we continued to just work with her, and we really focused not only on our respect for her but also on what was in the best interest of the patient. You know, sometimes it's not done as quickly as you would like, and sometimes it's not as easy as you would like, but what we always want to do is try to reach a consensus among all the involved parties. And help them really understand why something might be ethically justifiable or not, and then they can hopefully feel good about their decision, and know that they are working in what's the best interest of the party that is incapacitated and can't speak for themselves.

**Narrator**

**Sometimes, the conflict between the surrogate and treatment team centers around the interpretation of the patient's advance directive. The contents of the advance directive can shed light on the patient's preferences — even what the patient might have considered to be in their best interest — but the surrogate and the treatment team may interpret the contents of that document differently. When such a disagreement arises, it is important for the treatment team to remember that advance directives are often vaguely worded and open to interpretation, and that the surrogate is in a better position than the treatment team to clarify the patient's intent. Dr. Ken Berkowitz.**

Berkowitz

I think whenever you're having a discussion about the possibility of overriding a surrogate's decisions or removing a surrogate, I think you have to go back to our basic initial presumption that in general the surrogate has the same rights and authorities as a patient would have in health care decision-making. It's a pretty high bar to think about a circumstance where you're going to overrule a capacitated patient's decision. And I think similarly, it's a pretty high bar to think about when you as a treatment

team member will be on solid footing in terms of overriding a surrogate's decision or to have the surrogate removed, because that's well within their authority, usually, to make those decisions.

**Narrator**

**Barbara Chanko.**

Chanko

I think that when providers come across these situations, they need to recognize them as an opportunity to really try to unpack and uncover and deal with the source of the request. Why is it that the surrogate is asking for this? And again continue in a shared decision-making process, a collaborative process, to focus and sometimes refocus the surrogate on the patient, and/or explain why the procedures or the treatments that the surrogate is requesting would not advance the goals that they've determined for the patient.

Berkowitz

If, after all of that, you get to an intractable disagreement, where the team member feels really that the surrogate just can't be allowed to continue and that they really think they've reached an impasse and that in their professional judgment they can't allow things to continue, then I think that they need to get help. I think the ethics consult service can be an effective way of working through these impasses between teams and surrogates. And these are people who come in, in a neutral way, and hopefully be effective at laying out for everyone, clarifying really what's the source of the conflict, getting the right information that they need to think through the problem, and then helping, working with the people to analyze the situation, understand what are the ethically justifiable options, and actually who gets to make the decision about how things should proceed.

**Narrator**

**Additional information on conflicts related to a surrogate's decisions about treatments or procedures can be found in the Informed Consent Handbook — VHA Handbook 1004.01 — and the VHA National Ethics Committee report, "Ethical Aspects of the Relationship between Clinicians and Surrogate Decision Makers."**

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**Part 2: Managing Conflicts Related to Surrogate Requests or Demands**

**Narrator**

**Another common source of conflict between providers and surrogates is an unusual request or demand by the surrogate.**

Schneider

I do think that there are some areas where we need to establish limits in the kinds of requests that surrogate decision-makers request of us.

**Narrator**

**Hospitalist and clinician educator Dr. Paul Schneider is Ethics Consultation Coordinator with the VA Greater Los Angeles Health Care System.**

Schneider

A wife who had married a patient in the intensive care unit who was incompetent, on life support, had prohibited the ICU team from speaking to her husband. While I could agree to not write a DNR against her will, I couldn't agree to her request to not even speak to the patient. I felt that there's no surrogate decision-maker in the world who has the right to order doctors to not interact with their patient.

**Narrator**

**Dr. Ken Berkowitz says that there are circumstances when it may be ethically justifiable to decline to accommodate a surrogate's request or demand.**

Berkowitz

The obligation of the staff to comply with a surrogate's request is not without limits. In general, we should try to accommodate a surrogate's request just like we try to accommodate a patient's request, but if something that a surrogate is requesting is contrary to VA policy, or against the law, or contrary to clear medical standards, then that request shouldn't be accommodated.

**Narrator**

**Dr. David Alfandre says that circumstances under which staff should consider not accommodating a request include when the request is inconsistent with law, policy, or organizational values ...**

Alfandre

For instance, a surrogate might request that the entire intensive care unit team be a particular gender or a particular race.

**Narrator**

**...when the request is determined to place an unreasonable burden on the institution; when the request would compromise the safety of other patients, the staff, or the public; or when the request is inconsistent with professional standards. Dr. Ellen Fox.**

Fox

As a health care professional, you really shouldn't say "yes" to unreasonable requests. If a treatment is truly not medically indicated or if it's contraindicated, you shouldn't agree to provide it.

Alfandre

So a patient may have a communicable illness, where it's imperative that transmission within the hospital is minimized as much as reasonably possible. And so they're often put in negative pressure rooms. This does involve isolation. And to place a patient with a communicable illness within the room of another patient would expose other patients unnecessarily to potentially dangerous infections.

**Narrator**

**Dr. Berkowitz.**

Berkowitz

I think if staff are faced with an unusual request or demand from a surrogate, they need to conduct themselves in a manner similar to the way they always interact with patients or surrogates. They need to actively listen to what the surrogate is requesting or demanding; they need to consider the request or demand respectfully; if they're concerned about it or have questions about it they need to clarify exactly what the request or demand is and to understand the basis for it; and they need to really think about it with an open mind, get all the necessary information on which to make a decision about how they're going to proceed.

**Narrator**

**If a request is determined to be legitimate, but difficult to fulfill because it calls for services not provided at a facility, it still might be possible to honor the request by other means. Barbara Chanko.**

Chanko

In VA, we often, if there's a legitimate request, and the service is not provided at a facility, we will often contract it out or fee-base it out, and that, I think, is a way to meet some of the demands or the requests of the surrogate.

**Narrator**

**In some cases, requests from surrogates to change hospital practices have eventually resulted in changes to the entire VA health system.**

Chanko

Visitation is one of those issues. As we became more patient-centered, and as the value and the benefit to the patient of having visitors come was demonstrated, the visiting hours gradually opened, they were longer and longer, until at this point virtually any family member or surrogate can visit at almost any time.

**Narrator**

**When it is determined that a surrogate's request will not be accommodated, there are certain procedures that should be followed.**

Alfandre

There should be a clear discussion with the surrogate about why it can't be accommodated. I think the better you explain that decision, you give the reasons behind it, the more likely the surrogate is to understand the decision and accept the decision of the staff.

Chanko

We use the word "deny" request, but I think that, in thinking about patient-centered care, in thinking about shared decision-making, it's sometimes more to me a sense of being able to share with the surrogate why something is not possible. It's not just a straight out "no, we can't do that," it's really trying to engage in a partnership with the surrogate so that they can appreciate why it is that it's not feasible.

Berkowitz

I think it's important to tell the surrogate about what opportunities they have to have their request reconsidered or appealed to a higher authority. There's a clinical appeals mechanism which a surrogate can avail themselves of like a patient could, there's a patient representative, there's an ethics consultation. So if you're saying no to someone, and you explain it to them in an empathetic and open way and they still object, they still may have opportunities to have their request considered further.

**Narrator**

**Meanwhile, the staff should continue to work with the surrogate to identify other practical and appropriate options that meet the surrogate's identified concerns.**

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### **Part 3: Managing Conflicts Related to Surrogate Behaviors**

**Narrator**

**A third source of conflict between staff and surrogates is surrogate behaviors. Dr. David Alfandre.**

Alfandre

A behavior that undermines the safe delivery of care or threatens the safety of the patient or other patients is problematic, and therefore the staff can set limits on the surrogate's behavior. The overall term that would refer to these behaviors is disruptive.

**Narrator**

**Dr. Ken Berkowitz.**

Berkowitz

We don't have to tolerate, in a health care system, disruptive behavior, behavior that's disrupting care to others, that's creating a violent or an unsafe workplace, and we don't have to tolerate disrespect. Surrogate behaviors that might be considered disrespectful are cursing, name-calling, not listening, demands to be seen or spoken to at any given time that they wish.

**Narrator**

**Dr. Ellen Fox observes that for the safety of patients, staff, and visitors, it's best to deal with disruptive behavior as soon as possible.**

Fox

Disruptive behaviors really shouldn't be tolerated in a health care setting. They should be addressed as soon as they happen, and clear limits should be set. It's much harder to deal with these problems after they've been tolerated for a while, so it's best to catch things early, and deal with problems directly.

**Narrator**

**Dr. Lynn Van Male is Director of the VHA Workplace Violence Prevention Program. She says that, given the stress that surrogates are under, it's no surprise that their behavior can sometimes be a source of conflict.**

Van Male

When people are in a place of feeling vulnerable and scared and frightened and confused, their emotions are going to run high, and you're probably going to have to deal with their feelings first before they're able to make well-reasoned decisions. And their feelings, their affect, their emotions, can lead them into escalating behavior more rapidly than they otherwise would have.

**Narrator**

**Dr. Van Male recommends a number of strategies for de-escalating while attempting to maintain a positive relationship with the surrogate. One is mirroring calm behavior.**

Van Male

If you mirror for someone that you are breathing calmly, you're attentive, you are empathic, you're receptive to their needs, their emotional reaction and their affect can be defused simply by knowing that they have another human in the room who is breathing slowly and is being calm, so that they aren't escalating themselves, because you are not escalating.

**Narrator**

**Another is inviting the surrogate to take a break.**



Van Male

Taking a calming walk. Getting something cool to drink. Changing their location, their venue, so that they aren't in the place physically and emotionally that's causing the difficulty.

**Narrator**

**The next step is setting verbal limits.**

Van Male

And verbal limits are things along the lines of, lower your voice. Take a seat. So that you're giving clear behavioral statements about what you expect to have happen in the moment.

**Narrator**

**Dr. Van Male notes that there are organizational resources available in VA to assist when staff have concerns about safety. Although Disruptive Behavior Committees generally address concerns related to disruptive patients, they can be helpful in advising how to maintain a safe and therapeutic health care environment when a surrogate has been disruptive.**

Van Male

If there are clinicians who are concerned that their safety is at risk due to the disruptive behaviors, they can refer the case to the disruptive behavior committee in the facility, and ask the disruptive behavior committee to take a look at the behavior, to assess what's known, and to help determine whether or not the individual truly poses a threat, and if so, what to do about it.

**Narrator**

**When the situation cannot be defused and staff have immediate safety concerns, it is appropriate to call the VA police.**

Van Male

When individuals have become so escalated and so aroused that verbal de-escalation, good customer service, good empathy and reframing and options to vent emotion is not defusing the situation, they're still escalating and they do not respond to limits, it's time to get the police there.

**Narrator**

**Fortunately, VA offers training to its employees in dealing with disruptive behavior.**

Van Male

One of the things that providers can do to give themselves a skill set that could be helpful in advance is to take the Level Two Prevention and Management of Disruptive Behavior course. It provides the opportunity to work through scenarios in real time that require verbal de-escalation. So this is a course that provides people the opportunity to experience that, and to learn de-escalation skills, and also to know when de-escalation is no longer working and it's time to set limits.

**Narrator**

**Dr. Berkowitz and Dr. Alfandre suggest that providers look at disruptive behavior from a larger perspective: that of the overall relationship between staff and surrogates. Dr. Berkowitz emphasizes that it is the provider's responsibility to try to keep that relationship in good repair.**

Berkowitz

Disruptive surrogate behavior often is a symptom, in a way, of a dynamic in a relationship that needs to be addressed. And it may be that we have to support the surrogate in ways that we haven't been.

Alfandre

From an ethics perspective, it's really critically important to maintain that positive relationship with the surrogate. The surrogate is representing the patient, is, as we've said before, in the ideal position to represent the patient, and we have an obligation to work with the surrogate to make decisions on behalf of the patient.

Berkowitz

This isn't really a contest. It's not a power play. It's trying to mitigate the tension, mediate the situation, and continue to work with the surrogate as best as possible to achieve the patient's goals and the goals of continued health care delivery.

**Narrator**

**For links to documents and other resources mentioned in this production, visit [ethics.va.gov/education](http://ethics.va.gov/education). If you have a topic that you would like to see presented in a podcast or multimedia production, send an email to [vhaethics@va.gov](mailto:vhaethics@va.gov). *Sound Ethics in Health Care* is brought to you by the Department of Veterans Affairs National Center for Ethics in Health Care.**

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