Ethics in the Cardiac Operating Room

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Nashville, March 2019

Disclosures

• No financial conflicts of interest

Learning Objectives

• Review evolution of views towards patients and research subjects
• Apply the three tenets of respect for persons, beneficence, and justice to current ethical dilemmas
• Delve into our culture of (dis)respect in the operating room

Ethics

• How we approach medical research
• How we approach everyday care of patients
• How we behave towards our teammates in healthcare
Medical Research

2. Radioactive Materials in Pregnant Women

Unproven medical therapies

Code of Nuremberg

1. The voluntary consent of the human subject is absolutely essential.
2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.
3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the experiment.
4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.
5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.
6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.
Declaration of Helsinki (1964, 2013)

*World Medical Association*: The Declaration is morally binding on physicians, and that obligation overrides any national or local laws or regulations, if the Declaration provides for a higher standard of protection of humans than the latter.

- Respect for the individual (article 8)
- The individual’s right to self-determination and the right to make informed decisions (articles 20-22)
- Researcher’s duty is solely to the patient (articles 2, 3, 10, 16, 18)
- Subject’s welfare must take precedence over the interests of science or laws (article 5, 9)
- Vulnerable subjects require special vigilance (8)


- Respect for persons
- Beneficence
- Justice

Respect for Persons

An autonomous person is an individual capable of deliberation about personal goals and of acting under the direction of such deliberation. To respect autonomy is to give weight to autonomous persons’ considered opinions and choices while refraining from obstructing their actions unless they are clearly detrimental to others. To show lack of respect for an autonomous agent is to repudiate that person’s considered judgments, to deny an individual the freedom to act on those considered judgments, or to withhold information necessary to make a considered judgment, when there are no compelling reasons to do so.

Beneficence

Persons are treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being. Such treatment falls under the principle of beneficence. The term “beneficence” is often understood to cover acts of kindness or charity that go beyond strict obligation. In this document, beneficence is understood in a stronger sense, as an obligation. Two general rules have been formulated as complementary expressions of beneficent actions in this sense: (1) do not harm and (2) maximize possible benefits and minimize possible harms.
Justice

The selection of research subjects needs to be scrutinized in order to determine whether some are being systematically selected simply because of their easy availability, their compromised position, or their manipulability, rather than for reasons directly related to the problem being studied. Finally, whenever research supported by public funds leads to the development of therapeutic devices and procedures, justice demands both that these not provide advantages only to those who can afford them and that such research should not unduly involve persons from groups unlikely to be among the beneficiaries of subsequent applications of the research.

Routine HCG

- Does your hospital have a policy of performing a routine pregnancy test on every eligible female prior to surgery?
- If positive, would surgery be cancelled?

Routine HCG

- Mandatory in most ORs for females
- Considered unethical by most medical ethicists
- Not endorsed by ASA
- Preferred approach – discuss potential risks to fetus, woman chooses

Causes of death in the world 2015

56.4 millions of deaths /year

- 20 million: Communicable diseases
- Clinical contraindications
- 15 million: Cardiovascular diseases (26.60 % of the world’s death)
- Ischemic Cardiopathy 15.53%\(^\text{ OCD}\)
- Cerebral vascular accident (CVA) 11.06%\(^\text{ OR}\), \(^\text{ ODD}\)
- 3.19 million: Respiratory diseases 5.65%\(^\text{ OCD}\)
- 1.34 million: Traffic 2.37%\(^\text{ ODD}\)

*percentage of the world’s deaths

Source: WHO
http://www.who.int/mediacentre/factsheets/fs312/en/
Organ donation

Donation after circulatory death and its expansion in Spain

Eduardo Martínez*, Juan J. Robb*, Elisabeth Coit†, and Moisés Domínguez-Gea

Curr Opin Organ Transplant 2018, 23:120–129

The need and opportunity for donation after circulatory death worldwide

Merli Mery*, Helen Nelson*, and Francis C. Delmonico*

Curr Opin Organ Transplant 2018, 23:136–141

Ethical considerations

- Donor must have been listed in registry prior to critical event
- Decision made by physician not involved in donation team
- Judge or coroner involvement?
- Timing of discussion: WLST versus donation first
Fear and Loathing in the Operating Room: Sexual Misconduct, Harassment and Bullying in Healthcare

Joyce Wahr, MD, FAHA
AmSECT

Nashville, March 2019

Objectives

• Open eyes
• Open minds
• Open hearts

• Open the shades

My story

• Medical student 1974-78 (20% female)
• Surgical resident 1978-1980 (5% female)
• Anesthesia resident 1980-82 (20% female)
• Anesthesia faculty 1984 – present
  – 2009: 26%
  – 2015: 36%

• 62 studies (all of medical trainees)
• Risk factors: female, nonwhite (Middle Eastern), surgery
• 5% of trainees considering leaving their specialty, 30% deeply disturbed
Harassment of Medical Trainees

Table 1
Prevalence of Harassment and Discrimination Among Trainees, According to Studies Identified in a 2011 Systematic Review of the Literature

<table>
<thead>
<tr>
<th>Type of harassment</th>
<th>No. of studies</th>
<th>Sample size</th>
<th>Mean</th>
<th>Median</th>
<th>Min/Max</th>
<th>95% CI</th>
<th>I²</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Harassment</td>
<td>51</td>
<td>38,353</td>
<td>59.4</td>
<td>69</td>
<td>11/100</td>
<td>52.0-66.7</td>
<td>0.99</td>
</tr>
<tr>
<td>% Verbal abuse</td>
<td>28</td>
<td>27,256</td>
<td>63</td>
<td>61</td>
<td>28/94</td>
<td>54.8-71.2</td>
<td>0.99</td>
</tr>
<tr>
<td>% Gender discrimination</td>
<td>13</td>
<td>6,237</td>
<td>53.8</td>
<td>56</td>
<td>19/92</td>
<td>40.3-67.0</td>
<td>0.99</td>
</tr>
<tr>
<td>% Academic</td>
<td>14</td>
<td>5,319</td>
<td>36.1</td>
<td>37</td>
<td>3/71</td>
<td>24.9-47.2</td>
<td>0.99</td>
</tr>
<tr>
<td>% Sexual</td>
<td>35</td>
<td>27,919</td>
<td>33.7</td>
<td>48</td>
<td>393</td>
<td>27.6-38.5</td>
<td>0.99</td>
</tr>
<tr>
<td>% Racial discrimination</td>
<td>10</td>
<td>19,455</td>
<td>23.8</td>
<td>30.9</td>
<td>3.858</td>
<td>15.2-32.4</td>
<td>0.99</td>
</tr>
<tr>
<td>% Physical</td>
<td>24</td>
<td>23,776</td>
<td>15.3</td>
<td>52</td>
<td>3/100</td>
<td>12.1-18.6</td>
<td>0.98</td>
</tr>
</tbody>
</table>

Abbreviation: CI indicates confidence interval.
**The Spectrum of Misconduct at W**

Knowing when a behavior on the situation, history a tone of delivery, and norm.

1. Generally not off. Common remarks such as colortaste.
3. Niggardish/insulting or superior manner.
4. Highly offensive intentionally deeply comments or bel.
5. Evident sexual mi or behaviors that are or physically intr.
6. Inappropriate sexual behavior or sexual abuse, or a.

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**What Constitutes Sexual Harassment, Abuse, or Misconduct?**

- Unwanted sexual text messages/emails
- Comments about anatomy/body parts
- Propositions to engage in sexual activity
- Being asked repeatedly for a date
- Offer of a promotion in exchange for a sexual favor
- Threats of punishment for refusal of a sexual favor
- Deliberately infringing on body space
- Unwanted groping/hugging/physical contact
- Deliberate fondling of self
- Grabbing body parts
- Rape

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**Who Was the Perpetrator?**

- Physician: 47%
- Nurse: 16%
- Medical resident or fellow: 4%
- Medical student: 1%
- Nurse practitioner: 1%
- Other: 29%

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**Resident: Who Was the Perpetrator?**

- Physician: 54%
- Medical resident or fellow: 14%
- Nurse: 11%
- Medical student: 3%
- Other: 10%

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**Harassment of Medical Trainees**

**Table 2**

<table>
<thead>
<tr>
<th>Type of Harassment</th>
<th>No. of alunos</th>
<th>Sample size</th>
<th>Mean</th>
<th>SD</th>
<th>CI 95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harassment</td>
<td>30</td>
<td>28,735</td>
<td>53.8</td>
<td>31.4</td>
<td>46.7-60.8</td>
</tr>
<tr>
<td>Verbal abuse</td>
<td>16</td>
<td>18,865</td>
<td>54.6</td>
<td>36.2</td>
<td>46.6-61.6</td>
</tr>
<tr>
<td>Gender discrimination</td>
<td>10</td>
<td>4,957</td>
<td>50.6</td>
<td>36.6</td>
<td>41.5-60.7</td>
</tr>
<tr>
<td>Academic</td>
<td>10</td>
<td>3,852</td>
<td>50.5</td>
<td>37.7</td>
<td>41.8-59.2</td>
</tr>
<tr>
<td>Social</td>
<td>10</td>
<td>3,852</td>
<td>36.5</td>
<td>36.6</td>
<td>31.9-41.4</td>
</tr>
<tr>
<td>Fiscal</td>
<td>7</td>
<td>3,852</td>
<td>53.7</td>
<td>36.6</td>
<td>41.5-60.7</td>
</tr>
<tr>
<td>Physical</td>
<td>15</td>
<td>18,790</td>
<td>50.8</td>
<td>36.8</td>
<td>31.1-61.3</td>
</tr>
</tbody>
</table>

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**Sexual Harassment and Discrimination Experiences of Academic Medical Faculty**

Roshna Jaggi, MD, DPhil, Kent A. Griffith, MS, Rochelle Jones, MS, Chithra R. Perumalowami, MD, Peter Ubel, MD, and Abigail Stewart, PhD

Department of Radiation Oncology, University of Michigan, Ann Arbor (Jaggi, Jones); Center for Cancer Disparities, University of Michigan School of Public Health, Ann Arbor (Griffith); US Department of Veterans Affairs, University of Michigan, Ann Arbor (Perumalowami); Fuqua School of Business, Duke University, Durham, North Carolina (Ubel); Department of Psychology, University of Michigan, Ann Arbor (Stewart)

Recent high-profile cases of sexual harassment illustrate that such experiences still occur in academic medicine.1 Less is known about how many women have directly experienced such behavior. Most studies have focused on trainees, single specialties, and non-US settings or lack cautionary. In a 1995 cross-sectional survey,2 57% of US academic medical faculty women reported harassment in their careers compared with 5% of men. These women had begun their careers where women constituted a minority of the medical school class, less is known about the prevalence of such experiences among more recent faculty cohorts.
A Culture of (Dis)Respect

A substantial barrier to progress in patient safety is a dysfunctional culture rooted in widespread disrespect. . . . six categories for classifying disrespectful behavior in the health care setting: disruptive behavior; humiliating, demeaning treatment of nurses, residents, and students; passive-aggressive behavior; passive disrespect; dismissive treatment of patients; and systemic disrespect.

At one end of the spectrum, a single disruptive physician can poison the atmosphere of an entire unit. More common are everyday humiliations of nurses and physicians in training, as well as passive resistance to collaboration and change. Even more common are lesser degrees of disrespectful conduct toward patients that are taken for granted and not recognized by health workers as disrespectful.

Disrespect is a threat to patient safety because it inhibits collegiality and cooperation essential to teamwork, cuts off communication, undermines morale, and inhibits compliance with and implementation of new practices. Nurses and students are particularly at risk, but disrespectful treatment is also devastating for patients. Disrespect underlies the tensions and dissatisfactions that diminish joy and fulfillment in work for all health care workers and contributes to turnover of highly qualified staff. Disrespectful behavior is rooted, in part, in characteristics of the individual, such as insecurity or aggressiveness, but it is also learned, tolerated, and reinforced in the hierarchical hospital culture.
Harassment and Discrimination in Medical Training: A Systematic Review and Meta-Analysis

Naif Frias, MS, Charlene Sobhah, Maggie Hong Chen, PhD, MsC, Erin Ullie, MsC, Laura Penner, MEd, Mariam Tashkandi, MD, Sharon E. Straus, MD, MsC, Muhammad Mandani, PharmD, MA, MPH, Mohammed Al-Omari, MD, MsC, and Andrea C. Trinca, PhD, MsC

Academic Medicine, Vol. 89, No. 5 / May 2014

- 62 studies (all of medical trainees)
- Mean of 60-70% of trainees report harassment
- Risk factors: female, nonwhite (Middle Eastern), surgery
- 5% of trainees considering leaving their specialty, 30% deeply disturbed

Why They Don’t Report

- Shame, embarrassment
- Fear of not being believed
- Fear of retaliation
  - Overt
    - Poor grade on rotation
    - Inappropriate assignments
    - Blocked from participating in surgeries
    - Performance review
  - Covert
    - Vindictive comments in confidential setting (grant review)
Why They Don’t Report

• Shame, embarrassment
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What to do - bystander

• Team coach and check – the 2 minute conversation
• Report on the behalf of someone else (it may be your company’s policy)
• Support the victim, offer to help navigate reporting
• Check yourself

What you permit, you promote

What to do - victim

• Say no clearly
• Keep a written diary or log with dates, locations, witnesses
• Consult your HR office
  – Review your personnel file FIRST, make a record if possible
  – Report the harassment to HR
• File a discrimination complaint with a government agency (know your deadlines)
  – Equal Employment Opportunity Commission (EEOC) at www.eeoc.gov or 1-800-669-4000
References


Your turn...