ETHICS MAN **Daniel K Sokol**

Rethinking ward rounds

If you were a patient, would you prefer your medical team to use an ethics checklist?

It's the morning round in the hospital. In a dreary voice the doctor presents the patient, a 43 year old man with fever, chills, and a productive cough. He has a new diagnosis of HIV infection. He is married and has a girlfriend. The two bioethicists in the room, hitherto lulled by the long list of treatments, stir uncomfortably in their seats: there may be problems afoot. Do the wife and girlfriend know about each other? Can the team distinguish one from the other? Does the patient want to share the diagnosis with either? Should they be told of their likely exposure to HIV, even without the patient's consent?

The purpose of oral presentations in rounds is to tell the patient's story. It is primarily a medical story, which may start before the patient's birth (if genetics are relevant) and extend to the future. The narrative helps the healthcare team make sense of the patient's situation and provide safe, effective care. Although the stories should be comprehensive, they are often incomplete. The ethical aspects are omitted. At present the healthcare team has to tease these out from a heap of medical information. Sometimes the ethical issues stay buried in the heap, unnoticed. To reduce the risk of the clinical obscuring the ethical, a new section is needed in patients' notes.

The new category, named "ethical issues," would consist of a short list of headings (see box). It would not require much time to complete, nor would it require much knowledge of medical ethics. It would make explicit the key ethical issues of a case, helping to anticipate their emergence or aggravation. The team can then implement strategies to deal with them. Ethicists sometimes call this preventive ethics. As well as thwarting ethical problems, it can reduce complaints and lawsuits. It can improve the patient's experience and management and can help clinicians feel that they are providing ethically appropriate care. In the case above, the first "ethics" task is to discuss the issue of confidentiality with the patient.

The checklist should be concise and easy to understand (there may be dozens of patients to consider that morning), and the categories should capture the ethical issues most common in hospital medicine. The section would appear after the social or family history. In the case of the patient with HIV, such an ethics checklist might look like that shown in the box. In practice, the presenter might say, "With regard to ethical issues, patient confidentiality and disclosure of HIV status to the wife and girlfriend, because of the risk of HIV transmission, are notable. The patient's views on disclosure are not known."

The checklist serves as a prompt to help clinicians confront the ethical issues. Once these are identified, the team can decide how to address them. Depending on the complexity of the problems, they may handle them locally, consult a hospital ethicist, or refer the case to the clinical ethics committee. Often the presenter will simply say that there are no notable ethical issues. Completing the checklist should seldom take longer than 30 seconds, and the time spent doing so may well be saved later.

Recently a colleague and I went on rounds in an intensive care unit. One of the doctors was presenting the patient: a demented man who was terminally ill. The team spent 20 minutes discussing the patient's management. As the senior physician was putting the final touches to the chart, my colleague asked whether the patient had an advance directive. The nurse leafed through the voluminous notes and found an advance directive. It stated that in the event of an irreversible, end stage condition the patient wanted comfort care only—no ventilation or other life sustaining measures. The management plan was swiftly changed. Without my colleague's intervention the patient would have continued to be treated against his previously expressed wishes. The checklist, which in his case would have an additional tick in the forth row ("end of life issues"), would have prevented the error. The presenter might say: "In terms of ethical issues, the patient has a detailed advanced directive expressing a refusal of life sustaining treatment in end stage conditions. The goal of care should thus be reconsidered, with limitation of treatment, including DNAR [do not attempt resuscitation]."

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This is the ethics equivalent of the World Health Organization's surgical checklist (*New England Journal of Medicine* 2009;360:491-9). Like its surgical counterpart, it can prevent mistakes. It too takes only a handful of seconds. It too forces the healthcare team to acknowledge explicitly aspects that are often overlooked. Washington Hospital Center, in the District of Columbia, is currently piloting the idea (see figure on bmj.com). My hope is that others will follow suit.

To the sceptics I ask: if you were a patient, would you prefer your medical team to use an ethics checklist? Having seen many ethical mishaps in hospitals, I know what my answer would be.

Ethical issues (please tick any that apply)	
Patient's wishes are unclear, or patient refuses treatment	✔
Questionable capacity to consent to or refuse treatment	
Disagreement involving relatives	
End of life issues (advance directive, "do not attempt resuscitation" decisions, lasting power of attorney, limitation of treatment, etc)	
Issue over goal of care or appropriateness of current treatment	
Confidentiality or disclosure issue	✔
Resource or fairness issue	
Other (please note)	
No notable ethical issues	

DKS was a visiting scholar in bioethics at Washington Hospital Center, Washington, DC, in January and February 2009.
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