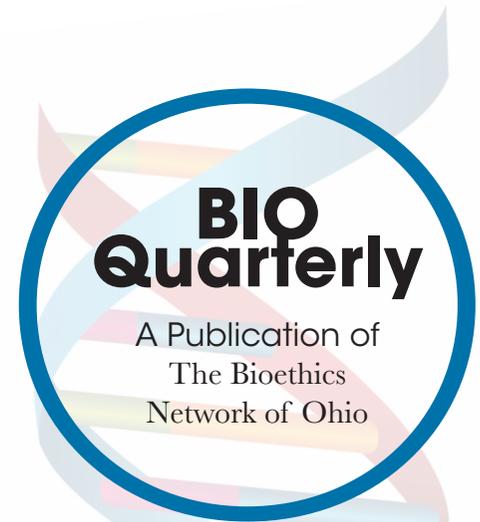


BENO



● 29th Annual BENO Conference



Stephanie K. Fabbro, MD, FAAD is Chair of the Ethics Committee for the Ohio Dermatological Association and co-editor of the BENO Bio Quarterly.

Held Friday, April 27th, 2019 at the OCLC Conference Center, the BENO Annual Conference focused on Ethical Issues in Mental Healthcare. This year’s annual conference comprised three general sessions and 6 different breakout sessions addressing a variety of pressing ethical issues in Ohio regarding mental health for a diverse number of patient populations. In her keynote address, “The Ethics of Autism 10 Years Later: What’s Changed and What’s Remained the Same?”, Deborah Barnbaum, PhD, of Kent State University, addressed the differences in autism care since she published her book *The Ethics of Autism* in 2009. Dr. Barnbaum emphasized the importance of the ability to mentalize, or the ability to think of what someone else is thinking, and what they are thinking of you, as a critical element to the diagnosis of autism. The specific changes she addressed within the last year were an overall increase in the amount of patients with autism spectrum disorder, the shift from DSM-IV to DSM-V, the neurodiversity movement, and the recognition for the need of services for those with

autism. The change in DSM was particularly impactful as multiple diagnoses became enveloped in the umbrella of autism spectrum disorder, and people strongly identifying with one particular subdiagnosis may struggle with this new classification. The conclusion of Dr. Barnbaum’s 2009 book was that people with autism should not be forcibly cured, to respect cognitive differences, and not to romanticize autism. Dr. Barnbaum continues to stand by her conclusions, but recognizes the needs of this community are even greater than she could have anticipated.

continued on page 2...



CONTENTS

The Intersection of Consultation-Liaison Psychiatry and Bioethics in the General Hospital

4

Case Conference: Violent Threats in the Psychiatric Population

7

Welcome New BENO Members

8

On September 5, 2019, the Cleveland Clinic will host an event entitled “Ethical Issues in Uterine Transplantation and Innovative Research in Reproductive Medicine.” For additional information, contact Chad Schlesinger (schlesc@ccf.org) or see www.clevelandclinicmeded.com/live/courses/uterustransplant/.



The Jim Barlow Memorial Lecture was presented by Xavier Jimenez, MD, of the Cleveland Clinic, and was entitled “Validation as Value: A Medically-Informed and Ethically-Balanced Approach to Mental Health, Addiction, and Chronic Pain”. Dr. Jimenez emphasized the importance of patient vs. biomarker validation, and how each are important when it comes to clinical validation. Biovalidation may function in the service of patient validation, and empathy may be a vehicle for validation in its own right. He discussed undermedicalization, to which patients with mental health, chronic pain, and addiction issues are oftentimes subjected, and how this is an area in which biovalidation can come into play. Conversely, he described the phenomenon of demoralization, which can result from

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Submissions

to Bio Quarterly are encouraged. Manuscripts may be original material or reprint with permission. Appropriate subject/topics include: issue analysis, cases, report of institutional activity or programs, legislative and policy commentary and book reviews. Please submit your article electronically to stephanie.fabbro@osumc.edu and alan.murphy@ohio-health.com for consideration. Quarterly deadlines are the 15th of February, May, August and November.

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During the opioid epidemic, pain relief often resulted in bioreducing the patient by simply providing analgesia, while post-epidemic, there is an invalidation of both disease and person.

overmedicalization and long hospitalizations. During the opioid epidemic, pain relief often resulted in bioreducing the patient by simply providing analgesia, while post-epidemic, there is an invalidation of both disease and person. He also described how pain is both a sensory and emotional experience, which may include central neurologic sensitization, an increased fight or flight response, and hypervigilance similar to patients with PTSD. Dr. Jimenez proposed a multidisciplinary model to best care for these complex patients' needs.

The break-out sessions focused on a number of diverse mental health related topics. In the morning, this attendee listened to the lecture on “Navigating the Limits of Autonomy” presented by Travis Hubble, JD, Assistant General Counsel at OhioHealth. Although autonomy is one of the major guiding principles of clinical ethics, Mr. Hubble delineated multiple examples where excess emphasis on autonomy may be hurtful to the society or to the healthcare system, stating that the more we downplay accountability, the more we erode free will; we don't need freedom if everything is medicalized. He mentioned several pivotal legal cases revolving around autonomy and disclosed that legal issues in ethics almost always revolve around autonomy. For instance, the reasonable patient standard that was brought into law in 1972 states that even rare adverse outcomes need to be discussed with the patient if it is something a reasonable person would want to know. He discussed the controversial issues of whether hospital and individual procedural risk rates should be disclosed to patients, and the role of therapeutic assurance, or conveying unrealistic expectations about a procedure that may increase hope. Other lectures offered included “Ethical Issues in Complex

Medical Discharges” by Lisa Applegate-Lewis, LISW, and “Care of the Transgender Patient” by Jody Davis, RN, LISW-S, PMP.

The afternoon session that I attended was “Confidentiality and Gossip in Patient Care” by Sherri Wongchaowart, MD, and Robert Guerin, PhD. Confidentiality has decreased as information is shared through larger interdisciplinary teams and with the evidence of electronic health records; particularly in the case of psychotherapy, this is problematic as without confidentiality, the fundamental rule to say whatever comes to mind in a session doesn’t work. But there are many types of objections to confidentiality that already have a precedent, ie duty to report child abuse or potential violence towards another person. Gossip can be either positive or negative; it can decrease caregiver anxiety by sharing the burden, but it can also increase negativity and decrease empathy and resilience. Appropriate types of gossip were discussed, including among people who mutually know the patient and feel like they can go back to work feeling less stressed and refreshed. The other sessions were “Ethical Challenges to Behavioral Health in Appalachian Ohio” by Richard Wittberg, PhD and Hilles Hughes, MA, as well as “Ethical Issues in Managing Patients with Acute Brain Injuries” by Alexandra Perry, M.Ed, Ed.D, and Brian Fletcher, NP.

The Founders’ Award this year was presented to Ellen W. Bernal, PhD, CIM, who volunteered for the first BENO Board of Trustees, and served on the board starting in 1990. At the time, she was also the Director of Ethics at St. Vincent Mercy Medical Center in Toledo. Dr. Bernal sat on the BENO Board of Trustees until 2001; she served as the Vice President from 1993-2000 and was the President from 2000-2001.



Dr. Elizabeth O’Toole, Division Director of Palliative Care at MetroHealth spoke at the Founders’ Plenary on the topic, “Ethical Issues in Dementia Care: Who Drives Decisions and Who Goes Along for the Ride?” This was an interesting case-based discussion of how and when to discuss advanced directives, perform social, physical, and spiritual value assessments, and ascribe goals of care

Dr. O’Toole taught the important lesson that dementia patients may change, as part of a new community, and become a new individual- we make advanced directives in anticipation of these new changes, but we must also consider the capability for adaptation that some patients make.

for patients who are at risk for developing dementia. Dr. O’Toole emphasized the importance of discussing these issues and having plans in place prior to patient deterioration and discussed the nuance of family dynamics in these situations. There were several dynamics that were expounded upon in terms of what drives changes in living environment for these patients including safety, resources, and family impact. Furthermore, changes in environment can be positive, providing new relationships and structure in the lives of dementia patients. Dr. O’Toole taught the important lesson that dementia patients may change, as part of a new community, and become a new individual- we make advanced directives in anticipation of these new changes, but we must also consider the capability for adaptation that some patients make.

As this synopsis suggests, this year’s conference afforded attendees the opportunity to learn about diverse topics in bioethics while making new connections (and renewing old ones!) with those engaged in this work throughout the state. If you missed this

year’s conference, please keep an eye on *Bio Quarterly*, benoethics.org, and your e-mail for information about next year’s conference; you can expect a notice to “save the date” by the end of calendar year 2019. Although this year’s conference is only months past, initial planning is already underway for the next one to ensure that it, too, will be a great event.

● The Intersection of Consultation-Liaison Psychiatry and Bioethics in the General Hospital: *Common Dilemmas and Lessons Learned Through Training the Next Generation of Providers*



David P. Kasick, MD, FACLP

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If you have been working in a hospital setting lately, chances are you've interacted with your hospital's psychiatric consultation providers. As a medical subspecialty, the field of Consultation-Liaison Psychiatry (formerly known as "Psychosomatic Medicine" until being renamed in 2018) has grown rapidly over the past 20 years to serve patients and providers at the interface of psychiatry and medicine through a variety of inpatient and integrated outpatient practice models.



Hospital-based inpatient behavioral health consultation teams typically comprise physicians, nurses, social workers, and advanced practice providers who are trained to respond when urgent clinical needs arise, providing a range of consultative and collaborative services to a patient and their medical providers. Interventions range from immediate crisis intervention to assessing more complex clinical dilemmas, often due to patient behaviors or clinical questions that are preventing progress toward a safe discharge.

In teaching hospitals, these collaborations foster a rich environment in which medical students, residents, and fellows are trained to develop expertise in applying classroom concepts at the bedside. With each new consultation request, learners have a chance to develop their professional skills in critical thinking, conflict resolution, and appreciating the role of uncertainty and distress among both the patients and staff who are urgently seeking their assistance.

Ethical dilemmas are frequently at the heart of calls for psychiatric consultation assistance, especially

given the risk for neuropsychiatric illnesses to disrupt informed decision-making abilities. While psychiatrists receive training in bioethics concepts during residency training and additional exposure in consultation-liaison psychiatry fellowships, we often seek additional input from our bioethics colleagues in challenging cases. This can be especially helpful when introducing additional perspectives might help generate undiscovered solutions, as well as to minimize dual agency conflicts or excessive paternalism in cases where involuntary treatment appears to be warranted. Sometimes, patients find themselves in gaps between personal needs and limited system resources, and we brainstorm together about how to prioritize needs and avoid unnecessary pitfalls.

Most consults start with a clinical question, stemming from an observation of a problem or behavior change. In developing the biological, psychological, and social context of this question, we often observe deeper conflicts between the patient, their support system, and healthcare providers. Trainees quickly learn that some acute behavioral crises can be remedied with a medication change or diagnostic clarification through additional medical testing. However, some of the most challenging cases reveal gaps where the medical teams and patients feel psychosocially "stuck" between competing needs and imperfect options for resolution. These are situations where questions lead to more questions:

However, some of the most challenging cases reveal gaps where the medical teams and patients feel psychosocially "stuck" between competing needs and imperfect options for resolution.

How do we deliver safe care without compromising our standards and values? How do we develop recommendations and treatment plans that balance the benefits and burdens of care? How do we advocate for what patients need, but is not often immediately available, without compromising their care, but avoiding protracted inpatient hospitalization? Here are a few examples of the tough questions that we are asked each day:

“Is this patient actually suicidal?” The suicide rate in the United States is increasing, as are the numbers of patients identified in our emergency department and inpatient medical units who are seeking care for suicidal ideation or suicide attempts. This summer, the Joint Commission is elevating the screening, assessment, and safety planning requirements for patients who are at risk for suicide and many hospital systems will be upgrading their procedures to meet these safety goals in response. While future behavior cannot be predicted with 100% accuracy, we strive to apply a risk assessment framework in situations where patients have been making threats to kill themselves, are feeling despair about remaining alive, or who are contemplating steps to inflict personal harm to ensure that the highest risk patients are able to remain safe

While an independent and industrious mindset can lead to great productivity during life, some patients are betrayed by their best qualities when these character traits evolve into maladaptive defenses, leading to levels of inflexibility, denial, and stubbornness that can make it difficult to adapt to rapidly changing health circumstances and can compromise autonomy (1).

through the assessment and treatment process. Unfortunately, conflicts often arise when paternalistic interventions are needed to maintain safety and uphold care standards. Young providers can learn to employ negotiation and conflict resolution skills with the goal of maintaining patient engagement when conflicts arise over the need for involuntary treatment. Our trainees also can experience high levels of distress when having to resort to utilizing medical holds to protect patients who are in imminent danger and are unable to prioritize immediate treatment. The ubiquity of this clinical scenario also allows for teaching young providers to dynamically reconsider the principles of autonomy, paternalism, and beneficence that are intertwined through the patient’s risk and protective factors for suicide. Fortunately, many patients retrospectively recognize the benefits derived from crisis treatment, and experience positive outcomes for interventions designed to optimize their personal safety.

“Is this patient safe to go home?” We are often asked to anticipate how a person’s behavior, personality, and ability to work with others will impact their future safety when discharged from the hospital, especially when there is little evidence that they are safely caring for themselves in the community. While an independent and industrious mindset can lead to great productivity during life, some patients are

betrayed by their best qualities when these character traits evolve into maladaptive defenses, leading to levels of inflexibility, denial, and stubbornness that can make it difficult to adapt to rapidly changing health circumstances and can compromise autonomy (1). Some patients will continually insist that they can care for their needs in the absence of caregivers or 24-hour supervision, despite the inability to walk, move, or remember basic self-care skills. Their assertion that they “will be fine” often leads to findings of “dispositional incapacity” that is rooted in neuropsychiatric problems and requires the activation of a surrogate decision maker to ensure that autonomous functioning can be preserved as much as possible without compromising personal safety (2).

“Can this patient with opioid use disorder and drug craving leave AMA?” As the opioid epidemic continues, we see more intravenous drug users experiencing long hospital stays due to bacteremia and infective endocarditis, with a dearth of community-based alternatives when weeks of intravenous antibiotics are needed. Boredom, craving, feelings of isolation, competing life needs, and other causes of emotional distress can prompt impulsive moments when frustrated patients propose leaving the hospital against medical advice, prompting the question of how the imminent danger posed by their diseases could impact the decision-making capacity threshold. Often, we question how the disease process of addiction can impair informed decision making, especially in situations when there is a consensus surrounding imminent danger. However, we also sometimes struggle to quantify the benefits



and rewards to temporary medical holds without models that simultaneously address the needs of the patient given the restrictive nature of inpatient hospitalization. In response, some hospital systems are working to deliver just and effective addiction treatments at the bedside: medication-assisted therapies (MAT), addiction counselors embedded in the general hospital, and specialized units and programming to allow concurrent addiction and infectious disease treatments. We hope these

continued on page 6...

innovations will lead to increased treatment benefits, diminished burdens of hospitalization, and improved long-term outcomes.

“Can a patient with schizophrenia consent to treatment of a life-threatening illness?” Oftentimes yes, although the disorganization of psychosis can impair a patient’s ability to demonstrate insight, reason, anticipation of risk, or rationally weigh the benefits and burdens of treatment. Sometimes, despite treatment, chronic psychotic illnesses serve to diminish the benefits of treatment when they impair one’s ability to work collaboratively with others, demonstrated by one recent patient with chronic psychosis who remained delusionally convinced that they did not have cancer, and viewed any attempts at care interventions as invasive personal attacks. Absence of assent, even with surrogate consent, can

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severely diminish the quality of life when fundamental consensus about illness and treatment planning cannot be reached with the patient. Collaboration with ethics consultants can be especially helpful to avoid dual agency conflicts when there are parallel needs for consultative treatment and opinions about decision making capacity.

“Does this patient need a guardian?” We are seeing increasing numbers of patients with cognitive decline and an inability to provide for their basic needs at home being brought to the hospital (often with law enforcement), without pre-hospital intercepts that had been effective in sustaining independent living. With an aging population, sparse family support, and when an independent spirit overestimates physical and cognitive capabilities, these individuals arrive to general hospital settings without a clear sense of what will happen next in their lives. For those without an identifiable surrogate, and incapacity to return home, guardianship is an option of last resort. We have been working with our ethics partners and other hospital leaders to streamline this process, exploring alternative and proactive pathways to ensure that beneficent and less restrictive interventions to hospitals serving as the



safety net for those who are unable to get their needs met elsewhere.

As an academic teacher guiding trainees through these common but challenging scenarios, some repeating themes have emerged. I have learned the importance of teaching young clinicians to think carefully about the ethical underpinnings of our consultation cases, as well as the power of developing relationships with colleagues to mitigate and untangle the mix of facts, emotions, and perspectives that surround each situation. Recognizing the amount of trauma experienced in the lives of our patients and the work of fellow providers is also critical to understanding the intense reactions that can arise during moments of crisis or uncertainty.

As a consultation team, we deliberately reflect upon and discuss how these situations relate to our professional and personal values. We think about how to maintain a resilient mindset given the distress that can surround the request for help from a colleague, and how a deliberate focus on supporting each other, monitoring our level of optimism, welcoming challenging opportunities, setting goals, maintaining a broad perspective, and being devoted to lifelong learning can all help us to better serve our colleagues and patients. One of my favorite things to say to a patient who is “stuck” in one of these situations is that “we’ve been able to help many others in the situation that you are in now,” as each of these dilemmas also brings hope that change for the better is possible. I hope some of these ideas will inspire you to embrace the chance to help improve the care of some of our most vulnerable, and most interesting patients.

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- (2) Bourgeois, et al. Decisional and Dispositional Capacity Determinations: Neuropsychiatric Illness and an Integrated Clinical Paradigm. *Psychosomatics.* 2017 Nov - Dec;58(6):565-573

● Case Conference: *Violent Threats in the Psychiatric Population*



Craig Dove, PhD is a chaplain with OhioHealth Hospice and a board member of the Bioethics Network of Ohio.

Severe mental illness complicates the treatment of otherwise straightforward health issues. It has been well documented that, even controlling for factors such as side effects of medications, lifestyle factors, people with severe mental illness have notably worse outcomes when dealing with their physical health. We recently had a home hospice patient who exemplified some of those challenges.

In many respects, Bob was a typical patient for the area I primarily cover: a Caucasian male in his late seventies with a progressive, now-advanced pulmonary condition that was ultimately terminal and complicated by ongoing use of cigarettes. He was a veteran, and had been receiving care through the VA clinic, including psychiatric care. His spouse's own health concerns affected her ability to provide adequate care, particularly as his ability to meet his own activities of daily living decreased. On admission, he appeared oriented to time and place, but had a difficult time focusing, and quickly became agitated when asked about guns in the home.

The patient's lack of focus and propensity to become easily agitated made some aspects of our support more difficult, but his access to firearms was our most grave concern. Although an unreliable narrator, he stated on multiple occasions that he had a large number of guns, rather than just the single gun his wife said was secure. No less concerning, the single gun was "secured" only insofar as it was hung up on the back of a door, where (it was hoped) the patient was unlikely to find it. The patient's wife reasoned that Bob didn't move very quickly, and that even if he were to find the gun hanging on the back of the door, he wouldn't be a threat.

Ethics' involvement was precipitated by the patient's threat to bomb a local care site. The FBI went to Bob's house to investigate, and declared that Bob was not, in fact, a threat. Bob's account was slightly different: as Bob remembered it, he held off nine FBI agents from his porch with a shotgun. Although the immediate worry about a bomb was resolved, the patient continued to allude to his ability to construct a bomb and, bomb or no bomb, the guns in the home were very real. The environment was pretty clearly unsafe for the spouse, our staff, and the patient himself.

Four courses of action were considered:
A. Discharge him due to staff safety issues
B. Place him in an in-patient psychiatric facility
C. Place him in an extended care facility
D. Leave him at home with a behavioral contract and help secure additional support for spouse

Option "A," discharging him, was discussed but rejected. He clearly met hospice requirements, and needed the support that hospice provides; additionally, his spouse continued to be overwhelmed with his care and needed (at the very least) the additional support hospice provides (as well as additional advocates to help secure resources). In addition, we couldn't discount her safety; and even as she minimized his ability to find and use the gun she was aware of, she also acknowledged that he had threatened her with the gun in the past.

Option "B" seemed the best from our service's perspective: we could keep him on our program, monitor the symptoms he was having for his hospice diagnosis, and we could coordinate with a staff trained to deal with the aspects of his care we were less comfortable with. However, his long-time mental health provider indicated that the patient was not appropriate for that level of care: while we struggled with his psychiatric symptoms, they weren't severe enough to warrant that level of care. The patient's long-time psychiatrist had many years of experience with this patient prior to our involvement, and was satisfied that he was maintaining an acceptable level of symptom management: this was his baseline, and a more aggressive line of treatment was unlikely to produce an acceptable outcome.



At this point, Option "D," leaving Bob at home, was no longer an option, not only for the spouse's safety but also because the spouse was also non-complaint regarding the securing of weapons in the home. Finding additional caregivers to come into the home was also fraught, since the patient was liable to fire caregivers who gave much resistance; also non-trivial was the difficulty in finding a caregiver who would be willing to work with him in the home.

Option "C" was the least-bad option that was practicable. The extended care facility provided 24 hour supervision for the patient (who would be deprived of access to his firearms), much needed relief for the spouse, and an extra layer of help for the hospice team. The locked unit for dementia patients was briefly considered, but Bob was deemed inappropriate for that environment.

Bob ended up in an extended care facility close to his spouse, who was able to visit him regularly. It also had a courtyard in which patients were permitted to smoke. The patient was not oxygen dependent during his time at the nursing home, so oxygen safety was not an issue, and he was able to continue to smoke.

In the Case Conference section, we welcome BENO members to submit commentary on difficult cases and review the options presented by the ethicist describing the case. If you are interested in providing a commentary to one of the Case Conference cases, please email it to Stephanie Fabbro at stephaniefabbro@gmail.com or Alan Murphy at alan.murphy@OhioHealth.com.

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