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Effective Ways of Mitigating Hospital Violence: What is the Ethical Option?

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As gun violence becomes more prevalent in our society, hospitals are considering various techniques to combat potential harms to patients and healthcare workers. While firearm-related death rates have continued to rise yearly in the United States since 2014, violence against healthcare workers and hospitalized patients may be overlooked. Health care settings were four times more likely to be involved in workplace violence than other private industries, according to a recent investigation by Occupational Safety and Health Administration (OSHA). [1] Other forms of violence against healthcare workers including verbal assault, harassment, and intimidation are likely to be underreported. With more societal awareness of increasing mass shootings, this has led some ethicists to consider the optimal methods, and conversely, various implications, of protecting those who populate hospitals.

Preventative measures that have been proposed range from simple interventions including enforcing visiting hours more stringently and flagging behaviorally problematic patients and visitors in the electronic medical record, to costly choices such as structural additions or adding

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more security personnel. Some local hospitals have considered adding metal detectors at each of the major entrances, but the implications can be costly as staffing the detectors has been estimated to cost up to $980,000 at other hospital systems like the Medical University of South Carolina. [1] About a third of hospitals employ metal detectors at the emergency room entrances, but only 3% utilize them at the hospital's main entrance. [2]

In consideration of security personnel, it is particularly important that these individuals, who are at continual risk to increased violence, undergo continuing training and assessment in using various forms of de-escalation techniques and when needed, tools to restrain and subdue perpetrators. Recent data from a nationwide survey of hospital systems concluded that only about half of hospital security employees have access to tools such as handcuffs, capsaicin aerosolized sprays such as pepper spray, and conducted electrical weapons (TASERs®). [3] More data is needed to assess if more standardized training for hospital security would be helpful.

The Veterans Health Administration (VHA) has helped to spearhead a campaign to increase employee recognition of potential threatening behavior and has utilized web-based awareness training for all employees. Depending on the specific area in which the employee is working, he or she may also participate in in-person sessions to teach observational and verbal skills, personal defense skills, and therapeutic containment skills. These techniques have been thought to help employees recognize signs of problematic behavior, which before may have gone overlooked, and prevent an actual violent event; however, no quantitative metric has been developed yet to show if these are actually effective. [4]

From an ethics perspective, there have been some voices of opposition regarding some of the intervention techniques suggested. For instance, one psychiatrist at a hospital system in Milwaukee, Wisconsin, suggested that the concept of labeling patients as being potentially aggressive or violent in the electronic medical record is a form of a "scarlet letter", which could potentially stigmatize them and affect the way that care is

provided to them. [1] Other arguments include the fact that not all people who interact with the patient have access to the electronic medical record, so may not be alerted to the fact that the patient may be violent, and that some people, like nurses and doctors, but not others, like social workers, may be able to do the flagging, which is difficult since patients may show different sides of themselves to different providers. Furthermore, since violence in many cases may be a spontaneous and unprovoked action, some argue that these interventions may not significantly reduce the overall incidence of violent episodes in the hospital.

Some physicians argue that guns should not be allowed in hospitals at all, citing a lack of competency training for security personnel in dealing with patients with mental illness; a recent *New York Times* article indicating that as many as 23 percent of emergency department shootings involved a gun taken from security. [5] Some also eschew the use of non-lethal electrical weapons, such as Tasers, due to the fact that it may lead to cardiac arrhythmia and death in a predisposed individual, suggesting the use of physical restraints and medications in their stead.

As healthcare providers, we have a duty to protect both ourselves and our patients from violence occurring in the hospital.

As healthcare providers, we have a duty to protect both ourselves and our patients from violence occurring in the hospital. More data should be gathered regarding effective methods of identifying at-risk individuals and the most appropriate de-escalation techniques if a violent episode is suspected. In the meantime, organizations like the American Medical Association (AMA) continue to encourage Congress to provide additional funding for OSHA to evaluate policies to prevent violence against healthcare workers, and encourage physicians to take an active role in their own safety by being better reporters of daily workplace violence, including episodes of verbal abuse and harassment. [6]

[1] Durkin M. (2019). *Hospitals fight back against violence.* [online] ACP Hospitalist. Available at: http://www.acphospitalist.org/archives/2017/12/hospitals-fight-back-against-violence.htm [Accessed 14 Jan. 2019].

[2] Wildemann, M. (2019). *SC hospitals can be difficult to protect from gun violence, experts say*. [online] The Post and Courier. Available at: https://www.postandcourier.com/health/sc-hospitals-can-be-difficult-to-protect-from-gun-violence/article_846fbede-aa39-11e8-8b91-73fb5172f9ca.html [Accessed 14 Jan. 2019].

[3] Schoenfisch AL, Pompeii LA. Security Personnel Practices and Policies in US Hospitals: Findings from a National Survey. *Workplace Health and Safety* 2016; 64(11):531-542.

[4] Krisberg K. *Keeping everyone safe: Violence prevention in hospitals.* [online] Association of American Medical Colleges. Available at: https://news.aamc.org/patient-care/article/violence-prevention-hospitals-keeping-everyone-saf/ [Accessed 14 Jan. 2019].

[5] Morris M. *Guns and tasers have no place in hospitals.* [online] Scientific American Monthly. Available at: https://www.scientificamerican.com/article/guns-and-tasers-have-no-place-in-hospitals/ [Accessed 14 Jan. 2019].

[6] Farouk A. *Taking steps to prevent violence in healthcare workplace.* [online] American Medical Association. Available at: https://www.ama-assn.org/practice-management/digital/taking-steps-prevent-violence-health-care-workplace [Accessed 14 Jan. 2019].

You are a dermatopathologist at a large academic medical center. A clinician in your department submits a shave biopsy specimen from a 33-year-old woman with a yellow papule on the nasal ala, concerning for basal cell carcinoma. According to the requisition, she has no personal or family history of skin cancer; no other family history is recorded. On review of the biopsy specimen, you find a dermal tumor comprised of basaloid germinative cells with admixed sebocytes. You sign out the case as sebaceous adenoma. As you know, this tumor is strongly associated with Muir-Torre Syndrome, a cancer syndrome associated with many internal malignancies, most specifically colon cancer. About 2/3 of people with a sebaceous skin tumor like a sebaceous adenoma will test positive for Muir Torre using a test on the biopsy tissue called microsatellite instability (MSI) testing. Individuals who get diagnosed with this condition require special screening examinations regularly to rule out new neoplasms and occasionally chemoprophylaxis.

Several days later, your clinician colleague calls you asking to have MSI performed on the specimen. Although many dermatopathology laboratories may perform this testing reflexively, yours does not. Upon review of the chart, you notice that the patient has not yet been notified of the histologic diagnosis, nor the implications of a possible hereditary cancer syndrome, namely Muir-Torre. When asked about this, your colleague states that the patient is recently married and planning to conceive. He does not want to discuss the potential reproductive ramifications of this syndrome with her until it is confirmed with genetic testing.

What is the most ethically appropriate action?

A. Perform MSI testing on the tissue per your colleague's request.

B. Do not perform the testing until your colleague discusses it with the patient and obtains informed consent.

C. Call the patient yourself, discuss the implications of testing, and proceed if she consents.

D. Request that another dermatopathologist perform the testing on the case for the clinician.

● Case Study: Informed Consent in Pathological Testing

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The unknowns of the scientific, confirmatory (MSI for Muir-Torre) testing mirror the unknowns of your colleague's shared decision-making with his patient. Your colleague seems aware that the lab does not reflexively test because he calls to have the MSI run. His comments make it reasonable to assume that the patient does not know of the general possibility that histology results may bear hereditary repercussions. A good, first step is a discussion with your colleague to appreciate his patient conversations.

Based on available details, value conflicts coalesce around two ethics topics. First, the context of informed consent was likely somatic – that is, focused on the person – and not (possible) offspring. Walking through the likely informed consent process may help. Informed consent has three elements after what Beauchamp and Childress label (two) threshold elements in *Principles of Biomedical Ethics*. The patient likely has voluntariness (freedom) and capacity, threshold elements. The three ethically appropriate steps are proper disclosure, exchange illustrating comprehension and understanding, and authorization (consent). [1]

Disclosure is key to this situation. Did your colleague say something to the effect of, "Let's run this to the lab for a test and see what it *is*,

which could be innocuous or more concerning?" Was identification the goal of the biopsy? If so, the information exchange may have included *a* single test's cost. This patient in a clinical setting is apt to understand potentially concerning results as pertaining to *personal bodily integrity*, in contrast to the broader implications of a patient undergoing genetic testing. The patient's authorization reflected her implicit, individual understanding.

Second, your colleague is practicing therapeutic privilege. Therapeutic privilege is similar to mental reservation, or withholding part of the truth, just specific to the health care setting. It describes an exception to informed consent when a practitioner intentionally withholds information about diagnosis, prognosis, or treatment from a patient when total disclosure may cause harm. [2] The word "is" appears in italics in the possible disclosure statement from the above paragraph. The biopsy yielded what the yellow papule *is*; it *is* a sebaceous adenoma. Your colleague knows, yet fails to disclose, this relevant information to the patient.

...with few exceptions, ethicists and clinicians denounce invoking therapeutic privilege.

The problem with therapeutic privilege is its historic misuses, prompted by faulty reasoning for invoking this paternalism. As a general rule with few exceptions, ethicists and clinicians denounce invoking therapeutic privilege. The AMA categorizes it as "ethically unacceptable" because it creates conflict. [3] The suggested litmus test for its use is a "definitive contraindication," often certainty that the information would slow or stop healing or have the high likelihood of harm. [4] From what we know, the threat of a distinct and severe contraindication does not exist. Your colleague should disclose what he knows.

Two additional considerations have merit. Numerous studies have considered the role of gender bias in medicine. [5] Does gender bias factor into the decision to not disclose results? For instance, is "planning to conceive" code for the judgment of the patient being hormonal? One should not rush to judge your colleague, just as he shouldn't judge, but be aware of the dynamic. Finally, knowing the high *likelihood* of Muir-Torre Syndrome is materially relevant to reproductive decisions *now*. For instance, the newly married couple could decide to wait to get pregnant until they know more about Muir-Torre.

Answer "A" ignores the ethical tensions. "D" abdicates personal responsibility without any identified discomfort with the issue. Likewise, "C" relinquishes your colleague's responsibility to accompany the patient during the shared decision-making process; namely, he had the informed consent dialogue with the patient and initiated the processes. "B" is the best answer.

[1] Junkerman C, Derse A, Schiedermayer, D. *Practical Ethics for Students, Interns, and Residents: A Short Reference Manual*, 3rd ed. Hagerstown, MD: University Publishing Group; 2008.

[2] Tubbs, J. *A Handbook of Bioethics Terms*. Washington, DC: Georgetown University Press; 2009.

[3] "Withholding information from patients." AMA Code of Medical Ethics Opinion 2.1.3. Accessed on January 23, 2019. https://www.ama-assn.org/delivering-care/ethics/withholding-information-patients.

[4] Bostick N, Sade R, McMahon J, Benjamin R. "Report of the American Medical Association Council on Ethical and Judicial Affairs: Withholding information from patients: Rethinking the propriety of 'therapeutic privilege.'" *The Journal of Clinical Ethics* 2006;17(4):302-306; and "Withholding information." AMA Code of Medical Ethics Opinion 2.1.3.

[5] See, for instance: Chang A, Mumma B, Sease K, Robey J, Shofer F, Hollander J. "Gender bias in cardiovascular testing persists after adjustment for presenting characteristics and cardiac risk." *Academic Emergency Medicine* 2007;14:599-606.

● The Ethics of Using Therapeutic Covenants in Pediatric Medicine

Bridget E. Wilson *is a is a fourth-year medical student at Northeast Ohio Medical University (NEOMED), and is currently completing a Medical Ethics & Humanities Certificate program in the NEOMED College of Graduate Studies. She is pursuing pediatric residency training and looks forward to incorporating bioethics into her future clinical practice.*

Therapeutic covenants, also known as patient care contracts or agreements, are documents outlining the duties of the patient/caregiver and physician in a medical management plan, and when signed, indicate understanding and responsibility for compliance. Therapeutic covenants have been used to strengthen the patient-physician relationship and improve medical management for many years. The current literature evaluates therapeutic covenants in adult medicine, covering topics such as behavior, opioid prescription, suicide prevention, and addiction treatment. [1] However, the ethics of therapeutic covenants in pediatrics has not been discussed extensively. Pediatric therapeutic covenants differ

significantly with the added intricacies of patients' young ages, caregiver involvement, and oftentimes, patients' dependence on caregivers for disease management. Covenants in pediatric medicine are used to manage children who require consistent therapy to prevent serious, life-threatening complications.

An example is the use of covenants for patients with type I diabetes who are noncompliant with their insulin regimen and, as a result, they are hospitalized multiple times with life-threatening diabetic ketoacidosis. Along with clinical and social interventions, a physician might deem it necessary for patients/caregivers to sign a therapeutic covenant stating that they will take their insulin as prescribed. A study has demonstrated the usefulness of "goal setting," which is similar to the aforementioned therapeutic contracts, in improving adolescent patients' compliance to type I diabetes treatment regimens. [2] Future randomized-control studies to further quantify the efficacy of therapeutic covenants in reducing medical noncompliance complications would be beneficial. The signed therapeutic covenant is a symbolic gesture of patients and caregivers taking ownership of chronic disease management and can be effective in preventing serious illnesses that could result due to noncompliance. I will discuss therapeutic covenants as a tool to promote compliance and bolster the physician-patient-caregiver relationship in the setting of chronic disease management, while upholding the ethical principles of beneficence, autonomy, justice, and care.

Describing covenants, Quill writes, "an ideal medical partnership encourages the patient to be independent and responsible for as much of his own care as possible. However, there is an equally important element of dependence on the physician to act with medical competence in the patient's overall best interest." [3] Although Quill stresses the importance of the patient responsibility, others argue that due to external factors in patients' lives, covenants may not be useful in all circumstances. For instance, Browne et al. argue that, patients cannot be held responsible for their noncompliance due to the effects of genetics and environment on decision-making. [4] But this seems unduly fatalistic. While genetics are non-modifiable, pediatric patients are young, and a physician has the opportunity to facilitate changes in patients' environments and attitudes about their illness through judicious use of therapeutic covenants. It has been suggested that explanations of medical care provided at age- or developmentally-appropriate levels for pediatric patients may improve patients' compliance. [5] Although pediatric patients cannot act autonomously, according to Kantian philosophy, they have a "moral potential" for personal autonomy, and this should be respected in healthcare decision-making. [5] Additionally, according to the American Academy of Pediatrics Committee on Bioethics, "[pediatric] patients should participate in

decision-making commensurate with their development; they should provide assent to care whenever reasonable." [5]

There are many benefits to therapeutic covenants, including "increas[ing] the patient's opportunity to participate in his or her own care, and potentially improv[ing] both quality of care and doctor and patient satisfaction"[3] as well as, "foster[ing] transparency… help[ing] doctors assess risk and express concern" [1] and acting as "educational tools." [1] Conversely, therapeutic covenants run the risk of paternalism, leading to coercion

Although some may view covenants as restricting autonomy, they actually provide patients and their caregivers a formal mechanism to take ownership of illness management.

and "forced trust," or even implying physicians' distrust in the patient or caregiver's abilities, as well as, undermining their "self-efficacy." [1, 6] Furthermore, Payne et al. write that the usage of therapeutic contracts for only certain patients can be potentially stigmatizing if used disproportionately for individuals of a particular race or socioeconomic status due to perceived noncompliance in these groups. [6]

Construction of an ethical therapeutic covenant for pediatric patients and their caregivers should focus on the ethical principles of beneficence, autonomy, and justice and care. With regard to beneficence, covenants should promote wellbeing by encouraging compliance with essential medications. Although some may view covenants as restricting autonomy, they actually provide patients and their caregivers a formal mechanism to take ownership of illness management. Furthermore, coercion should be avoided. For example, patients/caregivers should not be forced to sign a therapeutic covenant as a condition of receiving treatment, and parameters of the contract should be determined as a shared decision between the patient, caregiver, and physician. [6] To promote the principle of justice, it has been suggested that all patients/caregivers, regardless of history of compliance, should be asked to sign a therapeutic covenant in order to prevent a physician's implicit bias from leading to prejudice against certain race or socioeconomic groups. [6] And care ethics should be apparent in the covenant's focus to maintain a good physician-patient-caregiver relationship and promote shared decision-making.

[1] Lieber SR, Kim SY, Volk ML. Power and Control: Contracts and the Patient-Physician

Relationship. *International Journal of Clinical Practice*. 2011; 65(12): 1214-7.

[2] Schafer LC, Glasgow RE, McCaul KD. Increasing the Adherence of Diabetic Adolescents.

Journal of Behavioral Medicine. 1982; 5(3): 353-62.

[3] Quill TE. Partnerships in Patient Care: A Contractual Approach. *Annals of Internal Medicine*.

1983; 98(2): 228-34.

[4] Browne A, Dickson B, Van Der Wal R. The Ethical Management of the Noncompliant Patient.

Cambridge Quarterly of Healthcare Ethics. 2003; 12(3): 289-99.

[5] Katz AL, Webb SA, Committee on Bioethics. Informed Consent in Decision-Making in Pediatric

Practice. *Pediatrics*. 2016; 138(2): e1-16.

[6] Payne R, Anderson E, Arnold R, et al. A Rose by Any Other Name: Pain Contracts/ Agreements.

The American Journal of Bioethics. 2010; 10(11): 5-12.

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