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JOURNAL OF HOSPITAL ETHICS

THE JOHN J. LYNCH, MD CENTER FOR ETHICS

MedStar Health

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CONTENTS

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ROUNDING WITH THE EDITOR

Going Open Access: Meeting JoHE's Primary Educational Mission

Evan G. DeRenzo, PhD

Dear Readers,

Welcome to Volume 11, No 1 of the *Journal of Hospital Ethics* (JoHE). We have big news to share with all our readers; JoHE is going open access. After several years of debating the pros and cons of making this move, we have finally decided that it is in the best interest of our readers, our authors, and meeting the Lynch Center's educational mission. Now it's time.

Given the loss of subscription dues when a publication becomes openly accessible, some open access journals require funds from authors in order to be able to publish. We understand that need and appreciate that there are well-respected journals that simply must find funding elsewhere when shifting away from subscription-based publishing. But let us be very clear, JoHE will not be seeking any funding from authors. That is simply not a practice in which JoHE will engage.

Because JoHE is in the privileged position to be supported by the leadership of MedStar Washington Hospital Center, the hospital absorbs the expenses of our journal. Now, it is true that JoHE is produced with a bare-bones staff. That staff consists of mostly Christian Carrozzo (Managing Editor) and me. Our other editorial group members, as well as our editorial advisory board, give their time voluntarily, for which we are eternally grateful.

The other assurance we want to give our readers and authors is that copyright processes for JoHE are not changing, either. That is, in addition to being produced with the guidance provided by the World Association of Medical Editors (WAME), and the editorial standards and authorship criteria recommended by the International Committee of Medical Journal Editors (ICMJE), JoHE will transition to open access in accordance with the most restrictive level for copyright provided by Creative Commons licensing.

Creative Commons licenses "…give everyone from individual creators to large institutions a standardized way to grant the public permission to use their ["their" meaning Creative Commons licensed materials] creative work under copyright law…" [1] JoHE's copyright policy will be at the least permissive level. There are six different license types, ranging from most permissive to least permissive. The most permissive Creative Commons (CC) license, "CC BY," allows just about anything to be done to open access published materials. More precisely "[t]his license enables reusers to distribute, remix, adapt, and build upon the material in any medium or format, so long as attribution is given to the creator. The license allows for commercial use…" [1]

On the other hand, "CC BY-NC-ND," the license that will be used by JoHE, "…enables reusers to copy and distribute the material in any medium or format in unadapted form only, for noncommercial purposes only, and only so long as attribution is given to the creator…" [1]

Given these restrictions on attribution, derivative modification, and non-commercial use, and assuring there will be no changes to our rigorous, double-blind peer-review process for manuscript acceptance, we believe that in the new world of hi-tech access to just about everything, we are managing our transition carefully so that we protect the high standards we have always set for ourselves.

Nevertheless, what can no longer be ignored is that going open access increases prospects for broadening readership and thus the reach of the peer-reviewed work published within JoHE's pages. The broader the readership, the greater is the potential for expanding authorship pool. These are the keys to meeting what has always been JoHE's primary educational mission: get JoHE in front of as many eyes in clinical and academic hospital ethics as possible.

Relatedly, we're going paperless. I know there may be some among you who, like I, have always enjoyed receiving a hard copy of JoHE in the mail. Some among us still like the feel of reading a book or a journal with a hard copy in our hands. Nevertheless, it seems that the majority of readers are just as satisfied reading their books and journals on their electronic devices. Although, on occasion, we may consider the printing of special issues or for the purposes of exhibition, everything evolves and JoHE is working to evolve with the times.

And there's one more change to mention. We are adding peer-reviewed commentaries written and submitted in response to select feature articles. More on this in a bit. For now, we hope these changes will be acceptable to those who have been our loyal subscribers for so many years. I am confident that the publication of excellent scholarly

articles for which JoHE is known will continue, which is now where I'd like to turn.

The first article, by Agostaro et al. on the complexities of healthcare worker cannabis testing given the increasing decriminalization of cannabis use, is our first feature article selected for open commentary. This article helps us think through some of the organizational implications of changes related to the legal use of cannabis across state lines.

Specifically, Agostaro et al. discuss the matter of cannabis testing in healthcare workers as a requirement for their employment. The authors present a well-formed argument against this practice, with an appropriate focus on the tensions between stringent efforts to have increasingly safer work environments, and the complications the present legal patchwork poses for fair hiring and firing practices. Related issues have impacted medicine in all sorts of ways. For example, cannabis decriminalization, first for medical use and then for recreational use, was a significant consideration for practitioners involved with cardiac device implantation. For the longest time, cannabis testing for patients was routine, as evidence of cannabis use was an automatic disqualifier for surgery. Today the picture is mixed, with the potential clinical implications of cannabis use considered on a patient-by-patient basis.

Whereas Agostaro et al. present an even-handed and thoughtful article, laying out much of the legal terrain in an orderly fashion, nevertheless, this is certainly a controversial topic and thus the perfect article with which to include a commentary.

Ergo, our first commentary by Eaves et al. Their response brings a quite different lens to the topic. Their recommendation for continued pre-employment testing takes the winds out of one's oppositional sales and allows the reader to take seriously the argument being made: that we ought to shift away from legalities and towards a more holistic fitness-for-duty assessment model.

Taken together, the feature and the commentary help us think through the tensions between justice in the cannabis testing of healthcare workers, and hospital obligations for continuous improvement efforts in patient safety.

In our next piece, Jacob M. Appel reminds us of a problem that rears its ugly head often. I bet if each of you take the time to reflect, lots of cases would come to mind of critically ill patients for whom all sorts of decisions need to be made and either there is no one to help the team make them, or there are persons involved who may or may not be legitimate surrogates or who may or may not be sufficiently capacitated to take on that role. And how often, as one looks back over a career's worth of clinical ethics consultations, does one remember the feeling of wanting to pull one's hair out trying to navigate the situation so that the patient's preferences and subjective best interests – whatever they may be – can be identified, truly seen, and understood.

Getting stuck in an intensive care unit (ICU), when it is no longer medically needed, for example, is never in anyone's best interest. And when the sticking point is due to difficulties unrelated to differences of opinion on barely knowable preferences, but because of mental health or bad faith intentions on the part of someone who may not be an appropriate surrogate, hard situations just become frustratingly harder. Memories of such cases lead perfectly into this issue's book review.

In reviewing Virginia Bartlett's *Elements of Moral Experience in Clinical Ethics Training and Practice*,[2] Julia Kolak introduces her subject as, "...a provocative attempt to insert a wedge into the received view at the heart of the field of clinical ethics – namely, the presumption of the consultant's actual or intended personal detachment within the context of performing consultation…"

When I read Kolak's review, I screamed in my head, *"C'est magnifique!"* because that sentence perfectly captures Barlett's intent in a nutshell. As Kolak's review continues, it unfolds elegantly from there. Digging deeper into Bartlett's primary claim and then finding the soft spots, both intellectually and in the book's organizational style. Kolak's take is a balanced and measured assessment of what may be one of the truly revolutionary books related to clinical ethics consultation. The tenants surrounding the field as it advanced from its earliest days, when those interested in clinical ethics grouped together in small clumps, to the time after the American Society for Bioethics and Humanities (ASBH) took on the reins of received wisdom about how to do clinical ethics consultation, the bywords were objectivity and personal detachment on the part of consultants. That, however, never seemed to me to be either practicable or obtainable.

Rather, if we are honest with ourselves, we have to admit that there really is no such thing as objectivity in the work of clinical ethics consultation. At best, objectivity is aspirational. While critical for consultants to be neutral to outcome, the facts of a case, bit-by-bit, shape the recommendations a consultant ultimately makes. These facts must, in some ways, be informed by consult-

ant experiences, both personal and professional. Certainly, one is trained to guard against bias and undue influences of all sorts, but absolute neutrality and objectivity may be at best an ideal.

And so, although imperfect in ways Kolak makes clear, I recommend this book highly to anyone interested in learning about, and perhaps practicing, clinical ethics consultation. It will encourage readers to dig deep into their own moving experiences and to contemplate how those experiences might have informed one's beliefs and opinions. Such soul searching is good for all of us as we grow into wise adults and especially adults who play a role in life and death decisions for others.

Clinical ethics consultation is a serious responsibility and requires us to be life-long learners. So, it's never too late to read a book that just might upend one's most dearly held, professional assumptions. Remember, part of becoming as objective as humanly possible is to be open-minded. Being open-minded to change is hard, but clinical ethics consultation is hard, too. I look forward to evolving together.

Sincerely,

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FEATURES

Ethical Shortcomings of Healthcare Worker Cannabis Testing Highlighted by the Rise of Interstate Telemedicine

Gabriella Agostaro, PhD, HEC-C; Jason Lesandrini, PhD, FACHE, LPEC, HEC-C; and Tim Lahey, MD, MMSc, HEC-C

ABSTRACT: The Covid-19 pandemic fueled a rapid expansion in the use of telemedicine which in turn enabled healthcare employers to hire across state lines. As interstate telemedicine becomes increasingly common, healthcare employers in states where cannabis use is illegal will entertain more job applications from states where recreational cannabis use is legal. The conflicting interstate legality of cannabis forces healthcare employers to decide whether to adhere to zero-tolerance cannabis testing policies or to develop more flexible approaches that are less likely to aggravate healthcare worker staffing shortages. We argue that the national healthcare worker staffing shortages plus pre-existing ethical shortcomings of cannabis testing should lead to the discontinuation of routine pre-employment and healthcare worker cannabis testing.

KEYWORDS: Cannabis Testing, Interstate Telemedicine, Healthcare Staffing Shortages

Case Report

Shane, a 35-year-old man who lives in California, applies for a telemedicine position at a healthcare system in Georgia. A pre-employment drug screen indicates recent cannabis use. Recreational cannabis use is legal in California but not Georgia, where the health system in which he's seeking employment has a strict no-drug tolerance policy. The human resource department in Georgia is in discord regarding how to handle this scenario. Should the health system maintain its zero-tolerance policy, or should Human Resources advise a more flexible response amid a staffing crisis?

Background

Screening healthcare workers for evidence of cannabis use has complicated ethical and legal implications that have become more challenging as multiple states legalize cannabis during the rise of virtual work.[1] In this article, we summarize relevant ethical tensions, describe the federal and state legal landscape influencing healthcare institutions' use of drug testing, and weigh the pros and cons of drug testing healthcare workers in the context of national staffing shortages.

Ethical Tensions

Medical error is a major cause of patient morbidity and mortality.[2] Since upwards of 10% of healthcare workers may have a substance use disorder, an unquantified portion of medical error is likely attributable to healthcare worker intoxication.[3] The prevention of healthcare worker intoxication is thus a valid way to reduce medical errors in healthcare institutions.[4]

Workplace drug testing, the use of which correlates with worker cannabis use is one among many approaches to preventing healthcare worker intoxication.[5] In this article, we address cannabis testing of healthcare workers at the time of application and during employment.

Healthcare institutions that conduct applicant or employee drug testing must also contend with privacy concerns arising from employee cannabis testing. Individuals expect a reasonable amount of privacy in their personal lives and have an expectation of privacy with the use of legal substances during their time off. Healthcare institutions must assess what is legally permissible, the role of healthcare worker shortages, the role of virtual work, and the shortcomings of currently available tests for cannabis use. Below, we address each contributor to the complicated ethics of healthcare worker cannabis testing.

Legal Landscape of Healthcare Worker Drug Testing

The ethical tensions related to healthcare worker testing for cannabis use play out in a complicated federal and state legal landscape. The Drug-Free Workplace Act of 1988 (DFWA) aimed to prevent drug abuse and provide enhanced workplace safety throughout the United States. It requires that recipients of federal contracts over $100,000 and federal grant recipients promote a drug-free work environment to remain eligible for federal funding. A drug-free work environment requires that employees agree they will not engage in the manufacture, distribution, dispensation, possession, or use of a

controlled substance. The employer must also provide a drug-free policy to workers, establish a drug-free awareness program to educate employees on the availability of drug counseling and the harms of workplace drug abuse, and provide employees with documentation regarding drug-free regulations.[6]

The DFWA does not mandate employee drug testing, but many organizations have incorporated it into their drug-free workplace programs in response to encouragement, such as from the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.[7] Most large healthcare institutions rely on federal support, so DFWA requirements apply to their organizations.

There are some limits to the reach of the DFWA. The Americans with Disabilities Act does not restrict employer use of drug testing but does prohibit employment discrimination on the basis of a history of a substance use disorder or engagement in a drug and alcohol rehabilitation program.[8] Further, Title VII of the Civil Rights Act of 1964 bars discrimination against employees using controlled substances under the supervision of a clinician as well as any pattern of enforcement of a drug-free workplace that has an unequal impact by race or other protected demographic factors.[9]

The Joint Commission and the Drug-Free Workplace Act have aimed to reduce intoxication in the workplace. Standard MM.08.01.01 from The Joint Commission works to evaluate medication management systems to reduce drug diversion and ensure medication compliance but does not specifically advise healthcare worker drug testing.[10] Evaluation standards suggested by The Joint Commission include data analysis, evaluation of best practices, identification and implementation of improvement measures, and reevaluation standards.[11]

Federal laws and regulations thus give healthcare institutions latitude regarding employee or job applicant drug testing. That latitude has become more complicated amid rapid changes in state laws regarding the legalization of cannabis use. While cannabis is not legalized at the federal level, non-medical adult use of cannabis is legal in 24 states plus the District of Columbia.[12] Legal recreational use of cannabis products is not the only reason healthcare workers might use cannabis. Cannabis use has increased among patients with conditions such as chronic cancer-associated pain, certain forms of epilepsy, and perhaps some psychiatric conditions like post-traumatic stress disorder.[13,14]

Not surprisingly, given the federal regulatory latitude and variable state legalization of cannabis use, healthcare institution use of healthcare worker drug testing varies by state. In some states where the recreational use of marijuana has been legalized, such as New York, employers are prohibited from discriminating against employees based on cannabis use.[15] Recreational use of cannabis is legal in California, and random drug screening of current employees is explicitly prohibited, but pre-employment drug screens were legal until prohibited by a new law in 2024.16 [17] States where cannabis use is illegal are more likely to allow or even require employee drug testing. Georgia, for instance, requires drug testing in workplaces with a drug-free workplace program.[18]

The Interstate Medical Licensure Compact has streamlined the licensing process for individuals seeking to practice medicine in multiple states. As healthcare workers' ability to practice across various states becomes easier, human resource leaders need guidance for interstate practice.[19] The patchwork of federal and state laws has complicated institutional decisions to test healthcare workers for cannabis use pre-pandemic. Pandemic-era healthcare worker staffing shortages and the associated rise of telemedicine have created new challenges.

Healthcare Worker Staffing Shortages and the Rise of Telemedicine

Staffing shortages in healthcare institutions have reached an all-time high. Pandemic fatigue has fueled and been exacerbated by healthcare worker staffing shortages, forcing healthcare employers to enact creative approaches to staffing.[20] These have included an increasing number of traveling healthcare workers, often at inflated salaries that dramatically exacerbate hospital financial struggles.[21,22]

Many healthcare employers, initiated telemedicine and remote work initiatives during the pandemic and continued them as staffing shortages persisted.[23] This shift has worked to reduce operating costs for departments that can fully function in a remote environment. For example, numerous healthcare institutions have transitioned their billing departments to full-time remote work environments.[24]

Enabling employees to transition to remote work has brought benefits to the organization and the employees themselves. Remote work environments have allowed for enhanced opportunities for

individuals living with disabilities and chronic illnesses. Between February 2020 and August 2023, employment for American people living with disabilities increased by 33%.[25] Organizations have also seen increased productivity and geographic flexibility, these benefits beget new organizational challenges including interstate differences in the legal status of cannabis use.[26]

As telemedicine becomes increasingly common, healthcare employers in states where cannabis use is illegal will increasingly entertain job applications from states where recreational use is legal. This is likely to force more healthcare human resources departments to confront the same ethical conflict as the case we described at the start of this article: should healthcare institutions continue healthcare worker drug testing as part of drug-free workplace campaigns or prioritize alleviation of staffing shortages by being more flexible with applicant and employee drug testing?

Shortcomings of Current Tests for Cannabis Use

Employer decisions to continue or abandon healthcare worker cannabis testing should be influenced by the likely impact and efficacy of these testing methods. While pre-employment and random drug testing have been associated with lower cannabis use in general, we found no evidence linking workplace drug testing with reduced workplace intoxication or medical error.[27] This important blind spot in the existing evidence suggests that healthcare employer use of cannabis testing may be well-intended but not grounded in high-quality evidence.

Unlike blood alcohol level testing, current tests for cannabis use cannot distinguish current from prior use.[28, 29] Furthermore, some assays fail to differentiate between cannabis use and the use of other related legal non-intoxicants such as hemp oil or topical cannabidiol.[30, 31] Healthcare employers thus cannot use a biochemical test to assess whether an applicant or employee is intoxicated at the time of testing.

Cannabis testing thus has a reasonable likelihood of yielding false positive results in employees who are not intoxicated, potentially leading to unwarranted impacts on employee reputation and livelihood, leading to furloughs and other measures that can compound healthcare worker staffing shortages.

Beyond their risky inability to differentiate prior cannabis use from current cannabis intoxication, over-reliance on drug testing by healthcare workers has the potential to eclipse other more evidence-based responses to substance use disorder in healthcare workers, from preventive education, to intoxication testing, to support for ongoing safe employment.[32]

Since physicians and presumably other healthcare workers use alcohol more often than cannabis,[33] healthcare employers would need to justify targeted testing for cannabis use, especially if not used in conjunction with other proven methods of reducing workplace intoxication.[34, 35]

Proposal: Discontinue Routine Pre-Employment and Healthcare Worker Cannabis Testing

We propose the discontinuation of routine pre-employment and healthcare worker cannabis testing in response to the progressive legalization of cannabis around the country, interstate differences in the legal state of cannabis use, healthcare worker staffing shortages, the rise of virtual work, and the known shortcomings of clinical assays for cannabis use.

Benefits and Risks of Discontinuation of Routine Pre-Employment and Healthcare Worker Drug Testing

We believe that arguments against healthcare worker cannabis testing outweigh the arguments in favor, as summarized in **Table 1** (Page 7). As much as routine healthcare worker drug testing is intended to prevent workplace intoxication and thus, medical error, these good intentions fall short in reality and are associated with substantial downsides.[36]

Perhaps most worrisomely, routine healthcare worker drug testing can limit the supply of healthcare workers at a time when the nation's hospitals are struggling to staff adequate patient care. This makes the infringement on private legal healthcare worker behavior less justified, particularly since available biochemical tests cannot differentiate active intoxication from use weeks ago. Such testing inadequacies may exacerbate racial disparities and negative workplace consequences of testing since Black Americans are 6-10 times more likely to be incarcerated for drug-related offenses but are not more inclined to use illicit drugs.[37, 38] Employer-sponsored drug testing has already been shown to undermine diversity efforts

in the workplace. In a 2023 study, Black workers reported workplace drug testing at a rate of 15-20% points higher than White and Hispanic counterparts.39 Healthcare employers that invest in workplace initiatives aimed at improving diversity in the workplace must grapple with whether routine drug testing of applicants or employees undermines those goals.[40]

TABLE 1: Benefits and Risks of Discontinuation of Routine Healthcare Worker Drug Testing

Ethical/Legal Value	Argument Against Health Care Worker Cannabis Testing	Argument in Favor of Health Care Worker Cannabis Testing
Respect for healthcare worker autonomy	Cannabis use is a legal private activity in an increasing number of states that should not be abridged without sufficient justification.	
Prevention of workplace intoxication and thus medical error	Cannabis testing cannot differentiate current from prior use, so may yield positive results in employees who are not intoxicated or otherwise prone to medical error. Some states restrict or prohibit the use of employee drug testing particularly for cannabis outside of a known substance use disorder diagnosis.	Cannabis use may contribute to medical error. Employee drug testing is legal federally and encouraged by federal agencies. Employee drug testing is associated with decreased employee cannabis use.
Wise resource allocation	Disqualification of job applicants or employees due to positive cannabis tests may exacerbate healthcare system staffing shortages. The costs of health care worker employment may undermine investments in other evidence-based means of ameliorating healthcare worker substance use.	
Equity in healthcare worker cannabis testing	Drug testing unequally affects employees of color undermining diversity efforts in the healthcare workplace.	
Trustworthiness of testing methods	Current cannabis testing cannot differentiate current from prior use, so may yield positive results in employees who are not intoxicated or otherwise prone to medical error.	

Mitigation of Risk of Discontinuation of Healthcare Worker Drug Testing

While we believe the ethical upsides of eliminating healthcare worker testing for cannabis use outweigh the risks, we do recognize real risks and believe risk mitigation is an important component of the discontinuation of cannabis testing of healthcare workers.

Since workplace testing for cannabis is correlated with a lower prevalence of worker cannabis use, the discontinuation of routine pre-employment and healthcare worker screening for cannabis may be followed by increased healthcare worker cannabis use and some increased risk of healthcare worker intoxication in the workplace. It therefore remains important for healthcare employers to continue to invest in less deleterious approaches to preventing, detecting, and managing healthcare worker impairment. These can include education campaigns, no-stigma mental healthcare, psychomotor intoxication testing when there are concerns for healthcare worker impairment,[41] and confidential access to evidence-based substance use disorder treatment.[42, 43]

Importantly, our argument against testing healthcare workers for cannabis use should not be understood as an argument against testing healthcare workers for other illegal drugs of abuse. Workplace opioid intoxication, by contrast, can be detected by current clinical assays and may detect illegal drug use and therefore should not be prohibited.

Actionable Steps for Healthcare Leaders

Healthcare leaders such as in human resources, risk management, and organizational ethicists should ensure employment practices conform to federal and state cannabis-related laws as well as Joint Commission requirements. Within the considerable leeway typically allowed by those constraints, healthcare employers should:

* Discourage workplace intoxication as a threat to patient safety;
* Provide employees access to standard mental health care, including for substance use disorder;
* Discontinue routine pre-employment and testing for cannabis use;
* Educate supervisors on non-stigmatizing responses to concerns for workplace intoxication, including referral to evidence-based treatment for substance use disorder and development of workplace recovery plans that do not rely excessively on testing for prior cannabis use.

Conclusion

Healthcare worker cannabis testing was ethically fraught before the pandemic, but the practice has become untenable amid a historic staffing crisis in healthcare along with increasingly conflicting state cannabis laws. The removal of routine pre-employment and drug testing for cannabis use is likely to alleviate the healthcare worker staffing crisis for healthcare employers where cannabis use is illegal without impeding the use of other evidence-based approaches to the prevention of healthcare worker intoxication. While working through this type of implementation, it is essential to address the image and mission of the institution. This involves a continued focus on zero tolerance for impaired workers and the provision of evidence-based medical care for people with substance use disorder.

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Impaired Proxies, Bad Faith Surrogates, and Fraudulent Powers-of-Attorney: Navigating the Challenge of the Potentially Unfit Third-Party Agent

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ABSTRACT: Clinicians frequently rely upon third-party agents, such as proxies and surrogates, to render medical decisions for incapacitated patients. These agents are often able to use substituted judgment to effectuate the autonomy of individuals no longer able to make choices for themselves. However, on occasion these agents will themselves appear unfit for the task. Such unfit agents may genuinely be impaired, may act in bad faith, or may not even be the legally designated decision-makers at all. Unfortunately, the medical literature offers limited insight regarding how to address such situations. In many jurisdictions, case law and regulatory directives are also lacking. This paper seeks to raise awareness about this ongoing challenge and to offer some considerations that may help clinicians navigate such situations in the absence of firm legal or professional guidance.

KEYWORDS: Standards for Substituted Judgment, Surrogate Decision Making, Durable Power of Attorney for Healthcare

One of the fundamental tenets of contemporary clinical medicine in western societies is that capacitated adult patients have the right to make their own healthcare decisions. Starting with California in 1983, every United States jurisdiction has established the authority of individuals to appoint third-party agents to render most or all such choices on their behalf in the event that they lose decisional capacity in the future.[1] Although the terminology for such agents varies considerably, with the majority of states applying the terms "proxy" or "power-of-attorney," the principles governing these third-party agents are relatives uniform: The agent is to "stand in the shoes" of the incapacitated party and be guided by "the patient's previously stated preferences and values"—a concept often referred to as "substituted judgment." [2,3] More recently, many jurisdictions have established systems for default decision-making by knowledgeable third parties in cases where an incapacitated patient has not previously appointed an agent.[4] These unappointed agents are often referred to as "surrogates" and also generally are required to use a substituted judgment approach to decision-making.[5] All of these laws are grounded in the bioethics principle of autonomy, with the goal being to best effectuate the will of the patient himself.[6] In addition, in limited circumstances, usually involving either minors or never-capacitated individuals, the third-party agent is charged with making decisions consistent with the best interests of patient.[7]

In the vast majority of cases, third-party agents do partner with medical teams to ensure that their loved ones receive care consistent with those individuals' own preferences and values. At the same time, circumstances sometimes arise in which a third-party agent does not appear to the medical team to be fulfilling his duties responsibly. Although many motives and situations give rise to such concerns, these factors may broadly be classified into three categories: 1) third-party agents who appear to be incapable of rendering decisions consistent with their duties; 2) third-party agents who appear to be acting willfully in a manner inconsistent with their duties; and 3) third-party agents who appear to have fraudulently assumed the role of decision-maker. Each of these scenarios raises distinct challenges for clinicians, yet the ethical and logistical issues that emerge in such cases often overlap. Unfortunately, at present, minimal specific statutory or regulatory guidance exists in many jurisdictions regarding how to handle these all too common occurrences. What follows is a discussion of the sorts of issues related to potentially unfit agents likely to arise in the clinical setting and possible strategies for how medical providers might best assess and respond to such cases.

General Considerations

The decision to question the fitness of a third-party agent should not be undertaken lightly. Raising such concerns with a patient's agent has the potential to undermine this agent's confidence and trust in the care team. Any hostility that ensues risks making subsequent efforts to discern and effectuate the patient's wishes all the more difficult. Providers' suspicions may be well grounded, yet still prove false, and are subject to the same unconscious biases that continue to influence many aspects of clinical decision-making.[8] Agents from vulnerable populations and historically marginalized communities are particularly at risk of falling victim to such biases. Similarly, providers should be certain that the impression of

unfitness is not merely a result of low healthcare literacy on the part of the agent, a limitation the care team can resolve with enhanced educational engagement. In deciding how to proceed when contemplating whether to question the fitness of a third-party agent, the medical provider should make every effort to ensure that this decision is based upon empirical evidence and not merely unfounded instinct or intuition. Ideally, when time permits, a care team reflecting diverse backgrounds, experiences and training will reach a consensus that sufficient grounds exist to probe a third-party agent's fitness.

Providers must also recognize that third-party agents who make subjectively misguided choices for their wards are not necessarily unfit or acting in bad faith. Often, these choices may reflect the patient's wishes accurately. The principle of autonomy allows capacitated patients to render decisions that their physicians consider unwise; similarly, third-party agents often have both an ethical and legal duty to ensure that these supposedly unwise decisions are effectuated when they are indeed what the incapacitated patient would have desired. In addition, third-party agents are entitled to make good faith errors, although these errors should be corrected if they are discovered. For instance, an agent may state that he believes an incapacitated patient would have wanted to receive a certain form of care, while subsequent evidence, such as a Medical Orders for Life-Sustaining Treatment (MOLST) form, may reveal that the agent was mistaken. In such a case, the course of care should be changed, to the extent possible, but if the agent was acting in good faith, grounds do not exist to override his future decision-making role.

Ensuring that the incapacitated patient's preferences are vindicated is important. At the same time, a safe rule of thumb is to assume fitness, good faith and appropriateness on the part of third-party agents until reason exists to question these assumptions. Third-party agents often find themselves in challenging and emotionally charged circumstances, facing the illness or potential death of a loved one. They are all too often called upon to make high stakes decisions without advance warning. Upholding the principle of autonomy does not require physicians to assume the role of ad hoc detectives or prosecutors in vigilant pursuit of agents unfit to perform their duties. Of course, as discussed below, sometimes the available facts *do* give rise to concerns that cannot reasonably be ignored.

The Impaired Agent

The most likely to arise of the three scenarios of unfitness described here is probably that of a third-party agent who wishes to perform his duties responsibility but is unable to do so. Causes for such impairment might include cognitive disability and psychiatric illness. In many cases, an appointed agent might once have been suited to the task, but have since developed an impairing condition such as dementia. In others, the default surrogate will be an individual with longstanding cognitive challenges who may never have been fit for the role. The impaired agent may lack insight into his own limitations. As a result, the agent may offer directions that appear detached from underlying fact patterns, that display an inability to comprehend these patterns, or that vacillate illogically from moment to moment. Under such circumstances, allowing the agent to speak for the incapacitated patient does not further the latter's autonomy or interests.

When confronted with such a situation, the provider must bear in mind that the agent is not his patient and is not subject to his medical evaluation or care. Performing a capacity assessment upon such a third-party agent—even with that individual's consent—is inappropriate. So is conducting any form of psychiatric or neurological assessment upon the agent. Rather, if the provider believes such interventions are indicated, the agent should be referred to an independent physician for evaluation and care. Although enlisting the friends or family of the agent may be appropriate in some circumstances to persuade a third-party agent to obtain medical care for themselves, a provider should be careful not to entangle himself too deeply in the medical affairs of an individual who is not his patient.[9]

The prospect of an impaired agent is likely to prove a highly sensitive matter for all concerned. Whenever possible, an effort ought to be made to resolve the situation informally and without conflict. For instance, if a patient has also listed an alternate proxy on an advance directive, or if the default surrogate next in line is available, and the back-up agent appears fit, then the care team might suggest that the impaired agent yield authority to this other individual. This back-up agent could even be enlisted to help persuade the impaired agent to cede the position. Since the goal of the agent is to effectuate the wishes of the patient to the furthest extent possible, which specific third party plays the formal role of decision-maker ought not be of particular ethical signifi-

cance, assuming the incapacitated patient's wishes have been accurately ascertained.

Formally challenging the authority of an impaired agent should occur only as a last resort. Involving the hospital ethics committee, whether legally required or not, is usually indicated, as is discussing the case with the hospital's legal and risk management teams. With authorization from these parties, providers should be able to overrule or bypass the impaired agent regarding short-term and time-sensitive decisions. Ultimately, if the agent objects to his removal, these matters are likely to be resolved by court order or litigation. However, in light of the distress such legal engagement is likely to cause the challenged third-party agent, and the potential disruption such a challenge may cause for future dynamics between the interested parties, every effort should be made to resolve these cases before legal review proves necessary.

The Bad Faith Agent

In contrast to the impaired agent, the bad faith agent is capable of meeting the responsibilities of the role, but volitionally chooses not to do so. Instead, he chooses to prioritize either his own interests or another objective inconsistent with the goal of effectuating the autonomy of the incapacitated patient (or, when the law requires, serving the patient's best interests). Unlike the fraudulent agent, discussed below, the bad faith agent is the appropriate decision-maker, but he is volitionally making the wrong decisions.

State laws governing third-party decision-making frequently require that agents act in "good faith." For example, New York's Family Health Care Decision Act specifically authorizes the courts to remove a surrogate for a decision that "was made in bad faith."[10] Similarly, in Massachusetts, interested parties including physicians may petition the courts to "override the agent's decision about health care treatment on the grounds that…the decision was made in bad faith." Unfortunately, "bad faith" is generally not defined in these statutes.[11] What is clear is that the standard is high and requires an element of intentional subversion. In other words, bad faith is not synonymous with poor judgment. Nor does disagreement with the recommendations of the care team constitute bad faith.[12] Practical considerations may shape how the care team chooses to proceed in such cases as well. As Fried and Gillick have noted that, "[i]n the absence of clear evidence of bad faith or abuse," it is unlikely that the courts will second-guess an agent's decisions.[13] Yet in some cases, providers will develop sincere, evidence-based doubts that the agent is actually speaking for the patient and not serving another goal.

Some situations are more likely to trigger such suspicions. While third-party agents are allowed to make decisions at odds with medical recommendations, and also contrary to the views of other interested family and friends, if *doing so is consistent with what the incapacitated patients would have wanted,* providers might reasonably look more closely at the motivation and sincerity of agents when such discrepancies do arise. If an agent's decisions in such circumstances appear to result in his own economic benefit, further scrutiny may be required. At the same time, it is important to note that many agents are also heirs or legatees of incapacitated patients, so authentically vindicating the patient's autonomy might benefit the agent as well. In fact, in some cases, the incapacitated patient's guiding value might be been the financial wellbeing of the agent.[14] For example, an incapacitated patient might well prefer his estate be conserved to pay for his grandchildren to attend university or wish to donate his saving to his house of worship, rather than prolonging his life for a short period of time at substantial financial cost. Furthermore, an agent may be motivated simultaneously by his own interests *and* the interests of incapacitated patients simultaneously; parsing out which of these two factors is decisive is often not possible—and the agent himself might not know. As a result, a suspicion of bad faith should be well-grounded before a clinician seeks to override an agent.

Some jurisdictions explicitly authorize a clinician to challenge the actions of a bad faith agent in court. All American jurisdictions permit a clinician to do so. A more complex situation arises when the physician suspects a bad faith decision by an agent in an urgent, high-stakes situation in which immediate resolution by the courts is not possible. For instance, an agent may decline a potentially life-saving procedure (such as trauma surgery) in a circumstance in which the physician previously knows the patient and so has strong reason to believe that the patient would want the intervention and the agent may have an ulterior motive. In such "real time" cases, consulting with an ethics committee or even the hospital legal team may not prove possible. Unfortunately, neither state laws nor the bioethical literature offer clear guidance on how to handle such challenging

situations. One approach might be to favor life-preserving care, as the opposite plan may result in irreversible loss of life. Yet the subjective harms of both forcing care upon a patient contrary to his wishes and overriding a proxy on account of false suspicions of bad faith may also prove severe. In the absence of clear guidance, the prudent physician ought to be guided by empirical evidence. The third-party agent's directives should be followed unless the provider has persuasive grounds to doubt that they are being offered in "good faith." At present, how much evidence is required must be decided by the individual care team. In the future, medical professional organizations would be wise to offer clear guidance to their members in this area.

The Fraudulent Agent

A third category of unfit agents are those who are not legally entitled to be third-party agents at all. These fraudulent agents must be distinguished from individuals who step forward as decision-makers in the mistaken belief that they are empowered to do so. This latter category might include 1) an individual who erroneously believes he is the patient's appointed proxy, but is not, either because he was never appointed at all or because his appointment has been superseded; 2) an individual who falsely believes his underlying relationship to the incapacitated patient entitles him to be a healthcare surrogate. For example, an ex-spouse previously appointed a proxy during a marriage may not be aware that some jurisdictions void such appointments upon divorce. Among the cases that arise in the second category are 1) a "common law" spouse who in good faith states he is the patient's spouse in a jurisdiction that does not recognize common law marriage and 2) an adult child unaware that a parent has legally married a partner. In some cases, these mistaken would-be agents may still qualify as decision-makers through their status as "close friends" if no other party of higher rank or claim steps forward. In others, the appropriate party may assume responsibility, once identified, but the honest error of the mistaken agent should not be considered fraudulent—and, to the extent legally possible and clinically appropriate, every effort should be made to incorporate the mistaken agent into the decision-making process and other aspects of the patient's medical care.

In contrast, an individual may present himself as a third-party agent with full knowledge that he is not the appropriate party as designated by law. In some instances, this individual may act out of the best of intentions—for instance, genuinely believing he has a better understanding of the incapacitated patient's wishes than the legally appropriate decision-maker. A patient's romantic partner, for instance, may forge a signature on a healthcare proxy form in the hope of superseding the authority of a blood relative who is the default agent per the jurisdiction's surrogacy list because that partner sincerely believes he is most suited to advance the patient's autonomy. Alternatively, a proxy form may be solicited from a patient who is already incapacitated or through duress.[15] In other instances, the purported agent may have purely ulterior motives. In extreme cases, these motives may be pecuniary. For example, a live-in romantic partner may wish to keep the patient alive as long as possible to avoid vacating a shared home that will be inherited by the patient's next of kin upon death. In other situations, a psychological factor may shape the decision to engage in fraud, such as an estranged relative who hopes that the patient may recover sufficiently to reconcile.

Providers generally have a duty to ensure that the person claiming to be the agent is actually the appropriate decision maker. The degree of investigation required varies between jurisdictions, but may requires considerable effort.[16] For instance, New York State demands a "diligent" effort to locate and identify proxies, a standard that exceeds the reasonable effort required in most other healthcare related matters.[16] In most instances, either direct confirmation by the patient or the totality of circumstantial evidence will enable providers to accept the agent's claim to authority at face value. However, if doubts do arise, the care team has a clear ethical duty to ensure they are empowering the correct decision maker. Liability may even arise from failure to do so.

The amount of time available may also shape the degree of due diligence required: The care team might defer to an individual claiming to be an agent in an emergency situation, but inquire further regarding the agent's authority once time permits—especially if high stakes decisions must still be rendered. Ethics committees can prove helpful in negotiating genuine disagreements between parties regarding who is the appropriate agent. In some jurisdictions, they must be consulted in such disputes. In contrast, cases in which outright fraud is suspected will likely require legal adjudication. The wise physician should not raise concerns about fraud gratuitously, without a foundation in empirical evidence and careful consider-

ation, ideally in consultation with colleagues. At the same time, to ignore clear indications of deception by purported agents is highly irresponsible and an abandonment of one's fiduciary duty to one's patients.

Conclusions

The purpose of this paper is not to offer algorithmic solutions. Each case of a potentially unfit agent will present its own complexities and nuances. Different jurisdictions impose distinct rules regarding specific elements of third-party agency, so prudent physicians will consult with their hospital's counsel and/or their own malpractice insurance attorney prior to proceeding in such cases. However, recognizing that not all cases of unfit agents should be handled similarly is crucial to minimizing conflict and distress. Why the agent is unfit may matter as much, or more, than that he is unfit. Whether or not he is restorable to fitness in the time frame necessary for decisions to be rendered matters as well. An agent with dementia and an agent temporarily intoxicated do not call for the same approach. Needless to say, the agent who is unable to carry out his duties and the agent who willfully flouts his duties must be managed differently.

Empirical evidence regarding how physicians in the field address the challenges of unfit agents remains sorely lacking. As more data becomes available and a body of literature emerges, professional organizations should be able to develop formal guidance regarding "best practices" when the fitness of a third-party agent is questioned. In the interim, this paper seeks to offer some general guidance regarding how clinicians ought to think about such cases as they arise. As with many issues in bioethics and clinical medicine, placing an issue on the proverbial radar screen and raising the right questions may prove a first step toward better care.

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COMMENTARY

Workforce Drug Testing in Healthcare: A Piece of the Patient Safety Puzzle, Not the Whole Pie

Aaliyah K. Eaves, JD, LLM, PhD; Suhash C. Harwani, PhD; and Hope E. Karnes, MD, PhD

ABSTRACT: Hospital policies that target illegal drug use per se rather than unsafe impairment on the job arguably seek to mitigate liability rather than improve patient safety. Nonetheless, we advocate for routine pre-employment cannabis testing, even as legalization expands, and workforce shortages persist. We propose a risk-based assessment model that more effectively evaluates a provider's ability to deliver safe care while maintaining compliance with the Drug-Free Workplace Act, Joint Commission accreditation standards, and the Americans with Disabilities Act (ADA). Ensuring healthcare providers' fitness for duty is a fundamental legal and ethical obligation of the hospital, particularly for safety-sensitive roles. By aligning with ADA requirements for nondiscriminatory hiring and workplace accommodations, our proposed model fosters fairness while prioritizing patient safety through holistic fitness-for-duty evaluations that assess multiple factors influencing impairment risk, including substance use, alcohol use, physical and mental health, workload, and fatigue. Pre-employment screenings without ongoing assessments fail to capture evolving risks, as individuals' health and life circumstances change over time. Our proposed risk-scoring approach integrates technological advancements in impairment detection, confirmatory testing, and real-time performance monitoring, ensuring that decisions are based on functional impairment rather than cannabis use alone. By focusing on intoxication rather than impairment, and legality of the intoxicating substance rather than fitness for duty, "Ethical Shortcomings of Healthcare Worker Cannabis Testing Highlighted by the Rise of Interstate Telemedicine" by Agostaro et al. fails to address how hospitals will mitigate the patient safety risks that result from healthcare provider cannabis use. Alternatively, we propose evidence-based mitigation of unsafe impairment on the job, including when care is provided through telemedicine.

KEYWORDS: Cannabis Testing, Drug Testing, Patient Safety, Healthcare Woker Impairment, Risk Management

Introduction

Healthcare professionals are care providers, dedicated to the health and wellbeing of others. Those who choose to pursue healthcare professions inherently accept the four principles of clinical bioethics: beneficence, non-maleficence, autonomy, and justice. Upon graduation, they also verbally demonstrate their commitment to the Hippocratic Oath or the Nightingale Pledge in front of peers, family members, and other members of the profession. They also accept the expectation of professionalism that accompanies their privileged positions, and which, throughout their extensive training, is repeatedly reinforced.

At the core of effective patient care is patient safety, and a prerequisite to patient safety is provider safety.[1] Patients, too, expect that the providers in whom they entrust their care, are of sound mind and judgment, and are fit to work. Likewise, employers of healthcare professionals have an obligation to patient safety, and much attention has been paid to implementing systemic, institutional processes and controls (like provider work hour restrictions and workplace supports) to optimize patient safety. Hospital accreditation standards also reflect this norm.[2]

Like other safety-sensitive workforces, healthcare professionals may be asked to participate in drug testing as part of the pre-employment process. Healthcare employers may also use drug testing when investigating workplace accidents, patient safety concerns, or medical quality incidents. Courts have historically upheld employee drug testing (EDT) for healthcare workers in order to shield patients from potentially impaired, and therefore, unsafe providers.[3] EDT's utility in maintaining workplace safety has been demonstrated in transportation, manufacturing, and other regulated industries.

Although patterns of substance use have shifted over the last 40 years, alcohol and drug use remain a significant public health concern, including among healthcare workers. Healthcare workers are at increased risk of abuse by virtue of their access to prescription medications. Moreover, given the strong association between substance use and mental illness, as well as the steady increase in reported burnout among American physicians, substance use may be an indicator of a more complex condition. We therefore advocate for the continued inclusion of EDT in the healthcare workplace but suggest its utility is optimized when incorporated into a holistic risk assessment model. In this way, the health and safety of both patients and healthcare workers are optimized.

In lieu of a one-dimensional approach which may miss more critical health risks, a holistic risk assessment model is proposed, one that evaluates a range of health factors (physical, mental, and substance related) to more accurately identify which employees pose a genuine risk to patient safety.

This model aligns with the principles of bioethics; beneficence, nonmaleficence, autonomy, and justice. Below, we offer legal and ethical arguments for such a comprehensive risk-based screening system in hospital settings.

Ethical and Legal Duties to Prioritize Patient Safety

Healthcare professionals have an ethical and legal obligation to remain unimpaired while on duty, ensuring their patients are not put at risk by their compromised performance and putting patient safety above personal practices or preferences, including the recreational use of impairing substances. The fundamental duty of any clinician is captured by the maxim "primum non nocere" (first, do no harm).[4] Professional codes of ethics include this responsibility. Further, providing safe, high-quality care is "fundamental to physicians' fiduciary obligation to promote patient welfare."[5] A physician who is under the influence of drugs (legal or illegal) is not only endangering patients but also violating a core ethical duty of the profession. Similarly, the American Nurses Association's (ANA) Code of Ethics directs nurses to "protect the patient, the public, and the profession from potential harm when practice appears to be impaired," further stating that nurses are "responsible for identifying and reporting signs of impairment."[6]

Hospital policies focused exclusively on detection of illicit drug use are generally perceived as punitive in nature and arguably seek to mitigate employer liability, rather than protect patient safety and promote provider wellbeing. Impairment can be caused by any physical, mental, or behavioral disorder that interferes with the ability to practice medicine with reasonable skill and safety.[7,8] Evidence shows that a clinician's own health conditions, if unmanaged, can directly impact performance and lead to medical errors. For example, a nurse or physician with poorly controlled diabetes could suffer hypoglycemia on the job, leading to disorientation or even loss of consciousness.[9] Similarly, other undiagnosed or unmanaged conditions (like seizure disorders or serious cardiac issues) could incapacitate a provider at a critical moment. Even subtler issues like uncorrected poor vision or hearing can lead to misreading a medication label or not hearing a monitor alarm in time. All these examples underscore a crucial ethical point: protecting patients from harm requires monitoring clinician well-being. A clinician with severe, untreated sleep apnea or chronic fatigue may be as impaired on the job as someone under the influence of alcohol.[10] Fatigued healthcare professionals have slower reaction times and impaired judgment, which can result in medical errors and mistakes. One study found physicians with depressive symptoms made nearly twice as many medical errors as their peers.[11]

In contrast, consider a healthcare professional who uses physician-prescribed medical cannabis off duty for a legitimate condition. If this clinician never comes to work impaired, the measurable risk they pose to patients could be negligible and less than the risk from an actively sick, sleep-deprived, or cognitively impaired clinician. Ethically, it is inconsistent to rigorously screen for past drug use while ignoring health issues that more directly threaten patient safety. A holistic model treats clinician health (physical and mental) as an integral component of patient safety, rather than an afterthought. An approach that regards the employee as a whole person upholds the bioethical principle of nonmaleficence by proactively identifying providers who might inadvertently harm patients due to treatable health issues, and ensuring they get help or are re-assigned before harm occurs. Thus, it is more rational and ethical to screen for overall health and impairment risk rather than to narrowly rely on drug testing focused on past drug use alone.

Scientific Reliability of Drug Testing: A Piece of the Whole Puzzle

The reliability of workplace drug testing for cannabis use is not the central issue raised by Agostaro et al., their argument is one that is put forth to justify discontinuation of EDT for cannabis.[12] Drug tests developed and validated by reputable vendors in the diagnostic service industry are scientifically sound and highly reliable.

Forensic workplace drug testing uses a two-tier testing methodology which involves an initial screening test on an aliquot of the specimen followed by a confirmatory test on a second aliquot of the specimen for those that are non-negative (i.e., presumptively positive). Generally, the initial screening is performed using immunoassay screening. While this immunoassay screening is sensitive, this testing methodology can cross-react with related and non-related substances that produce a presumptive positive result. Therefore, all presumptive positive screening test results are confirmed, using a second aliquot of the specimen,

on definitive testing methodologies.

Laboratories often use gas chromatography-mass spectrometry (GC-MS) or liquid chromatographymass spectrometry (LC-MS/MS) for confirmation testing. These confirmatory methodologies are considered the gold standard due to the high degree of specificity and accuracy used to identify the presence or absence of a specific substance above a specific cutoff concentration. In the end, the two-tiered model used in forensic EDT has a level of scientific rigor which ensures that healthcare employees, or any employee or candidate being drug tested, are not identified as positive erroneously.

Laboratories conducting EDT are held to high accreditation standards and are required to follow regimented calibration and quality control checks. After testing, these certified labs often report results to a qualified medical review officer (MRO) for interpretation. While the reporting of results to an MRO will depend on the employers drug testing policies, the role of the MRO is pivotal. The MRO will review and interpret the drug test results, ensuring their accuracy and integrity. If the specimen is not negative, the MRO will verify whether a legitimate medical explanation exists (e.g., a prescribed medication). This added medical oversight further guarantees that results are valid and fairly interpreted. In sum, the science of EDT is robust and reliable: when a reputable lab reports a positive delta-9 tetrahydrocannabinol (THC), the psychoactive ingredient in cannabis, there is an extremely high-level of confidence that the individual had THC in their system.

The most common matrices for EDT are urine, oral fluid, and blood. Each of these matrices allows for the screening and confirmation of multiple substances, including cannabis and/or cannabis metabolites. No matter the reason for the use of cannabis, recreational or medicinal, laboratory testing for cannabis and/or cannabis metabolites are scientifically reliable at detecting use or exposure to cannabis. Urine drug tests target inactive metabolites of cannabis (carboxy THC), which can remain detectable for days or even weeks after use. The important detail to remember is that EDT was designed as a deterrence mechanism and not proof of on-the-job impairment. It provides employers critical information about a candidate's or employee's recent use or exposure to the substance. This is valuable because cannabis use has well-documented effects on cognition and motor function. Marijuana can significantly impair memory, concentration, decision-making, and increase reaction time. In fact, studies on marijuana users have shown that higher THC levels correlate with greater cognitive and motor impairment. In high-stakes medical settings, knowing if an individual has recently used cannabis (even off duty) helps ensure that those who might be prone to impairment are identified. In short, EDT provides scientifically valid data to support a finding of recent cannabis use, which, given the potential to affect performance, is pertinent to patient safety.[13-15]

Focusing on Safety vs. Illegal Substance Use in Policy

Agostaro et al. distinguish between legal cannabis use in California and illegal cannabis use in Georgia where the healthcare services are provided.[12] Hospitals should clarify that EDT in healthcare is a safety initiative, not a criminal justice program. Courts have upheld drug testing policies when they serve a legitimate purpose and are applied fairly.[16]

The objectives of an EDT policy and the criminal law system are quite distinct. When hospitals test employees, the intent is not to catch a criminal, but to ensure that the individual is an appropriate candidate to care for patients. Hospitals must distinguish between workplace policies that target illegal drug use per se and policies that address unsafe impairment on the job. A key counterargument to discontinuing cannabis testing is that the goal of such testing in healthcare settings is not to moralize about illegality, but to proactively ensure no staff member is working under the influence of any substance that could make them an impaired provider. The aim ought to be safety, not punishment. No responsible hospital would make it acceptable for a surgeon to operate while drunk, or for a nurse to be heavily sedated on prescribed painkillers during a shift. Impairment is impairment, whether caused by an illegal drug, a legal substance, or even exhaustion. Any condition that diminishes a healthcare professional's capacity to provide safe care must be addressed to protect patients. Well-crafted workplace policies should not single out cannabis, or any drug, based on legality alone, but rather set a universal standard that no caregiver should be practicing in an impaired state.

Cannabis's effects can persist into working hours or reflect a pattern of use that could lead to on-duty impairment. The presence of THC in a drug test is used as an objective indicator that the individual has recently consumed a substance known to affect cognition, coordination, and reac-

tion times. This is analogous to how an employer might treat evidence of alcohol use: if an ICU nurse doesn't drink on the job but shows up smelling of alcohol and test results demonstrate elevated blood alcohol content, it is treated seriously even though alcohol is legal. The distinction lies in impact: policies are justified when off-duty behavior has potential on-duty consequences. A positive cannabis test is treated as a red flag regarding fitness for duty, not simply a badge of illegal conduct.

Importantly, truly safety-focused policies apply equitably to all impairing substances and behaviors. They are "substance-agnostic" in the sense that whether a drug is legal (e.g., alcohol), semi-legal (e.g., prescription narcotics, used properly or improperly), or illegal (e.g., cocaine), the same fitness for duty and patient safety standard applies. In an ideal policy framework, a healthcare institution's rules would encompass any cause of impairment. Many positions in healthcare are considered safety-sensitive[17] and involve some aspect of heightened danger that requires an employee's full and unimpaired competency and capacity. For such roles, it is reasonable to require that employees refrain from any substance use that could compromise their performance during working hours. The ability to test for impairing substances means employers have a tool to verify compliance, but the underlying principle is broader. It would be inconsistent and dangerous to tolerate impairment from one substance but not another. Therefore, rather than scrapping cannabis testing, the fair approach is to implement comprehensive impairment policies: test for drugs where feasible and vigilantly monitor and enforce rules against other impairing factors (like alcohol use, extreme fatigue, or medication side-effects) through other means. The overarching goal is an even-handed policy that says: no one should be delivering patient care unless they are in an unimpaired, safe condition. A fair counterargument to the idea of dropping cannabis tests is to instead promote a culture where all mind- or mood-altering substances and conditions are treated consistently and compassionately.[5]

Historical Drug Policies: Limitations and Ethical Concerns

Marijuana remains illegal at the federal level as a Schedule 1 controlled substance. Healthcare institutions often receive federal funding or are federal contractors, so they commonly adhere to the Federal Drug-Free Workplace Act (the Act,)[18] which prohibits the use of controlled substances in the workplace. While the Act doesn't explicitly mandate EDT, it does require employers to maintain policies against the use of controlled substances in the workplace. Hospitals have adopted comprehensive EDT policies to demonstrate compliance with the Act and to mitigate legal risk. Tort litigation is a polarizing topic in healthcare. On this most can agree; a hospital employee under the influence of cannabis that is involved in a serious medical error significantly increases the risk that the hospital will face devastating lawsuits, state and federal regulator scrutiny, and reputational damage.

The Americans with Disabilities Act (ADA) [19,20] prohibits discrimination against individuals with disabilities but allows for drug testing if it is job-related and consistent with business necessity. Agostaro et al. correctly assert that a positive cannabis test does not indicate impairment, only past use, which underscores a valid critique of the hospital's drug testing policy and its application in the demonstrative case.[12] While employers have the right to implement drug-free workplace policies to ensure a safe and productive work environment, they must also ensure these policies are applied fairly and consistently.[19] Mandatory EDT can have significant ethical and practical flaws if improperly implemented. If drug testing is used as a blunt instrument, it may brand a responsible, unimpaired worker as "risky" due to off-duty conduct, while giving a free pass to other significant risks. For instance, zero-tolerance EDT tends to disqualify people who use cannabis legally as medicine, which can screen out individuals with disabilities who rely on physician-prescribed marijuana for relief. Notably, the ADA[20] does not protect illegal drug use, and cannabis remains illegal under federal law, putting these individuals in a catch-22.

From an ethical standpoint, policies that broadly exclude candidates based on one factor (past drug use) can violate principles of justice and proportionality and create stigma and fear in efforts to normalize the provision of support services, rather than identify impaired providers.[21] This reflects the idea that someone could pass a drug test but have an undisclosed health condition that does affect their work and patient safety.

Modernizing our Approach: Beyond the Pee Cup

Contemporary perspectives on occupational health are shifting away from simplistic drug screening toward more nuanced methods of ensuring safety. Some progressive employers are exploring impairment detection technologies such as cognitive alertness tests that provide computerized assessments of reaction time or decision-making that can be done before a shift.[22] These tests, and other innovations in wearables and artificial intelligence (AI) algorithms, are evolving to potentially catch whether a person is fatigued, ill, or under the influence at that moment, regardless of cause.

Some U.S. states are updating laws to accommodate the reality of legal cannabis. California's AB 2188 law prohibits employers from discriminating against off-duty cannabis use and bans singular reliance on urine or hair tests for THC that only detect inert metabolites. The law explicitly allows employers to use other types of impairment tests to act on positive drug screens.[23] These types of laws direct employers to focus on whether the employee is impaired during work through observable signs or performance-based tests, not what they do outside of work. This legal trend aligns with an ethical view that autonomy and beneficence should be balanced. In sum, hospital policies that use traditional drug testing alone as a proxy for safety are arguably outdated. A more enlightened approach acknowledges that impairment has many sources (illness, fatigue, stress, substances) and that we should directly address those sources rather than relying on antiquated attitudes about illicit versus legal drug use.

Integrated Health and Risk Factors: A Risk Scoring Model

Given the shortcomings of isolated drug screening, we propose a holistic risk assessment model for healthcare hiring and employee retention, grounded in patient safety and risk management principles. This model would evaluate multiple dimensions of a candidate's health and wellness to generate an overall risk score indicating the likelihood that uncontrolled health issues could impair their job performance and endanger patients. Importantly, the goal is not to find "perfect" people, but to identify manageable risk factors, and to do so in a way that is fair, evidence-based, and supportive of the employee.

The calibration of the risk model should be based on multidisciplinary input that is representative of the workforce, including, but not limited to occupational medicine, surgery, nursing, patient advocacy, trainees, social services, risk management, patient safety, legal, and clinical ethics. Clear guidelines and objective criteria should be developed for what constitutes low/medium/high risk in various categories.

The risk assessment would be conducted post-offer (as a condition of employment) by an occupational health team based on the safety-sensitivity of the position. The risk assessment may include:

Physical Health Metrics: These are basic laboratory tests and exams intended to flag uncontrolled physiological conditions. For example, HbA1c blood sugar levels to check for poorly controlled diabetes (high A1c might indicate risk of on-the-job hyper/hypoglycemia episodes), cholesterol and blood pressure (as indicators of cardiovascular risk), and liver function (could reveal undisclosed alcohol/drug issues or other illnesses). Any concerning results would be reviewed with the applicant with the aim of ascertaining whether the condition is well-managed.

Sensory and Functional Assessments: The screening would also include a vision test (e.g., reading an eye chart, color vision if relevant) and a hearing test, ensuring the candidate can perceive alarms, read small print on medication vials, etc., or else is using appropriate corrective devices. Applicants who fail to meet standards would not be automatically rejected if reasonable accommodations can make them safe. The key is to identify if any uncorrected sensory deficits pose a risk.

Substance Use and Medications: Rather than a binary drug screen for illegal substances, the model takes a contextual approach to substance use. It would involve a toxicity panel for drugs and alcohol and a review of the person's prescription and over-the-counter medication use. The focus in terms of medications would be to identify which could impair cognitive or motor function at work. For example, if an applicant is using opioid painkillers, benzodiazepines, or other sedating medications, the occupational health team would evaluate whether the dosage/regimen could affect their performance. A positive test for an illegal drug would be investigated – with evidence of actual dependency or likely impairment yielding a high-risk score, not merely a historic positive. Crucially, this model distinguishes between use and impairment.

Fatigue and Sleep Health: Because fatigue is

such a potent source of error, the assessment would screen for sleep disorders or chronic fatigue issues. Applicants might complete a sleep questionnaire or undergo a brief evaluation for conditions like severe insomnia or obstructive sleep apnea. Someone reporting heavy snoring and daytime sleepiness might be asked to undergo a sleep study or show compliance with continuous positive airway pressure (CPAP) therapy if already diagnosed. The goal is not to punish someone for a sleep disorder but to ensure it's being treated.

Mental Health and Neurocognitive Status: The screening would also incorporate an evaluation of mental health – done in a sensitive and confidential manner. This could involve a self-reported mental health history, a brief psychological questionnaire, or even an interview with an occupational psychologist for higher-risk roles. By including mental health and neurocognitive status, we ensure the process is inclusive and that any accommodations needed are identified early, rather than the person struggling silently or facing bias later.

After gathering data on all these dimensions, the occupational health team would synthesize the information into a risk rating. A 'Low-Risk' candidate is someone that has well-controlled (with or without accommodations) conditions with no evidence of anticipated impairment on the job. For instance, an ICU nurse that uses glasses for nearsightedness and takes thyroid medication but effectively manages both conditions would be 'Low -Risk.' A 'Medium-Risk' candidate is someone that may be experiencing health conditions that require monitoring or accommodation but do not pose an immediate danger on the job. This candidates are essentially "fit for duty with conditions." For instance, a surgeon with untreated hypertension could be considered a manageable risk with treatment and monitoring. These candidates would still be hired but required to show improvement over time. A 'High-Risk' candidate is someone who has one or more acute or serious uncontrolled health issues that pose a direct threat to patient safety in the immediate future, even with reasonable accommodations.

Use of the Risk Score

To address concerns about bias and privacy, the details of this holistic evaluation would be kept confidential and blinded by the hiring managers. The manager would only receive the outcome of the fitness determination, e.g., "cleared," "not cleared" or "conditionally cleared." Ethically, this protects candidates' privacy and their right to be evaluated on abilities, not stereotypes. Our model embraces individual consideration: one diabetic applicant might be low risk (well-controlled), another high risk (uncontrolled) – the outcome depends on the person, not a label.

The hiring team would use the risk classification to make final decisions in an ethically principled way. 'Low-Risk' candidates proceed with hiring as usual. 'Medium-Risk' candidates also get hired (thus avoiding discrimination), but their risk factors are addressed through a tailored, confidential and supportive plan akin to a "conditional clearance." 'High-Risk' candidates, in fairness, would not be summarily discarded if there are ways to mitigate the risk. The employer could issue a conditional offer contingent on the candidate mitigating the risk (e.g., getting treatment). Only if a risk is truly unmitigable, or the candidate refuses mitigation, should the offer be rescinded.

By limiting exclusion to the 'High-Risk' cases, we ensure that no one is denied employment unless necessary for safety and 'Medium-Risk' individuals are not punished for their health status; instead, the workplace shares responsibility in managing the risk (through accommodations, flexible scheduling, peer support, etc.) thereby exercising justice and compassion.

The risk assessment model should be continually refined with data gathered from periodic and for cause evaluations. If analysis shows that certain risk factors fail to correlate with any incidents, the model can be adjusted to be less concerned with those factors. The model should be an adaptive learning system, in line with data-driven quality improvement in patient safety. This demonstrates responsiveness and responsibility to employees.

Legal Concerns

The ADA prohibits employment discrimination against qualified individuals with disabilities and tightly regulates medical examinations in hiring. The ADA allows for EDT if it is job-related and consistent with business necessity, and employers must make reasonable accommodations unless it imposes an undue hardship.[20] Similarly, health screenings policies must be applied uniformly to all employees to avoid discrimination.[19]

Notably, pre-offer inquiries about disability or

health are largely forbidden. Our model avoids legal issues by conducting the health risk assessment after a conditional job offer, applying it consistently to all candidates. The ADA also requires that any screening criteria that tend to screen out disabled persons must be justified by "business necessity" and the candidate must pose a "direct threat" (significant risk of substantial harm) that cannot be eliminated by accommodation.[20] This sets a high bar for excluding someone for health reasons, a bar our risk scoring policy respects. We deliberately only filter out those in the 'High-Risk' category, which are cases of likely imminent harm that cannot be mitigated reasonably. Lesser risks trigger accommodations, not exclusion. This approach is in line with ADA regulations calling for individualized risk assessments rather than blanket policies. Courts have increasingly struck down one-size-fits-all medical standards, insisting on a person-specific evaluation of risk . Our model provides exactly that: a personalized review of each candidate's health profile, weighing the actual probability and severity of harm in that role. This helps protect the employer legally (by documenting a thorough, case-by-case determination) and protects applicants from unfair exclusion due to myths or generalizations.

Privacy and Ethical Use of Health Data

Inevitably, holistic screening collects sensitive personal health information, raising privacy concerns. Privacy is a valid concern, but in certain occupations the status quo already involves some health inquiries (e.g. vaccine status, TB tests, EDT).[24] While employees have privacy rights, these are diminished in highly regulated industries such as healthcare. Courts have consistently found that the need to ensure safety in healthcare settings outweighs privacy concerns, especially when the testing is conducted in a non-intrusive manner and serves a compelling interest.[25] Ethically, we must handle this data with the utmost confidentiality. The information gathered would be used only for the purpose of determining fitness/safety and planning accommodations. It would be stored in confidential occupational health files, not the general human resources (HR) file, and not shared with those outside the evaluation process. Candidates would provide informed consent for this medical screening (just as they do for a standard pre-employment physical or EDT). They should be informed what will be tested and why, and how the results will be used. Emphasizing the patient safety motive and the protective nature of the program can help alleviate some privacy worries. Employees may appreciate a thorough, free health screening that could catch issues early for their own well-being, similar to free employee wellness screenings for health insurance benefit plans. Transparency is a paramount concern, and candidates should have the right to see their own results and be given an explanation of any risk rating. If a candidate disagrees, there should be an appeal or re-evaluation process (perhaps involving a second independent physician opinion) to ensure no one is wrongly categorized. By treating applicant health data like patient data (confidential, need-to-know access only), the model upholds ethical standards of privacy and trust.

Ongoing Monitoring and Safe Harbor Provisions

A one-time preemployment screening, no matter how comprehensive, is not sufficient in isolation. An employee's health status can evolve over time, and new risks can emerge during their employment tenure. Therefore, an ethical risk management approach should include periodic and for cause testing/assessments of healthcare providers throughout their careers, coupled with a 'safe harbor' system that encourages self-reporting of health concerns.

By normalizing routine health evaluations, we make it clear that fitness for duty is an ongoing responsibility, not a one-and-done hurdle. This is analogous to routine competency assessments or CEUs for maintaining licensure – except here we focus on the person's well-being as part of competency. Importantly, periodic assessments must remain non-punitive and confidential. They should be scheduled (e.g., an annual employee health exam that includes these elements) so that employees aren't blindsided, and results should again be used for supportive measures.

In addition to scheduled check-ups, there must be a for cause protocol when there are signs that a healthcare worker may be impaired. Currently, many hospitals handle this via 'fitness for duty' policies or peer reporting to an impaired clinician program. The for cause health assessment can be integrated into those processes to assure due process for the employees.

Perhaps the most ethically important feature of an ongoing program is a 'safe harbor' policy that encourages healthcare professionals to voluntarily report risk factors or impairments without

automatic punitive consequences. A true culture of safety treats impairment like the medical issue it is, not a moral failing. Safe harbor clauses should be written into hospital policy: e.g., employees who proactively disclose a risk factor that could affect practice will not be subject to punitive action or automatic disqualification. They should be offered a personalized support program and allowed an appropriate leave or job modification, with the goal of safely returning to work. Only if the individual refuses help or cannot achieve a level of control necessary for safe practice should more drastic measures be considered, and even then, such measures should be taken through a fair process.

Addressing the Critics

It is important to address skepticism, especially about practicality and cost-effectiveness. Implementing this comprehensive screening will have costs, but these must be weighed against the cost of adverse events, bad hires, and workforce retention. A single major medical error can cost a hospital millions in malpractice, suffering and cost to the patient, and loss of public trust.

Investing in a robust employee risk-assessment program may be relatively small by comparison. Many healthcare employers already require a physical exam, immunization checks, EDT, and impaired provider monitoring; expanding this to include additional health screenings and impairment detection technologies may be feasible for larger health systems. In fact, streamlining it into one 'fit for duty exam' could be efficient. As for logistics: large systems can build internal occupational health capacity, while smaller practices could outsource to specialized clinics that perform preemployment medical evaluations (this is common in industries like manufacturing and public safety). With modern electronic health records, tracking these results and follow-ups is manageable. Over time, if the model proves effective, insurance incentives are likely to emerge (e.g., liability insurers might lower premiums for hospitals that demonstrate a rigorous employee health risk management program, health plans may develop employee wellness program discounts). On a societal level, healthier clinicians likely mean higher productivity and less turnover, which has cost benefits too (burnout and impairment lead to absenteeism and physician turnover, which can be costly). In short, while not easy to implement, the program is an investment in quality, safety, and a culture of inclusion.

Conclusion

As Agostaro et al. point out,[12] healthcare provider shortages, evolving attitudes around cannabis use, and state legalization warrant a more complex and nuanced assessment of how hospitals can comply with state and federal laws that require a drug-free workplace. Health systems have ethical obligations to patients and to their staff. The holistic risk-assessment model stands as a promising, ethically robust option to improve patient safety and clinician welfare in tandem. By examining factors like physical health, mental well-being, sensory abilities, and responsible medication use, hospitals can more accurately evaluate who is fit to provide safe patient care. From a broader bioethical perspective, a holistic risk assessment model strikes a balance between beneficence, nonmaleficence, autonomy, and justice. It seeks to do good (protect patients and support employee health) and prevent harm (avoiding unsafe situations), while also treating candidates fairly and compassionately. It moves us away from a punitive or moralistic stance on certain types of drug use toward a public health stance on clinician wellness. It recognizes the clinician as a human who can be vulnerable to illness or impairment, and it builds a system to manage that reality in a constructive way rather than ignoring it or punishing it. By implementing such screenings and follow-ups, an organization signals that provider health is a priority, thereby encouraging clinicians and trainees to value self-care (which can mitigate burnout, etc.). It also sends a message to patients and the public that the hospital is diligent about who it entrusts with care, potentially bolstering trust in the larger healthcare system. Of course, the program must be implemented equitably: the standards used in the risk model should be based on clinical evidence and safety data, not on subjective bias.

Conflict of Interest Statement: Aaliyah K. Eaves, JD, LLM, PhD, is the Chief FDA Counsel and Executive Director of Legal Regulatory at Quest Diagnostics. She also completed an Advanced Fellowship in Interprofessional Patient Safety funded by the Veterans Affairs National Center for Patient Safety. Suhash C. Harwani, PhD, is the Senior Director of Science and Workforce Solution R&D at Quest Diagnostics. Hope E. Karnes, MD, PhD is the Medical Director of Clinical Solutions and Workforce Health Solu-

tions. She is also the Medical Director for ExamOne, a Quest Diagnostics Company. The authors receive a salary and own stock in Quest Diagnostics. The views expressed by the authors are their own opinions and do not represent an official position, view, or policy held by Quest Diagnostics.

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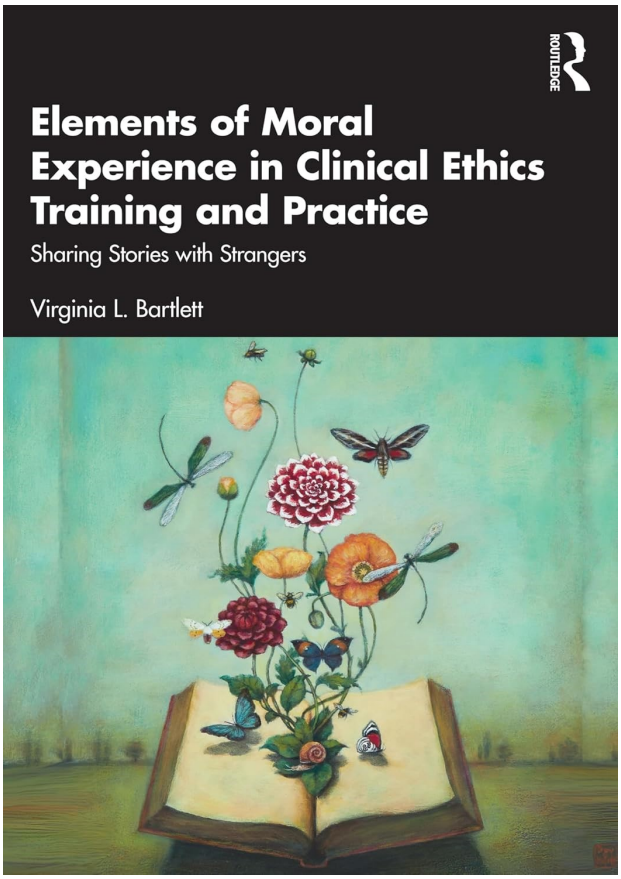
BOOK REVIEW

Elements of Moral Experience in Clinical Ethics Training and Practice: Sharing Stories With Strangers*

Review By Julia Kolak, PhD

*Bartlett, Virginia L. *Elements of Moral Experience in Clinical Ethics Training and Practice: Sharing Stories With Strangers.* Routledge; 1st Edition. December 1, 2023. 171 p. $52.99 ISBN: 978-1003801559

Virginia L. Bartlett's new book, *Elements of Moral Experience in Clinical Ethics Training and Practice: Sharing Stories with Strangers*,[1] is a provocative attempt to insert a wedge into the received view at the heart of the field of clinical ethics—namely, the presumption of the consultant's actual or intended personal detachment within the context of performing consultation. Rather than embark on a systematic effort to identify the unrealized potential for engagement with the experiential dimensions of consultation, Bartlett's is a more subtle introspective undertaking, comprised of a cluster of personal 'stories' from her early training in the field. Interwoven with an assembly of reflections from philosophy, sociology, anthropology, and literature, Bartlett recruits a narrative and phenomenological lens to impart meaning to the various elements and flavors of the vivid situational encounters that constitute the raw underbelly of the institutionally sanctioned role of the clinical ethicist. Though the theoretical or practical significance of the effort to animate the supposedly displaced inner life of the consultant is somewhat diminished by Bartlett's style of shifting between storytelling and exegesis, the project overall provides a timely and stimulating examination of the often unacknowledged affective, interpersonal, and reflective causalities brought about by the professional expectations of clinical ethics consultation (CEC).



While Bartlett's enterprise resembles more of a loose internal roadmap than an analytic tool in this respect, her aim is clearly to suture these individual contingencies into elements of practice. Bartlett is presumably called to this adventure by the seeming imbalance between the multitude of ways in which one might provide meaningful answers of what it is "actually like to do clinical ethics work,"[1(p1)] that exceeds the acceptable range of options contracted by what she takes to be the professional steamrolling towards standardization and certification. With the intrusion of this bid for an operational equilibrium within the field, Bartlett finds an implicit expectation that experiences will be "neutralized and anonymized, tamed and flattened into 'case studies' or 'examples' for kinds of consults."[1(p2)] Bartlett's book might therefore be read as an exercise in resisting this conformity, by attempting to capture the irreducible variety of the experiences which innervate clinical ethics work—though the reader is frequently left to wonder whether Bartlett is in fact offering a new methodological insight, critiquing existing ones, or disavowing the question of how the future of CEC should be professionally regulated.

Of course, one might have chosen to address this question by appealing to the very different ways in which CEC is in fact practiced; those ex-

pecting to find an appeal to value pluralism,[2] the insecurity of foundationalism,[3,4] the debate about standardization,[5] or a robust treatment of the epistemic norms of different consultation approaches[6] should look elsewhere. Rather, through her quiet urging towards the interiority of the work of consultation, Bartlett invites other scholars and those within the medical profession to descend into these labyrinthine, unresolved issues percolating throughout bioethics, contemporary metaethics, and applied ethics more broadly. Her primary grappling hook here is the first-person account of specific, situated encounters during embedded rounding in the Intensive Care Unit (ICU), upon which she layers a confluence of ideas from different disciplines, retrofitted as tentative footholds for thinking through her own narrative descent into clinical immersion as a "legitimate source of understanding."[1(p2)] While this indirect method is interesting, as elsewhere in the book, the reader may be left with a sense of interpretative ambiguity, particularly when Bartlett's conceptual leaps in association fail to clearly connect back to the broader questions she introduces at the outset of the project.

The structure of the book largely mirrors this embarkation into the unknown—or, more precisely, what is hidden beneath what we think of as the givens of CEC. To alert us to these undercurrents, Bartlett draws in Alfred Schultz's metaphor of the stranger[7] "who has to place in question nearly everything that seems to be unquestionable to members of the approached group"[7 (p502)] but who can wield their distance from "believed-in"[1(p18)] meanings to enact a viewpoint for partaking in critical engagement with the accepted patterns and norms of the dominant group to locate new possibilities for reconciliation and understanding. Kurt Wolff's notion of "surrender-and-catch"[8] and "surrender-to"[8 (pp25–26; 59)] are also nicely integrated for their respective unchosen and deliberate surrender to the disruption of the unexpected and the "befallenness of being thrown into question"[1(p33)] as an occasion for curiosity and opportunity for learning. Together, these two pillars work well as an interpretative structure for working through the disorienting effect of being thrust into the human messiness of her subject matter, though it is often not clear whether Bartlett intends this to serve as a self-reflexive point about the misguided norms of CEC or as a regulatory framework for thinking through patient and stakeholder encounters. Still, these sections will be of particular interest to clinical ethics consultants looking to reinvigorate their own orientations to practice.

Concluding Part I of the book with an 'interlude' for exploring these influences together as a kind of 'method of unknowing,' Bartlett hopes to shed light on the paradox of what we might come to understand when we relinquish our blind reliance on the prefabricated benchmarks for navigating patient-facing encounters. This goal, while commendable, is notably weakened by the lack of a clear reference frame, leaving the reader without sufficient context to fully understand Bartlett's methodological starting point or the traditions she is working within—or diverging from. This is perhaps the book's most significant shortcoming, especially given the throughput of Bartlett's frequent allusion to the meaning and significance of one's reference frame. What are these "taken-for-granted, typical recipes for understanding a situation"[1(p28)] she rails against, and *why* are they inadequate? While one can guess at them, Bartlett's insights into the promising directions for illuminating the relational, intersubjective, and existential dimensions of consultation work risk being trivialized as personal touchstones when she defaults on opportunities to openly evaluate them against the expectations of clinical moral reasoning, process standards, or the theoretical foundations of bioethics more broadly. What is needed—but never explicitly provided by Bartlett—is an argument for why these contextual features matter; without it, the project risks leaning too heavily on description rather than offering substantive insight into the moral dimensions of clinical ethics work. Given the significant diversity of perspectives on these complex issues, some may also find it an oversimplification to suggest that there exists a neatly configured 'received view' that mandates detachment or uniformity in clinical ethics consultation—especially considering the rich and varied sources that shaped Bartlett's own training several decades ago.

Certain sections in Part II offer more grounded discussions, particularly when Bartlett presses on the idea of moral engagement as an embodied practice. Taken up within the context of Frolic's work in critical-interpretive medical anthropology (CIMA) and auto-ethnography, Bartlett extends a hearty endorsement of "tearing away the veil of neutrality and objectivity."[9] Despite the notable omissions of the feminist tradition or standpoint epistemology which first introduced the assault on neutrality within discourse, the allegiance to this critical stance challenges, for Bartlett, the "hiddenness of the ethics consultant's presence and voice." [1(p60)] Combined with the 'actual' happenings chronicled in her memoir of working with

a pregnant woman and her partner who consider enrolling in a trial for open-uterine prenatal surgery to repair spina bifida, Bartlett gathers some momentum for gesturing at the connection between the mirror held up to her own experience and what is constitutive of moral deliberation through the benefit of interlocuters such as Pierre Bourdieu,[10] Richard M. Zaner,[11,12] and Mark Bilton[13] among others, from whom she distills the concept of *attunement and affiliation.*

Described as a dynamic, iterative, and reflexive practice of inquiry, Bartlett sees attunement as involving three interrelated activities: careful attention to the unfolding circumstances of potentially disruptive encounters as 'invitations' to an unfolding conversation, and vigilance towards maintaining respect and inclusion of the perspectives of those involved which in turn creates the demand for reflective attention to one's own understanding and responsiveness.[1(p74)] Though Bartlett sometimes appeals to Shultz's 'stranger' and Wolff's notion of surrender and catch as informal devices for approaching consultation, Bartlett appears to regard attunement as a distinctive method for navigating what is at stake when we permit ourselves to more fully inhabit the strangeness of each clinical encounter. Here, Bartlett is rescued by the application of the descriptive claim that the 'disruptions' of lived experience and bearing witness to the vicissitudes of health and sickness *qua* consultant may be disruptive precisely because of its propensity to shatter our pretensions of a well-ordered view from nowhere.[1(p68)] In turn, Bartlett takes it that the assortment of activities and orientations she provides are important to the moral activity of clinical ethics consultation insofar as they hone our ability to perform this surrender, which is in turn essential to the responsible practice of ethics facilitation.

Regrettably, the other-directed components of this disposition towards approaching consultation will no doubt leave some readers unsettled by the exclusion of any reference to bioethics mediation or conflict resolution. Likewise, Bartlett's notion of 'affiliation' also approaches a stock-and-barrel restatement of the description of ethics facilitation by the ASBH Core-Competencies,[14] resurrecting questions about what exactly it is Bartlett intends to be repudiating. Despite these shortcomings, Bartlett's exploration of the hazards of the distorting influence of personality, visceral and sometimes automatic responses and reflexes triggered at the bedside, primal tolerance, intersubjectivity, or even simply 'what is at stake' in an encounter are ripe with possibility for integration into teaching or mentoring contexts, or simply as an aid in helping novices communicate about the alienation and discomfort they may feel when entering into ethically fraught situations. Though Bartlett stops short of taking the leap into concrete transferability, there is much to admire in her boldness in exposing these wounds, and their clear need of redress.

Indeed, many of the early narrative pieces—while admirable for their candor and confessional quality—reveal Bartlett's deep uncertainty about her own preparedness during her initial immersion in clinical ethics practice. This is not to detract from her implicit point about their profundity, which one imagines Bartlett would see as continually unfolding as an illimitable source of the work of consultation. However, it is surely unreasonable to deny the steadying virtues of guidance, supervision, and mentorship which fellowship training might aspire to recruit as a mitigation for some of the unpleasant disruptions in confidence, purpose, and skill that Bartlet appears to be describing in the burgeoning and tender stages of her important work at the bedside. To this point, it does not follow from the great variation of experience or expertise of practicing clinical ethicists (which is probably explained in part by widely inconsistent fellowship training models) is in fact something to be desired—though of course there is precedent for this interpretation. Though Bartlet insists her intention is not to provide guidelines for training, it is often difficult to accept some of the protracted narrative-based sections that circle around these themes without a focal point around which the direction of her thinking can be clarified and structured. In this respect it seems an oversight to dismiss the opportunity for harnessing her experientially informed perspectives as an augur of what clinical phenomenology,[15,16] and the narrative tradition might have to offer the future of HCEC training and practice.

Again, Bartlett is probably correct that the 'firebreaks' of ideal theory or universalizability out of which we may unconsciously seek to armor ourselves is not enough to reassure us of the art and skill of the consultant at bedside, but it is difficult to see a principled way of getting at the question of how to impart or improve upon the professional resources of the clinical ethicist without contending with our foundational methodological commitments and those germane to the institutionally-specific roles we occupy. Moreover, many ethicists do not in fact perform bedside consultation,[17(pp10,12)] and the stakes of this growing integration will most certainly require standardiza-

tion or professionalization to ensure that responsible, qualified, CEC support is implemented. More urgently, given the sheer lack of consistency and reliability with which the label 'ethics consultant' is applied,[18 (p14)] the ASBH Core Competencies serve as a stark reminder here that just like clinical medicine itself, the very intimacy and proximity of ethics facilitation that Bartlett champions may also introduce patient *harms*—a challenge conceded but not fully answered by Bartlett's allusions to the vulnerability and attendant responsibilities of the work.

For this reason, while trainees with interdisciplinary experience might find Bartlett's integration of sociological, anthropological, and literary traditions validating, they may struggle to come away with a balanced view of the current state of the field, especially where more tangible procedural elements of clinical ethics consultation are well-established. Indeed, because Bartlett chooses not to mention or outline these backgrounds from which to approach CEC, she risks portraying clinical ethics as improvisational or ad hoc, rather than as a structured practice guided by identifiable tools, strategies, and frameworks. As a result, the book may not be well-suited for those without prior experience in clinical ethics consultation, though it would be an excellent resource for fostering classroom discussion within advanced master's seminars, or faculty seminars in areas pertaining to the philosophy of medicine, medical humanities, or bioethics broadly construed.

Elements of Moral Experience in Clinical Ethics Training and Practice [1] provides a compelling exploration of the hidden dimensions of ethics consultation, challenging readers to critically reflect on their assumptions and practices. While certain sections might benefit from more concrete exposition on the links between the self-reflective and moral stakes inherent to the procedural and analytic aspects of ethics consultation, the book remains a valuable resource for professionals and scholars in clinical ethics. I particularly recommend it to those curious about the possibility of deepening their integration of, and appreciation for, the lived experience of consultation, while resisting—or at least bracketing—the desire to explain it away. Though I often found myself grappling with this tension, unable to fully resist the impulse to pursue the fragments of an overarching argument, I cannot help but feel that Bartlett's memoirs, at least in part, reflect the dislocation of this certainty within actual clinical encounters. One moment in particular captures this duplicity: observing the involuntary and unexpected exchange in which she locks eyes with a patient's sister, Bartlett writes, "our eyes bounced away: the moment too raw to share with a stranger."[1] While not without its limitations, this book offers a stirring invitation to refine our collective gaze.

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