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Features

Beyond Ethical and Legal Borders: The Case of a Complex Factitious Disorder
Valérie Badro, PhD; Annie Descoteaux, MEd, PhD (c); Michelle Pimont, MD, MPH, MBE; and Marie-Ève Bouthillier, PhD

Developing a Clinical Organizational Ethics Program
Kelsey Miller, MHA, MLD and Jane Hartsock, JD, MA

In Practice

Vaccination Decision Making of Involuntarily Committed Psychiatric Patients: A Clinical Case Series
Amal Cheema, BA; John Hinck, MD; Jeffrey C. Fetter, MD; and William A. Nelson, PhD

Book Reviews

Clinical Ethics: A Graphic Medicine Casebook
Review by Patrick Herron, DBe, HEC-C

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Rounding with the Editor

Features

In Practice

Book Reviews

JoHE VOLUME 9, NUMBER 1

ROUNDING WITH THE EDITOR

Focusing and Expanding

Evan G. DeRenzo, PhD

Dear Readers,

Welcome to our winter issue, Volume 9, Number 1 of the Journal of Hospital Ethics (JoHE). Happy new year to you all. We hope you are warm and dry. To our readers who are suffering through the crippling manifestations of climate change, please know that we have you in our thoughts.

To our readers who are safe, dry, and warm and who can spend their winter days reading, we give you a JoHE issue that offers interesting, and perhaps quite controversial, pieces along with our new Book Review section, about which we are excited. More specifically, I start here by focusing you on two pieces about psychiatrically impaired patients who present ethically complex, perhaps controversial, and difficult management challenges.

One is about a patient with factitious disorder. Factitious disorder is sometimes referred to as, other times differentiated from, Munchausen syndrome.[1-3] Factitious disorder is a serious mental disorder that presents diagnostic difficulties for clinicians. How rare this condition is, is not yet known.[4] Nonetheless, the patient in this feature, by Badro and her colleagues, raises complex and fascinating ethical challenges.

Our second feature, by Miller and Hartsock, moves outward from a patient-specific focus. The authors present a novel organizational ethics program that are like those that arise, as they state in their introduction, "…out of patient care but are not isolated to single patient encounters." They describe their program as one that will, "…overlap with existing policy or law and may require collaboration among and between multiple departments…" This is just the kind of organizational ethics program of which we need more. Organizational ethics has been discussed for many years in the field of clinical ethics but we seem to have made far less progress than in patient-specific hospital ethics programs. Hospitals that are just realizing that they need to build clinical ethics programs are far away from working systematically on building clinical organizational ethics programs.

In a potentially transformative article directly challenging The Joint Commission (TJC) to expand and more deeply specify their standards for hospital ethics, one can easily imagine an organizational program such as presented here developing to cover all ethically-relevant issues in a hospital.[5] This is a reverie that brings hope to the hearts of those who care deeply about patients, families, and clinicians and who love hospitals as places whose mission it is to provide such care.

Our In Practice section includes a piece by Cheema, Hinck, Fetter, and Nelson addressing the care of a series of psychiatric patients who are involuntarily committed and who do not want to receive a COVID-19 vaccine, even when their guardians have given consent. From these patients, all in the same psychiatric hospital, we learn of the varied approaches the hospital's ethics committee took in making recommendations for patient management. These cases may provide readers who are having similar challenges with their involuntarily committed patients useful insights into their own patients' management.

Finally, we conclude this issue with the introduction of our newest JoHE section devoted to book reviews. We thank Patrick Herron for his willingness to contribute his excellent review of *Clinical Ethics: A Graphic Medicine Casebook* by Myers, Osborne, Wu, and Schein. Given that this title is most likely used by those who teach clinical ethics, Patrick's extensive experience teaching medical students made him the perfect choice to inaugurate this new section.

We have thought about adding a book review section for many years. A wide variety of medical journals carry book reviews. There is surprisingly little written, however, about how to write, or what ought to be included a book review in a medical journal. For example, there is no mention of book reviews in the contents of the Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals from the International Committee of Medical Journal Editors.[7] Nonetheless, useful information on standards for writing book reviews is available from the Journal of the Medical Library Association (JMLA).[8]

There is an old but engaging study about book reviews that examined 480 reviews over a six month period from the Annals of Internal Medicine, the Journal of the American Medical Association, the Mayo Clinic Proceedings, and the New England Journal of Medicine.[9] Of the several interesting pieces of information that emerged, reviews were short, averaging 389 words. Length of review, however, did not correlate with length or scope of the book reviewed or with the reviewer's assessment of the book. As expected, there were many more positive than negative reviews (88.5% vs. 11.5%).

For the most part, these book reviews are written by persons invited by the journal's editorial group, and we plan to follow this practice. Although we are willing to entertain proposals for book reviews that come over the transom (an old-fashioned expression from the days when an editor's door had a transom at the top through which unsolicited manuscripts were thrown), in general, we expect to invite our book review authors.

Because this is a new section, and we only produce two issues per volume (not counting our proceedings issue with the International Conference on Clinical Ethics and Consultation — ICCEC), we are still considering what would be an appropriate number of books reviewed per volume, or if there may be no set pattern.

Nevertheless, we hope you become interested in reading the graphic medicine casebook after reading our section-opening review; it seems that a wonderful teaching tool has been added to the field. And we are especially grateful to Patrick Herron for initiating this section and helping to make book reviews a useful addition for you, our readers.

As always, we would love to hear what you think. We are interested in your thoughts and comments on what we do in JoHE.

Sincerely,

Evan

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Beyond Ethical and Legal Borders: The Case of a Complex Factitious Disorder

Valérie Badro, PhD; Annie Descoteaux, MEd, PhD (c); Michelle Pimont, MD, MPH, MBE; and Marie-Ève Bouthillier, PhD

Abstract: This article presents the case study of Charlie, a person who suffers from factitious disorder (FD) imposed on self (previously called Munchausen syndrome), a serious psychiatric condition. As described in the Diagnostic and Statistical Manual of Mental Diseases (DSM-5), individuals with this disorder intentionally fabricate physical or psychological symptoms for medical attention with no obvious gain. It is extremely difficult to care and accompany patients with factitious disorder. As Wong and Detweiler mention, "Many clinicians remember their first Munchausen syndrome case as if they were seeing medicine through a distorted prism and struggle with residual conflicting thoughts, as the clinical and ethical implications can be challenging."[3] Clinicians may unknowingly do harm by prescribing unnecessary tests, medications, and procedures (e.g., narcotics, surgeries) with the associated risks and iatrogenic consequences of being in a hospital for so long. Once it is known that the patient suffers from FD, reactions are ambivalent even perhaps negative, as Denis and Denis outline.[4] Some may be reticent to admit that the patient is lying or cheating, some may avoid the issue altogether or just prefer to err on the side of prudent belief and treat accordingly. How then should we respond to Charlie's manifestations of suffering?

Introduction

As described in the Diagnostic and Statistical Manual of Mental Diseases (DSM-5), individuals with factitious disorder (FD) imposed on self intentionally fabricate physical or psychological symptoms for medical attention with no obvious gain. Deceptive behaviors may include exaggeration, fabrication and induction of injury that causes others to perceive them as more ill, impaired, or injured. An individual with FD may, for example, add blood to a urine test or ingest a substance to falsify laboratory test results, deceptively report abnormal episodes (e.g., dizziness or seizures) or symptoms, physically injure themselves or induce an illness (e.g., by injecting fecal material to produce an infection) to convince others that treatments, even invasive surgeries, are needed. Patient with FD primarily have somatic concerns and present in medical rather than mental health settings with persistent levels of anxiety and distress about being sick. They may or may not have co-morbid physical conditions or other psychiatric disorders which makes diagnosis difficult.[1,2]

Charlie is a 50-year-old woman who sought medical attention for an array of physical ailments. Her symptoms seemed somatic in nature. Our ethics team first encountered Charlie and her husband, her silent sentinel partner always at her side, in August 2017 in the cardiology department of Hospital A. She had been hospitalized for over a month complaining of heart palpitations and digestive symptoms. She was refusing to eat (at least in front of the staff) because of reported allergies and food intolerances and an irritable bowel. Worried and determined to help Charlie, the medical team ordered an impressive number of medical exams, from blood and urine analyses to more invasive diagnostic tests. The medical team was unanimous; nothing could explain her physical symptoms and a discharge was anticipated. Charlie refused the discharge and requested a feeding tube, claiming she was not able to eat otherwise. The team suspected that perhaps she was suffering from anorexia and offered her psychological support, which she refused. After many discussions, the team concluded that a gastrostomy was not indicated and that there were no further medically indicated reasons for her to stay at the hospital. She was discharged. As Charlie was discharged against her wishes, the emergency department was informed not to hospitalize her again unless she presented with a new condition that wasn't already examined. As suspected, a few hours later, Charlie appeared at the emergency department claiming she was not able to eat. She was offered psychological help which she refused again and left.

Several weeks later, the ethics service was called by an internist at Hospital B who was struggling with a complex case. This hospital was one of four hospitals served by the same group of ethicists. As the internist described her struggles with her patient, the ethicist recognized that it was in fact Charlie. She had been admitted shortly after she had been discharged from Hospital A. By the time the ethics service was involved, Charlie had undergone an impressive number of medical exams from various areas of specialty, which, just as in Hospital A, did not identify any treatable physical malady or explain her reported symptoms. The team's suspicion of the presence of a factitious disorder was becoming stronger. It was decided by the medical team, which included a psychiatrist, that the same approach as that of Hospital A's would be appropriate: offer her psychological help (which she refused) and discharge her. However, Charlie insisted on having a feeding tube placed. She was discharged, and the emergency department was also informed.

Charlie and her husband came back less than 24 hours later but she was not admitted. Given the last two hospitalizations, it was expected that Charlie would present at yet another near-by hospital that same night seeking medical attention and hospitalization. The same pattern would follow; admission and repeated scans and laboratory tests, exposing her to considerable risks if she could convince a physician to install a feeding tube or gastrostomy or another invasive procedure. Over a year passes without any news from Charlie from any of the hospitals she had previously visited. During that time, Charlie was hospitalized in the gastroenterology unit of Hospital D. During that period, she sued the physicians and the hospital to force them to install a feeding tube because the health care team refused to do so. The judge did not allow the feeding tube to be placed. As Charlie again refused to be discharged, Hospital D obtained a court order to have her transferred by ambulance to her local hospital which was Hospital C. She was well known at that hospital because of previous long-term hospitalizations. The diagnosis of factitious disorder was already on the table of possible afflictions, but because Charlie refused access to her medical records, this information and other health information was unknown by Hospitals A, B, or D. Upon arrival, she was evaluated by a psychiatrist. He proposed to admit her in the psychiatric ward, which she refused, but he concluded that she was competent to make her own decisions. She was discharged immediately and offered to be seen at home as an out-patient by a psychiatrist. She refused again.

Several months pass during which the ethicists did not hear about Charlie to find out that she was hospitalized in Hospital E. There, she convinced a physician to perform a gastrostomy. She then returned to the emergency department of Hospital C with a new pattern. Every night around midnight, she presented to the emergency department with her husband and would be registered and triaged as low priority. At first, and for several weeks, whenever called to see the emergency physician, they would ask for examinations to be performed. Faced with refusals from medical staff, Charlie and her husband would wait all night in the waiting room but would leave in the morning before seeing a physician. Before leaving the premises, they would stop at the cafeteria to eat. According to the emergency staff, they would often stay and sleep in the emergency room without disturbing anyone. On the odd days they were not present, they would go to another emergency department across town where they would reproduce the same pattern.

Finally, the ethics service at Hospital C organized another meeting which included many teams within the hospital, including emergency, internal medicine, psychiatry, and the chief medical officer. It was decided that the couple would be confronted and questioned to find out how the hospital could possibly offer better services. So, in the middle of the night at the emergency department, the couple was approached by a clinical ethicist and a physician. The couple refused to talk and left the emergency department in a hurry. They were not seen again. Where and how is Charlie doing today is unknown.

Caring in the Distortion

It is extremely difficult to care and accompany patients with factitious disorder. As Wong and Detweiler mention, "Many clinicians remember their first Munchausen syndrome case as if they were seeing medicine through a distorted prism and struggle with residual conflicting thoughts, as the clinical and ethical implications can be challenging."[3] One distortion exists within the doctor-patient relationship since one of the implicit premises of that relationship is that both parties collaborate honestly with one another to reach an appropriate plan of care for the patient. This principle is so fundamental that it becomes a challenge for clinicians to integrate FD’s intrinsic distortion as part of the relationship. Another distortion touches on the general goals of medicine to do good and avoid harm. Clinicians may unknowingly do harm by prescribing unnecessary tests, medications, and procedures (e.g., narcotics, surgeries) with the associated risks and iatrogenic consequences of being in a hospital for so long. Once it is known that the patient suffers from FD, reactions are ambivalent even perhaps negative, as Denis and Denis (2016) outline.[4] Some may be reticent to admit that the patient is lying or cheating, some may avoid the issue altogether or just prefer to err on the side of prudent belief and treat accordingly. In our discussion with the clinical teams, the question came up as to whether Charlie is suffering “for real” or is lying for medical attention. The answer to this is never straightforward as FD is a disorder that compels a behavior due to suffering and results in additional suffering because of the behavior. As Denis and Denis state, patients lie because they suffer and suffer because they lie, and the will to lie is, from the patient’s perspective, is not necessarily appreciated as it is often pathological.[4]

How then should we respond to Charlie’s manifestations of suffering? Taking an initial medical history to assist with diagnosing leads to a spiral of tests, consultations, and exams only to conclude after days or weeks of hospitalization that nothing can be appropriately diagnosed and thus no interventions are medically indicated. In many cases it would seem that psychiatric approaches could be indicated care options but are systematically refused by the patient. Even when the disorder is known to be factitious, a crying wolf puts physicians on the edge since no physician wants to be the one who overlooks a serious but treatable pathology (e.g., appendicitis) from which the patient is actually suffering and may die. With collaboration distorted, along with trust, the core of the therapeutic alliance is at stake and empathy suffers.

Is it even possible to implement a partnership relationship with Charlie? In addition, it becomes evident that we might be harming Charlie through undesired side-effects and iatrogenic consequences by enabling Charlie to remain in this vicious cycle. For example, because of her long hospitalization, she was extremely weak from lack of exercise and presented signs of biochemical alteration from too many blood tests and other examinations. She claimed that her legs had neurological issues that made her too weak to walk. She refused physiotherapy and preferred to use a wheelchair. She was prone to infection because of her gastrostomy tube and claimed to be scared to eat by mouth. The clinical team now further suspects that she has become dependent on narcotics. Shouldn't something be done to protect her from (self) harm?

Caring While Maintaining Confidentiality?

Another major ethical and legal obstacle is the patient's right to privacy and the duty of professionals to respect all confidential information shared by patients. Usually, confidentiality serves the higher purpose of maintaining trust within the therapeutic alliance. This trust is essential for patients as otherwise they would not have a privileged and protected safe space to be able to share or reveal sensitive information that is necessary for proper diagnosis, appropriate treatment, and caring. For Charlie, this space is compromised. She mistrusts the clinical team and is mistrusted by the clinical team once FD is suspected. More so, important medical information is purposely omitted by the patient when, for example, Charlie is seen by a health care team for the first time. When health care professionals work with partial information it hinders their obligation to provide medically safe and appropriate care. Over and again, she undergoes unnecessary examinations with health care teams who struggle to piece together a diagnosis tabula rasa as if starting from nothing or for the first time with only partial information from the patient, a process Charlie underwent in every hospital.

Differentially diagnosing FD requires time and collaborative efforts. Charlie systematically refused to consent to the medical team having access to her medical records from other hospitals which in-and-of-itself was considered suspicious. In our case, only after consultation with an ethics team that covered many of the hospitals visited by Charlie did the pattern become more obvious; Charlie was not aware that some of these hospitals shared a common regional electronic medical record system. When a patient's physical integrity is at risk (e.g., unnecessary invasive surgery with lasting consequences), is it justifiable to bend the rules of confidentiality? Confidential grey zones do exist and, practically speaking, in many cases strict confidentiality seems extremely difficult given the nature, specificity, and complexity of this case. Maintaining strict confidentiality does not seem in Charlie's best interest when defined in terms of the prevention of her self-harm.

Caring with a Concern for Justice

The feigning of symptoms by a patient leads also to very long hospitalizations and the non-appropriate use of medical resources along with their associated cost.[5] From a social justice perspective, in a universal health care system, as mentioned in the Code of physicians, there is a duty to use health care resources judiciously.[6] Resources are limited and access to professionals and health care services should not be wasted. Charlie underwent an impressive number of scans, exams, and engaged quite a few medical specialties during their attempts to diagnose her. Not to mention, Charlie mobilized hundreds of health and legal professionals. Whether any of this helped her is unclear.

Caring and not Abandoning the Patient

How do we maintain an appropriate level of empathy for such patients? Caring and not abandoning is certainly a struggle. At some point and after a long stay in a hospital, suspicion of FD creates an odd dynamic that leaves little space for empathy and opens the door to reject Charlie. In their interactions with her, professionals question whether she knows that the medical team is aware that her condition is factitious and are challenged by considering whether they should confront her on her "lies" and, if so, how. Healthcare professionals can also become exhausted over what seems to be a therapeutic dead-end and a vicious circle. Feelings of being deceived, even if deception is understood as an essential aspect of FD presentation, may lead to complete detachment and avoidance. Loss of meaning and an uncaring stance may overwhelm professionals and deeply undermine empathy.

Further, the diagnosis of factitious disorder can carry a stigma, and by extension Charlie might be subject to discrimination. Will she be treated differently, not taken seriously or perhaps ignored? Will her psychological well-being be overlooked over her physical complaint?[7]

Conclusion

Is contemporary medicine capable of treating someone like Charlie? Despite all of the time she spent hospitalized and attempts to connect with her, she seemed only to accept treatments (e.g., gastrostomy) that would perpetuate her fundamental illness (FD) and refused care that the team thought would help her physically and mentally (e.g., physiotherapy, psychological and psychiatric support, routine home care to avoid hospitalization, and ER).

Charlie's case resulted in quite a bit of distress and helplessness among several healthcare professionals. The ethics team played an essential role in building spaces for moral understanding and support to struggling clinical teams attempting to care for Charlie. One recommendation that emerged was the importance to have a clear, concrete, and coherent plan of care for Charlie that would help channel her anxiety for medical attention. This plan included her pain being managed, scheduled routine home visits and easy access to a team composed of 3 designated physicians: a psychiatrist, an internist, and a family physician in an out-patient setting. The objective was to avoid chaotic emergency room visits and her wandering from hospital to hospital. Such care would be orchestrated by a single health professional (the family physician with assistance from the psychiatrist and the internist) across institutions for coherence and efficacy. This would also help Charlie not feel abandoned, a major concern in caring for an FD patient. She would have direct access to the same health professionals with whom she would, in time, build a trusting relationship. This trust could be a powerful element capable of convincing Charlie to share confidential information (e.g., medical records from other institutions). This professional would additionally engage Charlie in a way that would delicately point out incoherencies in her discourse but without making her flee to another institution. Furthermore, this person would coordinate all additional health and social services if needed. The second objective that emerged was the need to help teams find meaning in caring for Charlie. It may be helpful to discuss ways to engage and remain meaningfully empathetic with her by shedding light on her underlying psychiatric condition, even if she refused treatments that would seem beneficial, and even if she continued to fabricate symptoms and seek inappropriate medical treatment.

One question that was considered was whether clinical ethicists from different institutions should share general information about Charlie, namely the possibility of her having FD to awake suspicion earlier in her pattern. As discussed above, clinical ethicists might find themselves on a tightrope with respect to confidentiality across institutions, given they are also tasked with providing consultations to institutions that do not share an electronic medical record system. After all, they are not only witnesses to the misuse of resources, but also the willingness of at least some clinicians to provide harmful, nonindicated interventions that could compromise Charlie's physical integrity. To say nothing meant also that ethics support and intervention could not facilitate a coherent course of action or really help Charlie. In our opinion, confidentiality as a general rule has exceptions. Is it breaking confidentiality when, after a while, Charlie’s pattern becomes clear given how many institutions had become involved in her care? Also, in a public health care system, borders between institutions are mainly administrative and regionally delineated. Many initiatives already exist to merge health data within larger hospital systems as well as across institutions, especially in relation to laboratory results for better and more efficient care. We argue that the concept of confidentiality should follow and be interpreted clinically and not administratively. As mentioned by Caselli et al., early identification of a factitious disorder by a multidisciplinary team can save precious time, reduce harm from inappropriate treatment and self-harm, and save resources. Finally, in our situation, we considered that the benefits of building and sharing a coherent care plan outweighed the potential harms of breaching certain confidential information. Perhaps this was a necessary step for Charlie to begin a healing process or at least obtain safer care as well as personalized and adapted support for her complex condition.

AUTHORS

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Developing a Clinical Organizational Ethics Program

Kelsey Miller, MHA, MLD and Jane Hartsock, JD, MA

Abstract: Within the healthcare industry, organizational ethics has historically addressed professional or business ethics within a system that included financial incentives, salary scales, promotion criteria, the investment activities of the organization, billing, or similar activities.[1] While these issues are important, they do not fully capture the range of organizational ethics issues that directly affect patients. Developing a clinical organizational ethics program requires a systematic approach for addressing recurrent ethical dilemmas that arise in patient care settings implicating policy, law, or structural/societal constraints. In this paper, we provide one framework for a successful clinical organizational ethics program, identifying The Joint Commission (TJC) requirements for ethics presence, key structural elements such as the existence of an embedded ethics infrastructure, leadership buy-in and support, collaborations with other key stakeholders within the organization, and a process for identifying and responding to these issues, which are often embedded in clinical ethics consultations.

Introduction

Addressing clinical organizational ethics issues at a "system level" is a valuable way of approaching ethical dilemmas in the healthcare industry. We propose a definition of clinical organizational ethics which denotes those clinical ethics issues that are recurrent and require a systematic approach. For clarification, in this article "clinical organizational ethics" (COE) refers to those ethical issues that arise out of patient care but are not isolated to single patient encounters. They often overlap with existing policy or law and may require collaboration among and between multiple departments within a single healthcare institution. This article will differentiate organizational from clinical ethics, identify the necessary components for a successful COE program, and provide examples of COE issues that have been addressed within a large academic health system where this program is currently being developed and formalized.

Background

The Joint Commission (TJC) has required healthcare organizations to have a method for addressing ethics.[2] In 1995, TJC set forth a mandate they called organizational ethics that required "healthcare organizations to conduct their business and patient care practices in an honest, decent, and proper manner".[3] Although TJC's 2016 update to its Code of Conduct requires some sort of method to address ethical concerns, the focus appears mostly to pertain to the ethical business standards of healthcare organizations to ensure the conduct protects the organization's values and integrity.[2] Other than mandating healthcare systems to "treat all customers, fellow employees and contracted third parties with respect, honesty, fairness, and integrity,"[3] TJC does not set forth requirements for addressing COE within healthcare institutions. In 1995, the Commission for Accreditation of Healthcare Organizations also required healthcare systems to include organizational ethics as a part of their standards.[4] But, like TJC, these standards address issues closely related to business ethics such as advertising and billing.[4] The consistent conflation of organizational ethics and business ethics has permeated the literature, as well.

For example, Magill & Prybil's Guidelines for Organizational Ethics, offers the following important perspective that equates organizational ethics with business ethics:

> *"Organizational ethics, by contrast, deals with value-related issues concerning an organization in the broadest sense: mission, vision, sponsorship, governance, and leadership. (The term, as we use it, encompasses what some writers allude to as "business ethics" and "corporate ethics.") Organizational ethics is related to, but broader than, compliance programs, which typically try to ensure that organizations abide by legal and regulatory requirements. At its best, organizational ethics seeks to foster a virtuous organization, in which ethical principles inspire appropriate decision making and moral behavior among all its personnel."* [5]

Generalizing this to a clinical organizational ethics framework, decision-making should be centered around an organization's values.[6] Values help organizations identify what is most important and serve as a foundation for what the organization stands for.[7] For example, **Table 1 (page 13)**, outlines four healthcare systems' values. Presumably, the expectation of the institution is that decisions made by team members should align with these core values. When conducting COE, ethicists should consider the organization's values to guide their decision-making, recommendations, and to create a positive ethical climate within the organization.

Table 1: Healthcare Organization's Values

Organization	Values
Ascension	Service of the poor, Reverence, Integrity, Wisdom, Creativity, and Dedication[9]
Adventist Health	Be love, Be a force for good, Be a mission owner, Be welcoming, Be curious, and Be brilliant[10]
IU Health	Purpose, Excellence, Compassion, and Team[11]
Kaiser Permanente	Respect, Scientific Discipline, Integrity, Pioneering Spirit, and Stewardship[12]

As demonstrated further in **Table 2**, there are various definitions of organizational ethics. As noted in **Table 2**, many organizations have adopted organizational ethics programs that reflect the standards of decision-making regarding business or professional ethics. Importantly, a review of these definitions suggests there is inadequate attention within the definitions of "organizational ethics" to actual ethical issues that arise in clinical spaces within a healthcare organization. Lahey states "organizational ethics programs often are created to address tensions in organizational values that have been identified through repeated clinical ethics consultation requests."[8]

Table 2: Definitions of Organizational Ethics

Definition
"The organization's efforts to define its own core values and mission, identify areas in which important values come into conflict, seek the best possible resolution of these conflicts and manage its own performance to ensure that it acts in accord with espoused values".[13]
"The study and practice of the ethical behaviour of organizations. It involves clarifying and evaluating the values embedded in organizational policies and practices, and seeking mechanisms for establishing morally acceptable values-based practices and policies".[14]
"Organizational ethics programs often are created to address tensions in organizational values that have been identified through repeated clinical ethics consultation requests".[7]
"Organisational ethics is concerned with the ethical issues faced by managers and board members and the ethical implications of organisational decisions and practices on patients, staff, and the community".[15]
"Organizational ethics deals with an organization's positions and behavior relative to individuals (patients, providers, and employees), groups, communities served by the organization, and other organizations".[16]

Organizational Ethics vs. Clinical Ethics

While it is important to distinguish between clinical ethics and clinical organizational ethics, there are occasions when a clinical ethics consultant will reveal a need for systematic change.[17] Highlighted in **Table 3 (page 14)**, we identify the primary characteristics of COE in contrast to clinical ethics. Below, we discuss in detail how a COE ethics program might be structured within a large healthcare system.

Developing a Clinical Organizational Ethics Program

Ethics Infrastructure

Developing a foundational ethics infrastructure is crucial to the success of a COE program. Appropriate ethics infrastructure ensures the healthcare system's existing decision-making is aligned with the organization's values and/or their mission statement. Different approaches may guide how a healthcare system implements a COE program. As noted above, a system could align their COE program with their overall mission; this is typical of Catholic health systems.[17] Systems could also approach COE with a quality improvement lens, as the Veterans Health Administration has in the past.[17, 18] This will likely look different across healthcare systems, but can include adopting a code of ethics, creating ethics committees (clinical consultation subcommittee, organizational ethics subcommittee), collaborating with leadership and other departments/entities to build a working relationship, and providing continued ethics training to those who are on the committees.[17, 19]

Table 3: Organizational Ethics vs. Clinical Ethics

Clinical Organizational Ethics	Clinical Ethics
• Issue-Based • Arises out of patient care but impacts multiple patients at the conclusion of the consultation. • Typically requested by organization's team member. • Leadership involvement in most cases. • Recurrent clinical ethics dilemmas. • Results in procedure/policy revision or implementation of a new procedure/policy making long-term effects. Potentially implicates legislative or governmental action.	• Individual Patient-Based • Directly impacts a single patient. • Patients, families, and any healthcare provider or anyone involved in the patient's care may request consultation. • Leadership buy-in is not necessary unless preferred by ethics consultant or ethics committee. • Isolated issue involving a single patient. • Results in recommendations related to a specific patient encounter.

Because COE issues are often embedded within clinical ethics consultations and can arise while working through a consult,[18] a COE program may thrive if it is housed within or operated by the clinical ethics committee. Ethics committee members with specific ethics education, have the training and experience to take on the role of conducting COE consults, which tend to be complex and implicate both micro and macro structures. Further, developing an ethics infrastructure is imperative to the success of the program as this will be a way to make team members aware that the program exists. While we anticipate requests will come from clinicians, such as nurses, physicians, social workers, or other healthcare providers, any team member at a healthcare system should be able to request a COE consult; awareness of the program's existence is critical for utilization of the service.

Admittedly, various resources will be available across different healthcare systems. Most academic health centers will have a medical school and graduate programs, along with other resources they can tap into, while smaller hospitals or systems may only have a handful of part-time clinicians who serve on their ethics committee. Ideally, a well-developed ethics infrastructure includes individuals with time dedicated to ethics issues, which could include clinical organizational issues. COE implicates underlying issues at healthcare systems; therefore, a successful program requires collaboration across multiple departments, as well as buy-in from leadership, who may be called on to change practice, revise policies, or work for legislative change.

Other Key Stakeholders

Beyond the practical benefit of having intentional analysis of concerns, a well-functioning COE program may improve the morale of team members at the organization. As Lahey, et al. have suggested, "giving voice to the ethical challenges of organizational decision making may not only alleviate some of the moral distress experienced by health leaders in making difficult decisions, it may also bridge the perceptual gap between health leaders and frontline staff by creating conditions for shared understanding and, hence, trust."[7] Given the considerable research on moral distress, empowering clinicians to identify and request change at a systematic level, the work of the COE program could reduce moral distress.[20] Multidirectional conversations connect the organization's leaders with bedside staff and other clinicians to give them a voice, alleviate moral distress, and build trust between the leaders and clinicians/healthcare professionals. These multidirectional conversations and relationships more than likely do not only align with the organization's values but could also increase employee satisfaction.[7] The importance of leadership buy-in is crucial.

Leadership buy-in is important to ensuring awareness of the existence of the resource. For example, leaders who are aware of the program will be able both to refer team members to the service, as well as identify and bring forward their own ethical concerns. Key collaborations for the success of a COE program include legal, risk, government affairs, and service lines at the forefront of "hot button ethical issues," such as reproductive health services, genetics and precision medicine, and palliative care. Laying this groundwork and creating working relationships with these individuals and departments will be beneficial to the COE program. Not only will key stakeholders and departments realize that the COE program exists, but they could also provide insight on clinical organizational ethics if an issue comes up that could use input from a certain department.

Simple vs. Complex Clinical Organizational Ethics

Contemporary healthcare systems emphasize reportable metrics as a way of monitoring productivity and improvement. While clinical consults are relatively easy to “count” – a simple tally or hours expended may be the unit of measurement – COE consults are a bit more nuanced. Because work on a consult may extend several weeks or even several months, tabulating hours becomes difficult. Likewise, the tally is likely to be low – perhaps one or two a month. One way to classify COE issues is into two categories: simple vs. complex. A simple COE issue is classified as an issue that can be resolved with perhaps not much more than a quick literature search with recommendations delivered in a few hours or a day.

The “deliverable” with a simple COE issue could merely be a recommendation in the form of a memo, or even an email to the team that requested the clinical organizational ethics consult. Occasionally, a quick turnaround time is required; therefore, verbal recommendations may be the only feedback given to the team. Another instance where verbal recommendations are given is when there is no literature for the ethics consultant to review because the issue is so new (i.e., COVID-19).

These types of clinical organizational ethics issues are typically classified as simple COE. As you will see in **Appendix A,** an example of a simple COE is a consultation that could be surrounding COVID-19 vaccination and conscientious objection. This ethics issue was addressing physicians who were declining to provide the Johnson & Johnson COVID-19 vaccine to patients based on their individual religious views and questioning whether a specialized consent for the Johnson & Johnson COVID-19 vaccine should be provided to patients. This was considered a simple COE consult because the issue was rectified in a few days with verbal recommendations given by the Ethics Committee.

In contrast, a complex COE consult is one requiring a more extensive analysis of the literature or collaboration with outside experts. It may take several days or even weeks to complete. The process of developing or revising a policy or procedure at the organizational level may extend the consult for several months. **Table 4** identifies the characteristics of simple and complex consultations. Again, as you will see in **Appendix A**, an example of a complex COE consultation could be in reference to the ethical appropriateness of Sterilization of an Incapacitated Patient. As one can imagine, this topic is very sensitive and requires multiple departments to collaborate over time to produce recommendations and a formalized process on how to address each request for sterilization. This is considered a complex COE issue because of the multi-department collaboration along with the time it will take to address each sterilization request. See a complete list of examples of simple and complex COE consultations listed in **Appendix A.**

Table 4: Simple Consultations vs. Complex Consultations

Simple	Complex
• Quick literature review, review of policies/ procedures. • Often resolved in a few hours or one day. • Typically results in an ethical analysis and recommendations in the form of a memorandum completed by ethics consultant. Could also be as simple as a verbal recommendation (depending on turnaround time) or recommendations via email.	• In-depth literature review, review of policies/ procedures/legislation. • May require several days or weeks to complete, depending on the deliverable. • Typically results in procedure/policy revision or implementation of a new procedure/policy or potentially proposed legislative changes.

Framework for intake and processing of COE

Figure 1 (page 16) describes the process for how a healthcare organization can address COE issues. The framework mimics the process at a large academic healthcare center with a clinical ethics consultation service in place as well as resources available to complete comprehensive research when necessary for a consult. See **Table 5 (page 16)** for a more in-depth, step-by-step process.

Figure 1: Intake and Processing of COE Framework

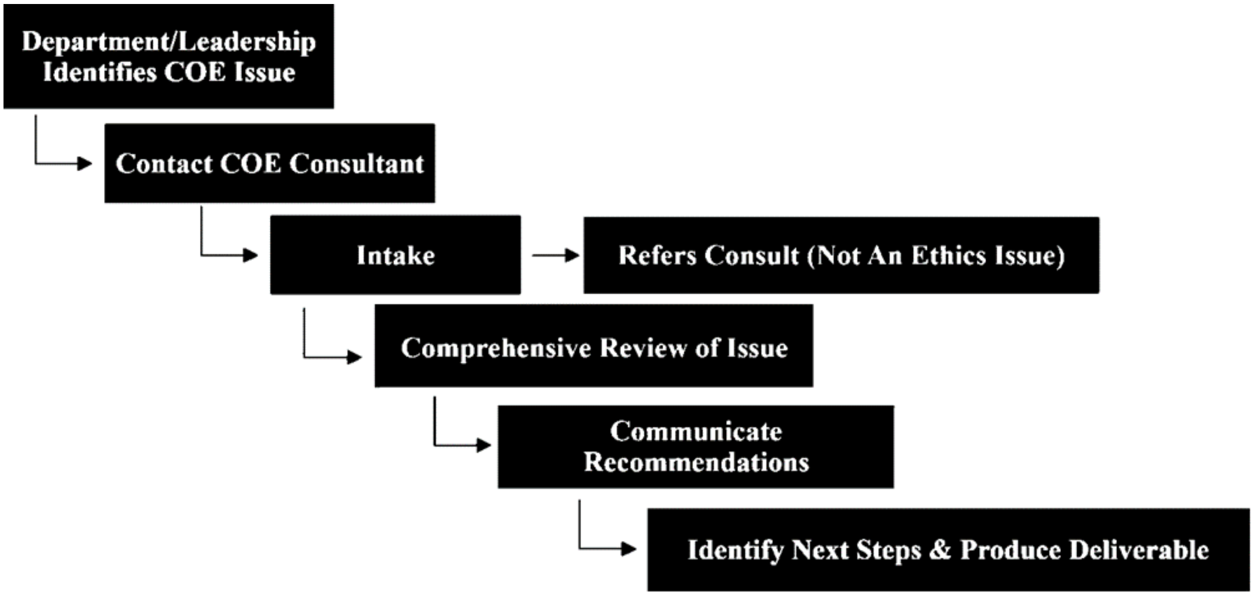

Table 5: Step-by-Step Guide		
Department/Leadership Identifies COE Issue		
Step 1	Contact COE Consultant	Contacting a COE consultant can be done through the organization's preferred pathway for contacting the ethics consultation service or individual ethicist.
Step 2	Intake	Consultant will gather information from the requestor regarding the COE issue. The consultant will determine if they will include other key stakeholders to help in the next steps of the consult.
Step 3 (If Necessary)	Refers Consult (Not An Ethics Issue)	If the issue is determined to not be an ethical dilemma, the COE consultant can refer the requestor to the person/department who is more appropriate to address the issue, (i.e., legal, patient advocate, or another department). The consultant would not proceed with the following steps.
Step 4	Comprehensive Review of Issue	Research can be conducted individually or in collaboration with other stakeholders involved in the case. Depending on the ethical issue, research will include literature review, review of policies, procedures, legislation, etc.
Step 5	Communicate Recommendations	This step will depend on the COE issue and what is being requested from the ethics consultant. A memorandum including an ethical analysis along with recommendations is typically drafted for the team.
Step 6	Identify Next Steps & Produce Deliverables	If the end goal was to develop or revise a policy or procedure, the requestor can use the analysis and recommendations provided to do so and can contact ethics consultant throughout the process if additional assistance is wanted.

Conclusion

Above, we have presented a framework for a COE program that could be implemented in most functioning healthcare systems' ethics departments. Appendix A provides examples of COE consults that we have addressed at our large multi-campus health system, as well as how they were resolved. Integrating a COE program into healthcare systems could allow for a positive systematic change that could ultimately improve patient care at the organization, as well as alleviate moral distress amongst the clinical team. Ensuring there is a set standard of care across an organization that aligns with their mission, vision, or values is what a COE program should strive for when implementing their program.

APPENDIX A:

Examples of Clinical Organizational Ethics Consults

Below are examples of clinical organizational ethics consults. Included with the title is the ethics issue, whether it was a simple or complex consult, who it was requested by, any collaborators/key stakeholders on the consultation, and the end product/result:

Athletes Returning to Play Following COVID-19 Diagnosis

- **Ethics Issue:** Balance risk vs. benefit of athletes being granted clearance to return to training and competition following a COVID-19 Diagnosis.
- **Type of Consult:** Simple
- Requester: Primary Care Sports Medicine Service
- **Key Stakeholders:** Primary Care Sports Medicine Service
- **End Product/Result:** The Primary Care Sports Medicine Service requested ethics to review and analyze the protocol they developed asking for assistance with ethical soundness of recommendations, clarity of instructions, and terminology. Prior to implementation, revisions were made to the protocol based on ethics feedback.

Prescribing PrEP to Adolescents Without Parental Consent

- **Ethics Issue:** Can adolescent patients who are at risk for contracting HIV consent to PrEP (pre-exposure prophylaxis, an HIV preventative medication) without parental consent?
- **Type of Consult:** Complex
- **Requester:** System Title X Clinic
- **Key Stakeholders:** Legal Department, Adolescent Pediatrics, Title X Clinicians
- **End Product/Result:** Following an extensive literature search that included reference to guidance from many organizations such as the World Health Organization, American Academy of Pediatrics, and the Centers for Disease Control and Prevention, a detailed memo with recommendations was provided to LifeCare on the process for handling this complex issue.

COVID-19 Vaccination and Conscientious Objection

- **Ethics Issue:** Under what circumstances can physicians decline to provide the Johnson & Johnson COVID-19 vaccine to patients based on their individual religious views; Should a specialized consent for the Johnson & Johnson COVID-19 vaccine to be provided to patients.
- Type of Consult: Simple
- **Requester:** Physician faculty with Department of Family Medicine.
- **Key Stakeholders:** Department of Family Medicine, Legal Department, Hospital Administrative Leadership
- **End Product/Result:** Issue was presented to the Ethics Committee, which made verbal recommendations to hospital leadership on how to move forward.

Access to Interpreter Services in the Outpatient Setting

- **Ethics Issue:** An Ethics Committee Community member advised the Ethics Committee of increased barriers to access of translations/interpreter services for patients in the outpatient setting, particularly in pediatric clinics.
- **Type of Consult:** Complex
- **Requester:** Ethics Committee Community Member
- **Key Stakeholders:** Ethics Committee, Department of Diversity, Equity, and Inclusion, Interpreter Services, Hospital Leadership
- **End Product/Result:** Hospital leadership and the department of Diversity, Equity, and Inclusion were briefed on the issue by the Executive Director of Clinical and Organizational Ethics for IU Health.

Sterilization of Incapacitated Patients

- **Ethics Issue:** Ethical appropriateness of permanently sterilizing cognitive disabled patients (whether underage or disabled).
- **Type of Consult:** Complex
- **Requester:** Pediatric OB-GYN Service
- **Key Stakeholders:** Legal Department, Hospital Leadership, Dept. Obstetrics and Gynecology
- **End Product/Result:** Multi-department collaboration resulted in memo of analysis and recommendations including a formalized process of reviewing all requests for sterilization of incapacitated patients.

Pelvic Exam by Learners

- **Ethics Issue:** Proposed legislation would prohibit learners (i.e. Medical Students, Residents, and Fellows) from conducting or participating on pelvic exams on patients without specific consent (even where pelvic exam by faculty physician is medically indicated for care and treatment).
- **Type of Consult:** Complex
- **Requester:** Government Affairs
- **Key Stakeholders:** Government Affairs, School of Medicine.
- **End Product/Result:** Review of other states' statutes and collaboration with the above key stake holders with recommendations forwarded to the legislator based on similar statutes in other states.

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IN PRACTICE

Vaccination Decision Making of Involuntarily Committed Psychiatric Patients: A Clinical Case Series

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Abstract: Involuntary civil commitment and treatment of patients with severe mental illness pose significant ethical questions when guardians of these patients authorize COVID-19 vaccination. Legally, involuntary commitment for psychiatric illness curtails personal rights to a degree that is rare outside the criminal justice system, so that a patient may receive treatment for a mental illness that poses putative danger to self or others . Once dangerousness is established to justify involuntary commitment, comes the question of treatment and care for severe mental illness and to what extent is medical intervention justified given the context of care. To illustrate the role of ethics committees, we present three chronological case studies to illuminate ethical issues arising from guardian-approved COVID-19 vaccination of involuntarily committed patients. Despite the benefit of the guardian's consent, patients may not assent to vaccination. Thus, these chronological cases explore whether psychiatric hospitals ought to vaccinate their inpatients against COVID-19 without assent, and how should they do so ethically, when civil liberties are already curtailed.

Introduction

Involuntary civil commitment and treatment of patients with severe mental illness pose significant ethical questions when guardians of these patients authorize COVID-19 vaccination. Legally, involuntary commitment for psychiatric illness curtails personal rights to a degree that is rare outside the criminal justice system, so that a patient may receive treatment for a mental illness that poses putative danger to self or others. As early as 1845, court opinions required that the degree of dangerousness to self or others be "great enough to justify such a massive curtailment of liberty."[1,2] Since the 1970s, dangerousness no longer needs to be imminent or entail violent behavior; rather, a person's risk to behave violently and cause injury to self or others can justify commitment.[3] In every state, inpatient commitment laws include component parts: mental illness, putative dangerousness, and need for treatment. Some states also include incompetence, deterioration, and grave disability.[3]

Once dangerousness is established to justify involuntary commitment, comes the question of treatment and care for severe mental illness and to what extent is medical intervention justified given the context of care. In a "principlist" grounded framework,[4] ethical care often prioritizes beneficence of the treatment over patient autonomy, with the hope that involuntary psychiatric treatment may itself restore patient autonomy. People with severe mental illness are often limited in decision-making so as not to have the capacity to weigh risks and benefits of a proposed treatment. Treatment could restore autonomy or a patient's rational judgement so that they may safely return to society, as outlined in Winick's concept of "therapeutic jurisprudence."[5] However, patients who are involuntarily committed should be allowed to make decisions for which they retain capacity and may be entitled to additional legal protections.[6] In some cases, involuntarily committed patients may have uncertain decision-making capacity. If a court finds that a patient is incapable of consenting to medical care, treatment, or service, a guardian, also known legally as the Guardian of the Person, is appointed to facilitate decision-making. The guardian has the right and authority to determine if refusal or consent should be made to "any" health care, treatment, or service, except for admitting the patient to an institution, or consenting to psychosurgery, electroshock therapies, sterilization, or experimental treatment without the prior approval of the court.

Legally, the statutes of 19 states and the District of Columbia direct guardians to use a specific decision-making standard. Of these, 12 are best interest states, requiring a guardian to make decisions based on the guardian's belief of what is in the patient's best interest. Seven states direct guardians to use a "Self-reliance" standard which seeks to foster the patient's independence. Five states use a "Least restrictive alternative" standard which instructs that guardian to make decisions that minimize restriction of the person's decision-making agency.[7] Seven state statutes, such as that of New Hampshire, are silent or reference other standards like "Substituted Judgment" which directs guardians to substitute the patient's values and desires for their own. The Uniform Guardianship, Conservatorship and other Protective Arrangements Act, model legislation that reflects the ethical framework of the professional guardianship discipline, directs guardians to use a "Substituted Judgment" standard when possible and "consider the adult's previous or current directions, preferences, opinions, values, and actions to the extent actually known or reasonably ascertainable by the guardian."[8] No substantive difference in such standards exist when a guardian is a court-appointed stranger or a family member.

Given complex medical, ethical, and legal issues of decision-making involving guardians, the care for patients with severe mental illness is rife with ethical concerns of providing medical interventions in an environment of the patient's limited autonomy. Thus, New Hampshire Hospital, a state psychiatric hospital, developed an ethics committee to promote constructive discussion about patient care and to facilitate resolution of conflicting ethical values. A permanent committee of the Medical Staff Organization, the Ethics Committee consists of at least two active members of the Medical Staff Organization, the hospital chaplain, plus representatives from nursing, social work, and administration. The Committee assists the organization in the development and review of policies and procedures and provides consultation regarding the ethical care and treatment of individual patients referred by treatment teams.

To illustrate the role of ethics committees, we present three chronological case studies to illuminate ethical issues arising from guardian-approved COVID-19 vaccination of involuntarily committed patients. Case 3 highlights the involvement of legal standards of decision-making. These three patients are assumed to receive significant benefit from COVID-19 vaccination.[9] They are less likely to have received vaccinations generally and are at greater risk for COVID-19-related complications, hospitalization, and death.[10,11] Severe mental illness positively correlates with environmental variables that are risk factors for COVID-19 infection: physical illnesses, homelessness, socioeconomic deprivation, and poor adherence to infection control. Admission to a psychiatric hospital may range from days to years; longer stays increase the risk of infection. Given increased risk for COVID-19 infection, morbidity, and mortality, the potential benefit of preventing infection through vaccination against COVID-19 is clear.[11,12]

Despite the benefit of the guardian's consent, patients may not assent to vaccination. Thus, these chronological cases explore whether psychiatric hospitals ought to vaccinate their inpatients against COVID-19 without assent, and how should they do so ethically, when civil liberties are already curtailed.

Case 1

A 70-year-old woman was admitted from a nursing home on an involuntary emergency admission. Her psychiatric history was significant for schizoaffective disorder with paranoid delusions and hallucinations. Her medical history was notable for insulin-dependent diabetes, breast cancer in remission, and obesity. She had significant weight loss due to delusions about people trying to poison her food, water, and air. Her care was managed by a co-guardianship held by family members. During her hospitalization, she attempted to leave the hospital several times and refused medications and much of her food. Her weight recovered with guardian-ordered food. Her delusions developed to include a fixed belief that the COVID vaccine would kill her. When ready for discharge, she was accepted to a nursing home with a secure unit, on the condition she receive a COVID vaccination. Her co-guardians approved administration over the patient's objection to the vaccine. A team member wondered if the patient could surreptitiously be given the vaccine.

Nursing leadership consulted the Ethics Committee: Is it morally justified to vaccinate a patient against their stated wishes, and can deception be used to avoid the use of force?

Ethical Analysis

Deception-based Vaccination

To address the idea of surreptitious vaccination without force, the Committee recognized how truth-telling is a paramount value in psychiatry.[13] Patients who lack capacity may not appear to be harmed by deceptive information, as they cannot use true or false information to decide. However, Potter writes, "medicating an uncooperative patient who does not understand what this medication is supposed to treat and whose risk to himself warrants medication by force is, at least arguably, morally preferable to a situation in which a cooperative patient has been tricked into taking a medication."[14]

While one may argue deception may spare harm to an individual patient, it can be detrimental to the public's trust in health professionals whose word needs to be believed for them to be effective. Psychiatrists must support involuntary patients' autonomy to the extent their capacity allows, even at the cost of open coercion. The Committee opined against deception on that basis.

Limited Rationality-based Vaccination

The patient had delusions that the vaccine was fatal. For the patient, it may have been traumatic to attempt to give her the vaccine against her wishes.

Declining a COVID-19 vaccine does not inherently demonstrate a lack of capacity; however, having delusions about a vaccine establishes the interference of psychopathology in impairing the patient's perception of reality and medical decision-making capacity.

In assessing whether vaccination aligns with patient values, a previous longstanding history of vaccination may serve as evidence that the patient's previously held personal values, such as a belief in vaccination, have been co-opted by a mental illness. Vaccination may be considered nonvoluntary. As Dominic Sisti wrote, "The concept of nonvoluntary psychiatric treatment recognizes that a patient may have held rational values that were co-opted by a mental illness."[15] For Sisti, involuntary treatment amounts to treatment over objection justified by imminent threat to a patient's or another's safety.

In this situation, there is an imminent threat of COVID-19 to the patient's safety. Thus, refusing a vaccination appears irrational. Discussion of the irrationality argument for imposing vaccination however ignores other aspects of voluntariness, such as previously expressed wishes to be treated in a crisis, or that the patient may have had a period of recovery in a mental state to which they would want to return.[15] The Ethics Committee decided against limited rationality as a justification for vaccinating the patient over objection.

Least Restrictive Alternative

Committee members also considered applying a least restrictive alternative: a similar ethical standard to the aforementioned legal standard that encourages clinical interventions which intrudes as little as possible on the patient's autonomy.[16]

Understanding what to avoid restricting is key; the preference to be vaccinated in a single moment is not the only element of the patient's volition. People choose to be vaccinated for various reasons, including the wish to end a pandemic, wish to protect their families, belief it is a civic duty, or a desire to remain healthy.[17] A patient's values can be obtained from collateral history such as vaccination records or a discussion with family and health practitioners.

Despite the staff's interest in seeking the patient's agreement for receiving the vaccination, there was no clear history that vaccination aligned with the patient's values, so the committee could not morally justify forced vaccination based on the ethical and legal priority of the least restrictive standard over other considerations, as discussed in Case 3.

The Ethics Committee recommended that the treatment team and guardian enlist others the patient may trust such as the chaplain and family to encourage her that the vaccine is safe and effective.

Thus, the patient met with family, and due to her strongly held religious beliefs, involved the chaplain, who shared position statements from various clerics encouraging vaccination. Neither of these actions convinced the patient to agree. The Ethics committee met again and continued to recommend applying the ethical principle of the least restrictive alternative. The treatment team and guardian could try to find alternative placements that did not require the vaccination. Ultimately, a nursing home with a secured unit that did not require vaccination was identified, and the patient was discharged accordingly.

Case 2

A 62-year-old male with a past psychiatric history significant for schizoaffective disorder, bipolar type, and several prior hospitalizations was admitted on an involuntary emergency admission from his skilled nursing facility for aggressive, disorganized behaviors. He held numerous delusions, such as believing he was a famous artist. His medical history was significant for hypertension, hyperlipidemia, and hypothyroidism. During his admission, his sister, who is also his guardian, stated her desire for him to receive his COVID-19 booster. The patient had been previously vaccinated, and the booster was not required for safe discharge. The patient articulated twice he would accept the recommended immunization. However, when offered by a nurse with whom he was unfamiliar, he refused.

The patient's situation was brought to the attention of the Ethics Committee: Is it ethical to use a trusted messenger to encourage a patient to accept a medical intervention?

Ethical Analysis

A prevailing belief among nursing staff was that the flu vaccine was not to be forcibly administered, even with guardian approval. This notion rested on the idea that the benefit of vaccinating against the flu did not outweigh the harm incurred by both patient and staff in forced vaccination. The idea of administering COVID-19 vaccination thus became a source of moral distress among the healthcare team, for which mitigation was necessary. Having chronologically followed Case 1, this case occurred as COVID-19 cases were rising across the country, raising concern for infection but not to a degree in which the risk of nontreatment was severe.

When considering the least restrictive alternative, the discussants of this case focused on why the patient's response to vaccination changed. Central to the analysis of this case are the approach of care ethics, which "emphasize relationship(s) as fundamental to being, eschew general principles, highlight the parent-child relationship as paramount, view moral responses as properly graduated, and identify emotions such as empathy, compassion, and sensitivity as prerequisites for moral response."[17]

In sum, care ethics seeks to promote the well-being of both caregivers and care-receivers by understanding how our beings and actions are enmeshed within a social context of relationships.

Recognizing that the patient was willing to discuss the vaccine with someone with whom he was familiar, the Ethics Committee recommended approaching the patient when he was less agitated and utilizing a trusted messenger, the nurse with whom the patient was familiar, as a least restrictive alternative. The use of a trusted messenger would not constitute coercion or deception, but an acceptable use of rapport. This strategy was successful, and the patient readily accepted the vaccine from the trusted nurse.

This second case demonstrates that the relationship of the nurse to the patient is fundamental. As Ida Jean Orlando described in the Nursing Process Discipline Theory, nursing requires investigating why patients behave in the way they do and what needs are unfilled.[18] This case relies on understanding the emotions of both patient and nurse and achieving of the nursing goal of meeting the patient's needs as well as mitigating moral distress at a time when it was not clear if the benefit of COVID-19 vaccination outweighed the harm incurred to both patient and staff from a forced administration of the vaccine.

Case 3

A 66-year-old male with schizophrenia and experiencing homelessness was on an involuntary emergency admission after a release from prison. He presented with paranoia and failure to complete activities of daily living due to food-related obsessions. His medical history was significant for orthorexia, resulting in B12 deficiency. His guardian, a family member, approved psychiatric treatment including forced administration of long-acting injectable antipsychotics and was adamant that the patient be vaccinated for COVID-19. The patient was unsure about the vaccination as he believed COVID-19 may be a hoax. He believed the vaccine was "unnatural," unaligned with his health beliefs. The approval of forced administration by his guardian raised the question of whether forced administration was appropriate if least restrictive alternatives were tried and failed.

This case occurred later into the pandemic than previous cases; recent outbreaks in the hospital had created a sense of urgency with a heightened risk of disease and death. Effective treatments for COVID-19 were not yet available, and this patient had multiple risk factors for bad outcomes. Perceiving the possible need for forced vaccination, preemptive consultation with the legal department and review of the guardianship order revealed that "the right and authority [of the guardian] to determine if refusal should be made or consent should be given to any medical or other professional care, counseling, treatment, or service provided." This case was brought to the Ethics Committee: Should the clinical team honor a guardian's request to use coercion to administer the COVID vaccine to a patient against his will?

Ethical Analysis

This case highlights the intersection of ethical and legal decision-making. The two attorneys consulted opined that the guardian has the authority to approve involuntarily vaccination. The committee's primary consideration, given the legal option rendered, was to ethically rely on the principle of beneficence. It considered that the worst outcome would be if a guardian lawfully requested the COVID-19 vaccine, the hospital failed to give the vaccine to the highly vulnerable patient, and the patient subsequently was infected with COVID-19 and consequentially died.

Given the guardian has the right to authorize the forced vaccination, which can be accomplished competently and with minimal physical risk to the patient by psychiatric staff accustomed to involuntary medication procedures and is the medically recommended treatment in the setting of a COVID wave, it would be difficult to justify not giving the vaccination.

An ethics committee may encounter a similar case with more challenging features, such as a different medical risk of vaccination inherent in the patient, such as prior reactions to vaccines, or complex history of patient-expressed wishes when not psychotic. An ethics committee may benefit from entering a dialogue with the guardian about the decision-making standard they used to decide to authorize the vaccination.

Given the complexities of the law, an ethics committee may choose to examine the legal limits to the decision-making powers of guardians. New Hampshire statutes do not direct a specific standard but the Office of Public Guardian, a nonprofit entity contracted with the state, relies on the Substituted Judgment standard as a matter of agency policy. State laws typically restrict substitute decision-making in areas deemed too personal for a guardian to exercise unregulated control, such as in the areas of sex, marriage, or birth control.[19] Likewise, vaccination being considered as a medical procedure is not sufficient for it to fall under the purview of guardian authority. Vaccination differs from most other medical procedures in that it does not treat a disorder of but alters physiology. Moreover, patients may never get the infection against which the vaccine protects, whereas medical treatment is for an existing diagnosis. Uncertainty around benefits, along with the possibility that society may consider vaccination too sensitive for the power of guardians to exercise their authority, casts doubt on guardian-authorized involuntary vaccination.

A guardian's power to authorize involuntary vaccination may have limits, but it may be permitted given additional oversight. For example, a New Hampshire guardian cannot authorize sterilization on his or her authority but may do so with the approval of a judge, who may limit the scope of a guardianship order on a case-by-case basis.[20]

Therefore, an option for an ethics committee faced with the complex task of weighing ethical considerations in such a case is to recommend that the clinical team seek judicial review of a vaccination request, to ensure that the guardian is not authorizing treatment outside their authority. The highest level of due process to protect the patient's legal rights amounts to the least restrictive imposition upon the patient's autonomy.

The Ethics Committee found the principle of beneficence paramount: the risks of a vaccine administration may be worth the lasting protection from the imminent threat of a severe disease in a high-risk congregate setting. However, the patient was discharged before the vaccination could occur. While ethics is not necessarily the same as law, and law is not necessarily same as ethics, this case illustrates how a contextually-driven dialogue between ethical and legal reasoning can inform clinical decision-making.

Discussion

Involuntary commitment inherently curtails personal rights to a degree not seen outside the criminal justice system. It carries the historical legacy of long-term institutionalization being used as a form of social control.[21] However, modern-day involuntary commitments seek to uphold due process and ethical values of autonomy, beneficence, non-maleficence, and justice while providing care. Court-ordered treatment can be viewed as "therapeutic jurisprudence" where the treatment is a means to an end and the individual regains their autonomy that was otherwise limited by untreated mental illness.[5]

Each of these cases highlights significant ethical questions whose answers depend on the context, including how acute the risk is perceived. The ethical principles of beneficence, autonomy, and non-maleficence, as well as the ethical virtue of truthfulness, were prioritized in answering these questions. Regarding beneficence, patients with severe mental illnesses have a greater risk of hospitalization and death due to COVID-19. The treatment teams and guardians believe that the benefits of the vaccines outweigh the risks for most such patients. Beneficence guides the treatment teams and the guardians to want to administer COVID-19 vaccines to highly vulnerable patients to prevent serious medical complications and deaths, especially with rampant viral transmission. Regarding autonomy, the probate court has found each patient to be legally incompetent to make appropriate medical decisions. Regarding non-maleficence, pursuing the least restrictive alternative guides the treatment teams, to try their best to find ways to encourage the patient to accept the vaccines with the least risk of patient injury. Ultimately, if efforts to employ less restrictive alternatives are ineffective and risk is perceived to a degree that the outcome of nontreatment is so severe, it may be legally and ethically permissible for the guardian to approve administration of the COVID-19 vaccine against the patient's wishes, which may be a lifesaving intervention during a pandemic.

The purposes and value of an ethics committee lie in the ability of an ethics-trained interdisciplinary team to engage in discussions regarding how treatment teams can ensure the best care possible that meets the needs of the patients, either articulated by the patient or their surrogate concerning a professional assessment of their behavior and history. The question to vaccinate patients in involuntary care is challenging and rife with ethical dilemmas. These cases demonstrate how ethics committees act as facilitators of constructive discourse of ethical values to foster consistent, value-based care.

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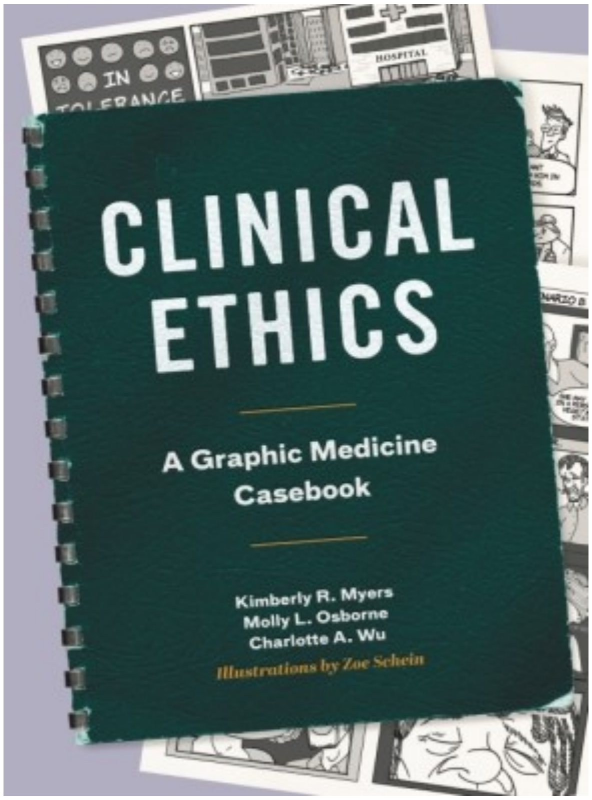
BOOK REVIEWS

Clinical Ethics: A Graphic Medicine Casebook*

Review by Patrick Herron, DBe, HEC-C

*Myers, Kimberly R., Molly L. Osborne, and Charlotte A. Wu. *Clinical Ethics: A Graphic Medicine Casebook.* Illustrated by Zoe Schein. Penn State University Press; 1st Edition. May 17, 2022. 112 p. $20.95 ISBN: 978-0271-09281-2



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Clinical Ethics: A Graphic Medicine Casebook[1] is a collaboration by scholarly experts in the fields of bioethics, comics, healthcare, and literature. Its aim is to present a more engaging medium for health professionals and trainees to explore ethical dilemmas in healthcare. The title references "graphic medicine," a phrase attributed to British physician and cartoonist, Dr. Ian Williams to describe an artform of comics to tell stories of health and illness.[2] The combined language of stories and illustrations offers approachability and emotional impact to the narratives depicted and the ways in which ethical dilemmas in healthcare unfold in real life. Clinical Ethics provides an excellent introduction to health care ethics using case studies designed to invite and facilitate engagement with learners and health professionals. Topics covered include respect for autonomy, confidentiality, futility, informed consent, mandatory reporting, medical mistakes, surrogate decision-making, and unconscious bias. Accompanying each drawn storyline is a written summary with key concepts, reflection questions, and recommended readings from the authors.

One of the distinct advantages of graphic medicine is that it has the ability to communicate an author's internal viewpoint of a patient's experience in conjunction with external clinical perspectives involving diagnoses and symptoms. It is also more amenable to interprofessional perspectives as noted by the varied interdisciplinary backgrounds of Clinical Ethics' authors and illustrator.

Some may view comics as merely a form of entertainment meant for kids and not suitable for scholarly pursuits, but such outdated perspectives fail to appreciate the meaningful cultural, humanistic, and ethical engagement they can offer to patients, families, and health professionals. Therefore, we should seek to include such works in our educational approaches with learners. Using these multifaceted accounts, traditional methods of instruction in healthcare ethics can be enhanced by using the artistic portrayals to convey experiential points of view.

Dr. Kimberly Myers is a Professor of Humanities, Medicine, and Distinguished Educator at Penn State College of Medicine. She is co-author of *Graphic Medicine Manifesto*, a creative collaboration by early scholars of graphic medicine who sought to introduce readers to the principles of the field.[3] Joining her for this endeavor are Dr. Molly Osborne, Professor Emerita of Medicine at Oregon Health & Science University and VA Integrated Ethics Program Officer, and Dr. Charlotte A. Wu, an internist and founder of Harness Health Global. The featured comic panels were drawn by Zoe Schein, an accomplished illustrator and art educator.

The format lends itself to fit well within any healthcare ethics curriculum. The forward by Dr. Michael J. Green provides a compelling argument for the distinct advantages of comics in comparison to traditional case presentations in written form. His perspective being that a visual story can convey more meaning than text alone, foster empathy, and provides the opportunity for the reader to be a more active participant in the co-construction of the narrative by inviting the reader to imagine what is not drawn for them but inferred. The stories included are based on actual cases, although the details have been modified to protect patient privacy and focused on specific aspects to optimize their use for teaching purposes.

Each of the eight chapters explores an ethical theme starting first with the visual story followed by a summary in which the issues facing the characters are clarified and framed for discussion. Rather than putting forth an abstract philosophical analysis, the authors have appropriately chosen to address the personal and professional impact of such ethical conflicts, tensions, and moral distress that arise in each of the vignettes. In addition to the stories, there are discussion questions to guide conversations with learners beyond what these narratives initially trigger as they unfolded from panel to panel. The selected themes are ones commonly experienced in modern day healthcare with multidimensional features that demonstrate their authenticity. In "Broken Speech," respect for personal autonomy is examined when a patient's adult children are relied upon for translating but his physician begins to suspect they are selectively relaying some but not all the medical details. The point of view and lived experiences of a patient are the focus of "In Tolerance," which demonstrates how easily unconscious biases often exacerbate health disparities. A physician and their medical student struggle with concerns for a family's wellbeing and whether there is sufficient evidence of abuse or neglect in "Sneaking Suspicion." In the above examples and other stories, the authors and illustrator present characters that are as authentically diverse, complicated, and complex as the patients and families cared for by health professionals. They also have taken steps to not perpetuate harmful stereotypes regarding gender, sexuality, and race that have historically contributed to the disenfranchisement of marginalized communities underserved by the US Healthcare system.

Many curricula for health professions training fail to see the benefit of incorporating health humanities into clinical education courses. Clinical Ethics demonstrates not only that such topics and mediums work well together when integrated but they also enhance the opportunities for engagement. The illustrated narratives combine the explicit meaning of words with the abstract expressiveness of art to create unique, multilayered case presentations. The metaphor of a suit of armor worn by a member of the healthcare team in "Critical S_P_A_C_E" is never acknowledged through the text but visually communicated to encourage deeper examination of the internal struggles and grief people have when discussing end of life care and decisions. Such is the power of graphic medicine to bridge the internal, individual viewpoints and emotion with external, clinical aspects of medical symptoms, diagnoses, and approaches to decision making and communicating with others.

English novelist, Jane Austen, once wrote, "if a book is well written, I always find it too short."[4] Thus my only critique of Clinical Ethics is that its brevity is disappointing. There are many other complex and commonly experienced ethical dilemmas in medicine that the authors could have opted to include in this text but perhaps and hopefully will be put forth in future publications. As it stands though, Clinical Ethics is best suited as a supplemental text to other scholastic works typically used in medical ethics curricula instead of serving as the primary text for students.

Clinical Ethics provides an innovative introduction for students to grapple with complex ethical questions faced by health professionals. The use of graphic narratives enhances student engagement with the principles of medical ethics and application of ethical frameworks to real life situations. The use of illustration enables readers to envision themselves as patients, family members, and the health professionals depicted.

I highly recommend this book to clinical ethics and humanities educators and those engaged in public health discourse. I recommend its use for not only undergraduate medical education, but also advance practice in nursing, physician assistant programs, and bioethics graduate training.

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