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Ethical Concerns When Calling Security Is Top Tactic to Handle Agitated Patients

Frantic calls for hospital security through overhead pages can be a knee-jerk reaction to patients who are becoming loud, threatening, or aggressive. For **Scott Zeller**, MD, that is an ethical concern: “The tendency is to look at it as a criminal matter, and that this is a bad person. But they are probably just a regular person who is demonstrating symptoms of a disease state.”

Some hospitals have put in place progressive policies to ethically manage agitated patients. “But my guess is that far too many still have a default plan, that it’s just an automatic call to security, and that’s the way to deal with it,” says Zeller, vice president of acute psychiatric medicine at Vituity in Emeryville, CA.

This underscores how those with psychiatric symptoms are, in many ways, treated differently than other hospital patients. “From an ethical standpoint, that is the one thing that always stands out to me. We don’t get angry at a person for having shortness of breath. We don’t yell at them for having chest pain,” Zeller observes.

Police officers are not mental health-care professionals, but often are the ones called to help a person in crisis, even if that person is in the hospital at the time. Instead, police should be teamed with a mental health professional to help de-escalate volatile situations, says **Dominic A. Sisti**, PhD, director of the Scattergood Program for the Applied Ethics of Behavioral Health Care. Co-responder programs exist in several cities and counties across the United States. The programs are helping prevent harm to mentally ill individuals.¹

“There’s an important role for medical ethicists — to first observe how these programs function, and then identify common ethical challenges,” says Sisti, assistant professor of medical ethics and health policy at the University of Pennsylvania. The next step is for ethicists to develop policies and procedures that ensure ethical care for individuals with serious mental illness.

The patient/physician relationship is based on trust, confidentiality, protection of patient autonomy, and the belief that clinicians will act in the best

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interest of their patients, notes **Keren Ladin**, PhD, MSc, director of the for Research on Ethics, Aging, and Community Health (REACH) Lab at Tufts University in Medford, MA. “When law enforcement is called in, it can undermine these tenets of the clinician-patient relationship,” Ladin explains.

The same is true if clinicians are constantly calling hospital security on patients. It raises concerns about whether providers are really acting in the best interest of patients. “Clinicians face additional obligations in their capacity as leaders on the healthcare team,” Ladin notes.

There is an ethical obligation to consider the safety of staff and other patients if a patient is behaving in a threatening manner. “Use of security in these circumstances should be guided by the principle of reducing harm to the extent possible for both patients and bystanders,” Ladin says. She recommends these approaches:

- Understand the underlying reason for violence. For example, if agitation is a symptom of illness, treating the cause can prevent a call to security.
- Develop clear policies on how to manage agitated individuals, with input from ethicists and the hospital’s legal and risk management departments.
- Analyze the number of calls to security or law enforcement by race, ethnicity, gender, age, and diagnosis. Bias of some kind may be playing a role in decisions to call security on certain patients. “Clinicians ought to be cognizant of their biases and aware that people may express agitation differently without being dangerous,” Ladin says.
- Use a multidisciplinary team approach, with ethicists, mental health professionals, social workers, community advocates, and patient

services teams. “This can help reduce conflict and ensure that patients’ rights are protected while ensuring safety for all,” Ladin offers.

Differences in communication preferences, high levels of untreated pain, alcohol withdrawal, or poorly treated psychiatric conditions all are possible reasons for agitation. “Often, these are best approached with care and compassion, not with law enforcement or hospital security,” Ladin stresses.

Notably, not all hospital personnel have undergone the right training in de-escalation. This is especially important for staff who come into contact with the public and/or see new patients regularly. “That is first and foremost,” Zeller underscores.

Some training focuses mainly on self-defense techniques or how to subdue an attacker. Instead, Zeller says the priority should be on how to calm people. That is something that, at first glance, seems counterintuitive. Staff usually argue that calling security whenever they feel threatened is necessary to protect everyone — until they see the results of de-escalation. “It’s actually just the opposite. The more you reduce security getting involved, you actually have assaults and injuries go way down,” Zeller reports.

Zeller has seen this firsthand as chief of psychiatric emergency services at John George Psychiatric Hospital in San Leandro, CA. Between 1,500 and 1,800 patients on involuntary holds presented each month, brought in by either police or ambulance. By the time they arrived at the hospital, most were angry, paranoid, and anxious — all of the preconditions that put them at risk for becoming violent.

Staff were dedicated to noncoercive interventions, and developed great expertise in these

skills. As a result, less than 1% of the highly agitated patients required physical restraints. “And that’s in the highest acuity psychiatric environment that you can imagine,” Zeller adds.

If an agitated person sees someone in a police uniform coming toward them with a badge and handcuffs, he or she is likely to think the only way to respond is violently, Zeller suggests. He recommends staff take the complete opposite approach by giving the person plenty of space and making statements such as “We’re here to help you,” “What do you need?” or “Tell me what we can do for you.”

Zeller says a change in mindset is needed to provide ethical care. Cases should be viewed as behavioral health emergencies. Just as clinicians call a code for heart attack and stroke patients, some hospitals use a “code agitation” team. These teams consist of a group of well-trained volunteers who agree to immediately respond to calls about an agitated individual anywhere in the hospital.

“They are the ones who ‘run the code’ if you will, and follow the prescribed methods of de-agitation and calming,” Zeller explains.

The problem is hospitals often come to this conclusion too late, only after a terrible outcome happens

and people are hurt. Administrators may be reluctant to make a financial investment in training proactively. Ethicists can help clinicians make the case that it is a small investment for what could be enormous preventive savings.

“It takes only one incident to get the hospital in all kinds of legal trouble, and ruin the hospital’s reputation,” Zeller adds. ■

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When Hospitals Refuse to See Medicaid Patients

There are healthcare providers who do not accept Medicaid patients because of inadequate reimbursement. The same is true of some hospitals, which say reimbursement does not cover the costs of care.

“Many individuals hold the view that hospitals have the same ethical obligations as the medical profession and should therefore accept all patients who are in need of hospitalization,” says **Robert M. Sade**, MD, director of the Institute of Human Values in Health Care at the Medical University of South Carolina.

Nevertheless, hospitals are businesses. As such, says Sade, one of their primary goals is to remain solvent. If it is a for-profit hospital, the goal also is to make a profit for the hospital’s owners. Assuming Medicaid pays hospitals too little to cover their costs, and that the number of Medicaid patients seeking services exceeds the ability of the hospital to absorb the financial shortfall, “hospitals are justified in turning away those patients, except

in emergencies, of course,” Sade adds. Hospitals must obtain sufficient revenue to at least cover their costs. By doing so, they can continue to serve their communities. That does not mean money is the only consideration. To gain the long-term trust of the community, says Sade, “requires following business ethics guidelines, such as decency, honesty, fairness, and avoidance of coercion.”

For example, it would be unethical for a hospital to advertise its outcomes falsely to generate business, or to permit unqualified providers to care for patients. Ethical practices regarding Medicaid patients also are needed.

Sade says that while hospitals refusing Medicaid could consider providing information about where those patients could receive the care they need, “they have no legal or ethical obligation to do so, in my opinion.”

Ethicists can help clarify the hospital’s obligations to this group of patients. Most ethics committees

review and revise hospital policies that carry ethical implications.

“That would include policies relating to hospital admission criteria, such as for patients with inadequate funding,” Sade offers.

Policies also can clear up confusion over ethical and legal obligations to Medicaid patients who present with emergencies. A patient who is treated for an emergency under EMTALA becomes a patient of that hospital.

“Once the emergency is resolved, the hospital might have no legal obligation to continue treating the patient. But it risks harming its reputation if it refuses to continue care for the patient,” Sade cautions.

A physician’s primary ethical obligation is to serve the best interests of the patients. “But they must also remain financially solvent,” Sade notes.

This means earning sufficient income to offset expenses. “Expenses for most physicians have increased enormously in recent years, owing largely to burdensome regulations,”

Sade argues. When uncovered costs become too great, physicians are ethically justified in refusing to accept Medicaid patients, according to Sade. “If they do accept such patients, however, they are ethically obligated to offer them the same care as they do for all of their patients,” Sade says.

For example, ICUs sometimes are filled when a new patient arrives needing ICU-level care. This may mean moving a patient of lesser acuity out of the ICU. A hospital should not allow a policy that specifies transferring Medicaid or any other low-pay patients before transferring other patients. “Such decisions should be made on medical considerations only, without regard to ability to pay,” Sade offers.

Sumit Agarwal, MD, an instructor in medicine at Brigham

and Women’s Hospital in Boston, frequently hears this argument: “If I accept patients on Medicaid, I won’t be able to pay my staff or keep the lights on.”

“I take issue with this argument for several reasons. First, the highest-paid specialties are often the most likely to reject Medicaid,” Agarwal observes.

Additionally, physicians do not need to necessarily open their practices to all Medicaid patients. “Would a self-imposed quota of 1% or 5% or 10% run practices into the ground? I am doubtful,” Agarwal says. “Would it require a bit of sacrifice from physicians? Probably.”

Agarwal says physicians’ status as a profession, which itself is derived from the public, comes with certain responsibilities. That includes caring

for the indigent and resolving health disparities. Agarwal is skeptical that physicians would really need to close their doors if they accepted some Medicaid patients.

“A safety net hospital might be able to make this argument, as we’ve seen with recent closures, but others providers cannot,” Agarwal says. “The real tradeoff is between healthcare as a business and healthcare as a service.”

Turning away all Medicaid patients is one way for physicians to call attention to the need for better reimbursement and less red tape.

“But it does so with questionable impact — and, more importantly, at the peril of patients who genuinely need care but have few realistic options by way of health insurance,” Agarwal adds. ■

Controversy Surrounds Exception from Informed Consent Enrollment

The term “exception from informed consent” for some clinical trials has been around for decades, but most patients know nothing about it. Researchers set out to explore attitudes about enrolling subjects in studies without consent.¹

Of 317 patients and surrogates, 90% agreed with or were neutral about a statement indicating they were glad they or their family member was included in a research study on status epilepticus treatment. However, 27% disagreed with someone enrolling them in the study without prospective consent. Black respondents were more likely to disagree with enrollment without consent (36%) than unknown race, other race, or white respondents.

“A basic principle of human research is that potential research subjects should have the ability to

prospectively choose to participate or not based upon receiving appropriate information regarding the potential risks and benefits,” says **Samuel Tisherman, MD**, a professor in the department of surgery and the program in trauma at the University of Maryland.

For patients who experience cardiac arrest, shock, or a severe head injury, resuscitation research is needed to improve outcomes, according to Tisherman. In these situations, the patient is unconscious and cannot provide informed consent. The patient’s legally authorized representative, typically the closest family member, is either unavailable or is under extreme stress after learning their loved one is in this critical situation. “In addition, the interventions that are being studied with resuscitation research usually

need to be administered within minutes,” Tisherman notes.

This leaves no time for a truly informed consent discussion. For resuscitation research to proceed, investigators can use an “exception from informed consent” process, developed by resuscitation researchers and federal agencies in the 1990s. The researchers must demonstrate:

- the patient cannot provide consent because of his or her current condition;
- available treatments are unsatisfactory or unproven;
- the intervention may help the patient directly;
- the therapy must start before consent from a legally authorized representative is feasible.

Further, Tisherman says investigators must work with the community in two ways. The first

is community consultation. This is meant to be a two-way conversation. “It provides feedback to the investigators and buy-in from the community,” Tisherman notes.

It can take many forms: town halls, meetings with community leaders, or surveys.

“Investigators should carefully define the ‘community’ from which research subjects could be drawn,” Tisherman cautions.

It could be based on location or the demographics of people who are most at risk for the condition under investigation.

“For instance, the typical person who develops a cardiac arrest is different from the typical person who suffers a head injury,” Tisherman observes.

Second, investigators also must work with the community via public disclosure. This lets everyone know that a particular research project is underway.

Regulatory requirements to govern trials granted an exception from

informed consent “are largely aimed at protecting individual autonomy, respecting community values, and promoting public trust,” says **William B. Feldman**, MD, DPhil, MPH, a research fellow at Harvard.

For example, trial investigators must allow patients or their surrogates a chance to opt out and notify all who are enrolled. “Experience with these trials over the past 25 years has revealed important challenges,” Feldman notes.

One study revealed African American patients, who make up about 13% of the U.S. population, made up 29% of participants in the “exception from informed consent” trials.² “It is critically important that the burdens and benefits of these trials be distributed fairly across society,” Feldman stresses.

Trial investigators also need to be more transparent. Data are needed on race, the number of refusals, the number of people who withdraw after enrollment once they regain capacity (or surrogate decision-makers who

withdraw on behalf of a patient), and the number of patients enrolled with and without consent.

There is no question trials granted an exception from informed consent address important research questions in emergency and critical care medicine.

“But we must ensure that these trials promote values of respect and autonomy, and that they avoid propagating existing disparities,” Feldman adds. ■

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Unexpected Issues Hinder Ethics Committees’ Effectiveness

Most hospitals have some type of ethics committee in place, but how effective they are varies widely, says **Mathew David Pauley**, JD, MA, MDR, a regional ethicist at Kaiser Permanente Northern California in Oakland.

Pauley provides oversight to 21 medical centers with 17 ethics committees. “There is some disparity in how they operate. But the general model is that we have co-chairs who are not ethics professionals. They are the standard well-meaning, ethics-interested person,” Pauley observes. These are some common issues Pauley has seen arise:

- **Ethics committees can become bloated.** Ethics committees may become so popular that they end up with too many members — as many as 42 in one case. With this many people in the mix, the meetings became more of a social club.

“We have found that the golden number is around 16. The more beyond 16 members, the less efficient the committee becomes,” Pauley reports.

- **Members may not know what role to play.** “We have seen the failure to thrive issue,” Pauley notes.

A job description on what is expected of a committee member

can help prevent this lack of clarity. In Pauley’s former role as an ethicist and co-chair of an ethics committee, he was handling 90% of that medical center’s consults. “Only a few consults required more than a single-ethicist approach. I was also doing so many consults that they all could not be discussed in retrospective review,” Pauley recalls.

Using the current co-chair model, some members also handle consults, although they are largely untrained as clinical ethicists. Members were included in the hospital’s committee on triage decisions. This gave them the appropriate training to become

involved should the need for scarce resource allocation ever arise. “But in the general day-to-day, the members are there as a reminder to bring their background and specialty to the conversation,” Pauley adds.

• **Some members are happy to be on the committee, then never show up again.** People may be well-intentioned, but just do not have the time to commit. An attendance policy can be helpful.

Ethicists can ask the member if there is something he or she can do to encourage their attendance. Ideally, says Pauley, “we give them the option to step down rather than get kicked off.”

• **Certain members report conflicts of interest.** Risk managers, lawyers, utilization managers, and discharge planners are not the typical people one would expect to see on an ethics committee. These individuals can offer valuable insights, but they also may be carrying conflicts of interest. “These are areas that we may want to have higher levels of scrutiny about their participation,” Pauley offers.

This can be tricky if an individual’s appointment on the committee comes from hospital higher-ups. Ideally, the committee selects its own members, all of whom are participating for the right reasons. Members should be there to ensure ethical care is provided, as opposed to keeping the committee in check.

Pauley has seen it work both ways. On one committee, a hospital risk manager came forward to join because she cared about ethics issues. Every time there was even the hint of a potential conflict, she brought it to the committee’s attention proactively. On other occasions, hospital administrators joined the committee, but seemed to express little interest or awareness of ethics. That can be an indication of an ulterior motive. “There have been times when risk management is there to prevent risk,” Pauley cautions.

• **Committees may lack representation from all relevant areas.** Those who needs ethics consults often (the ICU, hospital-based services, hospitalists, nursing, social workers, and chaplains) usually are well-represented. There may be other important specialty services left out.

If a hospital is well-known for its neurosurgery, a neurosurgeon probably should be on the committee. This can result in some push-back from hospital leaders concerned about cost. Administrators question why they should pay a neurosurgeon for several hours of time for something other than neurosurgery. “The ethics committee can get very pricey from that point of view,” Pauley shares.

One solution is for specialists to bill at a different, lower rate of reimbursement for their time spent on ethics committee work than for

their clinical work. Another option is to obtain input from specialists as needed, instead of enlisting them as official committee members. For instance, a neurosurgeon would be the designated “go-to” person whenever an issue involving neurosurgery arises.

• **There are committees that meet for hours, but do not achieve much.** If there are not tangible results or activities that benefit the whole organization, hospital administrators are going to question the value of the ethics committee. “If the ethics committee is in a silo only talking to itself, and not providing any sort of benefit, the administration may question why they are paying people a lot of money to sit in a room and talk to themselves,” Pauley cautions.

Agenda-focused committees, which provide education to various hospital departments or review policies, can avoid this negative perception. Building a good relationship with hospital administrators is helpful in more ways than one. It helps convey the value of the ethics committee.

It also helps when “outlier” cases come up. Ethicists may be faced with people threatening legal action regarding conflicts over brain death or non-beneficial treatments. “Administrators do have the ability to speak with more authority and commit the hospital in a way that ethics may not be able to,” Pauley says. ■

Family Members Encouraged to Offer More Care for Loved Ones in ICU

During his residency training, **Timothy H. Amass, MD, ScM**, often saw family members standing at the window, wringing their hands or appearing upset, in the room of a patient who was dying. It was as

though they thought things they would normally do, such as holding the person’s hand, was not allowed in the intimidating ICU setting.

“All professional societies recommend getting families involved,

but there’s not a lot of guidance on how to do that,” says Amass, an assistant professor of medicine in the pulmonary sciences and critical care department at the University of Colorado.

Many family members may suffer from various types of psychiatric disorders, including PTSD, after a loved one's ICU stay.¹ Problems may last for months or years. Families struggle with a loss of control, coupled with the need to make life-changing decisions and sudden changes of status. "I thought we could target the idea of control," Amass says.

Amass and colleagues gave some family members an informational booklet listing many ways they could participate in the care of their loved ones (if they wished to). The list included putting on some favorite music, posting pictures, massaging feet, holding hands, and brushing hair. Families were encouraged to ask nurses if they wanted to do something if it did not happen to be included on the list.

"The message is: You know your loved one best. Almost anything is OK as long as you are not putting the patient or others at risk," says Amass, the study's lead author.

Researchers talked to 131 family members in the "usual care" group and 129 in the intervention group to see how having more control in the ICU affected their stress levels.² They observed fewer symptoms of PTSD in the intervention group. Before

the intervention, only about 30% of family members touched patients at bedside before the intervention. "After we gave them permission, it went to almost 70%," Amass reports. "It's a very little thing, but also very powerful."

Amass says the intervention is a way to bring back the normalcy of what families ordinarily would do to care for loved ones, before ICU care existed and people routinely died at home. Making favorite meals or playing songs seems out of place in the high-tech, high-stakes, clinical ICU setting.

"Hospitals sort of sterilized that, and we wanted to find a way to bring that back in," Amass says.

Although the authors did not look at this specifically, Amass believes the intervention could reduce end-of-life conflicts because it gives families more control.

"When people say, 'We want you to do everything for our loved one,' they don't always mean aggressive treatments," Amass notes.

People might be making that kind of statement just to ensure their loved one is treated kindly and compassionately. On the other hand, if families feel disconnected from their loved one's care, they might demand more. This could include

aggressive treatment that is not in the patient's best interest.

"It is a really nice, simple, no-cost intervention that allows people who are stripped of their humanity in the moment to gain some of that back," Amass offers.

For one family, this meant ensuring the patient's hair was combed every day. The man always carried a comb in his shirt pocket, and the family's gesture was meaningful to him. Combing the patient's hair, using his own comb, became part of the daily nursing workflow. The simple intervention also meant a great deal to the family.

"The family felt like the nurses knew their family member better as the man he always was, as opposed to just the patient in the bed," Amass says. ■

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Growing Movement Toward More Family Participation in ICUs

Family satisfaction scores increased after ICUs implemented family-centered care initiatives as part of the Society of Critical Care Medicine's Family Engagement Collaborative.¹

"Active participation of families in the care of critically ill patients in the ICU can help to mitigate conflicts regarding goals of care," says **Ruth Kleinpell**, PhD, RN, FAAN, the

study's lead author and associate dean for clinical scholarship at Vanderbilt University School of Nursing.

ICU patients are incapacitated and often unable to speak for themselves. "We are meeting them with potentially no context on who they are as people," says **David Y. Hwang**, MD, another study author and an associate professor in the division

of neurocritical care and emergency neurology at the Yale School of Medicine. There is increasing recognition that families should be participants in ICU patients' care, as opposed to just bystanders, according to Hwang.

Each of the 63 participating ICUs chose a specific initiative to implement. "We were surprised at the

variety of initiatives they selected,” Kleinpell says. Some examples:

- Make it easier for families to be at the bedside with open visitation;
- Encourage families to be present during rounds to listen to what the plan is for their loved one that day;
- Allow families to be present if the patient’s heart stops and CPR has to be performed. “The idea behind this is that it allows them to have some closure and see what was done to save their loved one’s life, with nothing left on the table,” Hwang offers.

The ICUs collected data on family satisfaction before the project, and again 10 months later. “The point of the study was to show that this collaborative model could really

promote family engagement,” Hwang explains.

The study demonstrated families were more satisfied post-implementation. “It shows the value of connecting different sites, and understanding that other ICUs across the country are doing something similar,” Hwang says. “You don’t feel so lonely when you are trying to push one of these projects forward in your own unit.”

The COVID-19 pandemic stalled some of this progress. When ICU volumes surged in spring 2020, strict visitor restriction policies were put in place. “We went from 24/7 visitation to zero visitation, with maybe an exception here and there for an end-of-life situation,” Hwang reports.

ICUs have since worked through a number of iterations of visitor policies. “While we are not back to where we were before, we have slowly opened things up,” Hwang adds.

Family engagement is going to be challenging as long as families are not freely allowed at bedside. “The hope is, as areas are able to open up ICUs gradually and safely, the progress that’s been made over the past decade won’t be lost,” Hwang says. ■

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Conflicts Over Decision-Making Frequent in ICUs

Conflicts over difficult, complex decision-making is common in ICUs. Such disagreements negatively affect patients, families, clinicians, and institutions, according to the authors of a recent literature review.¹

“Since conflict is so prevalent in the critical care areas, understanding how to best prevent conflict from occurring is imperative,” says **Joshua B. Kayser**, MD, MPH, the study’s lead author and director of the medical ICU at Cpl. Michael J. Crescenz VA Medical Center in Philadelphia.

Of course, not all conflict can be prevented. “Methods of managing it and ultimately resolving conflict are key skills that can be taught to everyone in healthcare,” says **Lewis J. Kaplan**, MD, the study’s co-author and the VA’s section chief of surgical critical care.

Many ethical consults come about because the same circumstance is viewed through different lenses.

Kaplan notes conflicts often boil down to communication failure. This is a starting point to prevent conflict from happening in the first place.

Conflicts over withholding and withdrawal of care at the end of life are the most frequent issues that come up in ICUs, says **Claudia R. Sotomayor**, MD, DBE, clinical ethicist and an adjunct assistant professor at the Georgetown University Pellegrino Center for Clinical Bioethics.

Every day, ethicists participate in ICU rounds, along with the nursing and medical teams, social workers, case managers, PT/OT, nutritionists, and chaplains. If an ethical issue is detected, the ethicist on call proactively assesses the situation. During rounds, the ethicists ask these questions:

- Does the patient have capacity?
- Who is the decision-maker?
- Did the patient present with an advance directive?

• Are there any cultural/religious constraints to the decision-making process?

• Are there any communication issues among the teams, or the teams and the family members?

The ethicist listens carefully, facilitates the communication between all the involved parties, and ultimately gives a recommendation. “These rounds are an excellent way to apply the biopsychosocial-spiritual model,” Sotomayor says.²

This model considers psychological, biological, spiritual, and social factors, and the role they play in understanding illness and healthcare delivery. Using this model, clinical ethicists encourage dialogue between healthcare professionals caring for seriously ill patients.

Sotomayor adds that once ethicists identify the issues, they can aid proper communication and effectively combine all the perspectives of every stakeholder. ■

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Where Should Clinicians Draw the Line on 'Grateful Patient' Donations?

There are physicians who solicit “grateful patient” donations, but plenty of people disagree with common practices used at hospitals, according to the authors of a recent study.¹

“Hospitals and health centers have long relied on donations from patients and families grateful for the care they have received,” says **Reshma Jagsi**, MD, DPhil, the study’s lead author and director of the University of Michigan Center for Bioethics and Social Sciences in Medicine.

Development professionals identify potential donors, solicit gifts, and acknowledge donations in various ways. “Ethical concerns have been raised,” Jagsi notes.

These include conflicts of interest, erosion of trust, problems with the physician-patient relationship, privacy, and confidentiality. There also are ethical concerns that providing certain gestures of thanks to donors, or incentives to potential donors, could lead to unfairness in the delivery of clinical care.

Researchers asked 513 people to share opinions about some of the practices used to raise funds from grateful patients.

“The vast majority of the public found unacceptable certain approaches that are both legal and described as common in the literature of healthcare philanthropy,” Jagsi reports.

Wealth screening and spontaneous discussions of donations raised by physicians were two of these

problematic practices. Forty-seven percent responded that doctors giving patient names to hospital fundraising staff, after asking patients’ permission to do so, was “definitely or probably” acceptable. In contrast, just 8.5% endorsed this practice if the doctor did not ask permission from the patient. Most (79.5%) agreed it was OK for physicians to talk about donating if the patient brought it up first. This percentage dropped to 14.2% if it was the physician who raised the topic.

Most participants (83.2%) agreed or strongly agreed that if doctors talk with patients about donating, it could interfere with the patient/physician relationship. Participants also listened to a hypothetical scenario in which a patient donates \$1 million to a hospital. Half of respondents said it would be acceptable for the donor to be provided with nicer hospital rooms, 26% said that expedited appointments would be acceptable, and 19.8% thought giving the donor the doctors’ cellphone numbers would be acceptable.

The study’s findings supported the idea that giving is good for the mental and physical health of those who give. Most of the respondents

(85.2%) agreed patients feel good when they donate to the hospital. “Patients should have opportunities to give if they desire. However, these opportunities should be offered in ways that are ethically acceptable to them,” says **Sara Konrath**, PhD, one of the study’s authors and associate professor of philanthropic studies at the Indiana University Lilly Family School of Philanthropy.

Healthcare philanthropy is an essential activity, but approaches to encourage donations must be mindful of ethical considerations and public attitudes, according to Jagsi.²

“Public trust is important for its own sake, and also essential if organizations are to succeed in delivering on their missions,” Jagsi adds. ■

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1. Jagsi R, Griffith KA, Carrese JA, et al. Public attitudes regarding hospitals and physicians encouraging donations from grateful patients. *JAMA* 2020;324:270-278.
2. Collins ME, Rum S, Wheeler J, et al. Ethical issues and recommendations in grateful patient fundraising and philanthropy. *Acad Med* 2018;93:1631-1637.

COMING IN FUTURE MONTHS

- Ethical responses if family threatens to sue hospital
- Ethical concerns with personalized medicine
- Good reasons to remove someone from ethics committee
- Ethicists are improving end-of-life care in ED

Treatment Withdrawal Policies Could Harm Families

There was a physician who once told a heartbroken family, “We did everything we could. It is my decision that there is nothing more we can do. He had injuries that were incompatible with life.” **Donald Owens, Jr., PhD**, recalls the comfort those words brought to that family. In many cases, clinicians routinely ask the family for consent before removing a patient from life support. This may happen not because the clinician is seeking shared decision-making; rather, hospital policies require it. “That is a horrible thing to put a family through. What they hear is, ‘Are you willing to kill your loved one?’ And it’s not the family’s place to make that medical decision,” says Owens, chair of humanities and ethics in medicine emeritus and chaplain at the Tulane University School of Medicine.

Owens says it is the physician’s responsibility to inform the family if in fact they have done all they could for

this patient, and there’s nothing more they can do. “Some physicians don’t like doing that because it’s uncomfortable,” Owens observes. “Futility is an issue that some physicians are not comfortable working with.”

Hospital administrators may be worried about litigation. Some demand the family give written consent for legal reasons. “I have no patience with lawyers or HR folks who insist that hospitals require the family to sign off,” Owens says. “What you are really asking them, from their perspective, is to sign a death warrant for their loved one.”

Conflict may ensue if families are put in this terrible position. There could be family members who feel guilty signing off on it, and then refuse to accept responsibility or the reality of the situation. “People assume that the physician knows more than we know. They expect us to work miracles, but when it comes to

terminal moments, we can’t,” Owens explains. Ethicists can help develop policies so the issue is clear in advance. For example, the policy can state that it is the physician’s place and responsibility to determine when measures are prolonging death instead of life for a patient. “The ones to make this decision are the physicians, not the family, who are not usually trained in medicine,” Owens offers.

Bad policies can cause deleterious effects on family in both the short and long term, Owens says. He has seen some family members suddenly become distraught when asked to sign off on the decision to withdraw life support. It also interferes with the grieving process, since families now have to deal with the thought that they approved of and gave permission for their loved one’s death. “This is an issue of ‘do no harm.’ Your patient is not just the person in the bed. It’s the whole family,” Owens says. ■

Do Not Intubate Orders Becoming More Common

One important decision that some hospitalized patients face is whether to pursue a trial of mechanical ventilation should it become necessary.

“The outcomes of patients with respiratory failure who require mechanical ventilation can be quite

varied,” says **Michael E. Wilson, MD**, who works in the Mayo Clinic’s Division of Pulmonary and Critical Care Medicine.

Outcomes range from full recovery to prolonged hospital illness and recovery to death. Mechanical ventilation and the use of an ICU bed may

be a valuable (but sometimes limited) resource, Wilson notes. In addition, decisions about life support usage for hospitalized patients often primarily focus on whether to pursue CPR in the event of cardiac arrest. “This is a separate medical situation and decision, compared to whether or not to

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pursue a trial of mechanical ventilation for patients with respiratory failure,” Wilson explains. The likelihood of experiencing in-hospital cardiac arrest, and the likelihood of recovery following in-hospital cardiac arrest, are vastly different than the likelihood of experiencing and recovering from respiratory failure, Wilson offers. The rate of do not intubate orders in patients with acute respiratory failure has increased over time, according to the authors of a recent review.¹ “Our goal of this study was to shine a light on decision-making for mechanical ventilation and to better understand reasons for variability in decision-making,” says Wilson, the study’s lead author.

Wilson and colleagues analyzed 26 studies that included 10,755 patients. They found an overall rate of do not intubate orders of 27%. Rates increased over time (from about one in 10 patients 20 years ago to about one in three patients in the past five years). “The exact reasons for this increase over time remain unclear,” Wilson says. “It is possible that patient preferences have changed over time.”

The researchers were surprised to find that factors such as illness severity appeared to not significantly affect rates of do not intubate decisions. “This suggests that other factors may play a larger role in how such decisions are made,” Wilson says. Decisions about pursuing mechanical ventilation often are matters of life and death. “If there is suboptimal decision-making, then there can be devastating consequences for patients,” Wilson warns. ■

REFERENCE

1. Wilson ME, Mittal A, Karki B, et al. Do-not-intubate orders in patients with acute respiratory failure: A systematic review and meta-analysis. *Intensive Care Med* 2020;46:36-45.

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. When it comes to calling security on psychiatric patients:

- a. prioritize the safety of staff over an individual patient’s safety, even if it means frequent calls to security.
- b. ask mental health professionals to deal with the situation separately from security or police.
- c. encourage earlier calls to hospital security at the first sign someone is becoming agitated.
- d. create a group of well-trained staff to respond to agitated patients.

2. Which is an ethically problematic practice regarding Medicaid patients?

- a. Limiting the number of Medicaid patients if reimbursement does not cover the costs and inadequate reimbursement becomes overly burdensome

- b. Failing to provide information on where Medicaid patients can receive the care they need and following up to ensure they could access care
- c. Policies that require transferring Medicaid patients before commercially insured patients*
- d. Refusal of any Medicaid patient for scheduled procedures, regardless of the reason

3. Which resulted when clinicians identified ways families could be part of ICU patients’ care?

- a. Nurses reported more moral distress.
- b. Families reported fewer symptoms of PTSD.
- c. More family members touched patients at the bedside.
- d. More families asked for aggressive care at the end of life.

CME/CE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Discuss new developments in regulation and healthcare system approaches to bioethical issues applicable to specific healthcare systems;
2. Explain the implications for new developments in bioethics as it relates to all aspects of patient care and healthcare delivery in institutional settings;
3. Discuss the effect of bioethics on patients, their families, physicians, and society.



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