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Unethical practices may occur when medical errors are disclosed

Ethical issues often overlooked

"We are not completely sure what happened at this time. We are investigating, and will let you know what we learn as soon as possible." Providers may be uncomfortable saying these words to a patient when a medical mistake happens, but speculating about what happened is unethical, cautions **Patrice M. Weiss**, MD, chair of the Carilion Clinic and professor at Virginia Tech Carilion School of Medicine, both in Roanoke, VA.

For instance, if a mother asks why her daughter, diagnosed with meningitis, didn't have a spinal tap the previous night, a well-meaning physician may respond, "Well, I know the ER was really crazy last night and not all the docs feel comfortable doing taps."

Instead, says Weiss, the doctor should say, "I'm not sure. Spinal taps are not something that any of us do without a clear reason or indication. I was not present and evaluating your daughter last night, so it's not fair for me to guess. But we will review your daughter's care."

Similarly, if a patient's family member asks why wrong-side surgery occurred, a doctor may blurt out, "The wrong leg was prepped and I proceeded," which will simply engender more questions. The doctor might then go on to speculate that the OR staff confused the patient with someone else, that the X-ray films were mislabeled or hung up backwards, or the wrong history and physical was in the chart.

"The main ethical issue is, you put your colleague in a terrible, and at

EXECUTIVE SUMMARY

Error disclosure is becoming the norm in health care, but providers are struggling with this because ethical concerns have gone unaddressed, real-time coaching is needed, and there is a lack of patient-centeredness.

- Providers should *not* speculate about what happened.
- Teams should plan and possibly even carry out disclosures.
- Providers should offer reasonable compensation if patients were harmed.

times, no-win position when speculation occurs," says Weiss. "Further, you may foster anger and distrust within the patient."

Right to honesty

The ethical foundation for error disclosure is the patient's right to honesty in communication with health care professionals, according to **Sarah E. Shannon**, PhD, RN, an associate professor in the Biobehavioral Nursing and Health Systems Department in the School of Nursing, an adjunct professor in the Bioethics and Humanities Department in the School of Medicine at the University of Washington, and a clinical ethicist at University of Washington Medical Center in Seattle.

"Nowhere are we more challenged in our duty as clinicians to uphold honesty than in our communications with patients when a harmful error occurs," she says.

The idea that providers have both a legal and ethical obligation to disclose medical errors to patients or their proxies "appears, curiously, to be a relatively recent phenomenon," according to **Ben A. Rich**, JD, PhD, professor and an Alumni Association Endowed Chair of Bioethics at the University of California, Davis Health System's School of Medicine.

"This is curious, because 'truth telling' is integral to the establishment and maintenance of any fiduciary relationship, which that of health care professional and patient most certainly is," says Rich. Moreover, the doctrine of informed consent has been a part of the contemporary medical ethos for more than a quarter of a century, he adds.

Disclosure of medical errors is an emerging professional, ethical, and legal norm in health care, emphasizes Shannon.

"Health care professionals must develop a new set of communication skills to be able to do this effectively, compassionately, and expertly," she says, adding that medical schools are just beginning to incorporate error disclosure skills into existing curricula.

The fact that important ethical issues *haven't* been addressed is making it hard to turn principles into practice, however, says **Thomas H. Gallagher**, MD, professor of medicine and professor of bioethics and humanities at University of Washington. "All the evidence we have shows that providers are struggling to do this well," he says.

A team approach

Disclosure has been conceptualized as an individual doctor talking with a patient, but errors are made as teams, says Gallagher, and teams should plan and possibly even carry out disclosures.

Since several people are involved with the care that leads to a medical error, this brings up the ethical issue of accountability, adds Gallagher. "All may wonder what their role is in the disclosure process. Whose responsibility is it to be sure the patient learns about what happened?" he asks. "That lack

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of clarity leads health care providers to hold back and not step forward."

If the physician who accidentally ordered a lower gastrointestinal exam on the wrong patient and the nurse who administered the bowel preparation and took the patient to radiology for the exam are not part of a discussion about how the error reached the patient, key information is lost, says Shannon.

"Both need to contribute to planning for the error disclosure. It may be appropriate for both to disclose the error to the patient," says Shannon.

Unethical practices

Providers may "candy coat" information given to the patient, without fully admitting the error, says Weiss, or fail to maintain the patient's right to confidentiality. "When disclosure occurs, the patient should be asked whom they would like present," she adds.

Providers should *not* share occurrences involving other providers, or judge the performance of another provider in conversations with the patient or family, advises Weiss.

"As with informed consent disclosures, medical jargon should be entirely eschewed," says Rich. "Most patients do not understand complex medical terminology. Thus, it is a given that one cannot effectively communicate with someone using terminology there is no reasonable expectation they will understand."

Patients who have been harmed by medical error potentially deserve some compensation, but when clinicians think about disclosure, that rationale is completely left out of the equation, Gallagher says.

"In part, that is because the notion of compensating patients for medical injuries is a scary one," he says. "Our system has lots of pieces that are highly dysfunctional. It is still a highly punitive system."

Organizations are starting to combine disclosure with early offers of financial compensation, he reports, and are seeing positive results.

Providers may ignore compensation because they worry about being reported to the state board of medicine or increased malpractice premiums. "But for patients, this is an important issue," Gallagher says. "It really adds insult to injury if you were injured by care and then have difficulty getting compensation for the injury you've experienced."

Policies should include not only disclosure of the medical error, but also the sincere expression of regret, assurance that all necessary care resulting from the error will be provided, and, when appropriate, the waiving of costs associated with such care and reasonable compensation to the patient for any harm resulting from the error, says Rich.

"Such policies instill and exhibit an organizational ethos of error disclosure," he says. "They help to insure that, as a matter of justice and fairness, all patients are treated consistently and equally." *(See related story, p. 99, on mixed messages given to clinicians.)* ■

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Error undisclosed? Mixed messages could be reason

Patients want more transparency, not less

"We want you to be transparent, but don't admit fault." This is an example of a mixed message that clinicians may get involving error disclosure practices, leaving them to wonder, "What am I supposed to say?" says **Thomas H. Gallagher**, MD, professor of medicine and professor of bioethics and humanities at University of Washington in Seattle.

This may lead to disclosure conversations that, in some respects, are worse than none at all, he says, with incorrect, insufficient, or too little information shared.

"We generally see a lack of patient centeredness around disclosure," says Gallagher. "When something goes wrong, it's natural for the provider to focus on how the event affected them. The patient's needs and interests kind of get lost in the shuffle."

Some organizations use a coaching model for disclosure, with an expert available to provide real-time advice to clinicians. "That is something that ethics

consultants would be ideally positioned to do," Gallagher says. "They can play a proactive role in helping to close the gap between expectations for disclosure and what currently happens."

Define errors broadly

If a medical error doesn't harm the patient, some providers advocate a "no harm, no foul," approach to disclosure, says **Ben A. Rich**, JD, PhD, professor and an Alumni Association Endowed Chair of Bioethics at the University of California, Davis Health System's School of Medicine.

However, Rich notes that two widely read and frequently cited texts, *Clinical Ethics* by Jonsen, Siegler, and Winslade (7th ed. 2010) and *Resolving Ethical Dilemmas* by Bernard Lo (4th ed. 2009), advocate for errors to be disclosed even if patients weren't harmed, or if near-misses occur.

Patients tend to conceive of errors more broadly than their doctors do, says **Sarah E. Shannon**, PhD, RN, an associate professor in the Biobehavioral Nursing and Health Systems Department in the School of Nursing, University of Washington, Seattle. A delay in treatment might be viewed as an error by the patient, whereas a physician considers it to be just an inconvenience.

"When writing error disclosure policies, we need to guard against using a restrictive definition of errors, recognizing that patients and their families are likely to prefer more transparency versus less," says Shannon.

Health care professionals have sometimes invoked a "therapeutic privilege" exception to the duty to obtain an informed consent as a legal and ethical justification for nondisclosure of medical error, says Rich.

"This was based on the presupposition that some patients under certain circumstances are so psychologically vulnerable that disclosure of certain facts about their medical condition or treatment would be so disturbing that the harm or burden of the disclosure would be likely to far outweigh the benefit," says Rich.

The argument is that disclosure would undermine the patients' trust and confidence in the competence of their providers, even in the case of patients who would not otherwise fall within the therapeutic privilege exception, he explains.

"It is rare for clinicians to be able to credibly claim that they know enough about their patients to determine, to a reasonable degree of medical certainty, how any one of them might react to the disclosure of bad news, whether it is in the form of a grim prognosis or a medical misadventure," says Rich. ■

What if patient requests an advertised medication?

Patient's values are central

If a patient comes to a provider asking for a specific name-brand medication, how much weight should the request be given?

"There is a big difference between a patient saying, 'I need something' and "I need *this* medicine,'" says **G. Caleb Alexander** MD, MS, affiliate faculty of the MacLean Center for Clinical Medical Ethics and an assistant professor in the Department of Medicine at the University of Chicago. "My radar would be higher if the patient came in insisting that a single medicine was the right one, because that's rarely the case."

This type of request presents an opportunity for the provider to clarify misconceptions the patient may have about the medication, adds Alexander, and to explore other options such as lifestyle modifications or over-the-counter therapies.

Prescribers may face an ethical conflict between respecting the patient's wishes for a specific therapy and their obligation to act as an agent on the patient's behalf, he says.

"The concern is when the patient is requesting something that *isn't* clinically indicated," Alexander says. "Normal and pathological conditions aren't always crystal clear. There are gray areas in medicine, and physicians can be unduly influenced in ways they are not aware of."

EXECUTIVE SUMMARY

Patients may request an advertised medication that isn't clinically indicated, which can lead to ethical pitfalls because providers are conflicted over the patient's wishes and their obligation to act as an agent on the patient's behalf.

- Providers should clarify misconceptions.
- Options including lifestyle modifications or over-the-counter therapies should be presented to the patient.
- Physicians generally should *not* refuse to prescribe because their values differ from the patient's.

Balancing risks, benefits

The physician is not an expert on the patient's values, and "within the constraints of the law and conscience, these values necessarily should control the pharmaceuticals the patient consumes," according to **Robert M. Veatch**, PhD, professor of medical ethics at the Kennedy Institute of Ethics and a professor in the Philosophy Department at Georgetown University in Washington, DC.

"It cannot be the physician's responsibility to control what the patient consumes," he says. "Physicians retain the right to refuse to prescribe drugs requested by patients, and they usually should refuse when the drug is useless."

The physician's job is to educate the patient about the effects and then decide whether to prescribe the medication, he adds. "Balancing risks and benefits is a very complex process," he says. "The patient has an absolute right to refuse the physician's value judgments about which medications to consume."

While the physician retains the right to refuse to prescribe, normally he or she should *not* refuse based on the physician's beliefs and values when these differ from the patient's, Veatch argues.

"'Shared decision making' is a strange concept. No doubt it is more in fashion today, but we need to understand a proper sense of sharing," says Veatch. "If by 'shared decision making,' one envisions a situation in which physician and patient get equal vote or where there must be complete agreement, that is a bad version of sharing."

Instead, Veatch advocates for a "division of labor" approach. "The physician is surely the expert on the medical facts of diagnosis, prognosis, and pharmacology," he says. "He or she should be presumed authoritative on these matters of fact." ***(See related story, p. 101, on ethical concerns involving direct-to-consumer advertising.)*** ■

SOURCES

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Drug ads: "Ethical scrutiny" continues

Direct-to-consumer advertising of prescription medicines "remains an important area of ethical scrutiny," says **G. Caleb Alexander**, MD, MS, associate professor of epidemiology and medicine at Johns Hopkins University and former affiliate faculty of the MacLean Center for Clinical Medical Ethics at the University of Chicago.

"I don't think health care would suffer appreciably if direct-to-consumer advertising were to be banned. We are the only country in the world that allows it," Alexander says.

While advertisements viewed by consumers may help destigmatize conditions such as depression, he says, these clearly contribute to the overuse and unnecessary use of prescription medicines.

Direct-to-consumer ads are associated with increased prescription of advertised products, with a substantial impact on patients' request for specific drugs, according to one review.[1] A 2012 review linked the advertisements to less appropriate prescribing and switches to less cost-effective treatment.[2] A 2003 study suggests that more advertising leads to more requests for advertised medicines, and more prescriptions.[3]

Although there are several thousand drugs available on the market, the top 25 advertised drugs accounted for two-thirds of all spending on direct-to-consumer advertisements, according to Alexander. "People see the ads all the time and may think there are hundreds of drugs being advertised, but that is not the case," he says.

Advertisements tend to feature drugs with broader clinical indications for their use, such as therapies that can be used for multiple conditions or by a broad population, he notes.

"Based on most of the evidence about direct-to-consumer advertising, it's safe to say that patient requests can be influential in shaping treatment choices," Alexander says. "The ethical challenge for providers is ensuring that they are not *unduly* influential." ■

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Patient experience now linked to doctors' payment

Incentives may spur "cherry picking" of patients

The amount of reimbursement hospitals receive will be tied to physicians' ability to communicate with patients, manage their pain, and explain medications, as a result of the Centers for Medicare & Medicaid (CMS)'s Hospital Value-based Purchasing Program, which will affect Medicare reimbursements as of October 2012, notes **Marshall H. Chin**, MD, MPH, Richard Parrillo Family Professor of Medicine at the University of Chicago.

"There is more of an emphasis on value, both in public policy as well as the private marketplace," he says. "With health care organizations competing for market share, providers realize they have to provide higher quality care at lower cost. Part of that is assuring a high quality patient experience."

In CMS's value-based purchasing system, 30% of incentive payments are determined by patient experience ratings and 70% on clinical performance.

"For participating hospitals, their base operating DRG payments will be reduced by 1% to fund the program, so the potential incentives and penalties are relatively small," says Chin. "In the private marketplace, there are wider variations for how much a physician's salary is at risk."

Negative unintended consequences could occur if providers seek out patients that are likely to give higher experience scores, warns Chin. Sicker, complex patients, depressed patients, and non-English speaking patients tend to give lower patient experience ratings to providers, and ratings may be higher if there is patient-physician race concordance.

"There could be an incentive for providers to dump patients that may make them look bad in terms of ratings, or to 'cherry pick' easier, healthier patients that may be more likely to rate them higher," he says, while systems may penalize providers who care for sicker or non-English speaking patients.

The incentives may spur providers, whether consciously or unconsciously, to seek healthier, less complex patients and avoid caring for racial or ethnic minorities, says Chin, director of the Robert Wood Johnson Foundation's Finding Answers: Disparities Research for Change National Program Office.

Another ethical concern is that systems may be designed so "the rich get richer and poor get poorer," says Chin. It could be difficult for academic medical centers, hospitals that serve a large number of poor patients or minorities, or county hospitals with many non-English speaking patients to do well with these ratings, he explains, just because of the populations they serve.

Providers should be paid based on improvement as well as absolute levels, Chin recommends, and hospitals that are coming from a tougher starting point should be given adequate quality improvement resources so they aren't at a disadvantage.

"If the system isn't designed well, you can have a situation where affluent hospitals do well with reimbursement, while hospitals that tend to serve the disenfranchised have a harder road," he says. ■

SOURCE

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EXECUTIVE SUMMARY

Providers' reimbursement is now linked to patient satisfaction scores, as a result of the Centers for Medicare & Medicaid's value-based purchasing system, but systems need to be designed to reduce the risk of negative unintended consequences.

- Systems may incentivize providers to seek patients that are healthier and less complex, and avoid caring for racial or ethnic minorities.
- Providers should be paid based on improvement as well as absolute levels.
- Hospitals coming from a tougher starting point should be given adequate quality improvement resources so they aren't at a disadvantage.

When — if ever — is prayer with patients unethical?

Is it ethical for a physician to pray with a patient? The question that should be asked instead is, "On what grounds would praying with a patient be ethically problematic?" according to **Farr A. Curlin**, MD, co-director of the Program on Medicine and Religion and associate professor of medicine at The

University of Chicago's MacLean Center for Clinical Medical Ethics.

Shared prayer between a physician and patient is not a medical technique or a clinical intervention, he explains. "Properly understood, it is a response of a patient and at times, a physician, to the difficult situation the patient is in," says Curlin. "It is a very human interaction, one we would not imagine forbidding in almost any other human relationship."

Insofar as the interaction is voluntary and respectful, and not manipulative, then it is permissible, argues Curlin, adding that doctors have probably been praying with patients as long as doctors have been seeing patients.

"It is only recently that people started talking about prayer as an ethical issue," he says. "Questions have been raised as to whether prayer is incompatible with, or in tension with, physicians' professional roles."

Curlin adds it would be unethical for a physician to suggest that the prayer promises a benefit that the physician cannot guarantee, or to pray with someone without their permission.

Patients appreciative

In 2006, The University of Chicago's general internal medicine service surveyed inpatients about their religious and spiritual needs and found that less than 10% had religious or spiritual discussions with their physician, and only half of patients who wanted to have this type of discussion experienced it.[1]

"It is not as if there is an epidemic of too many doctors praying with patients. There is no evidence that prayer is happening very often," says Curlin. "It seems odd to put our focus on reducing the incidence of these already rare interactions to which few patients object."

Although few physicians pray with patients unless the patient brings it up, Curlin says, he doesn't see any reason why doctors cannot offer to pray with patients if they do so in a respectful way. The University of Chicago survey revealed that high patient satisfaction was linked to discussing religious and spiritual issues, even when the discussions had not been requested by the patient.

Ethical concerns about physicians praying with patients stem from medicine being thought of as a merely technical practice, where physicians are skilled providers of health care services with strict boundaries around the kind of interactions they have with patients, says Curlin.

"Some people think that a physician should limit their interactions with patients to dialogue about what technical options are available for patients and which one the patient wants," he says.

There is absolutely nothing illegal in any jurisdiction about a physician praying with a patient, adds Curlin, and no ethical norm that says this should be prohibited. Both patients and physicians, in the context of a patient's illness, reasonably recognize that the amount of control they have is quite limited, he says.

"It's a natural human response to turn to prayer in that situation," he says. To put an undue constraint on physicians just to prevent the possibility of offense to a small minority of patients doesn't make sense, he says, particularly when this risk can be mitigated with an appropriate approach.

"If people are putting pressure on health care workers to not pray with patients, they are focusing their efforts in the wrong places," Curlin says. "The last thing we need at this point in American health care is for physicians to have *less* human interaction with patients." ***(See related story, p. 104, on patient values and spiritual discussions.)*** ■

EXECUTIVE SUMMARY

Prayer between a physician and a patient is an ethical practice so long as it is voluntary, respectful, and not manipulative, according to bioethics experts.
- High patient satisfaction scores are linked to discussing religious and spiritual issues with providers.
- Many patients want religious or spiritual discussions with their physician, but few experience this.
- Barriers include lack of training to pray with patients, lack of reimbursement, and lack of time.

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Spiritual discussions: Patient values are key

Sensitive care has a spiritual quality that should be nurtured by all helping professionals, but more explicit interactions like prayer should be approached very carefully, cautions **Ralph C. Ciampa**, STM, director of the Department of Pastoral Care and Education at the University of Pennsylvania in Philadelphia.

This is mainly due to the inherent power imbalance in helping relationships, and the danger of subtle coercion, he explains. "However, I have seen situations where the relationship had developed to a point of mutual understanding and trust that more explicit sharing of a spiritual component could be appropriate," says Ciampa.

Physicians should pay more attention to the possibility of praying with patients, argues **Dan Finkelstein**, MD, core faculty at the Johns Hopkins Berman Institute of Bioethics and professor at the Wilmer Eye Institute at Johns Hopkins, both in Baltimore, MD.

"A physician's calling is to cure a disease first. If one cannot cure the disease, one wants to heal whatever suffering might be there," he says.

Of 124 ophthalmology patients surveyed at Johns Hopkins, 82.3% reported that prayer was important to their sense of well-being, and 45.2% reported weekly attendance at religious services.[1] Finkelstein says this reflects the percentages he sees in his own practice, and underscores the importance of physicians asking the question, "Are you a spiritual person?"

"If I find out that a patient goes to church or synagogue, and I know that they are suffering, I might say, 'Shall we pray together? Or, if you would like to pray, let me listen to your prayer,'" he says.

Physicians don't ask the question because they aren't trained to do this, it's not something that is reimbursable, and it takes some time, says Finkelstein. "Physicians who are unsure in their own spirituality would have difficulty with the conversation," he says. "But we know a lot of patients would want it."[2]

Part of taking care of the patient is to know the patient, and spirituality is part of knowing the patient, Finkelstein says.

"A physician may know a great deal about the patient and their family, but doesn't happen to know about their spirituality," he says. "It is an important area that is often overlooked." ■

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"Unholdable" patients are ethical dilemma

Physicians' hands may be tied

One emergency physician might feel comfortable giving a medication by injection to a man distraught from hallucinating and in danger of attempting homicide, while another might prefer a psychiatric consultation for almost all of the psychiatric patients seen in the emergency department.

Similarly, one primary care physician might feel comfortable prescribing for depression or anxiety, whereas another might prefer to make a referral.

Ethically, emergency and primary care physicians must limit their practice to their skills in serving people with psychiatric issues, but "the level of this skill varies enormously," says **Roger Peele**, MD, DLFAPA, chief psychiatrist at the Behavioral Health and Crisis Center of Montgomery County in Rockville, MD.

Legal requirements for involuntary admissions vary by state, says Peele, with most requiring that the person be dangerous to others or dangerous to themselves, including inability to take care of their basic needs.

If the physician involuntarily hospitalizes a patient and knows that the patient's condition does *not* meet the criteria for involuntarily admission, the list of ethical violations can be long, warns Peele. These include not providing competent medical services with compassion and respect for human dignity, not dealing honestly with patients, not respecting the law, and not respecting the rights of patients.

However, if a physician fails to involuntarily admit a patient who is possibly dangerous, he or she may inflict harm on self or others, not get the treatment he or she needs, or the patient's condition may deteriorate, warns **Katrina A. Bramstedt**, PhD, a clinical ethicist and associate professor at Bond University School of Medicine in Australia, and former faculty in the Department of Bioethics at Cleveland (OH) Clinic Foundation.

Furthermore, some patients present seeking treatment in a locked-care facility but are denied admis-

sion, sometimes due to the lack of bed capacity. "This can emotionally deter them from seeking treatment in the future, feeling abandoned by the profession," she says.

Other complex situations involve third-party payers refusing to provide benefits coverage for locked-care even while health care providers deem such care necessary. "Ethical dilemmas can arise when resources of money and bed space are in tension with the clinical need for locked psychiatric care," says Bramstedt. *(See related story, p. 105, on ethical concerns when patients don't meet the criteria for involuntary admission.)* ■

SOURCES

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Ethics "lost in the process" of involuntary admission

The decision as to whether a patient should be held involuntarily has become purely a legal and political decision, and "ethics get lost in the process," argues **Paul L. Schneider**, MD, FACP, an associate clinical professor of medicine at the University of California, Los Angeles School of Medicine and chair of the Bioethics Committee at the Veterans' Administration Greater Los Angeles Healthcare System.

"One of the biggest issues that I face very commonly is the dilemma of the 'incompetent but unholdable' patient," says Schneider. When physicians consult with psychiatry about a patient they believe needs to be held, they often learn that the patient doesn't meet the criteria for involuntary admission.

"The psychiatrist says, 'As much as you might think this person should be holdable, I wouldn't be able to win in mental health court,'" says Schneider. "Do we let this person go in order to do the legal thing, even though we feel it's unethical?"

Patients with dementia commonly fall into this dilemma, because local mental health courts determined it is not an illness that makes a patient holdable, he explains.

There is more room for ethicists to be involved in these cases, Schneider underscores. "A moral tension is set up when ER doctors consult psychiatry, who recommend the perfectly legal thing to do, but it's not the most ethical way to go," he says. "That dilemma is a very ripe area for ethics consultations."

Holding the patient anyway can result in several negative repercussions, he says, including the psychiatrist having to go to court and be scrutinized by opposing attorneys, and the doctor possibly being held liable for false imprisonment.

The result is that involuntary holds are reserved only for the "worst cases," says Schneider, which doesn't include patients who reject potentially life-saving treatment because they don't understand their medical condition. For instance, a schizophrenic with gangrene who doesn't comprehend the risk of refusing surgery likely wouldn't meet the criteria.

"Very commonly psychiatry will come back and say the patient is not holdable because they are coming here for their gangrene, and mental illness holds can't be used for a medical condition," he says.

The psychiatric determination of decision making capacity determines whether the patient is holdable or not, he explains, when in reality these are two different things.

"Psychiatrists will say, 'You can't do anything about a patient who is incompetent but not holdable, and my argument is, 'Yes you can, and you need to,'" he says. "Clearly, violent acts in society are highlighting the need for more scrutiny in this area. The public generally doesn't know about the extent of this problem."

EXECUTIVE SUMMARY

Physicians may be told that a patient doesn't meet the criteria for involuntary admission, even though the physician believes failing to hold the patient is unethical. Some ethical considerations:
• Emergency and primary care physicians must limit their practice to their skills in serving people with psychiatric issues, which vary widely.
• If a physician fails to involuntarily admit a patient who is possibly dangerous, he or she may inflict harm on self or others or deteriorate.
• Involuntary holds may not include patients who reject potentially life-saving treatment because they don't understand their medical condition.

Individual mental health practitioners have learned to influence their behavior based on the local political environment, he adds.

"There needs to be a lot more public discourse on the issue," says Schneider. "We are letting people go on a daily basis who don't really understand the details of what medical care they are refusing, but we let them go because our psychiatrists say that we have to."

This scenario has led Schneider and his colleagues to develop a system in which patients in this category could be held by another means other than what state law currently allows — that of a surrogate hold. Physicians would go to a surrogate decision maker and ask for consent to hold their family member.

"If a patient is lacking decision-making capacity, I think we owe them a surrogate decision maker who has capacity, out of empathy for the patient," he says. "When we allow a person to leave who doesn't understand, we are allowing them to go without that function." ■

Parents refuse vaccines? Ethical response needed

Many pediatricians feel some distress over parents who refuse to vaccinate their children, says **Douglas S. Diekema**, MD, MPH, attending physician and director of education at the Treuman Katz Center for Pediatric Bioethics at Seattle (WA) Children's Hospital and professor in the Department of Pediatrics at the University of Washington School of Medicine, also in Seattle.

About 10% of parents refuse at least one vaccine, about 20% either defer or refuse at least one vaccine, and 1-2% refuse all vaccines, estimates Diekema.

Of the 13% of parents following an alternative vaccination schedule, most refused only certain vaccines and/or delayed some vaccines until the child was older, while 17% reported refusing all vaccines, according to a survey of 750 parents of children aged 6 years and younger.[1]

Health care providers feel an obligation to protect the children in their practice from health risks, and they worry that when a parent refuses to vaccinate a child, they put the child at increased risk of contracting a vaccine-preventable infectious disease, Diekema explains.

In addition, these parents place other children at risk should their own child contract a communicable illness, he says, and there is a sense that these parents are not doing their part to contribute to the protection against the spread of infectious diseases within the community.

Many pediatricians believe that vaccination is one of the most important things a health care provider can do to protect the health of children, and that if a child's parent is unwilling to accept the physician's recommendation about something that central to the practice of pediatrics, "they have essentially rejected the most important thing the provider has to offer," adds Diekema.

Autonomy is issue

It is important for physicians to remember that the medical community and the community of parents who refuse vaccinations are probably thinking similarly about this issue, says **Jennifer C. Kesselheim**, MD, a pediatric hematologist-oncologist and the chair of the Ethics Advisory Committee at Dana-Farber Cancer Institute in Boston.

"Both parties want to minimize harm and maximize benefit for each child," she says. "In this way, parents and clinicians are on the same page, ethically speaking."

While clinicians usually view the risk of potentially life-threatening infections to be the greater harm, some parents conclude that this risk is quite low since many of these infections have become rare due to the success of vaccines, says Kesselheim.

"Parents therefore come to believe the larger risk of harm may be due to side effects from the vaccines themselves, leading them to refuse immunizations," says Kesselheim.

Providers must remember that ethical decision-making hinges not only on the balance of benefits and harms but also on the principle of autonomy,

EXECUTIVE SUMMARY

When a parent refuses to vaccinate a child, this brings up several ethical concerns for pediatricians, regarding risk to the child and others in the community.

- The physician has an ethical obligation to independently assure that children do not come to serious harm as a result of parental decisions in the health care realm.
- Pediatricians may encourage the family to find another physician if a substantial level of distrust develops.
- Continuing the relationship allows the provider to have future opportunities to discuss the issue of immunization over time.

stresses Kesselheim. "Respect for persons leads us to place high value on the autonomous decision-making of parents on behalf of their children," she says.

Refusal of treatment

A parent can refuse treatment or preventive care for a child as long as the decision to do so does not place the child at substantial risk of serious harm, notes Diekema.

The physician's role when a parent refuses treatment on behalf of a child is to assure that the parent understands the potential consequences of the decision, continue to counsel the parent with the child's welfare as the central concern, and to involve child protective services if the parent has refused a treatment in a situation where doing so places the child at substantial risk of serious harm, he explains.

"The physician has an ethical and legal obligation to independently assure that children do not come to serious harm as a result of parental decisions in the health care realm," he says. Generally speaking, refusing a vaccine does not place a child at substantial risk of serious harm, adds Diekema.

This is the case in a reasonably well-immunized community where there is some degree of herd immunity and where the likelihood of contracting a vaccine-preventable illness is still fairly low, or where the likelihood is that the child would recover from the disease without any lasting harm, says Diekema.

Clinicians do not force parents to accept immunizations and cannot administer them without parental permission, largely to honor the parental right of autonomous decision-making, says Kesselheim.

That said, clinicians are also granted a right to autonomy, says Kesselheim, and are ethically justified in protecting their own professional integrity.

"For this reason, some clinicians refuse to provide care to families who do not immunize," she says. "Just as the clinician cannot compel the parent to accept vaccines, the parent cannot compel the physician to provide care in a setting in which he or she feels unprofessional." ■

REFERENCE

1. Dempsey AF, Schaffer S, Singer D, et al. Alternative vaccination schedule preferences among parents of young children. *Pediatrics* 2011;128(5):848-856.

SOURCES

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CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions.
1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

CME OBJECTIVES

Upon completion of this educational activity, participants should be able to:
- Discuss new developments in regulation and health care system approaches to bioethical issues applicable to specific health care systems.
- Explain the implications for new developments in bioethics as it relates to all aspects of patient care and health care delivery in institutional settings.
- Discuss the effect of bioethics on patients, their families, physicians, and society.

COMING IN FUTURE MONTHS

- ■ Selling organs for transplant
- ■ Targeting unethical narcotics prescribing
- ■ Some screening tests may do more harm than good
- ■ Ethical practices for recommending limiting life support

CME QUESTIONS

1. Which is true regarding ethical concerns with disclosure of errors, according to **Patrice M. Weiss**, MD?
   A. It is an unethical practice for providers to speculate about what happened when patients ask why an error occurred.
   B. Disclosures should always be planned and carried out by individual physicians as opposed to teams.
   C. It is acceptable for providers to share information on occurrences involving other providers, or judge the performance of another provider, in conversations with the patient or family.
   D. When writing error disclosure policies, as restrictive a definition as possible of errors should be used.

2. Which is true regarding a patient's request for an advertised medication, according to **G. Caleb Alexander,** MD, MS?
   A. It is unethical for providers to explore other options such as lifestyle modifications or over-the-counter therapies after a patient has requested a specific medication.
   B. The provider should take the opportunity to clarify misconceptions the patient may have about the medication.
   C. Providers should remember that there is no association between direct-to-consumer ads and increased prescription of advertised products or patients' request for specific drugs.
   D. The physician retains the right to refuse to prescribe, and this refusal can and should be based on the physician's beliefs and values when these differ from the patient's.

3. Which is true regarding ethical considerations of physicians praying with patients, according to **Farr A. Curlin**, MD?
   A. It is ethical for a physician to suggest that prayer promises a benefit that the physician cannot guarantee.
   B. It is unethical for physicians to offer to pray with patients unless the patient brings it up.
   C. Insofar as the interaction is voluntary and respectful, and not manipulative, then it is permissible.
   D. Physicians should avoid religious and spiritual discussions simply because this has been shown to offend a majority of patients.

4. Which is true regarding ethical concerns of parental refusal to vaccinate a child, according to **Douglas S. Diekema**, MD, MPH?
   A. A parent cannot legally refuse treatment or preventive care for a child, even if their decision to do so does not place the child at substantial risk of serious harm.
   B. The physician's role, when a parent refuses treatment on behalf of a child, is to assure that the parent understands the potential consequences of the decision.
   C. Generally speaking, refusing a vaccine places a child at substantial risk of serious harm, and physicians should take appropriate steps to protect the child.
   D. A physician has an ethical obligation to refuse to have a child as a patient if vaccines are refused by the parent, even if a good working relationship exists between the parent and physician.