Victims of violence: An ethical conflict between patient rights and institutional policy

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A 34-year-old male is brought to the emergency department (ED) of an academic medical center after sustaining a gunshot wound to the abdomen by an unknown assailant. The triage nurse immediately identifies him as a victim of violence (VOV) and subsequently places him on protective restrictions as dictated by hospital policy. These measures include omission from the official hospital registry; a limit of three visitors to be determined on admission; seizure of the patient's communication devices (phones, tablets, computers, and so on); and confinement to the hospital floor to which the patient is admitted. Given the severity of the patient's injuries and his hemodynamic instability, he is rushed to the operating room. The social worker is unable to obtain names from the patient, and his list of preapproved visitors is left blank.

His injuries are serious, including complete transection of the superior mesenteric artery and vein, such that he requires a subtotal enterectomy with tube jejunostomy. He is left with only 10 cm of small bowel and develops severe short gut syndrome with complete dependence on total parenteral nutrition (TPN). During his recovery, the patient has trouble tolerating the restrictions of hospitalization. He is frequently found trying to leave the floor unsupervised and is intermittently noncompliant with his NPO (also known as nothing by mouth) orders. Prior to this hospitalization, the patient had a stable job and was serving as the primary caregiver for his mother, who suffers from end-stage chronic obstructive pulmonary disease.

Three weeks into his hospitalization, he is transferred from the surgical intensive care unit to a regular hospital ward. His condition is stable, but he still has multiple active medical issues, including electrolyte abnormalities and an elevated white blood cell count. Further complicating the situation, his ill mother passes away while he is still an inpatient. At this point, the patient requests that he be allowed to contact his family so that he can receive information and support in the midst of his grieving. His attending surgeon, who is new to the institution, assumes care of the patient and asks that his protective status be lifted. In accordance with hospital policy, a committee is assembled to review the request, which includes social workers, the charge nurse, his physicians, and representatives from public safety. In light of the patient's past history of several misdemeanors, his request is denied.

In response, the patient threatens to leave against medical advice (AMA), though he is clearly unable to maintain adequate hydration without TPN for a prolonged time, thus creating a potentially dangerous situation for himself. Psychiatry is asked to evaluate the patient. While he is found to be depressed—and the psychiatry team recommends starting appropriate pharmacotherapy and cognitive behavioral therapy—he is deemed to have the capacity to understand the severity of his injuries and the risks associated with leaving the hospital in his condition.

Ethical dilemma

The new attending surgeon who has assumed his care and convened the review committee faces a conflict between her responsibility to her patient and her responsibility to the institution. She faces several options in the subsequent course of action:

- Uphold the committee's decision to maintain VOV status, keeping the patient isolated and preventing him from leaving the hospital for his own safety.
- Respect the patient's wishes and allow him to leave the hospital against medical advice with no conditions for follow up.
- Facilitate TPN for discharge for the patient so that he can leave temporarily, with the stipulation that he is to return to the hospital after his mother's funeral so that his remaining medical issues can be treated.
- Return the patient's communication devices so that he can communicate with his family while keeping him as an inpatient, even though this directly challenges the committee's recommendations.

Discussion of the issues

All surgeons perform their duties within the context of an institution, ranging from a large academic center to a small private practice, with a variety of patient populations and resources. Each institution has specific policies and guidelines that provide parameters within which all stakeholders—physicians, administrators, patients, and so on—are expected to function. An institution's effort to manage and express the values and assumptions that guide business and patient care decision making is called organizational ethics.[1]

Ideally, organizational ethics align with an individual physician's ethical compass. However, a clinician often concentrates on the humanistic ethical principles of patient autonomy, beneficence, nonmaleficence, and justice, whereas organizational ethics draw attention to the continued safety, stability, and reputation of the institution.[2] As a result, some circumstances place an institution's ethics and a clinician's ethics at odds.

The policy influencing this case involves a VOV patient. VOV policies differ between institutions, and the discussion in this case is framed using one institution's policy. When patients are brought to the ED with injuries that are consistent with acts of violence, per the discretion of the triage nurse, they are placed on specific protective measures as described previously in the VOV protective status policy. The intent of this policy is to defend the privacy of the patient, specifically information regarding his whereabouts and medical condition, as a way to curb further violence should the perpetrator of the patient's injuries seek to cause further harm. If patients wish to be relieved of these restrictions, they must make a request that is then evaluated by a committee comprised of various staff members of the institution, as noted in the case scenario. Usually, patients remain on these restrictions throughout the entirety of their hospitalization, which may extend from days to weeks or even months.

Discussion of four options

The following discussion of the options available to the attending surgeon in this case elucidates the four basic principles of medical ethics that should be considered when faced with ethically challenging situations. As is the case with most ethical discussions, arguments can be made for and against each option.

Option one: Uphold the committee's decision to maintain VOV status, keeping the patient isolated and preventing him from leaving the hospital for his own safety.

The attending surgeon—who is convinced that the patient has decisional capacity—has difficulty with this option. The patient presumably signed a consent to be treated at the hospital, and though this document is far from legally binding, he is within his rights to withdraw consent whenever he chooses. He has voiced an understanding of what leaving AMA would mean for his health and has clearly expressed his preference. Preventing him from leaving would violate his autonomy to direct his own medical care and, arguably, his constitutional rights as well, which could lead to litigation against the attending surgeon and possibly the hospital.

On the other hand, an argument could be made for this option based on the principles of beneficence and nonmaleficence. The patient has multiple unresolved medical issues that the surgeon has the responsibility to address, with discharge not medically indicated at this time. Not only is keeping the patient in the hospital in his best interests from a medical standpoint (beneficence), but it is also in line with the intention of the VOV policy. Because no information is available yet regarding the circumstances around the patient's gunshot injuries, continuing to limit his communication is the best way to reduce the risk of further violence and thus protect him, the hospital, the hospital employees, and all other patients (nonmaleficence).

The opposite viewpoint is equally relevant. In the face of no new information, the care team must reconsider the assumption that the violence against the patient was purposeful and not a random act. It also is possible that the shooter has no idea who the patient is and does not intend to perpetrate further violence against this patient specifically. The surgeon is faced with balancing the potential physical risk to the patient and others while recognizing the patient's rights to decision making regarding his medical care.

Option two: Respect the patient's wishes, and allow him to leave the hospital against medical advice with no conditions for follow-up.

This option prioritizes the principle of individual autonomy and respects the patient's preference. He was evaluated by psychiatry, with confirmation from the surgical team's assessment that the patient is capable of understanding his condition and has the capacity to make decisions. However, it is important to emphasize that this process is imperfect. Despite the patient's ability to recite the risks associated with leaving AMA, it is impossible to determine if this interpretation is an accurate reflection of his understanding. Multiple factors contribute to this complex interaction, key among them being the question of whether a patient can truly make an informed decision without sufficient medical literacy.

In the surgeon's professional judgment, the patient is unready for discharge. Permitting the patient to leave before his medical issues are fully addressed strains the principle of nonmaleficence. The patient's severe short-gut syndrome makes it impossible for him to maintain his intravascular volume with hydration solely by mouth. If the patient leaves without TPN, he will quickly become dangerously dehydrated. Not only will leaving be risky for the patient from a medical vantage point, but, as mentioned previously, he may also be putting himself at risk of further harm if his attacker is, in fact, still looking for him.

Option three: Facilitate TPN for discharge for the patient so that he can leave temporarily, with the stipulation that he is to return to the hospital after his mother's funeral so that his remaining medical issues can be treated.

This option respects the patient's autonomy by allowing him to leave so that he may be with his family to mourn the death of his mother. Even though the attending surgeon plans to discharge the patient on outpatient TPN eventually, the necessary arrangements, such as consultation with nutrition specialists, home health managers, and occupational therapists, will undoubtedly take time to complete. This process is much lengthier than the patient might anticipate and will require substantial negotiation among many health care professionals. Ideally, the patient would leave the hospital in time to attend his mother's funeral, but it is impossible to expedite the discharge process in this challenging situation.

The argument against this option relies again on the principle of nonmaleficence. Even though arranging for TPN temporarily resolves one of the patient's active problems (his inability to maintain his intravascular volume), he still has other issues, such as his leukocytosis and electrolyte imbalances, which require further work-up and management. Discharge is clearly not medically indicated, and while the patient is outside the hospital, he is at serious risk for clinical decompensation. This risk is not in the patient's best interests and would leave the hospital and the surgeon open to liability should the patient develop any complications.

Option four: Return the patient's communication devices so that he can communicate with his family while keeping him as an inpatient, even though this action directly challenges the committee's recommendations.

Given the patient's dependence on TPN, his tenuous status, and his ongoing medical problems, he would be best treated as an inpatient and does not meet clinical criteria for discharge. Allowing the patient to communicate with his family, however, is a compromise that will improve the patient's overall experience and may alleviate the care team's dilemma in respecting the patient's autonomy to some extent.

When considering this option, one should evaluate whether it is in accordance with the ethical principle of justice. The intention of the VOV policy is to protect the patient, the hospital, its employees, and all other patients from potential harm should the perpetrator of the gunshot attack seek to commit further violence. Giving the patient the means to contact the outside world would reveal his whereabouts and put all parties involved at risk.

There also is inherent professional risk to the attending surgeon, as giving the patient access to his communication devices is in direct noncompliance with the committee's recommendations. As a new attending physician, acting against policy could lead to disciplinary action or even termination of employment. Is risking employment the most beneficial thing for the surgeon to do? This act not only puts the attending's livelihood at risk, but it also prevents her from participating in the care of other patients in the hospital. If this act were to lead to termination, it could jeopardize the surgeon's career, which would be a disservice to all potential future patients.

Ethical bottom line

Following the Las Vegas, NV, mass shooting incident in October 2017, the *Journal of the American Medical Association* published an article stressing the magnitude of the gun violence epidemic in the U.S.[3] Since 1968, more Americans have been killed by civilian gun violence than in battle during all of the wars in which the U.S. has fought combined.[4] In addition to being tragic, firearm injuries also are incredibly costly from a societal standpoint, averaging $734.6 million per year from 2006 to 2014 and disproportionately affecting the uninsured and thus the entire health care system.[5]

Unfortunately, until more recent events, the medical community's response to what many are calling a public health crisis has been slow. Part of the problem relates to the barriers physicians face. For example, although no federal statutes prohibit physicians from asking patients about gun ownership, several states have legislation that deter it.[6] Moreover, medical education does not adequately prepare physicians to counsel patients in firearm injury prevention.[7,8] The case described in this article reflects the need for national guidelines or standards across hospitals with regard to how best to protect patients who have been victims of firearm violence.

As noted previously, the intent of the VOV policy is to protect the patient, the institution, its employees, and other patients from potential harm. In situations where a patient is admitted with injuries consistent with violence, the details of the primary altercation are usually scant or unreliable. Was the patient an innocent bystander caught in crossfire? Is this incident gang-related? Was the patient harmed by an intimate partner? But most importantly, is the patient still at risk? The VOV restrictions are implemented ideally to prevent perpetrators of violence from learning the whereabouts and condition of the VOV patient in case they seek to instigate further violence. However, these policies must be reevaluated to determine whether they are accomplishing their intended goals.

For example, the hospital policy at the authors' institution limits VOV patients to three preapproved visitors and these visitors (like the patient) are prohibited from using their cell phones in the inpatient unit. However, it is impossible for the hospital administration to control what kind of information these visitors will divulge the moment they step out of the hospital, making the VOV policy potentially futile. Policies should be tools to facilitate patient care, and when they stop functioning to that effect, they must be reassessed. Is there a better way to keep our patients safe? Why is the onus placed on the victimized patient? Can we better monitor the individuals entering and exiting the hospital instead?

More generally, this case highlights the need for further discussion regarding the role a trauma surgeon should play within an institution. In particular, what tools are available to the surgeon when her perception of the patient's best interests contradicts the course of action dictated by hospital policy? This dilemma is especially relevant for surgeons who operate outside of large academic centers where ethics committees may be less accessible for consultation.

At the conclusion of this case, the attending surgeon is left with the central question of how to use this experience to improve patient care and refine the institution's policies. On the one hand, the attending surgeon can remain frustrated that she is unable to coordinate her patient's care to the satisfaction of all parties involved. However, perhaps this situation will serve as a call-to-action to effect change. It is imperative for physicians to gather data on the frequency of these conflicts between policy and patient care and to assess the severity of their impact on patients. Through quantitative analysis and clear characterization of patient outcomes, physicians may be able to leverage hospital leadership to change policy. Patient care is not limited to the operating room or the inpatient floor. Surgeons must serve the dual role of patient advocate and institutional policy enforcer, and must become active participants in policymaking itself to fully appreciate the complex dynamic between ethical principles at the individual and organizational levels.

References

1. Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. New York, NY: McGraw Hill; 2010.

2. Goold SD. Trust and the ethics of health care institutions. *Hastings Cent Rep*. 2001;31(6):26-33.

3. Bauchner H, Rivara FP, Bonow RO, et al. Death by gun violence—a public health crisis. *JAMA.* 2017;74(12):1195-1196.

4. Bailey C. More Americans killed by guns since 1968 than in all U.S. wars-combined. NBC News. Available at: www.nbcnews.com/storyline/las-vegas-shooting/more-americans-killed-guns-1968-all-u-s-wars-combined-n807156. Accessed August 8, 2018.

5. Spitzer SA, Staudenmayer KL, Tennakoon L, Spain DA, Weiser TG. Costs and financial burden of initial hospitalizations for firearm injuries in the United States, 2006–2014. *Am J Public Health*. 2017;107(5):770-774.

6. Wintemute GJ, Betz ME, Ranney ML. Yes, you can: Physicians, patients, and firearms. *Ann Intern Med*. 2016;165(3):205-213.

7. Yanes AF. Gun violence and firearm safety in medical school curricula. *JAMA Intern Med*. 2017;177(1):11-12.

8. Butkus R, Weissman A. Internists' attitudes toward prevention of firearm injury. *Ann Intern Med*. 2014;160(12):821-827.