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On Bias

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Philosophy is the battle against the bewitchment of our intelligence by means of language. — Ludwig Wittgenstein, *Philosophical Investigations, 109, part 1*

As a white boy growing up in the Jim Crow South, I saw my share of what many would call bias. Although I have no desire to defend the racist environment of my youth, I think we're using the wrong term to define the mindset of that time. In short, I think we're giving the term "bias" a bad rap.

Why is this more than a semantic quibble that would justify further examination?

The indiscriminate use of the term "bias" sets up a roadblock to meaningful conversations among people with divergent values. Precision in language can help clear up a lot of confusion. One of the problems with the English language is that it's "overrich with a plethora" of words. The substitution of one word for another leads to what the philosopher Ludwig Wittgenstein refers to in the opening quote: a "bewitchment of our intelligence."

The Oxford dictionary lists four separate definitions of the noun "bias." For the purposes of ethical analysis, I've distilled the definition of bias to "an inclination to action". In this stripped-down sense, bias is morally neutral. According to Aristotle, the virtuous person has an inclination, or bias, to seek the good. To label the bias I observed in my childhood, I would choose a frequently used synonym: prejudice. As virtue is a bias to the good, prejudice should be considered a bias to the bad.

Freeing the word "bias" from immediate negative connotations does a remarkable thing. Nothing is a conversation stopper like "I'm not biased!" It's time to realize that, based on our own experiences and what we've been taught, we all have biases, some good, some maybe not so good. Biases are a part of being human. Our lives are filled with them. Bias is essential to the human fabric and, without it, we are figuratively, if not literally, dead. If we admit that it is our nature to be biased, it's no longer a matter of if we have biases, but of what kind.

This level of self-awareness is necessary before we can begin to effectively share the experiences and teachings that shape us.

When discussing our biases with others, I recommend that we stick to our own experiences. Sharing stories engenders compassion and elicits an emotional attachment which is the

Continued on Page 3

IN THIS ISSUE

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The Ethicist Is In

KELSEY GIPE, PH.D.

The Case:

Janice is a 49-year-old woman who presented to the hospital emergency department with foot pain due to severe infection. She has a medical history of poorly managed type 2 diabetes, psychosis, active methamphetamine and cocaine use, nonadherence to medications, and leaving the hospital against the medical advice of physicians (AMA). Janice also has longstanding chronic infection of her left foot with multiple recent hospitalizations for foot pain. Over the course of these hospitalizations, amputation has been recommended to stop the foot infection at the source. Without amputation, it's clear that Janice will succumb to the infection and die. During the current hospitalization, Janice has repeatedly refused amputation along with all other medical interventions. She is emotionally volatile and abusive toward providers, both verbally and physically, including calling multiple providers racist and homophobic slurs and throwing a full bedside commode at staff. The medical team, especially bedside nursing staff, are distressed and frustrated by this situation and exhausted by the constant stream of abuse. They are upset that the patient doesn't allow them to help her and feel guilty when they find themselves avoiding her room. Ethics was consulted, with providers asking, "What are our obligations to this abusive patient who won't accept any of the treatments we're offering her?"

Determining Capacity

In a situation with an abusive patient who refuses treatments, the first question to answer is whether the patient has decision making capacity sufficient to refuse such treatments. In Janice's case, the Psychiatry service was consulted and determined that Janice did have capacity to refuse medical interventions – including life-saving amputation – and to leave the hospital AMA if she wished. Because the patient was determined to possess capacity, she could make her own medical decisions, even if those decisions were not in her own best interest.

If the patient were determined to lack capacity, a further question would be whether it's ethically appropriate to provide treatments against her refusal. However, since the patient was judged to possess capacity, the ethicist advised the team that it would be ethically appropriate to respect her refusal of treatments as long as the patient was informed of the consequences of her refusal. The ethicist spoke with the patient and reiterated the message she had been told by multiple providers: that refusing amputation placed her life at serious risk and that the medical team strongly recommended proceeding with amputation. Janice was very clear in this conversation that she did not want amputation, and while she persistently denied believing that she would die without amputation, she acknowledged that the physicians believed that death would be the ultimate consequence of foregoing the recommended treatment.

The ethicist debriefed with providers regarding their experiences with the patient.

Janice's case underscores the fact that decisional capacity is a complicated property. Janice's resistance to acknowledging that she would die without amputation displayed a lack of insight and a denial about the reality of her condition. However, Janice was otherwise capacitated to the point that she could make a decision regarding amputation.

Eliciting Goals of Care

Once Janice was determined to possess capacity, it was important to try to determine her goals. Janice's recent pattern of increasingly frequent hospitalizations indicated a trajectory of decline that could not be reversed without amputation. If she became sick enough the next time she presented to the hospital, Janice might not be able to tell providers what she wanted. For Janice to receive consistent care that was in line with her values, it was essential to know her preferences. Janice was generally very resistant to such discussions, but the ethicist was able to catch her in a good mood while eating lunch. In this discussion, the ethicist determined that Janice did not want to be resuscitated if she stopped breathing or her heart were to stop, and she did not, under any circumstances, want to end

Continued on Page 5

Welcome and Announcement!

Alexander Duvoisin, J.D., M.A.

Alex Duvoisin is the Program in Medicine and Human Values' current clinical ethics fellow. Mr. Duvoisin earned a master's degree in bioethics from Loyola Marymount University and a J.D. from UC Hastings. Before starting at Sutter, he held internships in bioethics and law at Kaiser Permanente and the Veterans Affairs hospital in Los Angeles.

A New Bioethicist: Kelsey Gipe, Ph.D.

Dr. Gipe has joined our team as a bioethicist after completing our program's clinical ethics fellowship at CPMC. She has been very closely involved with clinical ethics education for the graduate medical education (GME) program at CPMC. She'll be providing her clinical ethics expertise at Sutter Delta Medical Center in Antioch and at CPMC's Van Ness Campus in San Francisco.

On Bias

Continued from Page 1

key to reducing tension between people of differing views. On the other hand, professing dogma and reciting the teachings of others, is usually met with skepticism and resistance.

Once we recognize the ubiquity of bias, we're in a better position to talk about it. Dealing with bias is the next challenge.

To better understand our obligations to act in the face of bias, let's, for a moment, take it out of the typically moral context and look at it in the realm of health. Think about a person with diabetes who has a strong desire for a piece of chocolate cake. Someone with a sweet tooth could be expected to have a bias toward chocolate and that inclination might be strong. Remember that the second part of my definition of bias refers to a resulting action. For the sake of their health, the diabetic should be able to recognize their bias, and resist the impulse to act on it, based on the detrimental consequences. As a practical matter, in my many years of medical practice, telling a patient with diabetes that they're bad person for wanting chocolate has never been an effective strategy. Instead, praising them for recognizing the impetus to act has met with success.

In the realm of ethical behavior, the self-aware person becomes the virtuous one when they recognize their biases and choose to act only on those that aim at the good. Courage, for Aristotle, is the virtue that sustains this quest while promoting resistance to the bad.

…telling a patient with diabetes that they're bad for wanting chocolate is never an effective strategy. Instead, praising them for recognizing the impetus to act has met with success.

In memory of Albert Jonsen, Ph.D., cofounder of the Program in Medicine and Human Values, we launched a new speaker series entitled **Roots of Bioethics**. This series highlights early pioneers in the field. The inaugural session featured a discussion of moral distress and strategies to mitigate it.

Moral distress, a natural response to the violation of one's core values, is often triggered in healthcare settings when constraints prevent healthcare providers from fulfilling their perceived duty to their patients. If left unaddressed, moral distress leads to a number of behaviors and emotions, including burnout, that take a toll on the personal and professional well-being of healthcare providers.

We held the first **Roots of Bioethics** event virtually on Wednesday, January 26, with more than 270 national and international attendees. PMHV Medical Director William Andereck, M.D., moderated the panel. Dr. Andereck focused questions to the panelists on the relevance and impact of moral distress as well as how the phenomenon and experience of moral distress may have changed over time for healthcare professionals.

The panel included Andrew Jameton, Ph.D., the scholar and philosopher who first defined the term "moral distress," and Shilpa Shashidhara, Ph.D., senior clinical bioethicist at Sutter Health, who discussed strategies that providers at Sutter Health have used to mitigate moral distress. Specifically, Dr. Shashidhara shared the Moral Distress Debriefing Framework, developed to ensure a focused, productive debriefing session that can provide healthcare providers relief from moral distress ("Moral Distress: A Framework for Offering Relief through Debrief"). The session ended with an interactive, 30-minute Q&A.

The next session of **Roots of Bioethics** will focus on moral courage. It will be held this summer.

The Ethicist Is In

Continued from Page 2

up on machines. This was consistent with Janice's current refusal of treatments and history of medical nonadherence and AMA discharges. Additional information gathered from outpatient social workers and case managers supported foregoing aggressive interventions in the intensive care unit or resuscitation in the event of sudden death. It was apparent that the patient had a longstanding history of avoiding medical treatment and preferred to live life on her own terms.

Setting Behavioral Boundaries

One substantial source of distress in this case was the patient's persistent verbal and physical abuse toward providers. Her behavior was exhausting and demoralizing, particularly for bedside nursing staff, who dreaded interacting with the patient. Her behavior was also disruptive to other patients, as she would scream obscenities and throw tantrums when nursing staff attempted to close her door.

The ethicist counseled drawing strong boundaries with Janice regarding her behavior and encouraged staff to remove themselves from the room when she had outbursts rather than provide further attention in response to bad behavior. Regarding her refusal of medications and routine treatments, the ethicist explained that, in this sort of situation, all a provider can do is offer what they know the patient needs and explain why it's being offered, as well as the consequences of refusal. If the patient became abusive, the ethicist advised that providers inform the patient that her behavior was inappropriate and calmly leave the room. If the patient became agitated such that she became a danger to staff and/or herself, the ethicist discussed providing medications that Psychiatry had prescribed for agitation to help ensure the safety of both patient and staff.

Empowering the Team to Discharge

The ethicist helped empower the healthcare team to discharge the patient. Since Janice had the capacity to refuse all treatments that would warrant an acute hospitalization, there was no obligation to allow her to remain in the hospital indefinitely. With the ethicist's support, the medical team informed Janice that she was going to be discharged because she was refusing everything offered to her at the hospital. Janice was provided with clothing and medications in hand. She was also offered outpatient resources for substance cessation and counseling, which she declined.

The ethicist explained that liking a patient was not an ethical obligation.

Debriefing and Planning

The ethicist debriefed with providers regarding their experiences with the patient. One substantial component of this case was the distress among bedside nursing staff, not only regarding the way Janice treated them but also the way they felt about her. On the one hand, they felt sorry for her and were frustrated that she wouldn't allow them to help her; on the other hand, they were increasingly avoiding Janice and developing a strong antipathy toward her. Some of the ethicist's role was to reframe for them their professional obligations and help defuse their emotions. The ethicist explained that liking a patient was not an ethical obligation. In some situations, disliking a particular patient may be a natural reaction to that patient's behavior. The ethicist emphasized that as long as providers did their due diligence by offering care and treatments, monitoring the patient's status, and treating the patient with respect regardless of whether she responded in kind, they were fulfilling their professional obligations, regardless of what emotions they might feel. Providers were encouraged to draw strong boundaries with the patient in the event of future hospitalizations and to honor the goals of care that she had articulated during the current hospitalization. Although Janice had not allowed the team to provide her with the lifesaving care she needed, providers could feel secure in the knowledge that they had done their best as healthcare professionals.

PROGRAM IN MEDICINE & HUMAN VALUES

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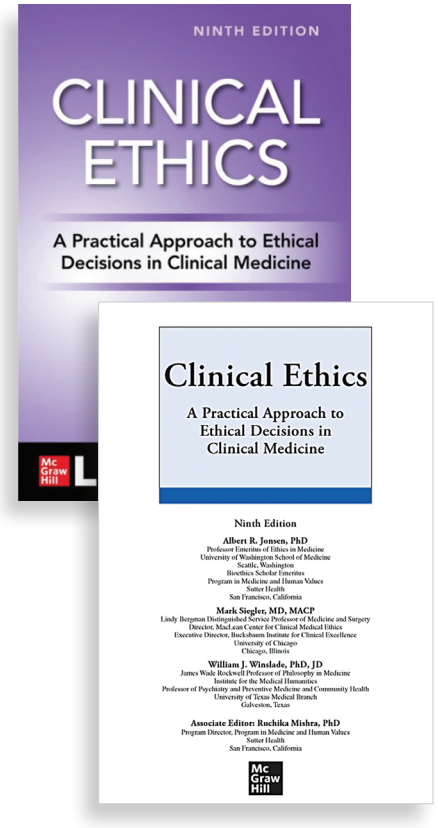

Publication Spotlight:

Clinical Ethics, 9th edition by Albert R. Jonsen, Ph.D., Mark Siegler, M.D., and William Winslade, Ph.D., J.D.
McGraw Hill, 2022

The 9th edition of *Clinical Ethics* was recently published. Our program director, Ruchika Mishra, Ph.D., joined the authors as associate editor. This seminal book in the field of bioethics focuses on the Four Topic method of ethical analysis, an approach now used by a wide variety of healthcare professionals, including doctors, nurses, allied health professionals, clinical ethicists, and chaplains. This edition was our cofounder Dr. Jonsen's last scholarly contribution prior to his passing.

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