***"Ask the Expert"** is a service of the HCH Clinicians' Network intended to be a resource for clinicians who work with people experiencing homelessness. We are unable to answer questions for individuals about their own health problems. There is useful patient information on numerous websites: **WebMD** answers basic questions and is straightforward and easy to use; **MayoClinic** features consumer-oriented information about both illnesses and drugs; **MedlinePlus** features the latest scientific studies and interactive tutorials illustrate a variety of procedures and conditions; **4Women.gov** is best for women's specific health issues and has a free call center; and **Medscape** is a place to look for timely news from medical journals.*

OUR EXPERT

John Y. Song, MD, MPH, MAT | Assistant Professor
Center for Bioethics | Department of Medicine | University of Minnesota Medical School | Minneapolis, Minnesota

Dr. John Song is an Assistant Professor in the Center for Bioethics and the Department of Medicine at the University of Minnesota Medical School. He recently completed a fellowship in General Internal Medicine at the Johns Hopkins School of Medicine, and in Ethics and Public Policy at Johns Hopkins and Georgetown Universities. His clinical interest has always been underserved populations, and he worked for four years at Health Care for the Homeless, Inc., in Baltimore. Dr. Song's educational and research efforts reflect his interest in these populations. His current research focuses on the end of life concerns of persons experiencing homelessness and he is the medical director for the Phillips Neighborhood Clinic, a volunteer clinic for underserved persons in Minneapolis.

Dr. Song: Answers to the following questions presuppose an ethical framework that relies on four principles derived from the Belmont Commission and the work of philosophers Tom L. Beauchamp and James F. Childress: autonomy, beneficence, nonmaleficence and justice. I use this framework because I am most familiar with these principles, and because they are the ones that are most commonly cited in Western bioethics. There are many other valid ethical theories, principles and standards that one can apply, which may lead to rather different conclusions. Although the points of view expressed here are indicative of mainstream thinking among bioethicists today, they are not the only right way of approaching these difficult issues.

1

A 60-year-old man with alcoholism has received medical detoxification and participated in addiction treatment programs repeatedly over years. He has had some good sober times for as long as 4 months, several times. His pattern is to ask Health Care for the Homeless providers to refer him for inpatient detoxification and then get him into a rehabilitation program. He often goes directly back onto the street following detoxification, or even drinks or "huffs" Lysol while in the hospital. The patient does not always follow through on the treatment plan after discharge. The hospital emergency department and our clinic's physicians are very frustrated and wonder if he is not sometimes just looking for a warm bed indoors. His medical comorbidities make outpatient detoxification inappropriate. Clinical staff at this Federally Qualified Health Center feels a moral (and legal) obligation to continue to offer this patient a chance. The hospital is putting pressure on us to devise another plan, and some of the doctors do not believe there is hope of remission at this point. What is your advice?

Dr. Song: This difficult situation raises many questions about the obligation to serve our patients and how far this obligation extends. There is an extremely strong moral and legal obligation not to abandon one's patient (which is beyond the scope of this discussion), and one must approach this situation, as all others that involve a patient-provider relationship, with this initial position.

There are many reasons why this situation is extremely frustrating. The patient is not adhering at all times to his treatment regimen. He has a long history of treatment failure and recidivism. He may have other motivations for seeking care; there is, for example, a suspicion that he merely wants a "warm bed indoors." As frustrating and difficult as this patient may be, however, frustration is clearly not enough justification for abandoning a patient. Neither are the causes of his frustrating behavior. For example, we cannot abandon a patient for nonadherence; if we did, we would abandon 20 to 50 percent of our patients, given the known rates of nonadherence to treatment plans and medications. Moreover, we certainly do not abandon our patients because of poor outcomes. Given the difficulty of treating chronic alcoholism, poor outcomes should be expected in some cases. Finally, if one believes that a patient has an ulterior motive for seeking care, one must address that need—especially if it is an essential need associated with health and well being—rather than abandoning the patient.

There are situations, however, in which abandonment might be morally justified. One such situation is if the provider believes that care is futile. The case above alludes to this (i.e., "some of the doctors do not believe there is hope of remission at this point"). In some cases of medical futility, providers have no obligation to provide care that has no chance of providing benefit. Medical futility is usually evoked, however, when there is no chance of providing benefit, such as providing life support in the intensive care unit to someone who is brain dead. It would be a dangerous stretch to compare someone suffering from chronic alcoholism to this kind of futility. In any event, the patient has allegedly had periods of sobriety lasting four months at a time, which is frustrating and probably without a great deal of hope, but certainly not futile. Even if the situation is futile—and this case is clearly not—sometimes there are compelling moral arguments to continue providing care. Legally, states have different approaches to futility and obligation to provide care.

In conclusion, I believe there are three possible ethical solutions: One is to continue care, however frustrating it may be. A better solution is to continue to adapt care for this patient, although I suspect these providers have been extremely creative and committed in their approach and may or soon will truly exhaust every possibility. Finally, if these alternatives are neither acceptable nor possible, clinicians should seek to transfer his care to another provider.

2

When providers of health care to homeless families suspect but lack strong evidence of child abuse or neglect, they are often reluctant to refer the child to Child Protective Services (CPS), fearing that the therapeutic relationship with the family will be impaired if they do so. In the experience of some providers, unless there is strong evidence of child abuse, CPS will only conduct one family visit without additional follow-up. What is your advice? How can clinicians meet both their legal and ethical obligations to the child and the family in such cases?

Dr. Song: This extremely difficult situation unfortunately is common. The ethical quandary is particularly complex because of the many relationships involved: Between the provider and the family, between the parents and their child or children, and between the provider and the child. There is a systematic way to think about this kind of situation, however, which may make the ethical choices clearer.

One should begin with a couple of ethical imperatives when faced with this situation: First, endeavor to protect the most vulnerable party. In most cases, that would clearly be the child. Second, recognize that children experiencing homelessness are particularly vulnerable. Data and experience clearly demonstrate that these children are more likely than other children are to suffer from physical, emotional and cognitive stress. Even with loving and caring parents, homeless children are more vulnerable than are children living with similar parents in a safe and secure environment. For that reason, I would argue that simply living without a home places children in a state of "neglect," however unintentional it may be. Of course, this does not mean that children experiencing homelessness should trigger an automatic call to CPS, only that these children must be viewed as particularly vulnerable, and that providers need to be especially vigilant in protecting them. All children, whatever their living circumstances, should be considered vulnerable, as they are dependent, trusting and have fewer resources than adults to protect themselves.

In determining whether to perform an intervention such as notifying CPS to protect a child, the provider should consider the following factors:

- First, determine the likelihood of harm to the child and whether s/he should remain in the current situation. Simply put, how sure is the provider that harm is occurring? This is the same kind of burden placed, for example, on a psychiatrist treating a potentially harmful patient: How likely is it that this patient will harm him/herself or someone else? The ethical and legal obligation for a psychiatrist to intervene when treating a potentially harmful patient is highly dependent on the likelihood of harm. The same obligation applies to this situation. When considering the likelihood of harm to a particularly vulnerable party, the standard of suspicion is lower. That is, before deciding to intervene, one does not need to be as sure that harm is occurring when children are victims as when adults are victims.

- Second, determine the proximity of harm. If someone is potentially harmful to another person but is not often in their company, then the obligation to report is less than if the potential victim is always in the company of the suspected abuser. In the case of parents suspected of child abuse, the proximity of the child to harm is usually very great.

An equally important consideration is the severity or magnitude of harm. What kind of abuse does the provider suspect? If the suspected harm is great, such as sexual abuse, then there is a greater obligation to intervene and report. If the potential harm is much less severe, such as gentle spanking (if there is such a thing), then the obligation to intervene is also less severe. Many ethicists would claim that the two most important considerations in cases such as this one are the likelihood of harm and the severity of harm.

There are other considerations one should take into account, including the likelihood that the intervention will be effective. As has been shown in some very highly publicized cases recently, not all Child Protective Services are created equal—often due to resource differences—and this must be taken into account. A related consideration regarding the intervention's effectiveness is the probable response of CPS. Because Child Protective Services are usually under local jurisdictions and have different procedures, they may vary in their responses to particular cases. For example, in one jurisdiction, this case may prompt a visit or opening of a case; in another jurisdiction, it may not. It is a good idea to know how the relevant CPS operates and how effective they have been in similar cases. If one is in a jurisdiction where this kind of case is likely to prompt only one visit, as the questioner suggests, one must weigh the potential benefits of such reporting (e.g., opening a formal case file, which might prompt a stronger response in the future) with risks (e.g., damaging the therapeutic relationship with the family).

This brings us to the very legitimate concern about damaging the therapeutic relationship through reporting, and how we ought to weigh this concern in our decision-making. As in all of our considerations,

I believe that one must view this concern in light of what is best for the child. If one believes that maintaining the relationship is best for the child, then perhaps it would be best to work within the relationship you have nurtured to resolve the issue. This decision should be made, however, only after weighing the above considerations. If the magnitude of suspected harm (such as sexual or physical abuse) is great, I believe it would be hard to argue that maintaining the therapeutic relationship is in the best interest of the child, even if you do not have "hard proof" of abuse.

In some situations, you will certainly have to report to CPS, despite the risk of losing the therapeutic relationship. Nevertheless, I believe there are ways to lessen the negative impact on the relationship when you believe you must report. One way is to predict what the likely response of the reporting agency will be, anticipate it and weigh it in your consideration whether to report. Anticipating the response can help you educate the family about your decision, which, I believe, is another way to preserve the relationship. One way to frame your decision to contact CPS is to let the family know that you are doing this to help the child and perhaps provide resources to the family to further the child's interests and well being. There are two main reasons for child protection laws: Protection of the child and punishment of the offender. If you emphasize the former, you may have greater cooperation from the parents.

As for your legal obligations, the degree of certainty or suspicion needed to report child abuse varies from state to state. Some states require a higher degree of suspicion before mandatory reporting than others. In any case, the spirit of these laws is to protect children, and you should keep this in mind when considering whether or not to report. Moreover, CPS often takes the ethical considerations discussed earlier, such as the likelihood and magnitude of harm, into account. If you deal with children in your work, you should familiarize yourself with mandatory reporting requirements in your state, including the degree of suspicion required for reporting child abuse or neglect.

In many medical ethics cases, the provider's clinical, ethical and legal obligations may conflict. In this case, I believe that if either the likelihood or the magnitude of harm is great, then the obligation to report probably outweighs any other concerns, including maintenance of a therapeutic relationship. If the likelihood or magnitude of harm is minimal, then other considerations, such as effectiveness of the intervention, the therapeutic relationship and local laws, should carry more weight in your decision.

EDITOR'S NOTE:

For information about mandatory reporting requirements in all 50 states, visit www.smith-lawfirm.com/mandatory_reporting.htm and the National Clearinghouse for Child Abuse and Neglect Information at www.calib.com/nccanch/statutes/index.cfm. Hot line phone numbers for reporting suspected abuse and neglect are available at www.acf.dhhs.gov/programs/cb/publications/ rpt_abu.htm.

If you are unsure whether to report abuse, call a local specialist in child abuse, which you can usually find in regional children's hospitals. See also the following online resources for medical practitioners: American Professional Society on the Abuse of Children (www.apsac.org) and Child Abuse Prevention Network (http://child-abuse.com).

The next three questions illustrate issues related to determining patient competency in making medical decisions.

3

A developmentally delayed, formerly homeless 25-year-old desires artificial insemination to get pregnant. She is her own payee, under the care of the developmental section of the state mental health program. Although the woman has demonstrated her capacity to pay bills and maintain residential stability, she once inadvertently killed a kitten by over-bathing it. What is the clinician's responsibility to provide artificial insemination to such a patient? This is a question of "relative competency," i.e., whether one can infer competency to have and raise a child from demonstrated competency to be reasonably self-sufficient.

Dr. Song: There are, I believe, two ethical dilemmas in this case. The first is whether an individual is competent, and whether competency in one realm assumes competency in all others. The second is whether a provider is obligated to provide a service or intervention when the provider believes it is not the right thing to do.

Competency is a very difficult concept to define. (Competency is the legal term; decisional capacity is the term used in medical ethics.) Indeed, the notion of competency varies across and even within jurisdictions. There are legal scholars and ethicists who have devoted careers to this question, and still it is one that causes a great deal of moral distress. Applebaum and Grissom provide very helpful guidance, claiming that an individual has decisional capacity if s/he has:

- the capacity to understand relevant information;
- the ability to manipulate the relevant information rationally;
- the ability to reflect and make a judgment based on personal values and situation; and
- the capacity to freely communicate a decision.

In this specific case, one must question the patient's capacity to make the decision about artificial insemination for several reasons. First, given her level of cognitive development, as well as her previous history of accidentally killing a kitten, there is serious doubt whether she can fully understand information that is relevant to the decision to have a child. Does she understand the process of pregnancy and the prenatal care required? Does she understand giving birth and decisions related to the birthing process? Does she understand the needs of a newborn? Etc. This must be assessed. From the information provided about this patient, I do not believe that she has decisional capacity. I also doubt that the patient has the rational ability to consider information that is relevant to this decision and other decisions required in raising a child. If, for example, she concluded that the method she used to bathe the kitty was appropriate, one must seriously entertain the possibility that she might make the same kind of decision in caring for a child.

The inquirer makes a valid point about whether decisional capacity in one area of life implies decisional capacity in other or all areas of life. Most people who think about this issue believe that competency in one area does not necessarily entail competency in all other areas. For example, ability to handle one's business affairs does not necessarily mean that one has the decisional capacity to handle medical decisions (and, unfortunately for some of us, vice versa). Many also believe that even if one has decisional capacity to make one medical decision, it does not automatically follow that they have the capacity to make all medical decisions. Consider, for example, allowing a child to make a decision about whether to take cough syrup for a cold. One might say that the child has the decisional capacity to make this choice. Take a different

medical situation, for example, a bone marrow transplant for leukemia. According to the criteria stated above, the same child would obviously not have the decisional capacity to make this decision.

I would also argue that having the capacity to make decisions that only affect the patient should be held to a different standard if another party might be affected. As in the situation described in Question 2, one must consider any other parties that might be affected by the patient's decisions, particularly vulnerable parties. As this case involves another (potential) person, the assessment of decisional capacity should be stricter than if only the patient's life were in question.

Finally, a provider has no obligation to provide any service or intervention s/he feels is morally or ethically wrong, regardless of the competency of the client. We certainly have an equally strong obligation not to abandon any client. In certain circumstances (if you were, for example, an ICU physician or nurse taking care of a dying patient that you no longer thought should be on life-support, but the family insists), you have a strong obligation to find another provider if you no longer feel you can morally take care of a client. In most situations, however, such as deciding to have a child (which may be considered a lifestyle choice), the clinician has no further obligation than perhaps to provide a list of other caregivers who might be willing to provide the service in question.

4

A homeless man with AIDS dementia was kicked out of a nursing home for having unprotected, consensual sex with a developmentally delayed woman who had uncontrolled diabetes (very high blood sugar levels). They met and fell in love while both were residing in the nursing home (where it was very difficult to get contraceptives). The man proceeded to try to get the woman out of the nursing home, planning to take care of her. The Health Care for the Homeless project tried to help the couple stay together, but eventually had to break them up to keep both individuals alive, much to the dismay of HCH staff. How does one weigh the right to self-determination with the clinician's responsibility to keep patients alive?

Dr. Song: In general, Western bioethics dictates that autonomy trumps beneficence; in other words, the obligation to respect the self-determination of an individual—if that person is competent—overrides one's obligation to help that individual. We all know of cases when a person with decisional capacity refuses a medical intervention that absolutely, positively will help this individual, and it drives us crazy. If that person, through valid informed consent, refuses an intervention, however, we must honor his or her wishes. Informed consent, at the minimum, includes:

- determination of a patient's decisional capacity;
- sufficient disclosure of relevant, material information for the decision at hand;
- understanding on the part of the patient of that information;
- voluntariness, i.e., the lack of coercion or manipulation; and
- the ability to intend a decision.

As the courts have asserted, this is true even if the decision seems foolish or just bad.

What makes this case difficult is the determination of whether both parties are consenting. Thus, one must determine if the man with AIDS dementia has the decisional capacity to make decisions about his health and behaviors; the relevant information to make a decision about his health and personal behaviors; sufficient understanding of his condition, his prognosis, his infectivity, and so on; and is not coerced into making any decisions. The same would apply to the woman. In terms of sufficient disclosure of relevant

information, she needs to know his HIV status and what it means to her health. Dementia and developmental delays do not automatically render an individual incompetent or without decisional capacity. If this man's dementia and this woman's developmental delay are not so severe that they are considered to have decisional incapacity, then one must honor their wishes. As in any relationship, one must make a special effort to determine if coercion is present. However, if there is not full informed consent with both parties, then, yes, one has the obligation to intervene.

If both parties consent without coercion, their right to self-determination—even if harm results—overrides any obligation or right that you have to protect them. The only exception to this would be if harm were intended to oneself or another. Thus, one should attempt to discern whether the man intends to infect his partner, and, if this is the case, one has the ethical, and, in some jurisdictions, the legal obligation to keep him apart from her. Intent is very hard to discern, however, and if both individuals consent to unprotected sex (and the woman is aware of his HIV status), then one must honor their decision. One can attempt to improve the situation, however, through education, persuasion and harm reduction.

5

Another client with a history of several minor strokes refused warfarin/Coumadin (medication used to prevent blood clots from forming or growing larger) and his physician determined him competent to make that decision. Later, he left his apartment because of hallucinations and refused mental health care. Again, he was considered competent to make that decision. Subsequently, the patient set fire to a bag in the Greyhound Bus depot and was hospitalized involuntarily for refusing psychotropic medications (i.e., the competency determination was rescinded). How should clinicians weigh a patient's right to self-determination with the potential to endanger him/herself or others?

Dr. Song: There are several issues raised by this case. First, I would question whether the individual is competent or has decisional capacity. Most believe that simply having schizophrenia (the presumed diagnosis) or depression does not automatically mean that one does not have decisional capacity. The presence of hallucinations, however, which might alter his ability to make rational decisions about his health (imagine, for example, auditory hallucinations telling him that medications are filled with poisons), would raise questions about his decisional capacity.

Clinicians have both an ethical and a legal duty to protect potential third-party victims. When determining one's ethical obligations to protect others, one should take into account the considerations discussed in the first case involving CPS. The provider should first consider two questions: how likely is harm to occur, and what is the magnitude of that harm? If the harm is very likely and the suspected harm is great, then the obligation to protect the third-party is very strong. Other considerations to take into account are the identifiability of the victim (the obligation is stronger if the patient in question threatened an identified person), the effectiveness of intervening, and the burden of intervening on the patient.

For example, a patient of yours is found to be HIV positive. He refuses to tell his wife and says that he has a right to confidentiality. In this case, the likelihood of harm is great; the potential harm is great; the third-party victim is easily identifiable; and by intervening—telling the wife—you have a good chance of preventing this harm. Thus, the obligation to protect is great.

In the above case concerning the mentally ill patient, the likelihood that harm would occur was unclear at the outset. (Had he been violent in the past? Did he threaten anyone? Etc.) Nor was the magnitude of potential harm clear. (Did he talk about setting fire to a bag? Did he have a gun? Etc.) There was no clearly identifiable victim, either. Given the information provided by the inquirer, there appears to be no

obligation before the fire to prevent harm. Once the person demonstrated harmful behavior by setting the Greyhound depot on fire, however, it was correct to hospitalize him and subsequently to perform another assessment, taking into account the considerations listed above. In general, there is a strong obligation to protect others from harm, particularly vulnerable parties. This obligation diminishes if the harm is unlikely to occur, if the harm is of little magnitude, if the victim is not identifiable, or if there is no effective intervention.

PREVIOUS ASK THE EXPERT TOPICS COVERED BY THE HCH CLINICIANS' NETWORK

- Borderline Personality Disorder
- Homeless Children and Youth
- Safety in the Work Place
- Homelessness and Diabetes

The HCH Clinicians' Network developed this **Ask the Expert** column with support from the Health Resources & Services Administration. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.

©2004
Health Care for the Homeless Clinicians' Network
P. O. Box 60427 | Nashville, TN 37206-0427
615 226-2292 | www.nhchc.org