



# MID-ATLANTIC ETHICS COMMITTEE

## NEWSLETTER

A Newsletter for Ethics Committee Members in Maryland, The District of Columbia and Virginia  
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The *Mid-Atlantic Ethics Committee Newsletter* is a publication of the Maryland Healthcare Ethics Committee Network, an initiative of the University of Maryland Francis King Carey School of Law’s Law & Health Care Program. The Newsletter combines educational articles with timely information about bioethics activities. Each issue includes a feature article, a Calendar of upcoming events, and a case presentation and commentary by local experts in bioethics, law, medicine, nursing, or related disciplines.

**Diane E. Hoffmann, JD, MS - Editor**

## Expanding Clinical Ethics Beyond the Hospital



Should clinical ethicists be constrained to the hospital? Has the scope of the clinical ethics consultation been too limited? Clinical ethics consultation has traditionally been an institutional “service provided by an individual ethics consultant, ethics consultation team, or ethics committee to help patients, staff, and others resolve ethical concerns in a health care setting to improve health care quality by facilitating the resolution of ethical concerns” (Fox, et al., n. d.). Traditional clinical ethics focuses on individual patient-provider scenarios. The ethics consultant or committee usually only becomes involved far downstream of the root causes of the issue.

By the 1990s, clinical ethicists had realized they needed to do more. Clinical ethics as it was traditionally practiced was too limited. Often by the time the ethicist had been called in, the issue was more complex than if the ethicists had been involved sooner. Further, clinical ethicists were neglecting the “underlying causes of ethical conflicts, such as social and institutional structures” (Forrow, Arnold, & Parker, 1993). As a result, the same issues arose again and again.

Clinical ethics services therefore expanded their scope to include preventive ethics “to identify, prioritize, and address systemic ethics issues” (Fox, et al., 2010).

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Addressing these issues might include changing hospital policy or educating providers to address root causes of ethical issues. But no matter how deeply clinical ethicists investigated social and institutional structures to address systemic issues, they stopped at the doors of the hospital. Thus clinical ethics remains an internal service within the institutional system.

Is this enough?

If we acknowledge that the social/institutional structural factors of the hospital can cause ethical issues and that they should be addressed, we can acknowledge that social, economic, and ecological factors in the community can also lead to ethical issues in the hospital. Communication can break down over cultural taboos against receiving bad news. Poor parents forced to work multiple jobs may not have enough time to talk to a healthcare provider. A lack of public transportation may prevent a surrogate from coming to the hospital even if they have time. Ambiguity in legislation and guidelines over “ethically inappropriate” medical treatment or how to “reasonably accommodate” an objection to brain death can cause severe divisions between families and providers over the goals of care.

So why haven’t ethics consultants expanded their scope? Why not open the doors of the hospital and try to address these broader factors in the community?

In my recently published article (Kuperberg, 2019), I argue for a Community Ethics Needs Assessment (CENA). A CENA involves

using community-based participatory research methods to work with a community to both identify broader communal factors that cause ethical issues in the hospital and collaborate on addressing those factors.

This can work from the top down, where a committee within the hospital analyzes the ethical issues it’s facing using hospital data and brings potential issues to the community. Or, a CENA can start from the bottom up wherein members of the community notify hospitals of their concerns at a town-hall meeting. But, no matter the origins, a CENA requires a collaboration between the hospital and the community built on mutual trust and respect.

A collaboration founded on mutual trust and respect is important for several reasons. A CENA can be controversial: for example, a religious community may have moral or religious objections to goals of care regarding a terminal diagnosis. The community may believe that everything should be done to prolong life whereas doctors and nurses may feel strongly such patients should be in hospice. This can result in conflicts between community members and the hospital, and moral distress among staff who feel they are providing futile care for a dying patient. Addressing this through a CENA may be perceived as an inappropriate paternalistic overreach by a community if they feel the hospital is trying to impose the hospital’s values on the community. If the CENA involves a critique of a community’s culture, there may even be accusations of discrimination. These accusations

can be mitigated by having community buy-in to the project. Even more fundamentally, a CENA cannot work without a successful collaboration. A hospital cannot presume to have fully understood the factors within a community without hearing that community explain its issues in its own terms. Further, a community cannot be expected to passively accept the conclusions and suggestions of a CENA if they have not been part of and bought into the process.

Together, the hospital and the community can work together to address the broader communal

factors. This can involve educating providers on how to work around cultural taboos, finding alternative methods of communicating with parents that considers their busy schedule, improving transportation to the hospital, or even advocating for policy reforms to remove causes of conflicts in legislation and guidelines.

And where do clinical ethicists fit into all of this?

Clinical ethicists are ideally placed to understand how these social, economic, and ecological factors come to a head in the hospital.

They can help explain how these issues arise, how they manifest, and how often they occur. They can keep track to see if the CENA's proposals are successfully addressing ethical issues in the hospital. A CENA team does not have to exclusively consist of clinical ethicists, but clinical ethicists should be on the CENA team.

Clinical ethics consultation should not limit its scope to the doors of the hospital. It should open the doors, expand its horizons, and try to address the deeper roots of the issues confronted.

*Etan Kuperberg, MS, MA*

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# A Lawyer's Lens: Hot Topics for In-House Counsel at Health Care Institutions

On October 11, 2019, the Law and Health Care Program at the University of Maryland Carey School of Law hosted a roundtable event that welcomed in-house counsel and related staff from health care institutions across the country. The event was co-sponsored by the American Health Lawyers Association and the American Society for Health Care Risk Management. Several of the topics discussed are likely of significant interest to hospital ethics committees and are summarized below.

## Discrimination by Patients and Staff



At a number of hospitals, legal counsel report cases where patients request a physician or nurse of a different race, gender or ethnicity or, alternatively, staff request to be reassigned to a different patient because of the patient's racist or sexist behavior. It has been legally as well as ethically challenging to resolve these cases.

Roundtable participants Kimani Paul-Emile, Professor of Law

at Fordham School of Law and Karen Smith, Clinical Ethicist for the Henry Ford Health System, presented an organizational approach to dealing with bigoted patients who request that health care providers (HCPs) of a certain race, ethnicity or other grouping not care for them. The process involves training all staff to evaluate and respond to such requests similarly, guided by an algorithm (see Figure 1, p. 10). If the patient's health status is unstable, he or she should be treated. If not, the patient's decision-making capacity (DMC) should be assessed, and if the patient has DMC, the request should be evaluated to determine if it is ethically appropriate.

An example of an ethically appropriate request for a different health care provider is a man requesting to only see female HCPs due to a history of trauma from previous sexual abuse by men.

There is also data that racial concordance between a doctor and a patient leads to better patient outcomes. Some argue that a request based on such grounds should be honored while others argue that this is not a sufficient basis to change providers in an acute hospital setting.

An example of an ethically inappropriate request is a woman who requests that only "white American" doctors care for her without giving any other rationale.

Paul-Emile argues that ethically appropriate requests should be accommodated when possible to "enhance patient and employee well-being" (Paul-Emile, et al., 2016). Ethically inappropriate requests should not be accommodated, as staff are entitled to a safe and respectful work environment.

In those situations, the patient should be informed using a similar approach across patients involving scripted language (e.g., "All of our providers are well qualified to provide excellent care to meet your needs"), the impact of the encounter should be discussed with staff, and available options provided (including administrative discharge of the patient whose behavior is disruptive). Incident reports should be filed to allow for evaluation, follow-up, and tracking. (See the Case Study in this issue of the Newsletter [p. 10] for more information about how to respond to inappropriate requests for an alternative HCP).

Paula Neira, Clinical Director of the Johns Hopkins Center for Transgender Health, provided examples of how healthcare staff unfairly discriminate against transgender persons. One way is by denying care or services that an HCP could provide – for example, a Pap smear for a transgender man who has not had transmasculine gender confirmation surgery. Another is by not making an effort to accommodate the basic needs of



transgender persons, such as by training all staff how to be welcoming and using intake forms and procedures that match patients' needs. Another example of discrimination is when a health care organization justifies denial of services to transgender persons by pointing to a lack of sufficiently specialized experts.



While it is true that transgender persons need and deserve specialized care, there are not enough specialized HCPs to meet this need. Organizations should do their part to meet the needs in their community, particularly for vulnerable persons who have limited alternatives and are often targets for discrimination and medical neglect. Davis and Berlinger (2014) provide one example of how a safety net hospital in New York

addressed this issue by focusing on improving access to primary care services for transgender persons.

### **Vulnerable Patients and Difficult Discharge Issues**

Hospitals across the U.S. are confronting a growing problem with patients whose hospital stays last months and sometimes years due to lack of available discharge options. For example, estimates are that about 10% of University of Maryland Medical Center's (UMMC's) patients are homeless, and about one-third have housing instability (Cohn, 2019). This creates a conflict between ethical duties at the organizational level to promote patients' well-being and the fair allocation of limited resources. Some hospitals are exploring alternatives such as providing housing to homeless individuals. Baltimore City and ten local hospitals recently partnered to do just this, that is, to provide housing and "wraparound" services for 200 people and families who face difficult discharges due to housing instability. This involved renovating public housing units and getting federal approval to use Medicaid money for extra

support services.

Hospitals involved in this two-year pilot program are Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, UMMC-Downtown, UMMC-Midtown, Sinai Hospital, Mercy Medical Center, MedStar Union Memorial Hospital, MedStar Harbor Hospital, MedStar Good Samaritan Hospital and St. Agnes Hospital (Cohn, 2019). The "Circle the City" initiative replicates similar outreach efforts in other cities (see <https://www.circlethecity.org/>). Other challenging discharge issues discussed included patients with mental health problems and children whose parents fail to pick them up from the hospital.

### **Other "Hot Topics"**

Roundtable participants discussed several other "hot topics" facing in-house counsel at hospitals throughout the country. They included how to manage (and whether to allow) medical marijuana use in hospitals, how to deal with opioid prescribing in the era of opioid misuse and overdose, and legal concerns arising from hospital mergers and acquisitions, such as cybersecurity.

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# CASE PRESENTATION

*One of the regular features of this Newsletter is the presentation of a case considered in an ethics committee and an analysis of the ethical issues involved. Readers are both encouraged to comment on the case or analysis and to submit other cases that their ethics committee has dealt with. In all cases, identifying information about patients and others in the case should only be provided with the permission of the patient. Unless otherwise indicated, our policy is not to identify the submitter or institution. We may also change facts to protect confidentiality. Cases and comments should be sent to [MHECN@law.umaryland.edu](mailto:MHECN@law.umaryland.edu).*

## CASE STUDY FROM A HOSPITAL

*This case study and commentary are reprinted with permission from the AMA Journal of Ethics (<https://journalofethics.ama-assn.org>), “How Should Clinicians and Trainees Respond to Each Other and to Patients Whose Views or Behaviors Are Offensive?” by Cory D. Mitchell, D. Bioethics, MA.*

Mr. K. is a 75-year-old man who presents to the emergency department at a metropolitan teaching hospital after falling in his home. SM, a fourth-year medical student who self-identifies as African American, notes that Mr. K. is agitated, confused, holds a confederate flag handkerchief, and has a faded Aryan fist (a white supremacist symbol) tattooed on his arm. SM is on a team consisting of an attending physician and two residents. SM begins to interview the patient by asking, “Mr. K., can you tell me where you are?” Mr. K. turns to SM and shouts, “The ‘hood!”

“No, Mr. K., you are in the emergency department; you fell at home,” SM clarifies. Mr. K. frowns and then his eyelids flutter closed. SM approaches Mr. K., preparing to rock Mr. K.’s shoulder to check his consciousness, but then pauses, afraid of Mr. K.’s response. SM decides not to touch Mr. K. and leaves the room. Dr. T., the senior resident physician standing just outside Mr. K.’s room,

asks, “What’d you learn about this patient? Let’s go through the history.”

“Dr. T., I do not feel comfortable continuing Mr. K.’s physical exam,” reports SM.

“Why?” asks Dr. T. upon walking closer to Mr. K. Dr. T. spots Mr. K.’s handkerchief and tattoo, thinks, “Oh, I see”, and wonders what to do.

### Commentary from a Bioethicist

Although this case raises many ethical questions, [I] focus on one here: Should racist symbolism displayed by Mr. K. influence SM’s response to the patient? I will assume for sake of argument in this case that the patient’s tattoo expresses his current—not just his past—views on white supremacy, although it is worth noting that, in some cases, such an assumption could be worth questioning. In emergencies, a physician’s duty

to care should transcend his or her personal responses to racist symbolism and even take precedence over a patient’s expressed wishes in emergent situations (Paul-Emile et al., 2016). However, if a patient’s speech or behavior is threatening, the patient’s care may need to be transferred to another physician who does not challenge the patient’s preference for a racially concordant clinician. Hand off among clinicians, if time allows, should entail some sort of formal ethics consultation.



It is important to note that reactions by persons of color to racist symbolism and images imbued with hate are not chosen in the sense that one chooses the color blue over the color green.

Responses to racism tend to be visceral rather than intellectual. In this article, I argue that refusal to treat solely on the grounds of a patient's expression of bias is never morally justified. I suggest how affect labeling can be an effective way for an offended clinician to process and overcome a visceral reaction to offer superb care to a patient wearing symbols suggestive of the patient's assumption of racial superiority.

### **Decision to Treat and Affect Labeling as a Coping Strategy**

*Decision to treat.* Paul-Emile and colleagues (2016) have proposed a decision tree for use in emergency settings when a patient has rejected a physician on the basis of race. Following this decision tree, Dr. T. and SM should first assess Mr. K.'s medical condition. If the patient is unstable, they should treat Mr. K. regardless of a patient's racial bias because Mr. K. could be suffering from delirium, psychosis, or dementia; refusal to treat the patient in such cases is unacceptable because such a cognitively impaired patient is not responsible for his or her actions (Id.). However, I argue that once a patient is stable Dr. T. should recognize that repeated exposure to racial discrimination can result in a cascade of biopsychosocial sequelae for SM, including elevated blood pressure and cortisol, increased heart rate, hypervigilance, amygdala activation, aggression, risk of depression, and increased incidence of substance use or abuse (Mays et al., 2007), and thus [Dr. T.] should seek to intervene to the best of his ability. Appropriate intervention may entail requesting an ethics consult.



*Affect labeling.* However, some amelioration of the situation is within every clinician's grasp. One potential approach is to use affect labeling to get both SM and Mr. K. to put their emotions into words. Affect labeling is an evidence-based approach to regulating emotional states that can result from anxiety-producing stimuli (Torre & Lieberman, 2018). SM's reaction to the confederate flag handkerchief and Aryan fist tattoo suggests that SM is experiencing some degree of emotional distress. Likewise, Mr. K.'s response to SM (uttering that he's in "the hood") suggests that SM's presence is an emotional trigger for Mr. K. Clinicians faced with a patient's race-based bias must balance the ethical principles of respect for autonomy against the equally weighty principles of justice and nonmaleficence—not just for the patient, but for themselves and their fellow clinicians as well. In what follows, I suggest an approach to achieving such balance.

### **Strategies for Intervening**

*Affect labeling by the medical student.* When the situation permits, Dr. T. should address SM's feel-

ings by asking SM why he does not feel comfortable continuing Mr. K.'s physical exam. Based on my personal experience, I know that there are times in clinical settings when racist symbols or speech simply surprise us African Americans, and at times that experience is difficult to articulate—especially when a person of color is the clinician and the person implicitly or explicitly expressing racist attitudes is in need of care. Dr. T. can help SM navigate this role conflict by providing SM with affect labels such as shocked, surprised, upset, hurt, sad, confused, or angry. This type of affect labeling can modulate emotional, neural, autonomic, and behavioral responses to aversive stimuli (Burklund et al., 2014; Costafreda et al., 2008; Kassam & Mendes, 2013; Kircanski et al., 2012).

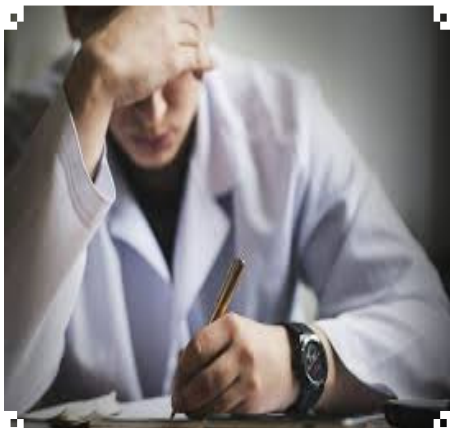
*Affect labeling by the patient.* Once Dr. T. has helped SM process and articulate his emotions, he can do the same with Mr. K. if necessary. In order to determine if affect labeling would be appropriate with Mr. K., Dr. T. should request a psychological consult to assess Mr. K.'s cognitive state and any potential barriers to following a treatment plan, such as adverse life experiences or refusal to follow an African American's instructions. If the patient is not opposed to being treated by SM or is cognitively impaired, affect labeling may not be appropriate. However, if Mr. K. expresses a desire not to be treated by SM, Dr. T. can help Mr. K. connect his emotions to his experience and thereby reduce his anxiety. For instance, Dr. T. could say, "When SM is in the room, how does that



make you feel? So how does it feel when I tell you that SM is one of our finest physicians and that he is capable of providing you with excellent care?” Dr. T. could have an initial conversation with Mr. K. in order to accomplish this goal. However, a subsequent conversation should take place with Mr. K., Dr. T., and SM together in order to facilitate trust, dialogue, and learning. The rationale for this approach is to give both the patient and the clinician a chance to process and reconcile negative emotions in a way that is safe and conducive to healing for all involved parties. Eventually, one would expect SM to handle situations like this one on his own, so Dr. T. must be explicit with SM about what he is doing pedagogically.

## Organizational Responses

Racial discrimination is detrimental to communication in health care relationships (Hausmann et al, 2011). Whenever and wherever communication breaks down, care is undermined (CRICO Strategies, 2015). Thus, health care organizations have ethical and operational responsibilities to facilitate communication across all levels of the organization.



*Affect labeling via expressive writing.* In order to facilitate communication in situations like this case scenario, policies for dealing with patient bias in clinical encounters can be helpful. Medical schools and teaching hospitals are especially well equipped to help medical students and residents learn protective practices, such as expressive writing in response to bias incidents (Cowen et al., 2016). These institutions could require that students write about their emotions in response to people or symbols that are racist or threatening as a means of affect labeling. Fifteen to twenty minutes of expressive writing about disturbing events over a few sessions has been shown to result in long-term reduction of harmful symptoms stemming from adverse emotional responses to noxious stimuli (Baikie & Wilhelm, 2005). Medical education would be greatly enhanced if all stakeholders’ experiences of bias could be reported and evaluated, perhaps through an expressive writing exercise that could be submitted to a staff bioethicist, for example, for consideration and response. Specifically, the staff bioethicist could evaluate whether and how the clinician or student connected his or her emotions with the experience of emotional threat induced by symbolic communication or other expressions of discrimination.

*System-wide use of affect labeling.* All clinicians should be taught to respond to racist symbolism through ameliorative practices such as affect labeling. Affect labeling heals through communication and dialogue—through language—which can build a better health system. Affect labeling is one way of increasing psychological safety in situations that are emotionally laden but morally ambiguous due to the conflict between the fundamental, overarching duty to treat and the principles of respect for autonomy and justice as they apply to clinicians as well as patients. Because of the potency of this intervention, all clinicians should be able to engage others in affect labeling. This practice can take place among clinicians themselves, between clinicians and patients, or between clinicians and other staff members as needed. So Dr. T. should be trained in and highly supportive of this approach to emotional regulation for the benefit of SM as well as Mr. K. Dr. T. is also well positioned to mediate discussions between SM and Mr. K. It is through safe encounters with others that we grow as persons (Chuwa, 2014). A health system that fosters such dialogue is better prepared to care for its own clinicians as well as patients.

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# Bioethics Programs at Yale University



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# Commentary From a Hospital Bioethicist

In our institution, the situation described in this case study would be evaluated following our policy regarding patient bias. We began development of this policy in January 2017 shortly after the Paul-Emile, et al. (2016) article "Dealing with Racist Patients" was published and we attempted to operationalize that model. It has taken until October 2019 to fully establish the policy and conduct the necessary training to ensure its consistent implementation. The policy includes many of the steps

and discussions that have been promoted by others including those made by Neuberger (1999), which include clearly informing the patient when they are being offensive and that such behavior is unacceptable in a healthcare setting. The case of Mr. K. and SM above is far from unusual—as reported by Paul-Emile (2019, p. 514), “frontline workers, (including residents) are more likely to be targets of patient bias than attending physicians. Recent studies show that 93% of trainees have

experienced disruptive patient behavior, including racial bias, and 63% have been the object of discriminatory verbal abuse.” Thus, it is important to have a consistent and supportive response to show that although we take patient rights seriously, we also take patient responsibilities to not impart intentional harm to our employees seriously. Providers at our institutions would take the following steps of our organizational algorithm when patients request alternative caregivers. (See Figure 1).

**Requests for Reassignment of Healthcare Providers Algorithm**

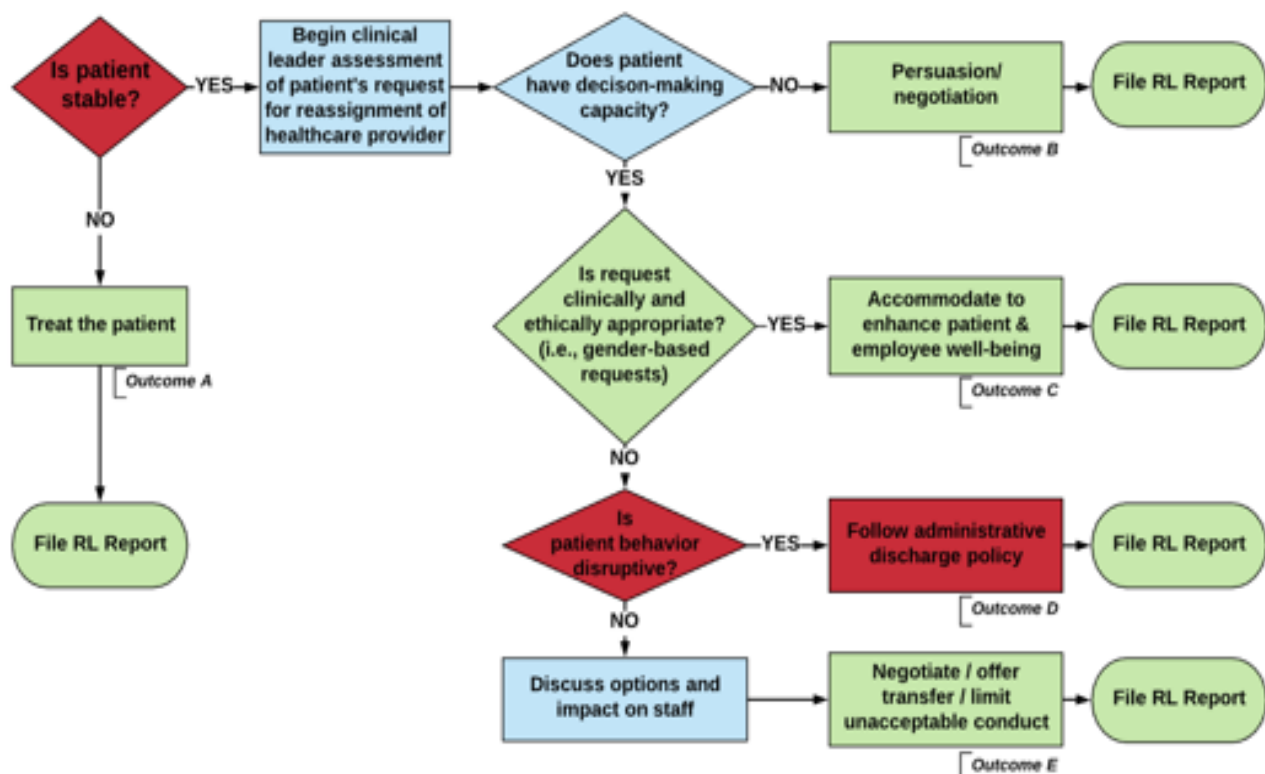


Figure 1

Our process begins by first alerting a clinical leader of the offensive behavior of a patient toward a member of our healthcare team. This step was taken by SM or immediately observed by her Senior Resident Dr. T. who would have responsibility to act. Dr. T., as the clinical leader in this case, is responsible for assessing if the patient is medically stable. I assume that Mr. K. is otherwise clinically stable in this situation. If the patient were unstable we would continue to treat the patient based upon EMTALA regulations, regardless of his offensive behavior, until he is stabilized.

The next step is to evaluate the patient's capacity. The case states Mr. K. "is agitated and confused" so we are left unclear as to whether he is confused but easily redirected or reoriented or if he is perhaps suffering from advanced dementia and unable to self-regulate. This clinical determination marks an important decision point in how we ought to continue to address this issue. At this point, SM as a Resident, could continue to follow the policy algorithm or notify his Attending physician, who has final patient authority to continue to evaluate which actions are appropriate in this situation. For the purposes of example, let's assume that SM is familiar with the policy and comfortable moving forward without escalation to the Attending physician.

If Mr. K. is found to be lacking decision-making capacity and/or the ability to self-regulate his behaviors due to dementing illness, then we would attempt to utilize persuasion and negotiation to



moderate his objectionable behaviors, perhaps involving his family members to assist in controlling his verbally offensive language, and we would continue to treat him. An additional step at this juncture is to evaluate SM's emotional well-being and willingness to continue to personally treat this patient. It might be that SM was feeling so threatened or intimidated that to support SM's well-being we would attempt to change care providers to another team member. It might also be that once aware that the patient was suffering from dementia and that his family was horribly embarrassed by his "old-South and awful beliefs," SM would be willing to continue. Often family will state a willingness to attempt to persuade patients to stop offensive behavior.

If there were no available family members, we would utilize staff to attempt to limit or eliminate the patient's offensive language by repeated reminders that this was unacceptable. We would still provide care, whether SM agreed to continue or another team member took over, based upon the patient lacking capacity to alter his behavior. The other team member may or may not be someone who meets the characteristics that Mr.

K. requests. Care must be utilized to ensure that the conversation with SM is focused on supporting him as our employee, confirming the patient's behavior as unacceptable, and determining SM's honest evaluation of his own comfort in continuing to treat Mr. K. In the end, in this situation, if Mr. K.'s agitation increases we may attempt to find a care provider who meets his requests in order to limit his agitation and staff disruption, but that may not be possible.

Were Dr. T. to find that although momentarily confused, Mr. K. did have decision-making capacity and he stated that he did not want treatment by SM due to his racial beliefs or he continued to make offensive statements, there would be another path to follow. Dr. T. is then responsible for asking Mr. K. some open-ended questions to further understand his request not to be treated by SM. He might ask, "Mr. K., can you tell me more about your request to not have SM provide your treatment? I am wanting to better understand, to see if we can meet your request." If indeed, Mr. K. admits being a life-long white supremacist who refuses to submit to care under any non-white doctor, then a different conversation would follow.

The patient would then be informed by Dr. T. that "It is not the policy of our institution to change providers based upon any specific personal characteristic [such as race or whatever is found objectionable by a patient]. All of our providers are well qualified to provide excellent care to meet your needs." Mr. K. would then be given the option to: (1) alter his

current behavior and accept any qualified healthcare provider assigned to meet his specific health needs; (2) attempt to transfer to another facility; or (3) leave against medical advice (AMA). The ethical point is that although all patients have the right to refuse even life saving medical treatment, there is no corresponding right to demand a particular type of provider if a qualified professional has already been assigned to provide the needed care. In fact, the misperception that such a right exists, and the willingness of some healthcare institutions to give into these demands, has contributed to legal discrimination cases (Ridley, 2014) as well as emotional distress and burnout.

The final step would be to determine whether or not the patient's behaviors are disruptive. It may be that after this discussion, staff determine that Mr. K. is not disruptive, and that intermittent agitation and confusion were leading to his offensive remarks. Although the patient will likely not ultimately change his biased beliefs, he will hopefully agree to keep his

thoughts and words to himself during his hospital stay.

As a professional, SM might also simply state that he would like to be reassigned to another patient and have another health care provider take over. However, there is no reason to then assume that it will be a provider of Mr. K.'s liking, as it will simply be the next available provider who meets the level of training required to treat Mr. K. If he objects to a new provider, the process may start back at the beginning. Thus, efforts to negotiate for acceptable behaviors, place limits on unacceptable behaviors, or continue to offer transfer may still be an option if the patient is not disruptive to staff and there is an evaluation that his impact is not hurtful to those involved. Again, there is not one absolute final response since personal evaluation of emotional harm varies. Some HCPs may honestly report that they are not bothered by a patient's remarks, while others may be deeply offended. If Mr. K. cannot or will not alter his offensive behaviors, remains stable, and has capacity,

then Risk Management will be advised. Once Risk Management is informed, the Administrative Discharge process will be evaluated as potentially in the best interests of advancing our staff needs while allowing Mr. K. his right to refuse the qualified professional services that we have offered to meet his current health care needs.

As one can see, there is not a "one size fits all" answer to the question of what to do about patient bias. It requires sensitive evaluation of the nature of the bias (was it subtle or egregious?) to determine the appropriate response, which may involve the use of persuasion, administrative discharge, or something in-between. I have addressed only one case with a couple of variable pathways through our organizational algorithm. We will continue to evaluate our process in addressing these sorts of issues by tracking them through the radial logic systems in our algorithm and making improvements in our process as needed.

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## REFERENCES

- Neuberger, J. (1999). Ethical dilemma: Dealing with racist patients. Commentary: A role for personal values and management. *BMJ*, 318-1130.
- Paul-Emile, K., Smith, A.K., Lo, B., & Fernández, A. (2016). Dealing with racist patients. *N Engl J Med*, 374(8), 708-711.
- Paul-Emile, K. (2019.) How should organizations support trainees in the face of patient bias? *AMA J Ethics*, 21(6), E513-520.



# CALENDAR OF EVENTS

## FEBRUARY

**5-7**

Evolving Clinical Ethics: A Working Unconference, sponsored by Baylor College of Medicine Center for Medical Ethics and Health Policy, Houston, TX. Visit: <https://www.bcm.edu/centers/medical-ethics-and-health-policy/clinical-ethics/unconference>.

**20-23**

29th Annual Association for Practical & Professional Ethics (APPE) International Conference, Atlanta, GA. Visit: <https://appe-ethics.org/annual-conference/>.

## MARCH

**5-6**

Annual John Collins Harvey Lecture & 7th Annual Pellegrino Symposium: In Celebration of Dr. Edmund D. Pellegrino's 100th Birthday, Georgetown University, Washington, DC. Visit: <https://clinicalbioethics.georgetown.edu/pellegrinoseminarandharveylecture/#>.

**5-7**

Conflict Resolution and Clinical-Setting Mediation for Healthcare, sponsored by the Center for Conflict Resolution in Healthcare LLC, Memphis, TN. Visit: <https://www.healthcare-mediation.net/trainings.html>.

**9-10**

Biotechnology and the Future of Medicine, sponsored by Harvard Medical School's Center for Bioethics, Boston, MA. Visit: <https://bioethics.hms.harvard.edu/annual-bioethics-conference>.

**20-21**

Fifth Annual Reproductive Ethics Conference, sponsored by the Alden March Bioethics Institute. Albany, NY. Visit: <https://imgssl.constantcontact.com/letters/images/sys/S.gif>.

**26-27**

Seventh National Nursing Ethics Conference 2020, Los Angeles, CA. Visit: <http://ethicsofcaring.org/registration/>

**27**

Debates, Decisions, Solutions: 28th Annual Ethics Program Conference, sponsored by the Florida Bioethics Network, Miami, FL. Visit: <https://fbn.miami.edu/conferences/forthcoming-conferences/index.html>.

### **March 31-April 3**

The 16th Annual International Conference on Clinical Ethics & Consultation: Beyond Borders: Exploring new frontiers. Spier Estate, Stellenbosch, South Africa. Visit: <https://www.bcm.edu/centers/medical-ethics-and-health-policy/clinical-ethics/unconference>

## CALENDAR OF EVENTS (Cont.)

### APRIL

2-3

Sim Lab Workshop in Pediatric Bioethics Consultation, sponsored by Children's Mercy, Kansas City, MO. Visit: <https://www.childrensmercy.org/> (search "sim lab").

17-18

What's in a Word: Exploring the Multiple Meanings of Humanism in Contemporary Healthcare and Health Professions Education, Creating Space 10, Vancouver, British Columbia. Visit: <http://health-humanities.com/cfp-creating-space-x-vancouver-april-17-18-2020/>.

20-24

Intensive Bioethics Course, sponsored by Houston Methodist Hospital and The Center for Medical Ethics and Health Policy at Baylor College of Medicine, Houston, TX. Visit: <https://www.bcm.edu/centers/medical-ethics-and-health-policy/education/bioethics-intensive-course>.

### MAY

28-29

UAMS Intensive Workshop in Healthcare Ethics & Humanities: Moral Distress. Little Rock, AR. Contact: [humanities@uams.edu](mailto:humanities@uams.edu).

## RECURRING EVENTS

Johns Hopkins Berman Institute of Bioethics Seminar Series, either at Johns Hopkins Hospital (1800 Orleans St., Baltimore, MD) Zayed 2117 or Chevy Chase Auditorium, 12N-1:15PM (unless otherwise noted) or Bloomberg School of Public Health Feinstone Hall (615 N. Wolfe Street, Baltimore, MD).  
Visit: <https://bioethics.jhu.edu/news-events/events/seminar-series/>.

**January 27:** “Healthcare Architecture: A Moral Imperative,” Diana Anderson, MD, ACHA, Healthcare Architect, Geriatric Medicine Fellow, University of California, San Francisco (Zayed).

**February 17:** “Recovering Inside? Ethical and Policy Challenges in Correctional Behavioral Health Care,” Dominic Sisti, PhD, Director, Scattergood Program for the Applied Ethics of Behavioral Health Care, University of Pennsylvania (Feinstone).

**February 24:** “Identifying and Assessing Barriers to Equitable Postpartum Sterilization,” Kavita Shah Arora, MD, MBE, MS, Assistant Professor of Reproductive Biology and Bioethics, Case Western Reserve University (Zayed).

**March 9:** Moral Distress: A Time for Hope? Alisa L. Carse, PhD, Associate Professor of Philosophy and Faculty Affiliate, Kennedy Institute of Ethics (Zayed).

**March 30:** Can agriculture save the planet before it destroys it? Jack A. Bobo, CEO, Futurity (Feinstone).

**April 13:** Can the Researcher-Participant Relationship Ground Ancillary-Care Obligations? Henry Richardson, JD, MPP, PhD, Professor of Philosophy at Georgetown University and Senior Research Scholar at the Kennedy Institute of Ethics (Feinstone).

**April 27:** Title TBD, Lisa S. Parker, PhD, Professor and Director, Center for Bioethics & Health Law, University of Pittsburgh (visit website for topic & location).

**May 11:** Applying Rigor to Data Collection in Machine Learning: Considerations in Fairness, Accountability, Transparency and Ethics, Timnit Gebru, PhD, Technical co-lead of the Ethical Artificial Intelligence Team, Google (visit website for location).

**The Law & Health Care Program  
Maryland Healthcare Ethics  
Committee Network  
University of Maryland  
Francis King Carey School of Law  
500 W. Baltimore Street  
Baltimore, MD 21201**

*The Maryland Healthcare Ethics Committee Network* (MHECN) is a membership organization, established by the Law and Health Care Program at the University of Maryland Francis King Carey School of Law. The purpose of MHECN is to facilitate and enhance ethical reflection in all aspects of decision making in health care settings by supporting and providing informational and educational resources to ethics committees serving health care institutions in the state of Maryland. The Network attempts to achieve this goal by:

- Serving as a resource to ethics committees as they investigate ethical dilemmas within their institution and as they strive to assist their institution act consistently with its mission statement;
- Fostering communication and information sharing among Network members;
- Providing educational programs for ethics committee members, other healthcare providers, and members of the general public on ethical issues in health care; and
- Conducting research to improve the functioning of ethics committees and ultimately the care of patients in Maryland.

MHECN appreciates the support of its individual and institutional members. MHECN also welcomes support from affiliate members who provide additional financial support.

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