The Evolving Legal and Ethical Landscape for COVID-19 Vaccination Mandates for Healthcare Workers

The State of Vaccine Mandates in Maryland

Since the Spring Issue of this newsletter, in which we published “Legal and Ethical Considerations for COVID-19 Vaccination Mandates for Healthcare Workers,” there have been major developments in the status of the COVID vaccines. At that time, all available vaccines were under an Emergency Use Authorization (EUA). Now, one of the vaccines has been fully approved by FDA. Additionally, due largely to the Delta variant and a spike in cases, there has been a shift from initial reluctance to implement employer vaccine mandates even in healthcare settings to widespread, if somewhat hesitant, adoption of such tactics. Some of the earliest mandates began with health care institutions and the number and scope of such mandates have since been greatly expanded, both voluntarily and by Executive Order. Mandates have now been implemented at private companies from tech giants to companies with as few as 100 employees. While such mandates have often been commended by public health experts and large professional organizations representing health care workers (HCWs), some legal and ethical concerns linger.

Vaccine Mandates for Healthcare Workers in Maryland and Nationwide

In June of 2021, the Maryland Hospital Association (MHA) released a “Consensus Statement” announcing that the state’s sixty hospitals and health systems had decided “to require all employees and clinical
team members to be vaccinated against COVID-19,” a move the MHA endorsed. While lauding the safety and efficacy of the available vaccines, the statement also highlighted health care workers’ obligations to patients, with Bob Atlas, President and CEO of the MHA, stating that “[t]his consensus demonstrates hospitals’ commitment to caring for their communities and fulfills their promise to put patients first.” Following this announcement, major medical systems began setting concrete deadlines for vaccination, with University of Maryland Medical System (UMMS) and Johns Hopkins Medicine requiring that all personnel be vaccinated by the end of the summer of 2021. Despite this seeming consensus, some Maryland health systems resisted putting such mandates in place immediately, or decided to wait until the vaccine was fully approved by FDA.

In July, the Department of Veterans Affairs (VA), which has over 25 clinical care locations in Maryland, became the first federal agency to announce that COVID-19 vaccines would be mandatory for its health care personnel working in, visiting, or providing care to VA facilities or patients. VA Secretary Denis McDonough noted the endorsement of mandated vaccinations by many medical organizations, including the American Hospital Association and American Medical Association, and that in the weeks immediately preceding the decision, the VA lost four employees to COVID-19 and had suffered at least three outbreaks among unvaccinated employees and trainees during the course of the pandemic.

In August, Maryland Governor Larry Hogan mandated the immunization of all HCWs statewide, requiring all nursing home and hospital workers in the state to obtain a COVID-19 vaccine or be subjected to regular testing. Given the stagnating vaccination rates over the summer and recent surges in transmission of and serious illness caused by the Delta variant, mandates have expanded beyond the health sector. In September, President Biden expanded the federal mandate to cover all federal employees, and directed the Occupational Safety and Health Administration (OSHA) to develop a rule and issue an Emergency Temporary Standard requiring “all employers with 100 or more employees to ensure their workforce is fully vaccinated or require any workers who remain unvaccinated to produce a negative test result on at least a weekly basis before coming to work.” According to the White House, “this requirement will impact over 80 million workers in private sector businesses with 100+ employees.”

**Legal and Ethical Implications of Vaccine Mandates**

In their piece in the Spring 2021 Mid-Atlantic Ethics Committee Newsletter, Brian Hutler and Rachel Gur-Arie stated that “there are significant ethical and legal concerns about mandating a vaccine that is still under an Emergency
Use Authorization (EUA). So long as there remains significant uncertainty about the risks of the vaccines, mandates seem difficult to justify.” In August 2021, the landscape for vaccine mandates changed significantly, with the full approval of the Pfizer-BioNTech COVID-19 Vaccine, marketed as Comirnaty. Nonetheless, vaccine mandates may still face legal hurdles and pose ethical concerns.

Legal and Political Challenges

Litigation involving employer vaccine mandates is ongoing, with challenges continually being brought by a variety of workers in numerous industries, from airlines to law enforcement. However, some private mandates have survived legal challenges, and as of late September, there has yet to be a successful challenge brought by HCWs. For example, in Texas, a lawsuit brought by hospital workers against Houston Methodist Hospital in response to its vaccination requirement was dismissed in June, and more than 150 unvaccinated employees resigned or were terminated later that month. In another instance, employees who had sued Henry Ford Health System, alleging its vaccine mandate was unconstitutional, dropped their suit the day after President Biden’s announcement that healthcare workers must be vaccinated. Nonetheless, it is likely that legal challenges will continue to arise. In Maryland, for example, in mid-September, students and employees sued the University System of Maryland for its vaccine mandate. In addition to facing litigation, some employers may also face employee resistance or departures, as well as pressure from local governments.

Ethical Imperatives and Concerns

Hutler and Gur-Arie noted that HCWs have historically been “among the most hesitant populations towards occupational vaccines, such as the seasonal influenza vaccine,” and that such hesitancy is a public health concern. They assert that HCWs are not only in frequent, direct contact with immunocompromised patients, but are also influential in swaying members of the public with regards to vaccination. These concerns have only been amplified since the spring, and these shifting circumstances may have been the reason policies and public sentiment have shifted in favor of vaccine mandates, especially for HCWs. The full authorization of the Pfizer vaccine, as discussed above, is just one factor. The rise of the Delta variant and its subsequent strain on an already overburdened health system, especially in areas with low vaccination rates, also provides a powerful ethical argument in favor of limiting the spread of the virus through increasing vaccination, especially among HCWs. Weighed against those important concerns, at the time, was the EUA status of all COVID vaccines. While this is no longer a relevant critique of mandates, as noted above, other outstanding concerns raised by Hutler and Gur-Arie remain.

Hutler and Gur-Arie also highlighted the legal and ethical imperative for employers to provide reasonable accommodations, such as those required by the Americans with Disabilities Act (ADA), as well as preventing religious discrimination prohibited under Title VII of the Civil Rights Act of 1964. Notably, since that piece was published in this newsletter, the Equal Employment Opportunity Commission (EEOC), which enforces these and other workplace anti-discrimination laws, provided updated “technical assistance on vaccinations” in May of 2021 stating unequivocally that “the federal EEO laws do not prevent an employer from requiring all employees physically entering the workplace to be vaccinated for COVID-19, subject to the reasonable accommodation provisions of Title VII and the ADA and other EEO considerations.” Balancing policies to ensure adequate medical and religious exemptions, while not permitting spurious or overbroad exemptions to violate the intent of such mandates, may prove difficult, but is likely possible.

One final ethical issue Hutler and Gur-Arie raised was “the disproportionate impact that a vaccine mandate may have on HCWs who are members of a minority racial or ethnic group,” given the “distrust of Black Americans in medicine is rooted in a history of oppression, exclusion, and exploitation evidenced throughout U.S. history, and specifically within

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American medicine.” The authors note both legal and ethical problems with such an impact. State data from July show that there remained a lingering racial gap, with only 22.4% of fully vaccinated Marylanders being Black, despite the fact that African Americans make up 31.1% of the state population. Some experts have argued that “lack of access is the main barrier to better vaccination rates -- not vaccine hesitancy,” although such hesitancy clearly persists among HCWs of color.

Despite the legal challenges and ethical concerns raised by mandatory vaccination of HCWs, new vaccine mandates have been put in place as COVID-19 continues to mutate and transmit at a high rate. Some mandates that have recently gone into effect, such as those in New York, seem to have had some initial success with increasing vaccination rates among HCWs, though labor shortages caused by employee departures remain a real concern. When employers choose to move forward with such requirements to protect their workforce and the public, it is crucial that they be aware of likely pushback from employees and politicians. Such employers must also remain vigilant about the various legal and ethical considerations, such as ensuring necessary carve-outs for valid and genuine medical and religious exemptions and making all efforts to minimize or eliminate any disparate impact of such mandates.

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3Messenger, H. (2021, August 3). From McDonald's to Goldman Sachs, here are the companies mandating vaccines for all or some employees. https://www.nbcnews.com/business/business-news/heres-are-companies-mandating-vaccines-all-or-some-employees-n1275808
6Path out of the Pandemic: PRESIDENT BIDEN'S COVID-19 ACTION PLAN. https://www.whitehouse.gov/covidplan/
11Id.
12See supra note ii.


9See supra note iv.

10See supra note vi.

11Id.


25The judge dismissed the suit’s claims that employees were being unlawfully forced to take “experimental and dangerous” vaccines as “false, and… also irrelevant” and noted that “market reaction is consistent with public policy. The Supreme Court has held that (a) involuntary quarantine for contagious diseases and (b) state imposed requirements of mandatory vaccination do not violate due process.” https://int.nyt.com/data/documenttools/houston-methodist-court-ruling/3468984fc566cea5/full.pdf See also https://www.nytimes.com/2021/06/13/health/houston-hospital-vaccine-mandate-lawsuit.html


37I.e. race discrimination under Title VII.

38One study of 10,871 HCWs from two “large academic hospitals found that, compared with White HCWs, vaccine hesitancy was increased nearly 5-fold among Black HCWs, 2-fold among Hispanic or Latino HCWs, and by nearly 50% among Asian HCWs and HCWs who were members of other racial/ethnic groups.” Momplaisir FM, Kuter BJ, Ghadimi F, et al. Racial/Ethnic Differences in COVID-19 Vaccine Hesitancy Among Health Care Workers in 2 Large Academic Hospitals. JAMA Netw Open. 2021;4(8):e2121931. doi:10.1001/jamanetworkopen.2021.21931


See also
Introduction

Vaccines represent one of the most effective 20th century advances for human health and welfare, and routine vaccination is overwhelmingly safe and effective (WHO Europe 2017, WHO 2021). Nonetheless, some individuals and groups remain hesitant to consent to vaccination, or flatly refuse vaccination, whether routine or emergency (Smith et al. 2015, Dubé et al. 2018, Lin 2021). It is unlikely that better evidence or improved and targeted communication will change the minds of those in the latter group, but inspiring those in the ‘moveable middle’ to overcome their hesitance and get vaccinated would make a significant impact on vaccination rates and public safety. The moveable middle is the large and diverse collection of individuals who have vaccine questions but who are open to changing their minds based on the advice of a trusted healthcare professional (MacDonald et al., 2021). Faced with obstinately hesitant or refusing individuals, physicians may have to:

- expend extra clinical time to discuss real and perceived risks, and sometimes dispel unfounded fears or exaggerated harms;
- undertake costly organizational steps to alleviate the risk to other patients in the waiting room posed by the unvaccinated;
- navigate interpersonal conflict or hostility arising from positional or ideologically-driven vaccination discussions.

Confronted with these additional burdens, some (busy, exhausted, or under-pressure) family physicians simply dismiss refusers and their families from their practice (Li 2012, Hough-Telford et al. 2016, Guido 2017, MacDonald et al. 2019). While this ‘nuclear option’ is potentially the easiest approach for the physician, it is—for moral, ethical, and professional reasons—absolutely the wrong approach. After outlining some of the parties’ relevant rights and duties, I argue that a better approach is represented by following seven steps in the physician/patient interaction.

The Broad Legal Context

It is important to acknowledge that in many jurisdictions, including across Canada and the USA, individual autonomy is the foundation of clinical care, and the right, under normal circumstances, to choose between offered medical treatments, or to refuse treatment, is robustly upheld. Whether material information about the risks of refusing treatment must be provided in order to validate that refusal has not been extensively considered, but court cases from both jurisdictions have confirmed a physician’s duty to disclose risks of foregoing a recommended medical treatment. In the USA, see In re Storar (1981) 52 NY 2d 363 (CA), and Cruzan v Director, Missouri Department of Health (1990), 497 US 261 (USSC). In Canada, see Reibl v Hughes, [1980] 2 SCR 880, and Hollis v Dow Corning Corp., [1995] 4 SCR 634.

Of course, matters become more complicated when those lacking capacity or legal competence are involved. When minors, for example, do not yet possess the legal right or ability to choose or refuse treatment, parents or guardians must choose on their behalf, but under most child protection laws, that decision must support the child’s ‘best interests’. Given the rights of children to protection and to adequate healthcare, and given the proven utility of vaccination to individuals and communities, North American children might expect to benefit from immunization, and parents should have to meet a high threshold in making a case that vaccination is not in the child’s best interests. When parents fail to take appropriate decisions for their children, or
are in conflict over the decision to take, public bodies and courts will ascertain and advance the best interests of the child.

At the centre of this conflict will be the family physician, who may (reluctantly) bear the responsibility—based on his or her duties to the minor patient—to initiate the process that leads to a court decision, for physicians owe both legal and ethical duties to all their patients. This duty arises from the physician’s legal responsibilities as a fiduciary of the patient. Under a fiduciary relationship, one party pledges to act in the best interest of the other, and the fiduciary’s obligations include loyalty, utmost good faith, and avoidance of conflicts of interest. The duty also arises from the physician’s professional and ethical responsibilities, which are often set out in a code the breach of which can result in disciplinary proceedings and loss of licensure.

Physicians who fail to provide sufficient information regarding the health-supporting and morbidity-reducing potential of vaccination, and who fail to ensure that those recommendations are clearly understood by the patient may therefore be in breach of multiple duties.

Dismissing Patients

Once the physician/patient relationship has commenced, physicians are typically bound to render ongoing medical services, though this obligation is not absolute. In the U.S. and Canada, Codes of Ethics and laws or rules of governing regulatory bodies generally require that physicians continue to treat a patient until: (1) services are no longer required or wanted; (2) care is transferred to another physician; or (3) the patient is given reasonable notice of the intent to terminate the relationship. They also prohibit, as discriminatory, dismissals based on religious, gender, sexual orientation, or political opinion or affiliation reasons.

All told, dismissal may be viewed as a breach of several ethical principles core to the physician’s role, including:

- Patient Autonomy: Physicians must accommodate patients’ right to refuse treatments, subject to best-interests considerations (where they are relevant) and legal mandates. Dismissal based on diverging views of immunization could be characterized as indefensible abandonment.

- Beneficence and Non-Maleficence: Physicians must act in the interest of their patients, doing good and minimizing harm. Dismissal undermines the duty owed to the patient, which duty persists even in the face of divergent beliefs, values, and attitudes.

- Solidarity: Physicians must stand with their patients, bearing costs for them and advocating for them. Dismissal undermines that solidarity, leaving high-risk patients particularly vulnerable. Indeed, solidarity with minors can appropriately serve to counterbalance the parents’ autonomy, offering the physician tools and justifications for intervention.

- Justice: All individuals should have access to adequate care regardless of their circumstances or views. Dismissal infringes the principle of distributive justice both directly by impeding equitable access to healthcare, and indirectly by shifting the clinical burden of treating that patient/family to others (who choose not to dismiss for refusal).

Ultimately, once the physician/patient relationship has been created, the starting point for physicians should be to strongly recommend immunization. When confronted with hesitance or refusal, these moral considerations should compel physicians to work sensitively and patiently with patients to reach that goal (i.e., to lead the patient to a vaccine-accepting stance).

Encouraging Vaccine Acceptance

Of course, this is not a simple feat, particularly when the issue is complex, subject to misinformation and disinformation, and polarizing. To help themselves, and their patients, physicians might adopt the following strategy (Harmon et al. 2019):

1. Avoid: While vaccine refusers can be frustrating to counsel, confrontational or positional debates, overly strong or strident messaging, and pressure-tactics should be avoided as they can entrench vaccine-negative views. Collegial and motivational interac-
tions can be woven into a routine visit with only a small increase in time.

2. Accept: Refusers should be accepted as autonomous persons deserving dignity. It is important to let them know that, regardless of their decision, their opinions are valued and are not being rejected outright. In family settings, the child is the patient of concern, and there is no basis for rejecting that patient.

3. Affirm: Acknowledge that parents and guardians have good intentions toward the minor or incompetent, and that this is a source of common ground. This affirms that all parties want the subject to be safe, healthy, and happy, and it builds trust, allowing for further (and more persuasive) conversations.

4. Active: Never assume or guess why the individual is refusing immunization. Instead, actively listen and ask them about their worries regarding vaccination, and about their understanding of disease risks and vaccine benefits; attempt to understand the values which inform the refusal, and correct misconceptions.

5. Advise: Physicians are often trusted advisors, well-positioned to remind individuals that not making a decision about immunization is itself a decision (i.e., correct the ‘omission bias’). Advise them not only about the personal benefits of immunization, but also the public benefits, and the potential consequences of non-immunization. Presenting information and outcomes in terms of gains and losses can be powerful.

6. Advocate: Physicians are and should be advocates for evidence-based decision-making, and for their more vulnerable patients (e.g., children). Thus, ensure that discussions focus on their objective and evidence-based needs and not the needs or views of the decision-maker (e.g., parent or physician). While physicians should not hesitate to advocate, it is important to remain empathetic and sensitive to concerns.

7. Annotate: Always document in the chart the refusal and the reasons, noting that the benefits, risks and responsibilities have all been reviewed.

The most powerful tool for combating vaccine hesitancy and refusal is a good doctor/patient relationship, the maintenance of which is a component of the physician’s legal, ethical, and professional responsibilities. A strong and continuing relationship preserves the possibility of future engagements that could alter the stance of the refuser. Even ultimately disagreeing in a cordial and honest way with minimal conflict is important for both physicians and patients, and permits the gradual accumulation of the trust that may lead to informed decision-making and vaccine acceptance in the future.

The Pandemic Context

The COVID-19 pandemic has highlighted and, in some cases, accentuated vaccine hesitancy. The rapid development of vaccines combined with the absence of extended systematic testing before widespread administration has agitated the mistrust that many refusers already feel toward the vaccine architecture (i.e., Big Pharma, captive regulators, opaque and abridged authorization processes). Given the demonstrated risks and harms of non-vaccination, and the proclivity of libertarians to assume them even if that puts others at risk (and to additionally ignore other recommended precautions), the importance of positive engagements with patients as opposed to dismissal of them is critical. Physicians have a responsibility to encourage and improve (justified) vaccine acceptance whenever possible, doing so in ways that are sensitive to context. While some outright refusers will never be convinced by the evidence, it is the moveable middle that physicians can influence, but only through engagement. It is that majority who will be critical to stemming the COVID-19 tide, and that of future pandemics.

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References


MHECN Forms Discussion Group for Hospital Chaplains and Clergy

Background and Formation

During the COVID pandemic, MHECN established a COVID-19 Working Group to meet regularly and discuss the multitude of issues that health care providers were facing resulting from the virus. (We described this work in the Fall 2020 and Spring 2021 Mid-Atlantic Ethics Committee Newsletters.) During those meetings it became clear that hospital chaplains were an integral part of hospital ethics committees but were not consistently included in relevant meetings regarding the pandemic. In response, Diane Hoffmann, Professor of Law and Director of MHECN and her research assistant, JD/MPH candidate Matthew Fleisher, began exploring the idea of establishing a separate discussion group of hospital chaplains and clergy who might meet together on a routine basis and share their experiences during the pandemic as well as other issues that come up for them as members of their institutions’ ethics committees. Prof. Hoffmann and Fleisher agreed to do some outreach to see if such a group would be of interest to chaplains. They found that many chaplains welcomed such an opportunity.

Fleisher explained that chaplains bring an important perspective to health care ethics, especially given their deep ties to the community and ability to build meaningful and long-lasting partnerships with community organizations. However, one consistent theme that came up during his early outreach was that such clergy often felt that they were “not asked to be at the table” or were “approached disrespectfully,” with a sense that because of the prominence of science in the health care space, “religion is a relic” and their work does not have “systemic buy-in.” Nonetheless, chaplains felt strongly that their work is part of direct patient care, and that there are in fact, clinical benefits of the services they can offer. Chaplains also shared that they often feel overwhelmed and underfunded, and consequently, are unable to do the strategic planning they feel is necessary to maximize their contribution to patients, staff, and family members.

Initial Meetings

The first group of chaplains and clergy met in May, and since that first meeting, the group has met four times. Meetings have included guest speakers and topics of interest to chaplains such as community outreach to increase vaccination of vulnerable populations, ethical considerations for chaplains during the pandemic when many of them were not permitted to see patients in person, and the role of chaplains in determining religious exemptions to vaccine mandates.

At the first meeting, attended by 13 chaplains, Prof. Hoffmann asked who was familiar with and/or on their hospital ethics committee, with mixed responses. She then provided an explanation of the legislation leading to the statewide ethics committee requirement. She also shared the genesis of, and issues discussed by, the MHECN COVID-19 Working Group, one of which was a desire for this group of chaplains/clergy to convene to advise on and share experiences and ethics concerns faced by chaplains during the pandemic. Prof. Hoffmann also asked if any participants were or had been a part of any similar group across Maryland where they had a chance to share experiences with each other. One chaplain shared that some of them belonged to a larger national or international group of chaplains, while another shared that while there used to be a local Baltimore chaplain fellowship, that had ended some years ago and there was not currently a statewide group. Prof. Hoffmann explained that MHECN believes there is value to convening this group to provide an opportunity for chaplains and hospital clergy to share the ethical issues they face as well as to find out what other chaplains are doing to improve the care of individuals in their institutions and their communities. Each of the participants shared openly about their many different expe-
periences during COVID-19, but similar themes emerged, such as the importance of chaplaincy not only to patients and their family members, but also to staff and the broader community. Many spoke of the lack of institutional engagement with their chaplaincy efforts prior to the pandemic while noting with some optimism that the pandemic experience seemed to highlight the importance of the role of pastoral and spiritual care within their institution. The Rev. Gail Mansell, Chaplain and Director of Supportive Care Services at Atlantic General Hospital & Health System, also spoke about her specific experience at Atlantic General with vaccine allocation in the community the hospital serves, and the importance of building and sustaining community partnerships to address disparities.

In June, at the group’s second meeting, 15 chaplains were joined by 12 members of the MHECN COVID-19 working group. MHECN Program Advisor Anita Tarzian began the meeting by introducing the MHECN COVID Working Group to the Chaplain Discussion Group and explaining how and why it was formed and the focus of its meetings. A primary topic of discussion she explained had been a plan for hospitals throughout the state to adopt if it became necessary for them to allocate scarce medical resources such as ventilators and ICU beds and making sure the plan was fair to all communities and groups across the state. After introductions, chaplains were asked to share their biggest concern in their role during the prior month and whether their hospital or health system had announced a policy regarding vaccinations for staff. If yes, they were asked how the staff had responded and whether they had any concerns about the policy.

In July, the meeting began with a presentation by the Rev. Dr. Paula Teague, Senior Director of Spiritual Care and Chaplaincy at Johns Hopkins Bayview Medical Center on “Ethical Issues in the Role of Hospital Chaplains & Clergy.” She shared her main takeaways of “Spiritual Care Practice During the Pandemic” which included the ethical dilemma posed by the COVID-19 pandemic of keeping clergy safe while maintaining presence for those they served. Dr. Teague turned to her colleague, the Rev. Peter Heikkinen, to share his experiences in balancing the mandate to provide bedside spiritual care to patients, family and staff during the pandemic while keeping pastoral care providers safe and minimizing visitors and staff in COVID-positive rooms. Dr. Teague noted that one positive effect of this ethical dilemma was the use and integration into practice of technologies like Zoom to allow families to see and speak with loved ones in the hospital. As the technology gained more widespread acceptance, she said it began to feel less like a dilemma and more like an innovation. Dr. Teague likened it, theoretically, to a redemptive process – seeing hope and possibility in things that had once felt oppressive. After this inspiring presentation, group members shared their own experiences with the ethical dilemma the Revs. Teague and Heikkinen discussed.

At the October meeting, Dr. Blake Zwerling, MD MSc, a fellow with Johns Hopkins University Gynecology & Obstetrics, spoke about a research project she was beginning about patients who experience a miscarriage or who must make challenging decisions regarding termination of a pregnancy. Her focus is on whether and how such patients use the chaplaincy services at the hospital where they are being seen. At the meeting, the chaplains shared their experiences seeing these patients and the challenges it brought up for them, including, in some cases, their own personal experiences. Dr. Zwerling asked the group specifically what questions they thought she should ask chaplains when she begins interviewing them. One question that elicited support from many attendees was how the chaplain’s own religious views affected their ability to serve these patients.

The November meeting included a thought-provoking presentation from the Rev. Dr. Jane Beers, Chaplain at University of Maryland Upper Chesapeake Health, on youth in crisis and a discussion based on a case study related to patient privacy and ethics. The group will meet again in early December.

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Culturally Specific Senior Care: Ethical Successes and Challenges

This article is based on interviews with Wayne Brannock, Chief Operating Officer at Lorien Health Services, and Dr. Sue Song, APRN, President of the Korean American Senior Association and Past President of the Korean American Community Association of Howard County.

As recent census data demonstrate, Maryland is an increasingly diverse state, with a growing, multicultural population. The 2020 census shows that “less than half of Marylanders now identify as white,” and “the share of Marylanders identifying as Asian… grew to 7% from 5% of the state’s population.” The 2000 US census identified Korean Americans as the largest group of Asian Americans in this area. According to the Johns Hopkins’ School of Public Health, “Korean Americans are one of the most homogeneous Asian populations in terms of language, ethnicity, and culture.” This growing, culturally vibrant community has helped reinvigorate business communities in places like Ellicott City, which is “one of the most densely Korean populated towns in the entire state.” As this group ages, their strong cultural ties and religious practices become increasingly important, and when it comes time to pick a retirement community or long term care facility, older Korean Americans are looking for places where they can continue their way of life. At least one provider in the state has sought to provide options for seniors that enable them to do that.

Lorien Health Services (“Lorien”), a large provider of senior care in the state of Maryland, strives to implement a “progressive vision” of senior care through unique facilities for its 9 locations, each of which is “different for a reason.” Lorien provides services for seniors throughout the state, including “rehab services, Tele-Health, Parkinson's treatment, Assisted Living care, Skilled Nursing expertise and coordinated Hospice Care.” It took this forward-looking approach one step further by creating, at the request and with the cooperation of the Maryland Korean American community, Korean Senior Care, first in its Columbia location and then in Mays Chapel. This culturally-specific approach to senior living has had its share of challenges, but has also shown great successes in providing ethical, comforting care for Korean and Korean American elders.

Background

The idea for a Korean-language facility did not originate within Lorien. Rather, the Korean American community in Maryland devised the idea after facing frustration at the lack of good options for a retirement facility that provided them the opportunity to “keep their independence, identity and elements of Korean culture, like their native language and foods” while remaining close to their families in America. Dr. Sue Song, an advanced practice registered nurse and community advocate, prioritized and elevated this important issue for her community. Dr. Song is president of the Korean American Senior Association, a past President of the Korean American Community Association of Howard County, and a member of the Howard County Asian-American/Pacific Island Work Group. She “noticed an unsettling trend over the past couple of decades among retirees in her community,” who established their families and professional lives in America but then “found themselves alone and cut off from their cultural identities” upon retirement. Dr. Song looked into various avenues for remedying this gap, eventually bringing the idea to Lorien, which embraced the idea. After striving to provide culturally specific care for all of its residents and meeting...
challenges including an inability to make authentic traditional cuisines or communicate clearly with residents for whom English was not their first language, Lorien saw an opportunity to work with the leadership of the Korean American community to provide this group of seniors “socialization and connection, living with people who share the same culture and time in life.”12 In response to this need, Lorien opened Golden Living private apartments, featuring common areas where residents can immerse themselves in social connection. Dr. Song describes the “cohort-living setting” as one where residents can “watch Korean movies, play Korean games, cook Korean food, have discussion groups and book clubs centered on Korean issues.” The first such facility was opened in Howard County near the Lotte Plaza Korean shopping area and a second, similar facility opened in Baltimore County soon after.

**Ethical Issues**

Enmeshed in cultural concerns are ethical ones. Culturally informed care goes beyond overcoming language barriers or providing ostensibly authentic food to patients from ethnic minorities. Competence in this area must ensure that providers “effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.”13 Dr. Song shared that in addition to important concerns like providing high-quality, authentic Korean food, access to Korean-language media and entertainment, and hiring bilingual staff, there are crucial ethical considerations that must be undertaken to provide the highest quality care for aging residents with a Korean background.

**Care Providers**

According to Dr. Song, Korean American residents may have requirements for care providers beyond Korean fluency, from their age to their perceived gender. Cultural differences may inhibit care if staff are not intimately familiar with such potential pitfalls. For example, Dr. Song described one resident treating a physician like a grandchild instead of a medical professional due to the provider’s young age, while a different patient took issue with a male nurse providing more intimate aspects of care. Another example Dr. Song provided was the embarrassment some Korean American retirees might face with acknowledging pain, or how culturally appropriate communication might look to some less informed staff like patients “fighting.” Even pastoral care can be an obstacle, as some Korean seniors are seeking a minister who is not only fluent in Korean, but also mature, as they perceive such maturity as coming with the ability to offer more comfort and peace at the end of life.

**End-of-Life Care**

Medical decision-making and end of life care present additional ethical wrinkles. In addition to ensuring that documentation like advanced directives can be translated with appropriate nuance, decision-making itself can be fraught if approached from a one-size-fits-all approach. While in some families, a signed advance directive might provide straightforward direction for end-of-life medical decisions, Dr. Song notes that many Korean seniors may prefer to defer to their oldest son or a religious authority figure rather than relying solely on autonomous decision-making regarding their own health. Idiomatic language can also pose a barrier here – in one instance, a staff member reported a patient for suicidal ideations after overhearing them say “I am so tired; I want to die,” failing to realize that this was a common phrase that didn’t truly express any such desire.

**Potential Hurdles**

All of these ethical and cultural considerations require a highly knowledgeable and engaged advocate like Dr. Song, but culturally specific care may still present obstacles even in the most ideal circumstances. It can be difficult, for example, to find staff members who meet not only the language needs of patients, but also have the requisite experience and gravitas to become trusted care providers. Even the creation of this unique cultural space led to complaints of “reverse discrimination” from patients who were moved as the Golden Living area was being configured, or who may have had their own biases. There is also potential research that could better inform how and
why this type of care is important. For example, anecdotally, seniors often regress to their first language as they age, no matter how long or fluently they may have spoken a second language, but more research is needed into why. Additional research into whether or not such a culturally relevant space does in fact lead to demonstrably better health outcomes would also be useful for advocates of such living arrangements. But securing any research grants to explore these issues may face obstacles like the need for translation of informed consent, research protocols, and other materials, which add costs and logistical challenges.

Finally, it is likely not possible for a facility or care provider with an outside perspective to try to create a responsive, fully-realized environment for a specific cultural group. Such an effort needs to be spearheaded and led by knowledgeable and organized community members. If and when these efforts succeed, however, there are many positive outcomes. As one family member states on Lorien’s testimonial page: “While my father has been in this country for over 50 years, the Korean food, TV stations, newspaper, and other residents [are] a great comfort to him.”

While we do not have the research to quantify the extent to which such facilities lead to better health outcomes for this aging population, residents who are living in these environments prefer them to traditional long term care facilities and appear to be thriving.

Rebecca W. Hall, JD
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Francis King Carey School of Law

4One community leader noted that "[m]ost of the people that are here came to the U.S. in the '70s and '80s and their kids were born here." See id.
5https://www.lorienhealth.com/locations
6https://www.lorienhealth.com/where-to-begin
7https://www.lorienhealth.com/locations/mays-chapel/services-offered/korean-senior-care
8https://www.lorienhealth.com/locations/columbia
10https://kacahi.us/about-us/
12See supra note ix.
13Cultural Competence in Health Care: Is it important for people with chronic conditions? https://hpi.georgetown.edu/cultural/
14https://www.lorienhealth.com/locations/mays-chapel
CASE PRESENTATION

One of the regular features of this Newsletter is the presentation of a case considered by 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.

CASE STUDY FROM A MARYLAND HOSPITAL

Patient P is in their sixties and a prisoner from a local detention center. They have a history of metastatic cancer and presented to a Maryland hospital for care. After initial evaluation they were found to have sepsis, renal failure and deemed critically ill.

Unfortunately, after completing chemotherapy and radiation less than a year ago, the cancer showed signs of progression a few months later. On arrival, the patient had already made the decision to be designated DNR/DNI, BIPAP OK.

Once admitted, in addition to the medical teams, Palliative Care was consulted. The patient made it clear that what mattered to them most was comfort at the end of life. A call was placed by the bedside RN for a Chaplain visit and a Hospice and Pain Management consult was placed by the attending.

After the Hospice team visited with the patient, they accepted comfort care measures only. When the Chaplain arrived at the patient’s room, they were denied entrance to complete the visit. Per the law enforcement officers, it was against policy for Chaplains to visit prisoners in their care.

The Ethics team was called regarding the denial of a Chaplain visit.

How should the Ethics team respond?

Response from a Hospital Chaplain

It is surprising that a policy would explicitly deny pastoral care to an inpatient hospitalized prisoner, determined to be end-of-life by a physician. Even death row prisoners scheduled for execution are provided chaplain care. No justification is provided for why the policy, to which the law enforcement officers refer, denies chaplain visits.

System issues

Several system issues may have impeded Patient P’s spiritual care.

Hospitals are wise to have a policy detailing the care provided correctional patients, as well as clear lines of communication and authority between institutions. Security leadership can often reach out to law enforcement agencies to clarify policies and resolve inter-agency expectations and communication, in a timely manner.

Additionally, it is unclear with which organization the chaplain is affiliated. Was this the hospital chaplain, hospice chaplain, palliative care chaplain or correctional chaplain? How much authority

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and institutional familiarity did the chaplain have to expedite resolution of this concern?

Standards of Care

A policy refusing chaplain services to end of life hospitalized prisoner-patients appears to be in conflict with accepted standards of care.

The obligation to provide care at the end-of-life that preserves human dignity in the correctional setting is not only an ethical one, but has legal underpinnings as well. In *Estelle v. Gamble* the U.S. Supreme Court established that deliberate indifference to serious medical needs of prisoners is a violation of the 8th amendment which prohibits “cruel and unusual punishment.” Subsequent case law has established that the incarcerated have a de facto right to a “community standard” of health care (*Estelle v. Gamble* 1976). Similarly, the United Nations Standard Minimal Rules for the Treatment of Prisoners (Mandela Rules) dictate that “all prisoners shall be treated with the respect due to their inherent dignity and value as human beings,” and “enjoy the same standards of health care that are available in the community” (McCall-Smith 2016).

The prisoner was in a hospital at the time of his death and had been deemed “end-of-life” by a physician. The Joint Commission on Hospital Accreditation, in the chapter on Rights and Responsibilities of the Individual (RI.01.01.01), states: “The hospital respects, protects, and promotes patient rights.” The element of performance for this standard reads: “The hospital accommodates the patient’s right to religious and other spiritual services.” Furthermore, the Joint Commission requires that “the patient’s comfort and dignity receive priority during end-of-life care.” (PC.02.01.13) The element of performance reads: “To the extent possible, the hospital provides care and services that accommodate the patient's and his or her family’s comfort, dignity, psychosocial, emotional, and spiritual end-of-life needs.” And, “the hospital provides staff with education about the unique needs of dying patients and their families.”

Ethical Framework

The ethics committee could use the traditional four fundamental ethical principles to guide their deliberations.

1. Autonomy: We have an obligation to respect the autonomy of other persons, which is to respect the decisions made by other people concerning their own lives. In the case under consideration, we are told that Patient P was given the autonomy to make a decision concerning end-of-life care and that Patient P made a decision to receive hospice care. Part of hospice care is spiritual care by a chaplain. While hospitals are mandated by the Joint Commission to provide spiritual care, hospice is mandated by Medicare to have chaplains as part of hospice care.

2. Beneficence: We have an obligation to bring about good in all our actions. The corollary principle is that we must take positive steps to prevent harm. In the case of Patient P, the hospital, hospice and prison all have an obligation to review and/or develop policies that clearly state what services patient-prisoners are allowed to have and by which agency. If law enforcement officers refuse chaplains, then the reason for that refusal must be clearly articulated in the policy and clearly communicated to agencies with which the detention center routinely works, such as hospitals and hospices.

3. Nonmaleficence: We have an obligation not to harm others. “First, do no harm.” In the case of Patient P, harm was done to the patient who was denied the opportunity to resolve end-of-life issues with the assistance of a chaplain. Those end-of-life issues may include sacraments or rituals of a particular religion. This may even require an additional clergyperson or religious representative who is permitted to provide the requested ritual. Confession and forgiveness, life review, and making amends may be desired at the end-of-life. In the case of Patient P, it is likely that the denial caused distress to this patient, their family (if they were even told), and those who witnessed it or subsequently heard about it.

4. Justice: We have an obligation to treat all people equally, fairly, and impartially. Combining
beneficence and justice we are obligated to work for the benefit of those who are unfairly treated. In the case of Patient P, prisoners are considered a vulnerable population. They are at increased risk of harm due to social and structural barriers, including restrictions on activity and visitor restrictions (access to family and friends by phone or in person).

Hospitals are encouraged to develop robust policies that address the care of patients under legal or correctional restrictions. Hospital security or senior leadership addressing issues with law enforcement agencies, in a timely fashion, may be advantageous to positive outcomes. Hospitals employing at least one board certified or board eligible chaplain, with knowledge and experience, advances spiritual care for all patients. Addressing the system issues, policy in question, and lines of authority and communication between the hospital and the detention center, will likely aid the implementation of the ethics committee recommendations.

Susan Carole Roy, D.Min., BCC
Director of Pastoral Care,
The University of Maryland Medical Center

References


The Joint Commission on Hospital Accreditation, Rights and Responsibilities of the Individual, (RI), Standard RI.01.01.01.

Commentary from a Former Maryland Assistant Attorney General

As Patient P is an inmate at a local detention facility, in general that facility has the legal authority to maintain custody of them and to limit their contacts with other people. In this instance I will assume that the law enforcement officers are employees of the detention facility and that the warden of the facility, not the hospital staff, prohibited the visit. Therefore, the issue is whether it is ethically appropriate for the warden of the detention facility to prohibit a face-to-face meeting between Patient P and a chaplain. An inmate, while healthy, will have limited opportunities to see a chaplain in the detention center in which they are incarcerated. Especially when the inmate is considered to present a security risk, they might not be able to meet face to face for a conversation. A visit might only be at a secure visiting room, without direct contact. Further, the conversation might be monitored by detention center staff. It follows that, pursuant to detention center policy, an inmate would not be allowed to meet a chaplain in a hospital because there is nothing to separate them and no system in place to monitor their conversation.

Patient P does not present security risks, given his terminal condition. The jail may have officers search the chaplain, per security protocols, and may monitor the meeting. These will address the limited security concerns presented by the visit. It may be, however, that an aspect of the “punishment” under the inmate’s sentence is to limit contact with family members, friends, and religious service providers.

This case presents matters that, while they are specific to a single prison inmate, involve important issues regarding human dignity. These are the central considerations:

1. Patient P is terminally ill and close to death;
2. Patient P has chosen to be allowed to die without medical interventions;
3. Patient P wishes to talk to a chaplain;
4. A chaplain is available and willing to meet with Patient P; and
5. Patient P does not present security risks physically or by way of communications with a chaplain.

These are similar to the ethical considerations set out by Lyckholm. As Dr. Lyckholm notes, “health care providers, the hospital and the prison have shared obligations to [the patient] as well as to public health and safety; however, their priorities differ. It is important for the ethics consultant to ensure that all obligations are considered and respected, rather than supporting one without regard for the others.”

Chaplains should also be recognized for the important role they play in health care. Loewy & Loewy assert that “hospital chaplains may, in appropriate cases, serve a critically important function in a patient’s care.”

There may also be applicable legal principles to consider. In Estelle v. Gamble, 429 U.S. 97, 1976, the United States Supreme Court ruled that the 8th amendment to the U.S. Constitution, which prohibits “cruel and unusual punishment,” includes deliberate indifference to a prisoner’s serious medical needs.

I believe that the ethics committee should determine the chaplain’s background and credentials, and then contact the head of the department of which the jail is a part. It should explain that the circumstances for Patient P. ethically require that they be permitted a visit with a chaplain and ask for an immediate response. If the response is not consistent with the committee’s perspective, it should quickly communicate with officials higher in the prison chain of command about permitting the chaplain visit.

The ethics committee should share with the hospital officials the information sent to the jail official. Also, the committee should note for the hospital that The Joint Commission (https://www.jointcommission.org/), which accredits hospitals, has applicable standards in its Patient Safety Systems document. These include:

- “The hospital accommodates the patient’s right to religious and other spiritual services.” (Standard RI.01.01.01.9); and
- “The patient’s comfort and dignity receive priority during end-of-life care.” (Standard PC.02.02.13)

If the visit is not allowed, the committee should communicate with county and/or state legislators about changes to applicable laws or regulations that would allow chaplain visits in circumstances such as that of Patient P.

Alan D. Eason, JD, CMMT
Retired Maryland Assistant Attorney General,
Maryland Department of Public Safety and Correctional Services
Chair, State Advisory Council on Quality Care at the End of Life

References:


Children’s Mercy Kansas City
Ethics Committee Brown Bag Workshop Schedule*

November 23
Conceptual and Practical Insights about Trauma Informed Care from Children’s Mercy Healthcare Professionals
Patty Davis, LSCSW, LCSW, IMH-E(III), Program Manager, Trauma Informed Care, Department of Social Work, CMKC, with Panelists Brian Carter, MD; Dena Hubbard, MD; John Lantos, MD; Tiffany Willis, PsyD

December 28
Lindsey Vaughn, MS, RD, CSP, LD, Clinical Nutrition Specialist IV, Nutrition Department

* All events take place from 12noon – 1PM Central Time. Non-employees of Children's Mercy, contact Jeremy Garrett (jgarrett@cmh.edu) and Jennifer Pearl (jepearl@cmh.edu) (preferably at least 3 business days in advance) if interested in attending.

Johns Hopkins Berman Institute of Bioethics Seminar Series

November 22
12:00 – 1:00pm (EST)
Elizabeth Barnes, PhD
Attend via Zoom
Passcode: Seminar

December 13
12:00 – 1:00pm (EST)
Sassy Molyneux, PhD
Attend via Zoom
Passcode: Seminar

January 24, 2022
12:00 – 1:00pm (EST)
Robin Lovell-Badge, CBE, FRS FMedSci
Attend via Zoom
Passcode: Seminar

March 28, 2022
12:00 – 1:00pm (EST)
Diane O'Leary, PhD
Attend via Zoom
Passcode: Seminar
CALENDAR OF EVENTS (cont.)

April 11, 2022
12:00 – 1:00pm (EST)
Robert G. Holloway, M.D., M.P.H
The Sheila Hutzler-Rives Memorial Lecture

April 25, 2022
12:00 – 1:00pm (EST)
David S. Wendler, MA, PhD
Attend via Zoom
Passcode: Seminar

University of Maryland Carey School of Law

Maryland Healthcare Ethics Committee Network (MHECN)

November 18
5:00 – 6:00PM ET
Webinar on Hospital Pandemic ASR Framework
To attend, please Register

The Law & Health Care Program’s Rothenberg Health Care Law & Policy Speaker Series

February 17, 2022
4:00 – 5:00PM ET
Dayna Bowen Matthew, JD, PhD
Dean and Harold H. Greene Professor of Law, George Washington University Law School
To attend, please Register

March 31, 2022
4:00 – 5:00PM ET
Ruth R. Faden, PhD, MPH,
Berman Institute Founder; Core Faculty; Philip Franklin Wagley Professor of Biomedical Ethics
Johns Hopkins Berman Institute of Bioethics

University of Pennsylvania

Tuesday, November 30
12:00 – 1:00pm (EST)
Aliza Narva, JD, MSN, RN, HEC-C. Director of Ethics, Hospital of the University of Pennsylvania
To attend, please Register
CALENDAR OF EVENTS (cont.)

Monday, December 6
12:00 – 1:00pm (EST)
Kim Smith-Whitley, MD, Clinical Director, Division of Hematology, Director, Comprehensive Sickle Cell Center, Children's Hospital of Philadelphia
To attend, please Register

Tuesday, December 14
12:00 – 1:00pm (EST)
Hope, bias, and survival expectations of advanced cancer patients: A cross-sectional study
Eric Finkelstein, PhD, MHA, Professor of Health Services and Systems Research, Duke-NUS Medical School, Singapore; Executive Director of the Lien Centre for Palliative Care
To attend, please Register

Tuesday, December 21
12:00 – 1:00pm (EST)
ELSI considerations in the use of direct-to-consumer genetic genealogy services among people of African descent
LaKisha T. David, PhD, Postdoctoral ELSI Fellow, Medical Ethics and Health Policy, Perelman School of Medicine
To attend, please Register

University of Pittsburgh Center for Bioethics & Health Law

November 17
12:00 –3:00pm (EST)
Grief, Loss, and Resilience in a Pandemic World—Session Three
Amy DeGurian, MSW & Melissa M. Kelley, PhD
Register here

Yale School of Medicine Program for Biomedical Ethics

December 1
Global Health Ethics
Joanna Radin, PhD - Rosana Gonzalez-Colaso, PharmD, MPH
Register here

December 15
5:00 – 6:30PM ET
Meritocracy, Medicine, and the Case Against Perfection: A Conversation with Michael Sandel
Michael J. Sandel, PhD
Register here
The Maryland Healthcare Ethics Committee Network (MHECN) is a membership organization, established by the Law and Healthcare 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 healthcare; 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.