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1 **Highlights**

- 2 • Self-determination falls short for incapacitated, unrepresented patients.  
3 • Homelessness yields vulnerability in a hospital setting.  
4 • Stigmatization of psychiatric illness may impair the autonomy of affected patients.  
5 • Early and streamlined ethics education may mitigate autonomy-limiting treatment.  
6

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17 **Discussion Points:**

18 Are providers equipped to provide ethically conscious medical care for an incapacitated, unrepresented patient?  
19 How can we improve #ClinicalEthics training models at the #MedicalSchool level? Read more in this case-  
20 based call to action for revision of current #EthicsEducation models.  
21

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1 **ABSTRACT.**

2 *Introduction*

3 Ethics education in medical schools lacks uniformity, yielding uncertainty when providers are faced with  
4 ethically complex patients. Without streamlined ethics training, providers are less confident in their ability to  
5 provide ethically appropriate care for all patients, particularly for those most ethically vulnerable. This case  
6 report seeks to elucidate ethical concerns when treating an ethically complex patient. Subsequently, the need  
7 for early ethics education is substantiated.

8

9 *The Case*

10 A 58-year-old unhoused patient with no known medical history presented to the emergency department (ED)  
11 for evaluation of an infected foot wound. Imaging confirmed acute gas gangrene osteomyelitis. The patient  
12 refused the recommended below-the-knee amputation (BKA) but was amenable to intravenous antibiotic  
13 therapy. He was subsequently determined by psychiatry to lack decisional capacity and met the DSM-5  
14 criteria for schizoaffective psychosis. Subsequently, the patient's brother deferred decision-making to the  
15 patient, who he believed should make his own medical decisions. Following an ethics consultation, the  
16 brother's decision, and by proxy the patient's, was respected.

17

18 *Conclusion*

19 In this case, the patient's autonomy was prioritized, despite his high level of ethical vulnerability. Ethically  
20 conscious treatment was provided despite the implicit stigmatization of homelessness and psychiatric illness.  
21 However, an ethics consultation was necessary for this to occur. Ultimately, this paper should serve as a call to  
22 action for standardization and prioritization of ethics education during and beyond medical training.

23

24 **Key Words:** case reports, ethics, clinical ethics, ill housed persons, personal autonomy

25

1 **INTRODUCTION.**

2 The 1990 Patient Self-Determination Act, which incorporates patient preference into medical decision-making,  
3 has incited a paradigm shift in healthcare from paternalistic to patient-centered. Through this act, patients are  
4 empowered to play a role in decisions about their own healthcare, for example by making advance directives  
5 while capacitated or deciding how much, if any, treatment they desire. By definition, a capacitated patient can  
6 understand their illness and treatment options sufficiently to make decisions that are aligned with their  
7 personal values. Today patients often do make their own health decisions, however, their legal next of kin can  
8 be called on in the event of incapacitation (e.g., traumatic brain injury, stroke, psychosis) without an advance  
9 directive (1).

10

11 The concept of self-determination empowers patients to make their own health decisions yet often falls short  
12 for unrepresented, incapacitated patients. Unrepresented patients, which include elderly, homeless,  
13 incarcerated, or mentally disabled patients, both lack advance directives and, “available friends or family to  
14 make medical decisions as ‘default’ surrogates” (2). These patients are a highly vulnerable population,  
15 necessitating a high level of ethical awareness from their healthcare providers. This ethical literacy can, and  
16 should, be implemented early in medical education. As described by clinical ethicists, the “necessity for the  
17 teaching of clinical ethics rests in the immutable fact that any serious medical decision involves two  
18 components—a technical decision requiring the application of knowledge of basic and clinical sciences to the  
19 patient's present problems, and a moral component demanding that the technically correct decision is also  
20 morally defensible” (3). When ethics and medicine collide, healthcare providers should be well-equipped to  
21 provide optimal care through robust medical and ethical knowledge.

22

23 This case-based discussion will highlight the need for improved ethics education in medical schools to mitigate  
24 provider uncertainty, as reflected in the care of an incapacitated, unrepresented patient. We will first discuss  
25 how providing autonomy for this patient requires an ethical understanding of medical decisional capacity and  
26 stigmatization of both homelessness and psychiatric diagnoses. We will subsequently address how early and  
27 streamlined ethics education can empower providers to advocate for patient autonomy. The subsequent case  
28 describes the treatment of a homeless, incapacitated, unrepresented patient who presented to our institution  
29 refusing treatment for a possible life-threatening illness.

1 **THE CASE**

2 A 58-year-old homeless patient presented to the ED for evaluation of an infected foot wound (Figure 1). The  
3 patient's brother endorsed a prior hospitalization, during which the patient received a psychiatric diagnosis  
4 that he did not disclose to his family. There was no other known medical history. Imaging demonstrated a heel  
5 ulcer associated with bone destruction, indicative of acute gas gangrene osteomyelitis. A psychiatric  
6 evaluation determined that this patient lacked decisional capacity and met the DSM-5 criteria for  
7 schizoaffective psychosis. The patient adamantly refused the recommended BKA but was amenable to  
8 intravenous antibiotic therapy. He stated that he knew people who had bad experiences with amputations in  
9 the past and believed that his antibiotics would cure him. The patient's closest living relative, a brother,  
10 deferred decision-making to the patient, whom he believed should make his own medical decisions. The  
11 ethics consultation team was contacted, and the brother's wishes were respected.

Accepted, in-press

1 **DISCUSSION.**

2 In this case, an unrepresented, incapacitated patient was given autonomy in his care in lieu of beneficence, as  
3 he inevitably did not receive the most highly recommended medical care, the BKA (Figure 1). The ethical  
4 framework underlying this decision will be described, followed by a discussion of the need for streamlined  
5 ethics education in medical schools. We will begin with discussing ethical aspects of this patients care  
6 (decisional capacity, vulnerability of homelessness, stigmatization of psychiatric illnesses) which will  
7 substantiate a subsequent discussion of improved ethics education in medical schools.

8

9 *Decisional capacity*

10 The patient described was limited in his decisional capacity, yet consistently stated that he did not want the  
11 BKA and insisted on continuing with antibiotic therapy. As with the assumption of innocence in law, medicine  
12 deems patients capacitated until proven otherwise, and the responsibility to recognize incapacity falls on any  
13 licensed physician. Yet, most physicians fail to recognize incapacity due to a lack of training on the matter or  
14 limited knowledge of local guidelines. To determine capacity, a provider should adhere to their institution's  
15 legal and ethical standards, while evaluating the patient's ability to do the following (4).

- 16 1. Comprehend the rationale for the proposed intervention.
- 17 2. Appreciate their current medical status.
- 18 3. Rationally come to a decision.
- 19 4. Communicate said decision appropriately.

20 Two established models of decisional capacity exist, called "four skills" and "sliding scale", but emphasis in  
21 recent years has shifted towards values-based models which question the concordance of a patient's current  
22 and longstanding values (5). In this shifting ethical environment, medical students may lack comprehension of  
23 the nuances of capacity assessment (6).

24

25 *Vulnerability of homelessness*

26 This patient presented to the hospital without a home or local family and was accordingly predisposed to  
27 experience vulnerability and bias. A 2020 study by Gilmer et al demonstrated that homeless patients report a  
28 negative perception of healthcare due to worse health outcomes, less preventative care (43-56% have a  
29 primary care provider), and high hospital readmission rates (7). These unfortunate experiences may, in part,  
30 be modulated by provider bias against this socially and medically complex patient population. When a  
31 provider is aware that a patient is homeless, the patient is more likely to report poor-quality treatment,  
32 particularly for mental illness, addiction, and chronic pain (8). This sub-optimal treatment coupled with high  
33 readmission rates implies that homeless patients simply do not receive appropriate care or resources to stay  
34 out of the hospital. Whether due to provider negligence in creating a feasible discharge plan or patient failure  
35 to cooperate in the therapeutic relationship (e.g., via limitations to accessing insurance, prescription  
36 medications, transportation, or primary care services), homeless patients are more at risk for neglect of  
37 chronic conditions that may land them in the ED soon again for a preventable outcome. This was the case for  
38 our patient, who through years of neglected treatment for his diabetes and psychoses, found himself highly ill  
39 and vulnerable in the ED yet again. Neglect of this vulnerable population violates beneficence, the principle to  
40 do good on behalf of every patient. It is never too early in one's medical training to seek awareness of the  
41 vulnerability associated with homelessness.

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### *Stigmatization of psychiatric illness*

Another factor increasing this patient's risk for vulnerability is the health system- and physician-level bias associated with psychiatric diagnoses. Notably, patients with ischemic heart disease are less likely to receive guideline-consistent treatment (e.g., coronary artery bypass grafting, beta-blockers) if they also have schizophrenia or a related psychosis (8). Due to associated communication barriers, patients with psychosis may experience a sense of implicit coercion, or the sense that they are being involuntarily compelled to make certain decisions. For example, a patient with dangerous psychoses may be coerced to remain in the hospital against their will. Although for their own safety, the unwilling admission of a psychiatric patient is not without harm. Implicit coercion by definition undermines patient autonomy and denigrates the therapeutic patient-provider relationship, leading to provider moral distress as well as patient dissatisfaction (9). Implicitly coercive and autonomy-limiting treatment of patients with psychoses may illicit failure to cooperate in a therapeutic relationship and worsen their outcomes in the long run.(9) If the patient described in this case experienced implicit coercion in a healthcare setting, his perceived lack of autonomy may have encouraged failure to cooperate with prior medical recommendations, increasing his risk for disease progression to this current hospitalization. Patients with psychosis are a highly vulnerable population at risk for implicit coercion, limited autonomy, and subsequent rehospitalization, and awareness of this social stigmatization should be built into medical education.

### *Inconsistencies in ethical curricula across medical schools*

Successful treatment of patients in socially marginalized groups (e.g., without a home, or with a psychiatric diagnosis) requires a commitment to the ethical principle of patient autonomy. Moreover, inadequate ethics education may inhibit providers from responding quickly and appropriately to ethical dilemmas in patient care. However, strong ethical awareness is not without strong ethics education. Thus, the authors propose standardized and hands-on ethics training among healthcare providers to provide optimal care for similarly incapacitated, unrepresented patients. To achieve this goal, the current state of ethics education requires restructuring.

A 1985 article "Basic Curricular Goals in Medical Ethics," argued that medical ethics should be a required component of the medical school curriculum, and this notion was added to the Liaison Committee on Medical Education standards the same year (10). Subsequently, medical educators began to incorporate human ethics into their courses, yet the early implementation of ethics education was fraught with inconsistency. Two decades later, in 2002, among syllabi at the 58 responding medical schools, there were ten course objectives, eight teaching methods, 39 content areas, and six assessment methods (11). This non-standardized, lecture-based education model may insufficiently or inconsistently prepare students to develop medical ethics literacy before they enter the clinic.

### *Proposed ethics curriculum for medical schools*

An optimal ethics curriculum would empower students to step outside of the textbook and think critically. Through a hands-on curriculum that introduces real-world clinical experiences of providers and patients, students can challenge each other and discuss their uncertainty in a non-clinical setting. Subsequently, these

1 students may be more comfortable questioning ethical decision-making as clinicians. More hands-on models  
2 have been successfully implemented in several medical schools. For example, the Students' Medical Ethics  
3 Rounds (SMER) model of ethics education, where students role-played, had discussions, and conversed with  
4 experts, improved confidence in tackling ethical problems in 89.8% of participating students (12). This model  
5 provides students with early exposure to ethically complex topics, which will increase their capacity to address  
6 ethical uncertainty and ultimately improve patient care. A standardized, clinically applicable ethical training  
7 model would equip students to challenge ethical dilemmas as they arise, ultimately improving patient care.  
8

9 In summary, in this case-based discussion we outline ethical aspects of treating an incapacitated,  
10 unrepresented patient including decisional capacity, the vulnerability of homelessness, and the stigmatization  
11 of psychiatric illness. We subsequently address the need for standardized ethics education to appreciate these  
12 dilemmas. Without providers committed to a critical awareness of capacity and vulnerability, the patient  
13 described may have been subject to an undesired amputation. When highly vulnerable patients require medical  
14 care, a strong ethics foundation can improve their provider's understanding of the way forward. By challenging  
15 healthcare students early in their careers to be critical of autonomy-limiting decisions, we can better care for a  
16 common yet unjustly treated population: the unrepresented, incapacitated patient.  
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1 **SUMMARY - ACCELERATING TRANSLATION**

2 Title: A Case-Based Call to Action for the Standardization of Medical School Ethics Education

3

4 Main Problem to Solve: Healthcare providers are inconsistently trained to care for ethically complex patients,  
5 for whom there is uncertainty in determining who will or how to make appropriate medical decisions. In ethics  
6 curricula at 58 medical schools, there were ten course objectives, eight teaching methods, 39 content areas,  
7 and six assessment methods (11).

8

9 Aim of Study: To propose a revision of ethics education in medical schools, through analysis of an ethically  
10 complex patient's story.

11

12 Methodology: A patient's hospital experience is first described, then specific ethical aspects are addressed,  
13 followed by a discussion of current and proposed medical school ethics education models.

14

15 Results: The patient described does not have the ability to consent for himself, however, he requests a treatment  
16 that is not medically recommended. This poses an ethical dilemma for his healthcare team, who decide to  
17 respect his wishes after consultation with an ethics committee. Were it not for consultation with the ethics  
18 committee, it is unlikely that each provider could address this dilemma with certainty.

19

20 Conclusion: Ethics education lacks uniformity. Thus, earlier, more clinically applicable ethics education models  
21 are necessary for the early stages of medical training. Moreover, increased provider comfort in addressing  
22 ethical uncertainty will promote patient-centered medical care.

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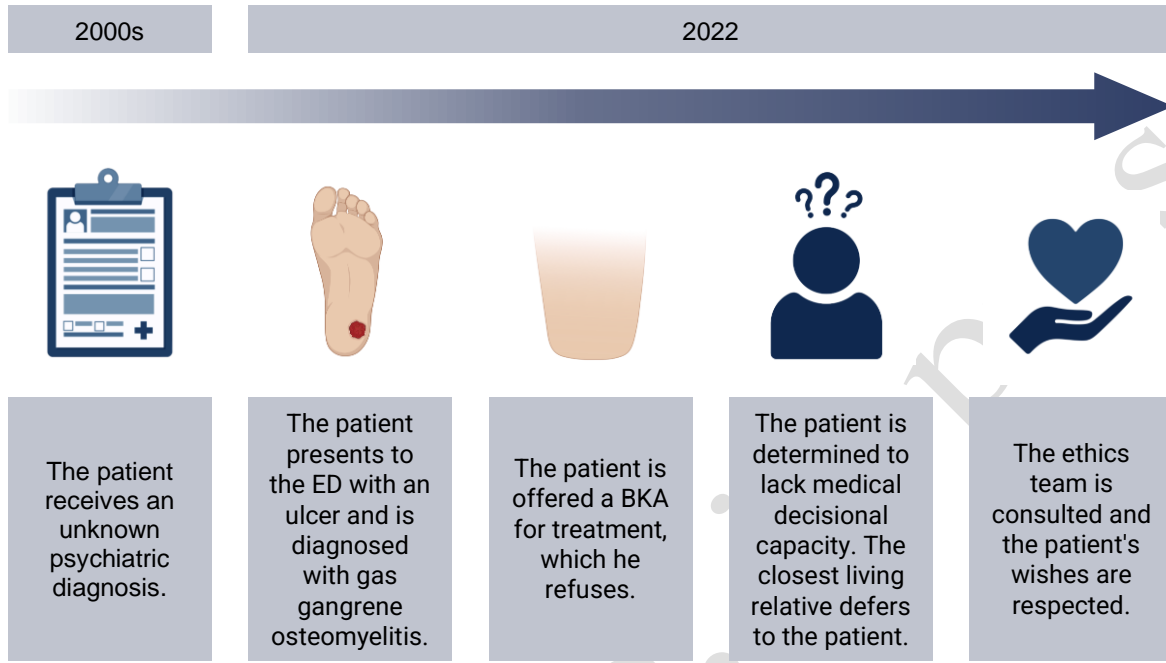
1 **FIGURES AND TABLES.**

2

3 **Figure 1.** Timeline representing the patient's clinical and ethical course prior to and during the described  
4 hospitalization. Pertinent details include the prior psychiatric diagnosis, presenting clinical signs, and  
5 subsequent ethics committee consultation.

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