ETHICAL DILEMMAS IN PATIENTS WITH INTENTIONAL FOREIGN BODY INGESTION: IS THERE A ROLE FOR STANDARDIZED POLICIES?

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Background

- Patients who present with recurrent, intentional foreign body ingestions (FBI) often require repeat endoscopic and surgical interventions that necessitate the use of substantial medical resources via multidisciplinary management and prolonged hospitalizations (Atluri et al., 2012).
- These behaviors can often be divided into four categories: malingering, psychosis, pica, and personality disorder. Regardless of the behavioral etiology, these patients can be behaviorally challenging for staff (Gitlin et al., 2007).
- Furthermore, challenging aspects of treating intentional FBI patients in a correctional setting are the underlying motivations of secondary gain and manipulation of treatment decisions and behaviors to extend hospital stays (Ribas et al., 2014). This may result in a conscious or unconscious bias towards what accommodations, safety precautions, or even treatments are made available to these patients.
- Most case studies in the literature regarding intentional FBI outline endoscopic/surgical clinical management decision making and very few discuss ethical considerations. Even fewer studies discuss ethical considerations of intentional FBI in the correctional setting.
- One of the few studies regarding FBI in correctional settings was by Applebaum et al. in 2011. They found that the psychiatric diagnosis most prevalent was borderline personality disorder and the management strategies employed by correctional settings included medications, restraints, and behavioral planning.
- In consultation-liaison (CL) psychiatry, psychiatrists are often leading multidisciplinary approaches to maintain safety and behavioral control in these patients, as well as helping multidisciplinary teams navigate provider frustrations that may inevitably arise in the context of recurrent FBI patients with varying motivations and personality structures.
- Staff at an academic hospital have suggested developing blanket protocols for all FBI patients that enter the Correctional Care Medical Facility (CCMF).
- We will examine the case of a patient with intentional FBI and focus on the ethical implications of instituting a standardized protocol meant to address patient safety but which may be influenced by unconscious bias.

Case Report

RD is a 30-year-old man with a history of Borderline Personality Disorder, Post-Traumatic Stress Disorder, polysubstance dependence, and multiple past admissions for FBI who presented to the CCMF after having ingested a pulse oximeter probe and cord while in jail. He had an urgent esophagogastroduodenoscopy (EGD) done with successful retrieval of the probe and cord. Our team determined he was not at imminent risk of suicide, did not need a 1:1 sitter for suicide or safety precautions and he returned to jail. After the patient's third visit to the hospital in three days, requiring two EGDs, CL psychiatry was approached by CCMF staff about developing a standard protocol for FBI admissions regarding environmental restrictions, 1:1 sitter protocols, and treatment restrictions (access to IVs/tubing, whether EGD should not be offered if there is suspicion that there was no ingestion).

Considerations of Medical Ethical Principles (Varkey, 2020) in Patients with Recurrent FBI

Beneficence: defined as acting for the benefit of the patient by preventing harm and removing conditions that may lead to harm.
- What are the interventions under consideration? Ie. Imaging, endoscopy, surgery
- What is the probability of success for each intervention?
- Does the benefit of the intervention outweigh the harm of not having it done?

Nonmaleficence: defined as physicians are employed to do no harm, to not cause pain or suffering, and to not incapacitate or cause offense.
- Are the methods of means restriction causing harm by reinforcing dysfunctional behaviors or unnecessarily traumatizing the patient?
- Given the chronic nature of recurrent FBI, can provider's frustrations lead to a bias of excessive means restriction or limit medical intervention?

Autonomy: defined by the patient exercising self-determination and decision making
- Can patients refuse interventions? Ie. Refuse EGDs. Though this does not apply to the current case, this can be a common ethical issue requiring CL psychiatry's guidance in capacity evaluation and medical decision making.
- What is a patient's role in forming a behavioral therapy plan to design the behavioral parameters which can lead to escalating means restriction?

Justice: defined as the fair, equitable, and appropriate treatment of all patients.
- Are providers utilizing medical resources in an appropriate way, unfettered by bias secondary to countertransference with recurrent FBI patients?

Discussion

Within the framework of the four medical ethical principles, we will examine three interventions common to the care of recurrent FBI patients: EGDs, environmental restrictions, and coercive measures.

1) Intervention under consideration: offering EGD. **(Beneficence, Justice, Autonomy)**
- The predominance of literature suggests conservative treatment due to low perforation risk with FBI. Furthermore, there is much literature suggesting the use of specific parameters (type, location, and size of object) to guide treatment decisions. Given published evidence and clinical algorithms that suggest a low perforation risk with foreign body ingestions, repeated endoscopies may not be indicated and this does not mean violation of medical ethics (Frei-Lanter et al., 2012).
- Therefore, even in patients with repeated ingestions in short time frames, we suggest following these protocols to determine need for EGD, rather than attempting a blanket policy that all of these patients should not receive EGD nor always receive EGD.
- Patients refusing EGD should be approached with a capacity evaluation and if they are assessed to have capacity, patients can refuse the procedure with clinical monitoring.

2) Intervention under consideration: applying environmental restrictions. **(Beneficence, Nonmaleficence, Justice)**
- Treating patients with repetitive FBIs often result in providers feeling a lack of control, which may then contribute to risks being overestimated by frustrated providers in an effort to regain that control and reduce feelings of helplessness. While we want to avoid providing potentially harmful outcomes, we must still provide fair, equitable, and appropriate treatment to all our patients.
- The published [relatively] low risk of perforation with ingestion of common hospital room contraband should not automatically outweigh the benefit of providing patients with basic necessities (e.g. toilet paper, hospital gown, utensils). When preferred treatment modalities (e.g. IV lines) provide a higher risk for perforation upon ingestion, more caution should be taken in the form of closer observation.
- This is why we suggest treatment as usual in FBI patients in correctional care facilities while under 1:1 observation for the first 24-48 hours, so they are treated fairly with opportunity to restrict environmental hazards on an on-going basis secondary to the patient's behaviors.

3) Intervention under consideration: Physical restraints and emergency/involuntary medications **(Nonmaleficence)**:
- Reisner et al. outline a reinforcing cycle of self injurious behavior in which the behavior causes hospitalization where providers use coercive and restrictive methods to enforce safety that then trigger negative emotions and negative social reinforcement which then cause the patient to engage in recurrent self-injurious behavior, thus starting the cycle again.
- Coercive methods such as restraints and involuntary medications can be negative social reinforcement of self injurious behavior as well as retraumatizing for patients who most likely have a history of trauma.
- Methods such as voluntary medications, behavioral redirection, and behavioral treatment planning should be utilized first in recurrent FBI patients with an emphasis on the importance of developing a behavioral treatment plan at admission.

Aims

1. What are the ethical considerations for patients with recurrent FBI in a correctional setting?
2. How can CL psychiatrists help multidisciplinary medical teams navigate ethical considerations in patients with recurrent FBI in a correctional setting?
3. Can there be a standardized approach to safety, security, and behavioral interventions for recurrent FBI patients in a medical correctional setting?

Key Points

1. Clinical decision making in the management of FBI will never be devoid of safety risks therefore consideration of balancing conflicting ethical principles and utilizing a cohesive multidisciplinary approach is essential.
2. The most restrictive safety measures may not be the best approach, even with recurrent FBI patients. Utilizing multidisciplinary team based behavioral plans can ultimately help bridge the conflict between beneficence/nonmaleficence and autonomy in the management of these patients.

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