ETHICAL PERSPECTIVES IN NEUROLOGY

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The practice of neurology presents a series of ethical challenges for the clinician. These rarely have simple or straightforward solutions but require careful consideration by the neurologist. This section of CONTINUUM provides a case vignette that raises one or more ethical questions related to the subject area of this issue. The discussion that follows, written by colleague(s) with particular interest in bioethics, should help the reader understand and resolve the ethical dilemma.

NOTE: This case is based on an actual experience.

A 45-year-old man presents with a concern that he is being exposed to chemicals at work. He says a number of chemicals are haphazardly stored in his work area. He does not know what they are but says a previous employee became ill a few years ago and is on medical disability.

The patient reports headaches and numb painful feet and hands. There is no significant medical or family history. He takes no medications except a vitamin from an online natural health Web site.

He appears very anxious and has sweaty erythematous palms. The neurologic examination is unremarkable. The physician needs more information about the workplace chemicals; however, the patient does not want the physician to call his place of work and says he will obtain the information himself.

The patient wants an EMG/nerve conduction study because of information he found on the Internet about chemical toxicity. Despite the normal neurologic examination, the physician orders the test, and it is normal. He also orders a chemistry profile, complete blood cell count, hemoglobin $A_{1c,}$ serum protein electrophoresis, and heavy metal screen (blood arsenic, lead, and mercury).

The patient calls 2 weeks later in a panic because his numbness and pain have increased and he cannot sleep. The next day in clinic he is anxious, and the neurologic examination is unremarkable. The blood tests are normal. The patient reports that old car batteries were stored near his desk, and the previous employee had arsenic in his blood. He is hesitant to provide hair and nail samples that the physician requests. With the patient's permission, the physician talks with his sister. She reports that foot problems "run in the family" and then adds that there is a history of mental illness in the family and that her brother has had paranoid delusions.

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Two weeks later, the patient calls, demanding to speak with the physician. The patient is agitated. He knows he has been poisoned and is on the way to the office. The examination is again normal. The patient demands that an arsenic level be drawn. A few days later the report shows the blood level is quite high, raising concern that the patient may have been poisoned. The patient is contacted, and he comes to the office. After being told about the blood arsenic level, he exclaims, "You see I'm not crazy! I have been poisoned." However, when presented with a plan for chelation therapy, the need to monitor arsenic levels, and the need for a poison center to investigate further, the patient inexplicably does not want to cooperate and leaves the office.

COMMENT

▶ A brief review of the some of the practical issues in this case may be helpful. The composition of the online-procured vitamin should be checked; very high doses of B_6 may cause a sensory neuronopathy. The family history of foot problems may suggest a familial peripheral neuropathy. Testing urinary arsenic is the much more common testing procedure in the occupational setting. Blood arsenic half-life is very short, approximately 16 hours, and not well associated with exposure. In this case, therefore, the timing of the exposure was very short, raising the question of self-ingestion or poisoning.

A few of the ethical and legal issues generated by this case are:

(1) Confidentiality of the patient and the medical information
(2) Respect for autonomy in the presence of the patient's behavior
(3) Nonmaleficence and beneficence in relation to possible imminent harm

CONFIDENTIALITY

▶ An important pillar of the physician-patient relationship is maintaining confidentiality of patient information. In the context of simultaneously investigating a potential workplace exposure and considering the patient/employee's privacy and confidentiality, the American College of Occupational and Environmental Medicine's statement on Confidentiality of Medical Information in the Workplace (2008) summarizes the dilemma:

> When considering requests for job accommodation, *addressing threats to health or safety* [italics added], or reviewing claims for workers' compensation benefits employers may require access to personal information. Additionally, employers shoulder an increasing responsibility for providing other types of benefits such as health and disability insurance, family medical leave, and employee assistance programs. As a result, the employer becomes inextricably and unavoidably involved in employees' personal and medical affairs. *Thus, competing interests between the worker's desire for privacy and the employer's legitimate interest in the health of the worker create sensitive ethical and legal dilemmas for physicians who practice occupational medicine* [italics added].

While many physicians might worry that the Health Insurance Portability and Accountability Act (HIPAA) would be an important consideration in talking with the patient's employer and conclude that any communication with the employer could result in the patient's losing his job and could also jeopardize the patient's confidentiality, there are explicit exceptions in the HIPAA regulations *and* processes for initiating an

investigation either with the Occupational Safety and Health Administration (OSHA) or the state occupational safety and health authority without disclosing the patient's identity. When neurologists are faced with ethical and legal dilemmas in a subject area for which they are probably unfamiliar (eg, toxicology, workplace hazards, and OSHA regulations), it is very important to conduct research and seek advice before reaching conclusions about what may or may not be done. There are exceptions to HIPAA that expressly permit the disclosure of personal health information to public health authorities who are ". . . authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability" (Public Welfare, 45 CFR Sect. 164.512(b)(1)(i), 2000). Therefore, even if physicians are regarded as being "a covered entity" for the purposes of HIPAA, the law still permits them to provide requested medical information to the National Institute for Occupational Safety and Health (NIOSH) or OSHA as "public health authorities."

In addition, the OSHA regulations (29 United States Code 657, Section 8) specifically state that employees have the right to request that their identity be kept confidential if they do not want their employer to know who filed a claim (US Department of Labor Occupational Safety and Health Administration, 2008a). Thus, one approach the physician could have taken in the case was to review the OSHA Workers Rights (2008b) explanation of confidentiality with the patient so as to reassure the patient that an OSHA investigation could be initiated without revealing the patient's name to his employer. OSHA also has a standard (Hazard Communication Standard) that requires employers to provide employees and their "representatives" with information concerning chemicals in the workplace.

Suppose the patient were not persuaded by review of the OSHA regulations and the protection they provide? Regrettably, the OSHA Act, as originally written in 1970, does not list an employee's personal physician as one of the "representatives" who can legally request information about workplace hazards on the employee's behalf. The physician, however, still has the option of contacting NIOSH to obtain advice while preserving the patient's confidentiality, and NIOSH physicians and staff will often ask physicians to call OSHA when there is an imminent danger or, in the case of potential exposure to other workers, when there is suspected harmful exposure that needs prompt attention (personal communication July 7, 2008, with Bruce P. Bernard, MD, MPH, Captain, USPHS, Chief Medical Officer, Health Hazard Evaluations and Technical Assistance, CDC/NIOSH). The approach of seeking expert advice is consistent with the AAN Code of Professional Conduct, Section 2.2, Consultation, which advises that neurologists should obtain consultations when indicated, and the obligation to "cooperate and comply with reasonable requests from . . . government agencies within the constraints of patient privacy and confidentiality," is described in Section 4.2, Respect for Agencies and the Law, (American Academy of Neurology Professional Association, 2008).

RESPECT FOR AUTONOMY

▶ Respect for patient autonomy is an important ethical principle because it furthers human dignity. Respect for autonomy requires physicians to permit the patient's values and health care preferences to guide decisions for care, so-called patient-centered medicine. In this case, the patient's refusal to permit the physician to speak with his employer and his refusal of treatment may or may not be rational and informed. Because of his possible intoxication or a psychiatric disorder the patient may conceivably lack decision-making capacity, a concept that neurologists usually apply to patients with dementia or

diminished levels of consciousness, but which would also apply to patients with encephalopathy or delirium. Patients who lack decision-making capacity cannot give a valid refusal of treatment. In the case as described, the physician cannot restrain or force the patient to have the testing, but because the risks of the diagnostic testing and treatment presented in the case are relatively minor, the physician should seriously contemplate the possibility of overriding the patient's autonomy in order to protect the patient.

In these situations, physicians should carefully document their recommendations as well as the patient's stated reasons for refusal. Consultation with an ethics committee or an attorney familiar with health law would be necessary before the physician could take steps to protect the patient by requesting or requiring a surrogate decision maker or by overriding the patient's autonomy, actions that would most likely require challenging the patient's competency before a court of law.

NONMALEFICENCE AND BENEFICENCE

▶ Physicians have a responsibility to minimize harm and keep the best interests of the patient as a main focus. More difficult issues in this case are that the patient's behavior suggests paranoid thinking and there exists the possibility of a toxic encephalopathy from a chemical ingestion. As a result, it appears that the patient's decision-making capabilities are impaired. His actions are most likely harmful to his health status as well as the possibility of harm occurring to his coworkers, who may be at risk for a toxic exposure. Physicians have a duty to warn if they feel the patient is an immediate threat to him- or herself or others (see the AAN Code of Professional Conduct, Section 5.5, Conflicting Ethical Duties). Even though the duty to warn is usually in the setting of a patient directly threatening an identified third party with physical harm (as in the 1976 Tarasoff case) (Tarasoff v Regents of University of California, 17 Cal.3d 425, 2008), or in the setting of a patient placing a third party at risk of a transmissible disease (as with sexually transmitted diseases), some experts feel the duty to warn can be extended as a duty to warn OSHA, NIOSH, or the patient's employer because other workers may be at imminent risk because of a dangerous condition in the workplace. The physician has the right to make a complaint to OSHA on behalf of the patient but can also make an anonymous complaint to OSHA about an employer.

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