THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

Commonly Encountered Clinical Dilemmas: A Case-Based Interactive Approach to Medical Ethics

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Session objectives

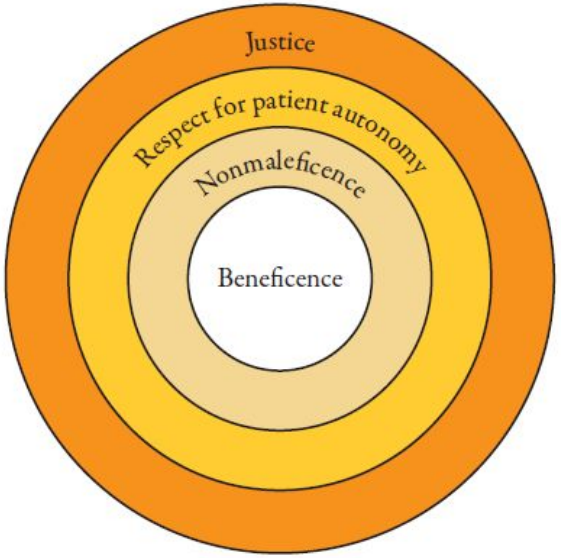
- Identify and differentiate the four prima facie principles of ethics
- Describe the case analysis approach to ethical dilemmas in clinical practice
- Identify and describe approaches to commonly-encountered ethical dilemmas in clinical practice

Clinical ethics

Beauchamp and Childress. *Principles of Biomedical Ethics*, 6th ed.

- Definition: the identification, analysis, and resolution of moral ("should") problems that arise in patient care
- *Prima facie* ethical principles:
  - Beneficence
  - Non-maleficence
  - Respect for patient autonomy
  - Justice

These principles often are at odds with each other.



Swetz and Hook, in Mayo Clinic IMBR Review, 11th ed., 2016.

Case 1

- 72-year-old man is alert and oriented to person, place, time (mostly) and situation.
- He scored a 19/30 Mini Mental Status exam, most deductions for short-term recall, attention and concentration.
- Patient has a liver mass that is readily accessible by percutaneous biopsy, and he has no other major risk factors for complications.
- You recommend biopsy of the mass
- Patient agrees to procedure; he can articulate the basic risks and benefits

Case 1
What do you do next?

1. Proceed with the biopsy as you have obtained adequate informed consent
2. Given the MMSE score, you must obtain consent from a surrogate
3. Obtain a psychiatry consult to determine if the patient has capacity
4. Call the Legal Department for advice

Reflection Questions

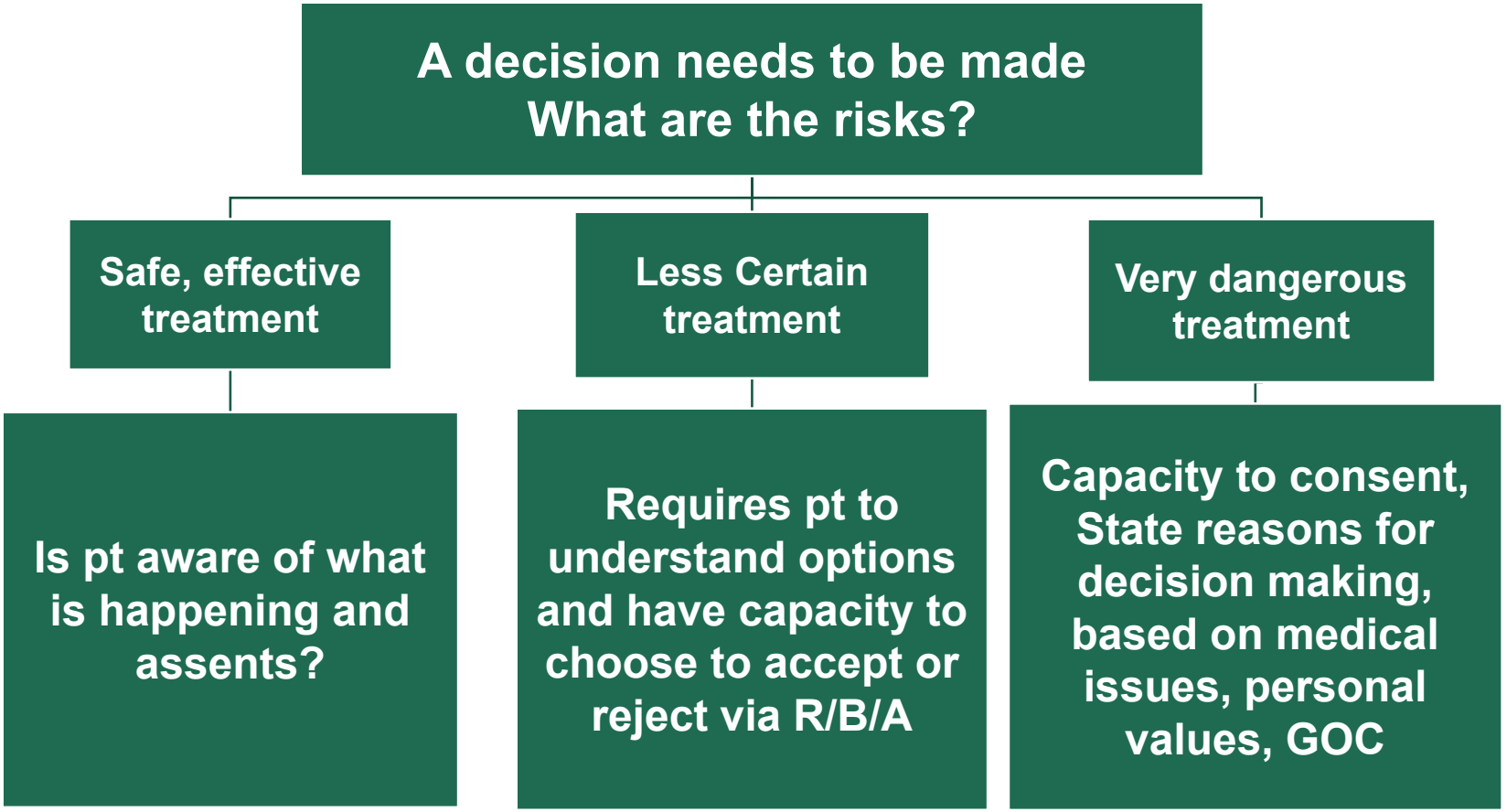
- How is *competency* determined?
- How does this differ from *capacity*?
- What factors impact medical decision making?
- Is autonomy absolute?
- How have goals evolved over time

Requirement for Informed consent

- **Informed consent**: must have **liberty** and **agency**

- **Determination of agency**
  - *Competency* is a legal term; under the law, competency is presumed
  - *Decision-making capacity* is a clinical term; clinicians determine decision-making capacity

The Sliding Scale of Capacity



Drane J. JAMA 1984;252:925-927

Case 2

- 71-year-old female Jehovah's Witness presents with life-threatening epistaxis
- Citing her religious beliefs, she declines a blood transfusion
- You have assessed patient and concur despite bleeding, she maintains decision making capacity and family agrees with her decision

What should you do?

Case 2

1. Transfuse her despite her refusal
2. Obtain a psychiatry consult since her refusal is irrational
3. Respect her decision and treat her without blood transfusions
4. Advise her to seek treatment elsewhere

Exceptions to obtaining informed consent

- Emergency
- Patient waiver
- Patient is incompetent or lacks decision-making capacity
- Therapeutic privilege
  - Rarely used
  - Consider involving a psychiatrist

Religious beliefs and medical decisions

- Issue is autonomy; patients have beliefs that influence their preferences
- Beliefs are not evidence for incapacity
- Courts have intervened for patients
- Respect, negotiate and don’t abandon
- Treat if you don’t know
- What if you conscientiously object?

Case 2b
You are a family physician, what would you do if the patient was 8 years old?

1. Transfuse her despite her refusal
2. Obtain a psychiatry consult since her refusal is irrational
3. Respect her decision and treat her without blood transfusions
4. Advise her to seek treatment elsewhere

Religious beliefs and children

- Issues: autonomy, decision-making capacity and informed consent
- Courts have consistently intervened to order transfusions for minor children of Jehovah's Witnesses
- Similar for other religious groups
- What about adolescents?

Case 3

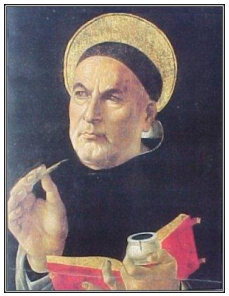
- 68-year-old woman with metastatic breast cancer hospitalized for pain control; she had been home hospice receiving sublingual morphine without benefit
- You write for a morphine infusion at 2mg/hr
- The patient dies several hours later, but nurses are concerned as the patient's respiratory rate was highly irregular and just 4 breaths/min just prior to death

Which of the following best describes what happened?

Case 3

1. Good palliative care
2. Medical Error / Inappropriate Dosing
3. Euthanasia
4. Physician or Medical Aid in Dying

The doctrine of “double effect”



Thomas Aquinas, *Summa Theologica*, 13th century

- 4 conditions for a potentially harmful act to be justified

2. The act must be good or morally neutral.
3. The agent may not positively will the bad effect but may permit it.
4. The good effect must be produced directly by the action, not by the bad effect.
5. The good effect must be sufficiently desirable to compensate for the allowing of the bad effect (proportionality).

Integrity in the Process of Palliative Sedation

Assumptions to fit ethical framework outlines

- Physician intent
  - Must be unambiguous and genuine relieve suffering
- Proportionate response
  - The selection of medications is appropriate given patient profile (goals of care, sx, etc)
- Success of the intervention
  - Death of the patient is not criterion for success, and goals of care should be met with proposed sedation

Case 4

- 65-year-old man with metastatic lung cancer and sepsis is now in a coma
- His advance directive (AD) states that he does not want life-sustaining treatments initiated or continued if his chance of recovery is small
- The family requests that IV fluids be discontinued; **what do you do?**

Case 4

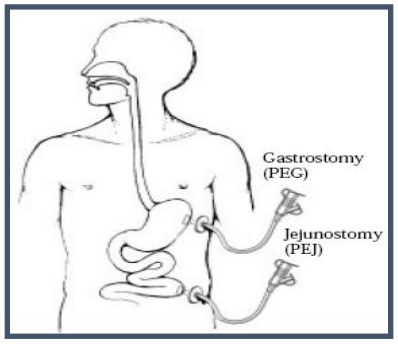
1. Withdraw the IV fluids
2. Refuse to comply with the request as hydration is not a medical treatment
3. Ethics consult
4. Refuse to comply with the request since there is no clear and convincing evidence the patient would not want IV fluids in this situation

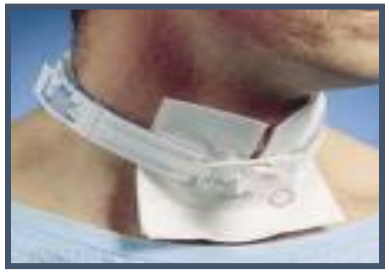
Differentiating Concepts

- DNR/DNI Orders
- Withdrawal of Life Support
- Advance Directives
- Goals of Care

These are not all the same thing and might not be best discussed all at once.

It goes beyond
“What is your code status?”





Case 4b

- 65-year-old man with metastatic lung cancer and sepsis is now in a coma
- His advance directive (AD) states that he does not want life-sustaining treatments initiated or continued if his chance of recovery is small
- The patient is on pressors and is intubated and is still hypotensive and with runs of V. tach.
- The family insists that they know his wishes were as stated above but they want everything done to give him a chance for a miracle.

Case 4b

1. Stop all medical treatments and allow for death to occur.
2. Ethics consult because you still aren't sure what to do.
3. Refuse to comply with the request of the family since there is no clear and convincing evidence the patient would want this treatment
4. How you answer the questions depends on where you work and what your state or hospital policy is
5. Since this isn't a standardized test, I won't pick one of the above because I'm still not sure

Case 4c

- 78-year-old man with COPD and dementia is in your clinic febrile and confused.
- You DO NOT think he would benefit from hospitalization or aggressive care
- His wife requests that “everything be done”, including admission to ICU and ventilation

What do you do?

Case 4c

1. Proceed with hospitalization and aggressive life-sustaining treatments
2. Request ethics consultation
3. Transfer the patient to another institution
4. Unilaterally Place DNR Order
5. Protective Custody Order

Precedence of landmark cases

Not a right to die, but a right to be left alone

- A competent patient has the right to refuse or request the withdrawal of LSTs
- The incompetent patient has the same right (exercised through a surrogate)
- Hierarchy of surrogate decision-making
- The court is not the place to make these decisions
- No case must go to court
- No difference between withholding and withdrawing
- Artificial fluid and nutrition are medical treatments
- No physician liability for granting such requests

Withholding and withdrawing LSTs, Palliative sedation, PAiD and euthanasia: What are the differences?

	Withhold LST	Withdraw LST	Palliative Sedation and Comfort Care	Physician Aid in Dying (PAiD)	Euthanasia
Cause of death	Underlying disease	Underlying disease	Underlying disease *	Intervention prescribed by physician and used by patient	Intervention used by physician
Intent/ goal of intervention	Avoid burdensome intervention	Remove burdensome intervention	Relieve symptoms	Termination of the patient's life	Termination of the patient's life
Legal?	Yes[+]	Yes+	Yes	No ^	No

LST = life-sustaining treatment
[+] There is variability in power of surrogates regarding LSTs by state in the USA.
* Palliative sedation may hasten death ("double effect"), though has come into question recently.
^ PAiD is legal in a few states, and this is evolving with every election cycle.

Swetz, Hook, and Mueller 2013 (updated)
Olsen, Swetz, and Mueller 2010

The law and advance directives

- Patient Self-Determination Act: protects a person's healthcare decisions via the AD
- AD must be honored if requests are reasonable and treatments available
- Surrogate must honor AD
- You cannot deny care if no AD
- What if the patient doesn't have an AD?

Case 5

- 71-year-old woman in a PVS due to anoxic brain injury
- Her advance directive names her daughter and son as her surrogates
- Her children claim she would want “everything done”
- Her husband demands withdrawal of life-sustaining treatments (LSTs) including a feeding tube

Who is the most appropriate surrogate?

Case 5

1. The husband
2. The children
3. A consensus of the husband and children
4. Given the conflict, no obvious surrogate exists and one must be appointed by the court
5. I need to know where the case is and what the state law says.

Advance directives

- Instructions for the time when one lacks decision-making capacity
  - Surrogate decision-maker
  - Specific healthcare instructions
  - Examples: living will, POA for healthcare
- Should be regarded as an extension of the fully autonomous person
- All 50 states and DC

What to do if the patient lacks decision-making capacity?

- Court-appointed guardian
- Advance directive
- Surrogate decision-maker:
  - Hierarchy varies from state to state
  - Must follow AD and use “substituted judgment”: “If the patient could wake up for 15 minutes and understand his or her condition fully, and then had to return to it, what would he or she tell you to do?”
  - “Best interest” if wishes unknown

The law and advance directives

- Federal law: Patient Self-Determination Act:
  - Passed in response to *Cruzan*
  - Clarify and protect a person's healthcare decisions via the AD
- AD must be honored if requests are reasonable and treatments available
- Surrogate decision-making

Tools for Caring for Dying Patients

DNR means

"**Do NOT Resuscitate** in the event of Cardiac Arrest"

Nothing Else

Some institutions now use the terms

Do Not Attempt Resuscitation

Allow Natural Dying

DNR Orders

- A DNR order may be compatible with maximum therapy…
  - Short of intervention for cardiac arrest

- ACLS Therapies administered for non-arrest emergencies may be given to a DNR patient:
  - Elective endotracheal intubation and assisted ventilation for respiratory failure
  - Elective cardioversion for symptomatic arrhythmia

Do Not Intubate (DNI) Orders

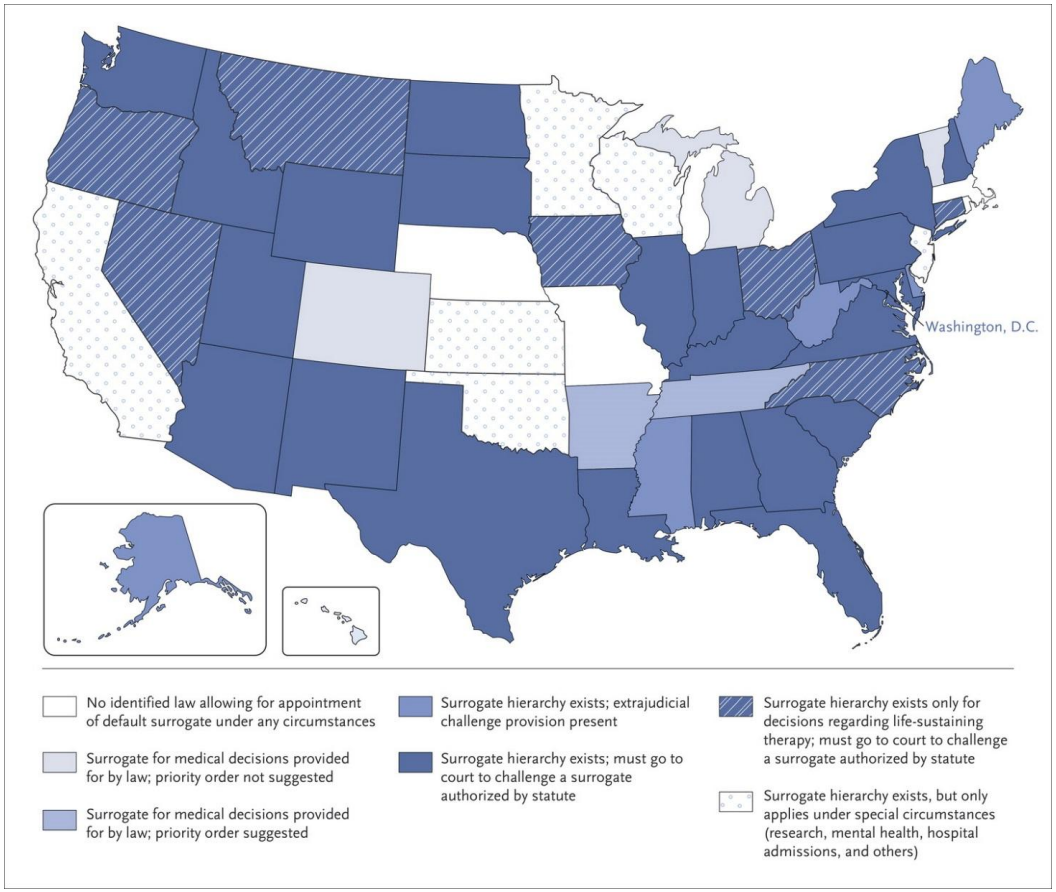
- A DNI order prohibits endotracheal intubation during both cardiac arrest and non-arrest situations.
- A DNR order should almost always accompany a DNI order:
  - Rare exception

DNR/DNI Orders

Informed Consent and CPR

- Universal presumption of consent to CPR
- Patients should be informed of this fact
- Discussions should be pursued as with any informed consent discussion:
  - goals
  - outcomes data
  - possible consequences and side effects

Surrogate Hierarchy State-by-State



DeMartino ES et al. N Engl J Med 2017;376:1478-1482.

Case 6

- 76 year-old woman with BRBPR and anemia; you are concerned she has colon cancer and you recommend colonoscopy; she speaks no English
- Her son demands that you not say the word “cancer”; they claim that in their culture patients are not told bad news

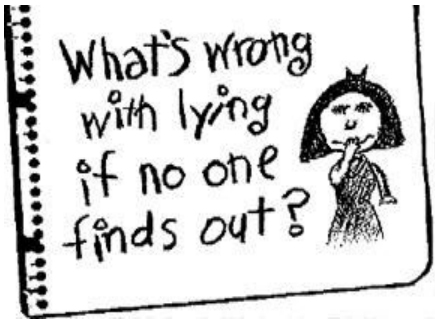
What do you do?

Case 6

1. Through an interpreter, discern the patient's desires for information
2. Comply with the son's demands
3. Proceed with colonoscopy and if a cancer is found, use obtuse terms to describe the findings
4. Refuse to comply with the son's demands and tell the patient the information

Purposes of truth-telling

- Respect patient autonomy
- To inform patients
- To allow patients to make informed decisions
- We have an ethical and legal obligation to tell the truth



Patient-centered Outcomes: Determining the Goals of Care

Exceptions to telling the truth

- Emergency
- Patient waiver
- Patient is incompetent or lacks decision-making capacity
- Therapeutic privilege

Truth-telling and cultural sensitivity

- Many patients delegate decision-making; varies from culture to culture
- Clinician discernment is a moral obligation

> "Thrusting truth on a patient who delegates "is a gratuitous and harmful misrepresentation of the moral foundations for respect for autonomy."

Edmund Pellegrino (*JAMA* 1992;268:1734)

Helpful tips

- Good communication often prevents ethical dilemmas
- Legal consultation may be helpful
- An Ethics Consultation Service may be very helpful in parsing out complex situations, or Palliative Care is the issue is more clinical and related to serious illness

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Thank you!

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