Case Studies from Clinical Ethics

Is it ethically permissible to treat patients over their objections?

VT/NH Society for Respiratory Care
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Disclosure

I have no financial disclosure or conflict of interest regarding material presented here today.

Introduction and Objectives

Objectives:

1. Review the 4 ethics principles, define clinical ethics
2. Explore how the principles and state law guides clinical practice when encountering patient refusals
3. Apply the principles and the law to clinical scenarios

Bioethics

A field of study and specialty practice that examines the intersection of moral philosophy, law, ethics and health sciences.

- Bioethicists are multidisciplinary professionals, and their work often arises from primary fields of expertise.

- Four main branches; theory, research, policy and clinical.

The Principles

- **Autonomy:** moral obligation to support, facilitate, and respect self-determination.

- **Beneficence:** moral obligation to provide beneficial treatment; acting in the patient's best interest; promoting good.

- **Nonmaleficence:** moral obligation of refraining, avoiding and protecting patients from harms, including physical, emotional and financial harms.

- **Justice:** fairness – moral obligation to treat like patients alike, as well as fair and appropriate stewardship of resources.

Beauchamp and Childress (2012)

Clinical Ethics

Defined as **identification**, **analysis** and **resolution** of moral and ethical problems encountered during the care of an individual patient. (*ASBH Core Competencies, 2011)*

Rarely a matter of right or wrong, more often about the least bad option.

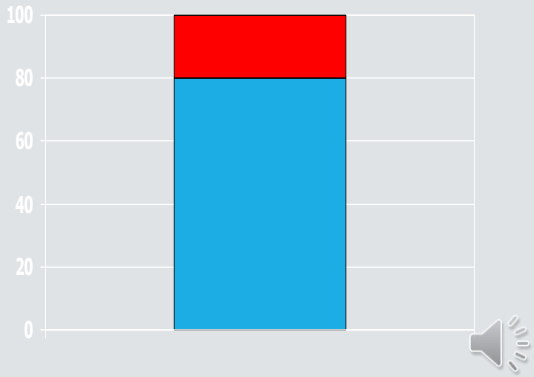
The Basic DMC Rule

Decision making capacity (DMC) is decision dependent, adults are presumed to have it.

All adult patients have the right to accept or refuse our offerings, **irrespective of DMC.**

- Refusals can be verbal or nonverbal
- Refusals can be informed (with capacity) or simple dissent (limited/lack of capacity).

Competence vs. Capacity



Ethical Framework for Decision-Making

AUTONOMOUS

- Decisions made **voluntarily** by an individual who has the **capacity** & **ability** to make decisions on their own behalf

SURROGATE

- Decisions made by someone who is **not the patient**
- Obligation is to the patient's values/best interest at minimum

Case 1

72 year old male with COPD, HTN, CKD, HF; DMC intact and now s/p repair of perf bowel

Remains on vent, ARF with dialysis

ACP names wife/both daughters as agents, “middle of the road”, would not want to be prolonged or have feeding tube.

Wife/daughters insist “everything”, but patient is shaking his head and pushing us away

Case 1, part 2

Patient worsening, now septic, CRRT initiated, vent, trach, settings increased, 2 pressors, MDs questioning reasonability of goals

Patient mouthing “no more” and shaking his head “no”, straining at restraints when awake

Agents pressing for full measures

Is it ethically permissible to continue?

Many Shades of Treatment Over Objection (Uses of Force)

- Chemical or physical restraint (not med/surg or Code 8)
- Sitters/Stand-by
- Isolation/Seclusion/Locked units
- Covert medication
- Undue influence or coercion (verbal, physical, resources)
- Medical hold

Ethically impermissible, few exceptions

Uses of force violates the ethical principle of **nonmaleficence** – infringes on:

- individual liberties
- violates bodily integrity (respect for persons)
- breaches trust
- fractures clinician patient relationship
- can cause enduring trauma, etc.

When is it ethically permissible to treat over objection?

When patients lack DMC and there is emergent need:

- Provide standard of treatment* and stabilize
- Once stabile, seek assent, or at least, not refusing
- Consider proportionality (benefit/burden) and utilize least restrictive measures
- Uses of force can not be a plan. For ongoing needs, will need to consider justification* and oversight.

Case 2

52 year old male with hx of multi substance misuse, pulmonary edema, HFpEF, homelessness

Found down, evidence of CPR

3rd presentation/week, AMA x2

Profound hypoxia (O2sat 70's), refusing

Can we treat over objection?

Refusals

CANNOT treat a patient over their objection (even if they lack capacity) unless:

They have an AD with a properly executed Ulysses Clause, and

- The agent authorizes the treatment;

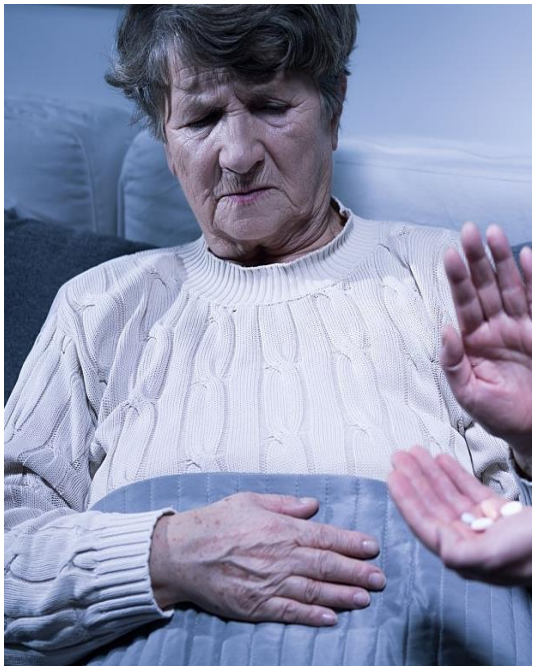
OR

- They lack capacity, will suffer serious and irreversible bodily injury or death if the health care cannot be provided within 24 hours, and:

(i) they do not have an agent or an applicable provision in an advance directive, or the agent is not reasonably available; or

(ii) the agent or advance directive authorizes providing or withholding the health care.

18 V.S.A § 9707 (g)



Case 3

Older, male patient with advanced/irreversible heart and lung disease

Admitted with DMC, wants “to stay alive as long as possible, but no ventilator”

Names wife as HCA, other family is at bedside

Pulls BiPAP off when awake (“NO”), family holding him down and asking for staff assistance “he wants this…you have to help!!”

Is this ethically permissible?

Take aways

- Is this REALLY emergent, or is there time to think?
- If capacity is lost, can it be restored?
- Utilize least restrictive measures/avoid disproportionate harms
- Seek assent, or at least, lack of refusal. Persuade, redirect, compromise
- Know the legal framework in your state, clarify with policy and/or your legal/risk department
- Document, document, document

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Thank you!