Medical Ethics for the Underserved: A Case-Based Approach to Complex Medical Decision-Making

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Workshop Goal and Objectives

• Discuss principles of medical ethics which may impact your practice

  • Apply 4 basic principles of medical ethics to sample cases
  • Understand capacity determination and informed consent
  • Consider point-of-care resources and references for complex ethical challenges

Acknowledgements and Disclosures

• No disclosures

• With gratitude to:
  • our patients who have who have taught us the importance of these principles
  • our colleagues at ZSFG and UCSF for collaborative work in medical ethics

Consumer Warning

This session may cause the following side effects:

• Confusion
• More questions than answers
• Perspective about how values may inform our care decisions
• Sense of how ethics impacts healthcare
• Skills to help you in the future
What principles guide medical ethics?

**Autonomy**

*A consenting person should have the right to choose their healthcare plan according to their values/preferences*

Can you describe a situation where autonomy is valued above other considerations?

**Beneficence**

*The duty to do well by our patients – to bring about those improvements in our patients’ health that medicine can achieve*

Can you describe a situation where beneficence is valued above other considerations?
Non-maleficence

“First do no harm” – providing medical care in the manner which reduces risk to the greatest extent possible

Can you describe a situation where non-maleficence is valued above other considerations?

Fairness / Distributive Justice

Resources and responsibilities in healthcare should be distributed in an equitable way to all participants in a system

Can you describe a situation where fairness/justice is valued above other considerations?

How to apply medical ethics to a patient case?

An “Ethics H&P”

- ID/CC
- HPI
- PMHx
- Social Determinants of Health
- Ethical Issues
- Group discussion/consultation
- Next Steps
The “Four Box” Approach

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*From Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*

Let’s apply the principles to cases...

**Case 1**

Mr. S, a 32 year-old man, is hospitalized with alcohol withdrawal and delirium tremens. You are his hospital provider.

- He becomes *severely agitated* and wants to leave the hospital.
- The charge nurse calls for your *assistance in managing the patient.*
**Case 1: Personal Reflection**

- Questions? Thoughts?
- What are your next steps?
- Which ethical principles are involved?
- What emotional response do you feel?

**Case 1: More Info about Mr. S**

- Mr. S wants to **go home to take care of his dog**.
  - **Lives alone; no friends** to feed/walk the dog.
- **IV lorazepam at high doses** q1-2 hours for withdrawal
- **Care for his withdrawal after discharge?**
  - Mr. S says “I’ll be fine. Prescribe me some medicine and I promise I will take it.”

**Case 1: Discussion**

**Informed Refusal and Capacity Impairment**

**Informed Consent**

- A **central process** in the modern **provider:patient relationship**
- **Provide unbiased information** to the patient about care options (**beneficence, non-maleficence, honesty**)
- **Allow the patient to discuss options and choose** the most preferable (**autonomy, dignity**)
- **Not all patients can provide informed consent**
Capacity for Informed Consent

*Does the patient:*

1. Understand the nature of the medical illness?
2. Communicate a consistent choice?
3. Understand the risks/benefits of the recommended treatment and of alternative treatments (including doing nothing)?
4. Manipulate information rationally in making a decision?

Myths about Capacity

- Capacity = durable, comprehensive, one-time determination
- Capacity = competency
- Psychiatric hold and/or psychosis = automatically lacks capacity
- Two physicians are needed to determine capacity
- Only psychiatry or neuropsychology can determine capacity
- If psychiatry/neuropsychology weighs in, you are bound to follow their determination of capacity
- If patients lack capacity, providers can pursue any course they want

Capacity Resources (click to open)

- A Clinical Decision Algorithm for Hospital Inpatients with Impaired Decision-Making Capacity; JHM 2015
- The Violent or Agitated Patient; Emer Med Clinics, 2010

Case 2
Case 2

Your primary care patient, Ms. L, is a chronically homeless woman with severe paranoid schizophrenia. She sustains a high cervical spine fracture with diaphragmatic paralysis. She is intubated and ventilator dependent.

You are called by the inpatient social worker to assist with care planning. The ICU recommends a tracheostomy and transfer to a LTAC (long term acute care) facility.

Case 2: Personal Reflection

- Questions? Thoughts?
- What are your next steps?
- Which ethical principles are involved?
- What emotional response do you feel?

Case 2: More Info about Ms. L

- Even when awake, Ms. L is unable to communicate her values and preferences about healthcare due to psychosis.
- No family/friends who can help make decisions for her
- Ms. L’s nurses feel uncomfortable with the situation: “she winces and tears come to her eyes every time I suction her. She’s suffering. I feel like I’m torturing her. Isn’t this futile?”
- Historically, she has been avoidant of medical care except treatment of discomfort.

Case 2: Discussion

Complex decisions and unbefriended people
Caring for the Unbefriended

• **No close contacts** to provide collateral information about the patient’s values, or to step in as a surrogate if necessary.

• **For incapacitated patients, the medical team must balance:**
  - Confidence in benefit of interventions (often invasive)
  - Limit unintended patient harm (e.g., Adverse effects, treatment failure)
  - Reduction in patient autonomy (e.g., institutionalization)
  - Intrusion into dignity (i.e. life of the **patient** vs life of the **person**)

• **Patient’s life pattern** can elucidate preferences and values

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**Case 3**

**Ms. H**, your primary care patient, is a 29 year old woman with **HIV**, is diagnosed at **22 weeks of pregnancy** with **cocaine-induced hypertension**. Ms. H’s partner is **physically abusive** and he is **unaware** of her HIV diagnosis.

Her obstetrician contacts you to discuss her HIV and cocaine use disorder.

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**Resources (click to open)**

- Making Medical Decisions for Patients without Surrogates; **NEJM, 2016**
- The Unbefriended Patient; **JGIM, 2013**
Case 3: Personal Reflection

- Questions? Thoughts?
- What are your next steps?
- Which ethical principles are involved?
- What emotional response do you feel?

Case 3: More Info about Ms. H

- Ms. H's partner is physically abusive and restricts her freedom of movement in the community. They use cocaine together. She is not ready to leave him.
- Partner says he would kill her if he discovered she is HIV+.
- Ms. H declines to receive HIV medications or cocaine treatment at her OB visit.
- Her obstetrician calls you and insists "you must treat her HIV and get her off cocaine. Should we call CPS?"

Case 3: Discussion

Risk reduction, autonomy and coercion

Care of At-Risk Pregnant Women

- Developmental theory/legal experience support the mother-fetus as an integral dyad.
- Legal efforts to protect the fetus as a separate entity often criminalize/restrict maternal behavior.
- Coercive efforts to change maternal behavior have not been shown to improve outcomes for the child – likely owing to the complex interdependence of maternal-child health.
Resources

- Refusal of Medically Recommended Treatment During Pregnancy; Committee on Ethics, American College of Obstetricians and Gynecologists, 2016
- Ethical Dimensions of HIV/AIDS; HIVinSite, UCSF

Conclusion

Lessons Learned

- Elicit & incorporate the patient's values into decision
  - What does/would the patient want?
- Reflect on your own reasoning
  - What's driving my decision for this patient?
- Know your limits
  - When should I reach out to colleagues?
- Utilize supportive resources
  - Colleagues, mentors, hospital ethics committee, hospital/health system risk management

Hospital Example: ZSFG Ethics Committee

- Multidisciplinary
  - MD, RN, SW, skilled therapists, chaplaincy, risk management, university philosophy professor/chair, community attorney
- On-call pager (24/7) or email
  - Phone consultation
  - Ethics Committee in-person consultation

ZSFG Ethics Consultation Intro Sheet (click to view)
Selected Resources in Medical Ethics
(click to open)

Centers with Online Curricula:
• Markula Center for Applied Ethics at Santa Clara University
• The Hastings Center
• UCSF Ethics Curriculum – Fast Facts

Journals:
• AMA Journal of Ethics (Virtual Mentor)
• Hastings Center Report
• Journal of Medical Ethics (BMJ)

Textbooks:
• Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine

References
• Eprognosis.ucsf.edu
• Ethical Dimensions of HIV/AIDS; HIVInSite, University of California San Francisco
• Introduction to Ethics Consultation, San Francisco General Hospital Ethics Committee, 2015.
2/25/2017

BONUS: Case 4

Case 4

Mr. J, a 42 year-old man, sustains a severe intracranial hemorrhage. Your hospital’s neurosurgeon performs a craniotomy and hematoma evacuation.

Mr. J patient survives in a persistent vegetative state. He has chronic respiratory failure and tracheostomy dependence. He is transferred to your care after two episodes of VAP.

On hospital day 45, Mr. J develops a CLABSI, NSTEMI and renal failure. The nephrologist recommends hemodialysis.

Case 4: Personal Reflection

- Questions? Thoughts?
- What are your next steps?
- Which ethical principles are involved?
- What emotional response do you feel?

Case 4: More Info about Mr. J

- Mr. J’s family, previously estranged for many years, request that the medical team “do everything” to keep Mr. J alive.

- Based on advancing multi-organ failure, the consulting ICU physician thinks that Mr. J has a terminal prognosis, but she feels compelled by the family’s request to continue life prolonging measures.

- The nursing & respiratory care teams feel increasingly distressed about the situation and turn to you for guidance.
Case 4: Discussion

Conflict and end of life decisions

Ethics of Care for Dying Patients

- Surrogate decision making can be complicated by grief and other factors specific to the surrogate
- Hospitals and health systems generally support providers in their discretion to avoid non-beneficial care
- Palliative care techniques may assist in finding consensus with patients and families at end of life
- Ethics consultation may help to limit the use of non-beneficial treatments including ICU days for patients who die in the hospital.

Resources (click to open)

- Effect of Ethics Consultations on Non-Beneficial Life Sustaining Treatments in the Intensive Care Setting: JAMA 2003
- Eprognosis.ucsf.edu
- AAHPM Statement on Withholding and Withdrawing Interventions, 2011