Inside Bioethics and Ethical Decision Making: Application with Suicide Attempt with Do Not Resuscitate Orders

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Announcements & House Keeping

- I have no conflicts to report
- I am not personally receiving any payment for this presentation. If an honorarium is being provided, all will go directly to the Center for Practical Bioethics, a non-profit entity.

Objectives

- What is ethics/medical ethics/clinical ethics?
- How do you recognize ethical issues?
- How can you utilize ethical decision making in clinical situations?
- How do you apply these to situations involving pts with suicidal ideation and DNARs

Case Scenario 1

- Mrs. S is a married 35-year-old pregnant childless woman who has lost four previous pregnancies between 16 and 23 weeks gestation. She currently has reached 23 weeks and 3 days of gestation, her fetus is seemingly healthy, and has an estimated weight of 550 grams (+/-1.2 lbs). She has ruptured her bag of waters and is now having labor that seems unstoppable with medication. Delivery seems inevitable.

Mrs. S questions

- Viability?
- Resuscitation?
- Quality of Life?
- How could ethics help?

Case Scenario 2

- Patient is a 90-year-old female, found down and presented to the hospital with multiple comorbidities.
- End-state dementia. Failed multiple swallow evaluations.
- Guardianship process started. Guardian ad litem appointed (public attorney).
- Guardian ad litem was demanding placement of PEG.
- Physician consulted ethics: Does she follow the guardian, or does she follow her medical judgement and refuse?

What is Ethics?

- Def – (1) a general pattern of “way of life”, (2) a set of rules of conduct or “moral code”, and (3) inquiry *about* ways of life and rules of conduct
  - Commonly used interchangeably with “morality”
  - Ethics versus morality
- Main branch of philosophy
  - Metaphysics, epistemology, aesthetics, and logic
    - Metaethics

Encyclopedia of Philosophy. Vol 3, P.81

Bioethics

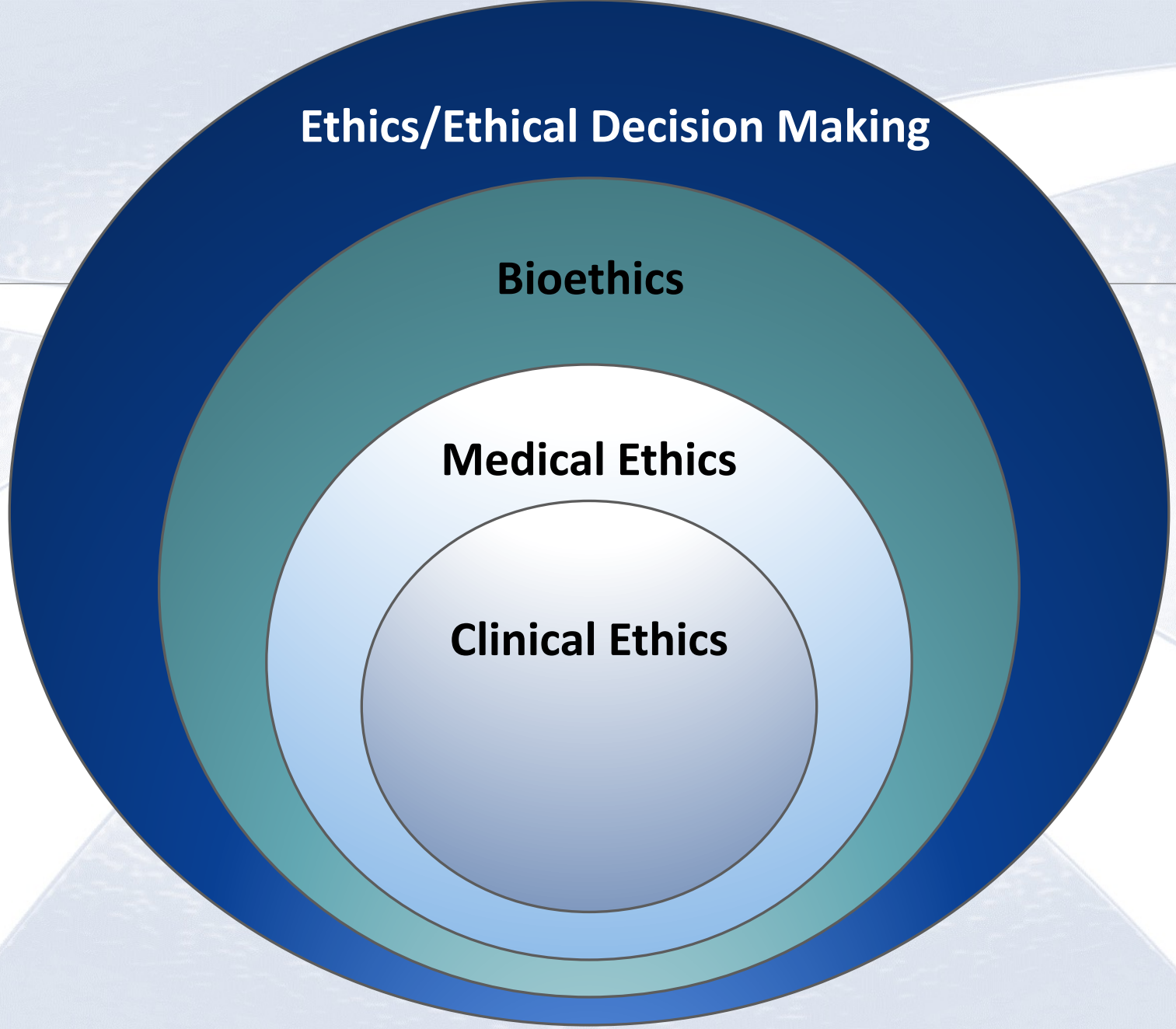
- Def – the subfield of ethics that concerns the ethical issues arising in medicine and from advances in biological science
  - Central area – relation between health care professionals and patients

Clinical Ethics

- Def – a practical discipline that provides a structured approach to assist physicians in identifying, analyzing and resolving ethical issues in clinical medicine.
- Bioethics – Academic, Clinical Ethics – Practical/applied

https://depts.washington.edu/bioethx/tools/ceintro.html

http://www.health.nsw.gov.au/clinicalethics/Pages/what-is-clinical-ethics.aspx


Ethics/Ethical Decision Making
Bioethics
Medical Ethics
Clinical Ethics

Ethical System

- Deontology
- Consequentialism
- Virtue Ethics
- Other systems:
  - Ethics of Care
  - Feminist ethics
  - Principlism

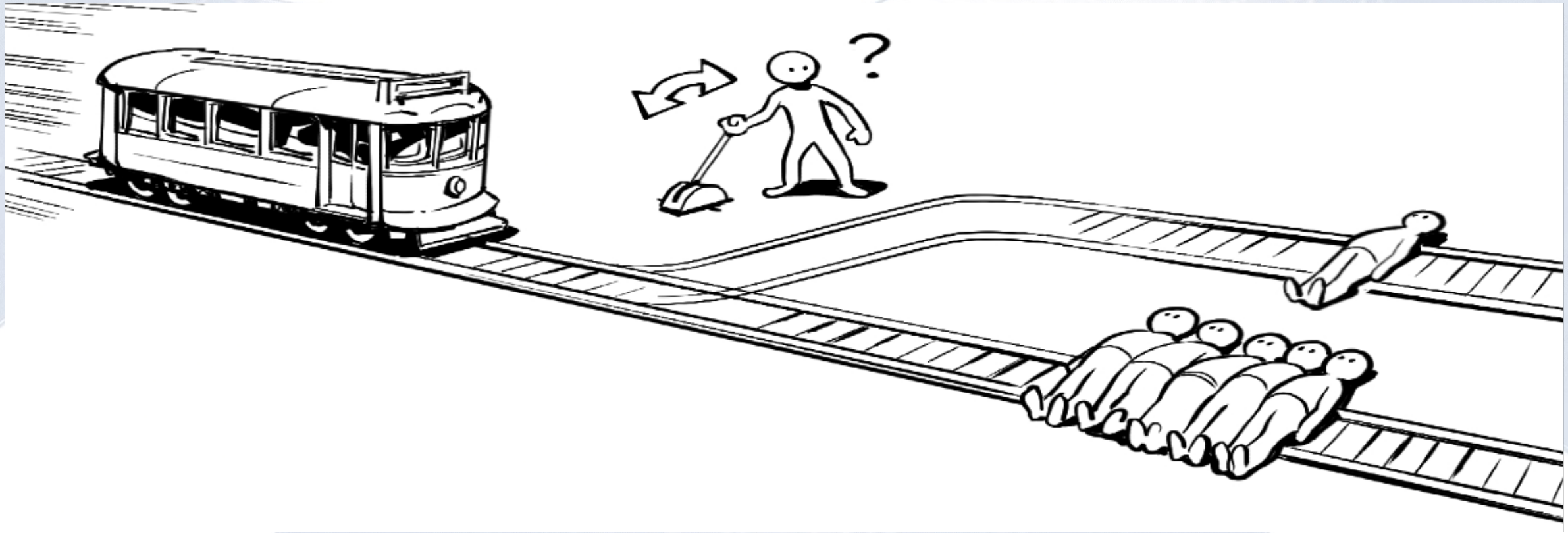
Deontology

- From Greek - duty (*deon*) and science (or study) of (*logos*)
- Immanuel Kant
  - Categorical Imperative
    - Act only according to that maxim whereby you can at the same time will that it should become a universal law.

Consequentialism

- Jeremy Bentham (1789), John Stuart Mill (1861)
- Definition of “good”:
  - That which produces the maximum amount of happiness for all affected
- Procedure for assessing the “goodness” of an action:
  - How much happiness did the action create?
  - Was there an alternative action that would have produced more happiness?
- Internal coherence:
  - Happiness trumps everything else
  - No internal conflicts

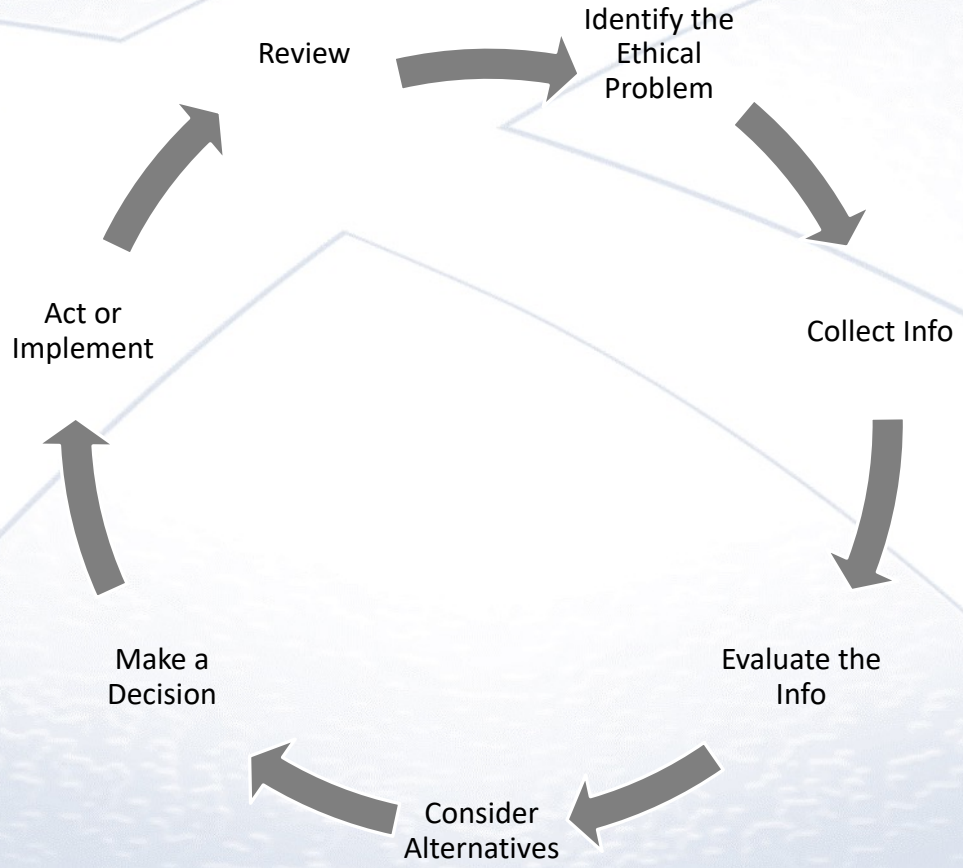
The Trolley Problem



Virtue Ethics

- Aristotle
  - Living in the virtue between two vices
- Saint Thomas Aquinas
  - Principle of the Double Effect
- Alasdair MacIntyre
  - Moral knowledge - “knowing how” rather than a “knowing that”

Ethical decision making?



Principlism

- First developed in 1979 – Belmont Report
- Practical/applied ethics
- Establish principles, then work from them
- Developed by Beauchamp and Childress
  - "The Georgetown System"
- System for identifying ethical conflicts

Ethical Principles

- Autonomy
- Beneficence
- Nonmaleficence
- Justice

Example Case

- A patient complains of frequent urination accompanied by a burning sensation. The physician suspects a urinary tract infection, obtains a confirmatory culture, and prescribes an antibiotic. The physician explains to the pt the nature of the condition and the reason for prescribing the medication. The pt obtains the prescription, takes the medication, and is cured of the infection.

Jonsen, Albert R. (1998). Clinical ethics : a practical approach to ethical decisions in clinical medicine. New York :McGraw-Hill, Health Professions Division

Potential Ethical Issues

Pt does have insurance to pay for medication

- Justice vs beneficence

Pt does not think the medicine will work

- Autonomy vs beneficence

Medication comes with heavy side-effects

- Beneficence vs nonmaleficence

Medicine is a gamble of known pain/suffering for potentially more life

- Risk benefit analysis
- Pt autonomy

Example case 1

- Pt has end-stage type 4 cancer. Pt is requesting another round of chemotherapy but the physician does not believe it will have any benefit.

Autonomy vs. Nonmaleficence

Example case 2

- Pt has an easily treatable stomach ulcer but is declining the treatment plan for alternative medicine.

Autonomy vs. Beneficence

Example case 3

- Pt an extremely premature child, that has a low life expectancy. The physicians believe that continuing care is futile and can be better served for other patients, while the family want all aggressive measures continued.

- Autonomy vs. Justice

Consults try to answer

- Goals of care
- Risks and benefits
- Informed consent

Suicidal ideation with Do Not Resuscitate Orders

- "Joe" is a 62 year old building contractor who has been in an ICU for the past 10 weeks. He had gone to his community hospital for bypass surgery (CABG) and aortic valve repair (AVR), and things didn't go well post-op. His sternal wound became infected with Methicillin-resistant Staphylococcus aureus (MRSA). Sepsis led to acute hypoxic respiratory failure, a tracheotomy, profound hearing loss, and then acute renal failure ameliorated somewhat by hemodialysis. Per chart notes, he is not improving sufficiently to warrant hope for recovery. The best that can be hoped for now, says his critical care physician, is discharge to a long-term acute care hospital (L-TACH). The prognosis does not include any likelihood of return to baseline, or to home. The situation is dire, and Joe seems to "get it".
- On Saturday, he mouths a message to his nurse, and then to the physician who is summoned, and then to an ethics consultant also. "Stop everything. Give me something. I want to die." Joe repeats his request with family at the bedside. In later conversation with the ethics consultant, they express frustration with Joe for wanting to "quit". "That's not Joe. He's stubborn. Never quits. He's been through worse than this, and then went back to work. He must be depressed or not thinking clearly now."
- Joe is deemed to have decisional capacity, per Psychiatry consult. He has been informed already that, "We can't give you something to die. That’s not legal, not in this state." Although that answer seems to frustrate Joe, he continues to ask that "everything stop." No more aggressive treatment. Stop the antibiotics. No more vent. "I want to die." The wife, a sister and two adult children--one of them a nurse in our facility—believe he does not have capacity and is only speaking from depression

Questions on the case

- 1. Is he depressed and not thinking clearly?
- 2. What now should be done for Joe--and his family?

Additional Pt situations

- Death with Dignity Pt
  - 30s F, metastatic breast cancer. In state of Washington.
  - IV drug abuser

- Suicidal attempt – neuro blockers
  - 80s M, ESRD. On hospice
  - Left alone, takes all neuro blocker medication

Say a patient presents in the emergency department after a suicide attempt

- How should you treat this patient?
- If you do not aggressively respond, are you a participant in causing that person's death?
- What if that patient was accompanied by a documented, valid Do Not Resuscitate Order?
- These questions leave clinicians in a difficult position of discerning between the duty to respect the patient's wishes (the principle of respect for autonomy) and obligation to do good (the principle of beneficence)

- There are at least three clinical responsibilities that apply to this situation:
  - 1. "Aggressively treat the immediately life–threatening consequences of a suicide attempt, regardless of the patient's wishes; "
  - 2. "Honor the clearly expressed and verifiable preference of patients who do not wish to be resuscitated;"
  - 3. "If there is doubt regarding the patient's wishes or the validity of a document, initiate resuscitative efforts"

Obligation to the patient

- The clinician's ethical obligation to care for the patient is not suspended because of a patient's willful action in precipitating the reason for treatment. This obligation remains even with attempted suicide.
- Probate Code even in California, a state that legalized physician aid in dying (physician assisted death) in 2015, states: "Nothing in this division shall be construed to condone, authorize, or approve mercy killing, assisted suicide, or euthanasia. This division is not intended to permit any affirmative or deliberate act or omission to end life other than withholding or withdrawing health care pursuant to an advance health care directive, by a surrogate, or as otherwise provided, so as to permit the natural process of dying" (California Probate Code 4653).
- Because suicide is not a "natural process" of dying, a provider would likely be in violation of this Probate Code if care were withheld.

Attempts after an attempt

- Interestingly, many patients whose attempt at suicide fails do not ultimately die of suicide.
- A study following 515 people prevented from jumping off the Golden Gate Bridge between 1937 and 1971 found after 26 years, that 94% were still alive or had died of natural causes.
- Another study conducted by Suominen et al. (2004), which followed persons attempting suicide by poisoning, found 87% alive or dying of natural causes after 37 years (Suominen et al., 2004).
- In 2002, a meta study looking at attempts that led to hospitalization found that 93% did not die of suicide ultimately.
- Clearly from these studies, there is substantial evidence pointing to the long term benefits of treating a patient following a suicide attempt (Owens et al, 2002).

So, what should guide a clinician's response in these situations?

- Patient with capacity
  - the adoption of the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) model is recommended.
  - 1. Identify risk factors
  - 2. Identify protective factors
  - 3. Conduct suicide inquiry
  - 4. Determine risk level and intervention
  - 5. Document
- Patient does not have capacity
  - Casey Frank (2013) says: "The reconciliation of autonomy and protective beneficence is achieved starting with the crucial initial treatment: a liberal dose of the tincture of time"

Conclusion

- What is ethics and ethical decision making
- What is principlism
- How can these apply to complicated medical situations
  - Suicidal ideation

Questions and Contact Info

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