Clinical Ethics Dilemmas: Capitulation to a Patient’s Demands

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Editor’s Note: This column presents a problematic case that poses a medical-ethical dilemma for patients, families, and healthcare professionals. As it is based on a real case, some details have been changed in the effort to maintain patient confidentiality. The intent of this presentation is to offer ethical analysis and medical recommendations that are consistent with biblical principles. In this case, we explore the weakness of professional healthcare when the patient is demanding, the medical team has weak communication, and there is subsequent capitulation.

Column Editor:  
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Question: Should a patient and family be allowed to demand continued medical or surgical care when the physicians believe that the patient will not benefit from further attempts at curative therapy?

Case Presentation:  
WB is a fifty-six-year-old woman with a known history of gastric carcinoma, first proven by biopsy during esophagogastroduodenoscopy (EGD) in October, 2009. The patient had a history of another medical event many years ago in another hospital (details not revealed) where she believes she was deceived by medical staff and underwent a procedure that was unnecessary. During her care following the EGD, WB was scheduled to be seen by an oncologist (Dr. R).
There had been numerous documented discussions by the physicians regarding her cancer, and she appeared to acknowledge her illness. Nonetheless, she remained reluctant to proceed with evaluation, treatment, or other interventions; she missed appointments and did not return phone calls.

In February 2010, when she sought care from a new gastroenterologist, WB requested a second confirmatory biopsy. In March 2010, a second biopsy was performed, and it confirmed the diagnosis of gastric malignancy. Several days later, emergent surgery was performed for acute gastric bleeding. At that time, in addition to partial gastric resection, a stoma was created for decompression. The surgeon noted that she had a "long discussion with many family members regarding incomplete resection . . . ." Unfortunately, at the time of the surgery, WB suffered a stroke and was sent to a rehabilitation center for recovery.

Dr. R remained involved in discussions with the patient, and a follow-up appointment was scheduled for WB to be seen after discharge. However, in April, 2010, the patient was readmitted to the hospital for a bowel obstruction. A CT scan of abdomen and pelvis showed widespread liver metastases, and obstruction was felt to be due to the metastases.

Later in April, the hospitalist (Dr. A) had several discussions with WB, emphasizing the fact that several doctors did not believe that there was any definitive intervention that would be helpful for her. PEG placement for comfort and decompression, pain control, and palliative care were considered to be her only reasonable options. The patient and family demanded further treatment and also insisted that all involved consultants meet with them later that week to confirm for them that the patient had cancer. (The patient had not used the word cancer in discussing her problem with her family, and they had not accompanied her to any previous appointments.) The family also requested transfer to a facility two hours away that advertised heavily through the media. This facility was reported to be an unaccredited hospital, and her current hospital did not condone transfer.

Dr. A suggested that if the patient and family requested, she would contact a tertiary facility three hours away to see if anyone there would be willing to accept WB in transfer. It was uncertain if they would, given the extensive nature of the disease process and unlikelihood of any benefit from surgical or medical intervention. WB and her family chose to decline this offer. The patient remained Full Code status despite the disease progression.

Dr. A contacted the Ethics Committee, as no staff member believed that any further medical or surgical intervention would be helpful for the patient, and all were convinced that further intervention could result in increased harm with complex complications. Dr. A asked that the Ethics Committee review the case and offer suggestions regarding management.

**Recommendations**
The Ethics Committee reviewed the medical case and interviewed the physicians caring for WB. The chair of the Ethics Committee did not feel that direct intervention by the Ethics Committee was indicated, as members of the medical team intended to meet with the family for a conference the next day. He offered that if the treating physicians believed that more direct intervention by the Ethics Committee was needed after the family conference, he would be glad to participate in ongoing discussion. Additionally, to clarify issues in light of the patient's extreme denial during
the previous six months and again in the last few weeks, the Ethics Committee suggested a formal Psychiatry Consultation to establish if WB should be granted decision-making authority regarding her care. Further, the Ethics Committee suggested that if the patient and family desired, the treating team should reconsider the possible transfer of WB to a tertiary facility.

The following day, prior to the full family conference, Dr. R reversed course. He met with the family alone, and negotiated a plan to institute one round of chemotherapy; he also told the family this might easily precipitate her demise. He dictated in the record that since the patient and family demanded further treatment, he would bow to their wishes.

Discussion of Ethical Principles

**Autonomy**: Patients and surrogates have long-established right to refuse treatment that they deem unwanted, even if providers believe such treatment could be beneficial. In this case, even when the patient refused interventions, physicians did their best to persuade her to seek a cure, but they had no authority to compel action. Providers have the right to not perform interventions that they deem to be more likely dangerous than beneficial. (Historically this has been particularly held true for surgical interventions.) Medical professionals, however, do not have the right to compel medical treatment in a decisional adult against his or her will.

**Beneficence**: No benefit was initially deemed possible by surgeons or the oncologist. The oncologist subsequently altered his position on this, though he equivocated as to the extent of benefit.

**Non-maleficence**: Significant risk of injury to patient could result from intervention.

**Justice**: Since little possible benefit and significant risk of injury pertain to this question, justice?making sure that the patient is given fair access to needed supplies or therapies?does not directly apply. On the contrary, one could argue that an appeal to justice would compel cessation of further intervention so that expensive resources would not be used on a patient who might not benefit from treatment, and these resources could be used for other patients who might benefit from treatment. (In reality, there is no quid pro quo: medicines not used on her would have no obvious intended recipient.)

**Compassion**: Patient would continue to be treated compassionately despite physicians? decision to withholding further medical or surgical intervention. The emphasis would be placed on pain and symptom management.

**Veracity**: Patient had been informed repeatedly in certain terms, well-documented in the record, by multiple physicians of her diagnosis and the prognosis associated with her cancer.

**Coordination of care**: This case demonstrates the difficulties that can arise when one member of a complex medical team alters his direction of care without informing the other team members of his decisions and actions. The morning after he agreed to initiate therapy the other physicians continued their plans to meet with the family. It was only when they checked the electronic medical record later in the day that they discovered the conference was no longer needed and would not be welcomed by the family.
**Competency:** No one specifically tested for decisional capacity or competence. It was generally assumed that the patient remained decisional. It was only when the Ethics Committee reviewed the record that this question was formally posed.

**Futility:** As a concept, futility is complex. Arguments can be entertained as to whether intended interventions will help in the short term, or will help provide significant long-term improvement or cure. In WB’s case, no therapy was deemed likely to do either during the first phase of the management. Dr. R reversed course, however, and stated that though the chance of long term improvement was nil, the chance of short term improvement was not negligible, thus arguing for some form of short-term intervention.

**Follow-Up**
Dr. R instituted chemotherapy and WB did ?quite well? for about seven days. Subsequently, she became hypotensive and went into septic shock. She was transferred to the ICU, but her condition deteriorated. Two days later, after discussions with the ICU staff and family members, the family asked that WB be moved from the Intensive Care Unit, and care level was changed to palliative care status. She expired ten hours later.

**Editor?s Comment**
We must not underestimate the intense pressure that accompanies decision-making at the end of life for the physicians, for the healthcare agent, and for the family. Understandable medical details and identifiable patient preferences are the primary sets of information that are necessary for medical decision-making. The family or the physician, once having made a decision, may become more anxious if it seems that their personal decision may contribute to the patient’s demise. This may give way to personal or group disquiet which can be made manifest in several different ways. For example, the family may become even more insistent and demanding, or the physician may acquiesce and agree to provide a treatment that he originally opposed.

So, how can we explain the oncologist’s apparent change of attitude or reasoning and the surprising decision to offer a round of chemotherapy at such a late stage in the patient’s medical course? The physician certainly had a claim to the right of conscience; perhaps he had remembered a singular case report from the past. Or perhaps, as our present case reports, there was pure capitulation to the family request. Patience, wisdom, and communication skills are of utmost importance in attempting to identify certain end-of-life choices. There are often several options that may be considered ethically permissible, and the most correct option may remain stubbornly elusive until very late in the medical course.

**Suggested Resources**

*Editor’s Note: This case study, used by permission, originally appeared in Ethics & Medicine: An International Journal of Bioethics 27(1), Spring 2011, 13-16.*
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