

Lecture 3.2

I've spent a lot of time laying foundations and providing context. Finally we can get to doing some reading (and maybe some discussion of the material)...

The reading for this week was pretty dense; I hope that the reading notes, if not the lecture notes, help a little bit.

Our authors all seem to put **cases** at the heart of their various recommendations. Does the nature of the case in question influence the recommendations that the authors make?

(Does the specialty of the author influence the recommendations? For next week, it may be interesting to know that Jay Katz is a psychiatrist.)

Let's see if we can put some of our background to work on some of the cases we were looking at this week...

Possible cases to consider: Monica's lung cancer

Carlos and the gunshot wound

Emmanuel's 43 year old woman c breast mass

Beneficence Today, or Autonomy (Maybe) Tomorrow?

Fletcher model:

Medical indications: respiratory problems ARDS dyspnea (=shortness of breath; labored breathing) that had brought her to the hospital. A coughing spell made her almost lose consciousness, and she was then intubated and heavily sedated.

Bronchoscopy reveals a tracheal tumor, squamous cell carcinoma of the lungs with mets to the lymph nodes. (=very sick; dead within 3 months.)

No appropriate treatments. Currently unconscious because of sedation

Contextual factors: single mum with two almost-grown sons. Capable; has been living at home and taking care of herself. Young (relatively). Smoker. No cultural anomalies or SEIs mentioned.

Patient's capacity: Pre-intubation and sedation, she was completely capable. She is now sedated.

Patient's preferences: We have no idea what her preferences are. (*that's a bit of a red flag.*)

Patient's needs: We don't know anything about her family's preferences; she has two adult children, but they don't seem to be involved in the discussion to any extent. We don't know about any competing interests (but we haven't looked very far, either.) The major power at play here is the power of the medical establishment, which now has an unconscious person to deal with.

Has everyone with a moral stake in the outcome been heard?

Not really. The sons have not been heard; and the patient herself has not been heard.

Medical alternatives proposed by the team: (a) immediately withdraw treatment (b) keep her in her present condition (=intubated and sedated) but do not treat any complications; (c) implant a stent without consulting her; or (d) wake her up and hold a discussion about the possible treatment alternatives.

What are the moral issues as you see them?

What are the possible options in this case?

What is the most desirable outcome? How can we get there?
What are the responsibilities of the people concerned?
What are the benefits and disadvantages of the various options proposed by the team?

Some of the 'ethically relevant' considerations do apply: benefit and burden, shared decision making, norms of family life.

Jonsen model:

Medical indications:

Patient's medical problem is respiratory difficulty caused by squamous cell carcinoma (cancer) with a tumor in the throat, lungs and lymph nodes. The prognosis is death probably within 3 months. She is currently intubated (for breathing problems) and unconscious from sedation. Her condition is critical and acute, I guess—certainly not reversible.

The goals of treatment are unclear: cure is not in question, but under one course of treatment the symptoms and present difficulties might be temporarily relieved...It's not clear what the team intends at this point.

Harm to the patient includes suffering with the progression of the disease (increasing shortness of breath, possible pain and distress from the breathing tube). Benefit to the patient: she might if returned to consciousness have some say in what tx she prefers.

Quality of Life:

The prospects of a return to normal life seem to be fairly small. The disease is advanced and progressive, and has already interfered with her breathing enough to require hospitalization.

Depending upon the degree of anticipated suffering, that might even be sufficient to consider her continued life undesirable; evidently some of the doctors do.

The providers have their eye primarily on the medical indications—not on the other aspects of the woman's life or interests. (paternalism?)

Her present condition is sedated; her future condition might well be more consciousness of more discomfort.

The team is not unified on one treatment option, but comfort/palliative care is among them.

Patient preferences:

There's a pretty obvious problem here: There is no information about the patient's preferences. She is currently unconscious, but when she walked into the hospital she was competent, and theoretically would be again if the sedation were stopped. She has grown children who would legally be her surrogates, but they have not been consulted. We don't know if she has an advance directive, or what her preference might be for tx alternatives..

Contextual Features:

Her family is apparently not in on this discussion.

Providers are heavily inclined toward avoiding her suffering.

No financial or economic factors are explicitly mentioned, although they may be raised by some of the treatment options proposed.

Religious or cultural factors: unknown

Limits on confidentiality? Apparently not.

Allocation of resources? None explicit

Legal impediments to any of the proposed alternatives? No

No research or teaching; no apparent conflicts of interest.

What do our commentators recommend in this case? What are the most salient issues for Elger and Chevrolet? Did reading their opinions bring to light issues you had not considered?

Chevrolet: “strong paternalism” vs. “a charade of autonomy”

“a question that is impossible to answer in conditions that could not permit sound judgment...”

What does Elger seem to have in mind with her notion of a ‘sliding scale of competency’? She also seems to pair that with a staged enquiry about preferences: ask her if she wants to decide herself or have someone else involved (and if so who); choose between options, or maybe just agree or disagree with the option preferred by the team.

(The agreement of the team on one option begins to look really important here: if they disagree, one person can offer one alternative, another person can offer a different one, confusing rather than clarifying the situation.)