

ETHICS IN ACTION

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CASE PRESENTATION

A 45 year old male with profound intellectual disability (IQ<25) presented to the emergency department following a respiratory and cardiac arrest at his long-term intermediate care facility. Per staff at the facility, the patient was in his usual state of health when he suddenly became cyanotic and experienced respiratory distress and arrest. On arrival to the ED, the patient had a return of spontaneous circulation, but was hypotensive and hypoxic. After airway suctioning and intravenous fluid provision, the patient's vital signs improved. Due to a high inpatient census, the patient remained in the ED for an additional five hours following admission to the ICU service during which time he was noted to have abdominal distention. Repeat radiographic imaging was ordered that showed evidence for bowel perforation and free abdominal air. General surgery was immediately consulted. Their consult suggested that operative treatment was the only likely option for curative management but that the odds of success were low given the patient's previous cardiopulmonary arrest and poor nutritional and functional status.

The patient's closest living relative was his sister. When informed of the clinical situation, she requested that surgery not be performed and that palliative care measures be instituted. She and other family members had noticed a marked deterioration in the patient's overall condition over the last year, with repeated hospitalizations and worsening functional status. The patient's family, prior to this event, had planned to discuss with his facility the initiation of hospice measures for the patient.

The intermediate care facility was also informed of the patient's condition. The patient had been resident at this facility for nearly 40 years, and the facility had the authority to consent to emergency treatment measures. The facility's management took the position that given that the patient had never had the ability to express his wishes in these circumstances, the presumption should be that the patient would want attempts at curative treatment through surgery. In addition, the facility cited regulation, court precedent and other legal authorities that they interpreted as preventing the sister from refusing consent to surgery.

To resolve this impasse, emergency ethical and legal consultation was requested.

DISCUSSION

This case presents a number of ethical and legal issues of interest to emergency physicians. The first issue surrounds who should serve as the surrogate decision maker for the patient. The patient himself never had the capacity to make medical decisions on his behalf or the ability to designate a surrogate decision maker. For patients such as this who are residents of a long-term care facility, it is common that, with improved longevity, the facility serves as de facto guardian of the patient. Yet as a practical matter, the family would ultimately be responsible for the patient, both in terms of having the ability to remove the patient from the intermediate care facility and the requirement to care for the individual if after surgical intervention, the requirements for rehabilitation were beyond the capacities of the intermediate care facility.

The second issue raised is how to judge the appropriate course of action for a patient who never had the ability to express for himself what he would want with regard to medical care in this situation. In ethical parlance, what is required is a judgment of the patient's best interests. In this case, those best interests may lie in the preservation of life or in a broader understanding of how surgical intervention would likely subject the patient to suffering with a low probability of success and thus place the patient's dignity at risk.^{1,2}

The final issue is whether legal mandates might require attempts to preserve the life of the patient through surgical intervention. In this jurisdiction, provisions in state law and a state supreme court case seem to indicate that in the profoundly intellectually disabled, a presumption should be made to initiate life-sustaining treatment.^{3,4} Whether that would extend to surgical intervention or just apply to those treatments that maintain critical bodily functions, such as ventilators or temporary pacemakers, is unclear. No provision of state law mandates invasive procedures such as surgery without informed consent in these circumstances.

CASE OUTCOME AND LESSONS LEARNED

The opinion of the ethics committee and the legal department at this institution was that the family was appropriately the surrogate decision maker for this patient and that it fell within the best interests standard to not subject the patient to a surgical intervention with a high likelihood of complications and a limited likelihood of success. The patient was admitted under palliative care measures and died shortly after.

Among the lessons learned in this case are that the particulars of the case matter in performing an ethics consultation. In this case, an easy position would be to assume that preservation of life should be preferred in a patient who had never had the ability to express his wishes regarding end-of-life care. However, to ignore the particulars of the patient's recent functional deterioration and the low likelihood of surgical success would be to violate the axiom that "good facts make good ethics". Another lesson learned is that emergency physicians and ethicists need to consider how improved longevity in patient populations who previously were short-lived may change the moral calculus of how medical decisions are made on their behalf. Finally, this case indicates that ethics committees and consultants need to be prepared for emergency cases where quick recommendations must be given. Without timely responsiveness, ethics consultation may be deemed irrelevant in the most exigent circumstances.

ACKNOWLEDGEMENT

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