Ethical dilemmas for the geriatric generation

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Scenario #1 REQUIRED: A 78-year old woman has been given the diagnosis of breast cancer after a biopsy. The surgeon responsible visited with the patient and told her she needs surgery, provides the form and requests she sign it. The Physician Assistant is to retrieve the signed consent.

There are many questions and ethical considerations that immediately come to mind in this scenario: does the patient understand the diagnosis as presented to her, did the doctor provide an adequate informed consent or just hand the patient the document to sign, does the patient understand the risk and benefits of the procedure, are there other alternatives to surgery that have been discussed and considered with this patient, and does the patient want the surgery? The overarching ethical principles encountered in this situation are autonomy and informed consent. Does the patient want the procedure, an alternative, or no procedure at all? She is 78 years old and may decide, after hearing her options, that her best option is no action. As a medical provider, while paternalism seemed to be demonstrated by the surgeon, it’s up to the PA to ensure the autonomy of the patient is maintained and the patient is given the opportunity to make the decision that’s best for her.

Secondly, encompassed in autonomy is the principle of informed consent; the other principle important to this case. Did the doctor adequately inform the patient? As outlined in the AAPA code of ethical conduct, the PA has a responsibility to provide “ adequate information that is comprehendible to a competent patient or patient surrogate. At a minimum, this should include

the nature of the medical condition, the objectives of the proposed treatment, treatment options, possible outcomes, and the risks involved.” [1] As the PA is required to collect the consent paperwork, it is imperative the PA verifies consent truly was given and the procedure, risks, benefits, and alternatives are understood. Failure of the PA to confirm this decision could result in drastic consequences for the patient, hospital, and providers.

Scenario #2 REQUIRED: A 68-year old man is admitted to the hospital for failure to thrive. Based on the diagnostic tests, the diagnosis is terminal adenocarcinoma of the pancreas. The patient needs to be told of the diagnoses. The only treatment options may extend his life by a few months; however, in the best case, he has 6 months to live.

End of life discussions can present difficult ethical concerns for providers. The principles of non-maleficence and autonomy are considerations in this case. The autonomy of the patient, to be provided with information to make the necessary informed decision, is ultimately the first aspect that needs discussed. Since the patient is acutely ill, it will be important to verify the patient is able to comprehend the information and has the mental capacity to decide. Secondly, allowing the patient to decide on his course of care will be important. After being presented with all options, will the patient want his life extended when the ultimate outcome of death is the same?

The second aspect to consider in this case is the principle of non-maleficence. The principle ensures the provider does not act in ways to cause undo harm to a patient. The “ principle of double effect, where the good must outweigh the harm [and] the secondary effects [while] foreseen,

[are not] the intended outcomes" [2] must also be contemplated when discussing treatment options. Will the treatment to extend the patient's life lead to unnecessary harm? Will the extension of life by six months, outweigh the possible suffering the patient may experience? Do the changes to quality of life the patient may experience justify the suggestions for treatment? These questions are things the PA needs to ruminate on with his attending and tumor board, prior to devising a treatment modality. After discussing with the tumor board, the PA can present to the patient and allow the patient to make and informed and autonomous decision.

Scenario #3: An 80-year old man was recently diagnosed with cancer. His family is arguing about what to do. His son wishes for surgery followed by chemotherapy to begin but his wife does not want to see him in any pain. Neither fully understand the medical issues and treatment to follow. The patient demonstrates understanding of the diagnosis and treatment. What steps do you take as the PA caring for the family?

The patient has autonomy to make decisions that are best for him, if he fully comprehends the information presented to him during informed consent. It is imperative the PA ensures the patient is of sound mental capacity and was fully informed of details. The concept of veracity and the fiduciary relationship the PA has with patients and families falls within this principle of autonomy. It also loosely crosses into the principles of beneficence and non-maleficence. [2] The PA needs to respect the autonomy of the patient, but also needs to work in the best interest of the patient without doing harm. When addressing the concerns of the family, the PA needs to act with integrity, compassion, and respect, but ultimately respect the patient's choice. If the

patient agrees, the provider can review the information regarding the diagnosis and treatment plan with the family members. When beginning, the PA should allow the family to ask questions. Doing this helps the PA gain an understanding about what topics the family needs education on and what they currently know about the patient's diagnosis and treatment options. Once the PA understands the concerns, fears, questions, etc., she can provide truthful and matter-of-fact information. The provider can address the wife's concerns around pain by explaining how pain can be relieved. The PA can help foster the communication between the patient and the family and help them understand the patient has the choice to decide his course of action. She can use her fiduciary relationship to help the family understand the patient's right to decide in addition to educating on his condition and treatment options.

If the patient decides he doesn't want his family involved it will be the role of the provider to gently inform the family of the patient's right and carefully educate family without violating HIPAA or the patient's choices. The fiduciary relationship instilled by nature of the PA position comes with the responsibility to act with veracity. [2]

Scenario #4: A 67-year old man presents to the emergency department with acute respiratory distress and showing signs of respiratory failure. An advanced directive indicates that no heroic life saving measures be taken and he does not wish to be put on life support. The family argues their loved one would change his mind if he understood what the options were. How should the medical team navigate this scenario with the family?

The points the emergency team needs to consider in this situation are was the document signed by the gentleman before he lacked the ability to decide his future care or was it signed after the onset of his inability, what is considered heroic measures, and did the patient name any people to act as surrogate decision makers? First, without further evidence to the patient's state of mind prior to signing the document, the facility needs to honor the advanced directive, especially since it is a legally binding document. While time is of essence in the ED, the team could contact the witness and doctor who initiated the directive, if available, and confirm the patient was duly informed prior to signing.

Secondly, the question about what is considered heroic measures needs to be defined if not clearly enumerated in the directive. Is NIPPV or medications considered heroic measure or only mechanical ventilation and CPR? The providers coming to a uniform decision about what care is considered life support versus standard treatment of critical conditions is crucial to this scenario. They may want to meet with risk management and discuss the specifics. A study conducted by Jesus et al. posed similar questions when considering if individuals with a POLST or advanced directive against resuscitation should be admitted from the ED to ICU for care. [3] The study emphasized that the standards of care for the disease management is not superseded when there is an advanced directive in place. The providers need to provide the appropriate care and admit to whatever unit the care warrants. Jesus et al. conclude " If, based on the specific wishes stated in these documents, patients would benefit from the unique treatment the ICU can provide and there are beds available, patients should be admitted to the

ICU, even if not all life-sustaining interventions would be utilized.” [3] The utilization of resources and types of care fall under the principle of justice. Despite the advance directives, is the ED team providing care according to the standards of practice, or has the directive changed how they view the patient’s right to receive care?

Thirdly, the providers should determine if a surrogate decision maker is present and/or was named. If there is a surrogate, the decision regarding specifics to the advanced directive and types of care the patient desires can be filtered through the surrogate. As noted in Jesus et al. without specific language denoting the exact care desired a surrogate may be able to bridge the gaps between “ the patient’s goals and preferences regarding care”. [3] These decision and considerations fall under the non-maleficence and beneficence principles. The provider wants to act in best interest of patient, while also not providing care that may unknowingly cause pain or harm.

Finally, when information has been gathered, the team can meet with the family to discuss. Risk management, clergy, and social work would be valuable entities to include in the discussion as well. The team needs to present a unified approach and allow the family to voice and express concerns. Ultimately, baring any problems with informed consent, the autonomy of the patient’s wishes would need to be respected both legally and ethically.

Scenario #5: An 85-year old woman has been hospitalized with pneumonia. The treatment for her disease process results in acute delirium disabling her

from making any medical decisions for herself. Her Advanced Directive identifies her youngest child, a nurse, as her surrogate decision maker.

The advanced directive and surrogate will serve as the “ proxy” for this patient since she is unable to make decisions for herself. [4] Since this is an acute decline in mental status, the provider will need to contact the daughter and inform her of her mother’s decline. While the advanced directive may detail specifics to what the patient desired, any questions or uncertainty as to type of care the patient wanted can be leveled at the daughter. By naming a surrogate for medical decisions and creating an advanced directive, while still able to make informed decisions, the patient exercised and maintained her autonomy. The role of the provider is to work with beneficence and veracity to further conserve the patient’s autonomy. These principles become critically important if the daughter is unable to come to a difficult decision immediately. She will be trusting the provider to give her the details needed to make informed decisions. The provider must act in a way to provide care that’s appropriate, evidenced based, and fair.

When the patient recovers from her delirium and is again able to make decisions independently, it will be important for the provider to transfer decision capacity from surrogate back to the patient. This transfer should include a discussion with the daughter explaining the condition changes in her mother and the provider’s assessment of the patient’s ability to make decisions. If the surrogate “ pushes back” to relinquishing control of decisions, it will be important for the provider to educate the daughter. Involvement of legal to explain the language and context of the directive may be helpful as well.

Finally, if there was conflict between the directive instructions and the proxy requests, once the patient recovers mental capacity, the provider may want to revisit and update the advance directive specifics with the daughter and patient.

References:

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