CASE REPORT

Ethical Dilemma in multiple co-morbid respiratory failure patient: Patient autonomy against family wishes?

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ABSTRACT

An 82 years old patient with background history of severe COPD, heart failure, multiple co-morbidities and poor quality of life was admitted with pneumonia and subsequently developed acute respiratory distress. There was an obvious conflict of opinion among her family members regarding decision making in her case. The patient time and again insisted against being resuscitated if she ever became seriously ill. However, she did not appoint a proxy decision maker or give an advance directive. This created an ethical dilemma, resulting a clash among the family members as well as her treating physicians concerning the withholding of active treatment and DNR orders in case of cardiorespiratory arrest. In the end the clinicians took lead and, with effective communication with the patient and the family members, made a final decision of withholding treatment in respect of the patient's dignity and autonomy.

Key words: Ethical dilemma; Patient autonomy; Ethical conflicts; Withholding; DNR; Do not resuscitate orders

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INTRODUCTION

Withholding or withdrawal of treatment in a patient with multiple co-morbidities in acute illness setting involving end of life care develop complex ethical dilemmas when conflict arises between principles of ethics specially autonomy, beneficence , nonmaleficence . Patient right of self respect, determination, his or her wishes regarding management or refusal for getting treatment describes patient's autonomy.[1-6] When patient become incapacitated and if surrogate decision maker is not nominated then conflicts arises among the family members for the decision regarding provision of aggressive management or withholding treatment.[7] It also create complex matter for clinician in respect to patient's DNR in case of cardiorespiratory arrest as there is no clear guidelines worldwide.[10] A clinician faces ethical issues, dilemmas and their resolution in his day to day practice in acute clinical setting. This interesting case report addresses the various factors which lead to complex ethical dilemma and ultimately the resolution reached by the concerned parties by effective communication.[9]

CASE REPORT

An 82 years old patient was admitted to medical ward with lower respiratory tract infection with history of COPD, heart failure, rheumatoid arthritis and mild dementia. Due to multiple comorbidities she had a poor quality of life. Patient went into acute respiratory distress on the third afternoon after admission. Medical registrar-on-call called the anesthesia registrar to review the patient and to discuss the transfer to ICU of one of the tertiary hospitals. The anesthesia registrar assessed the patient to be in acute respiratory distress. She had tachypnoea, tachycardia, SpO_2 ranged from 80 to 90%; she was slightly cyanosed, confused, with normal blood pressure but unable to communicate properly. Chest examination revealed bilateral crackles and scattered rhonchi. ABG's showed PO_2 8.2 kpa, PCO_2 11.5 kpa, SaO_2 88% with pH of 7.21. Patient was on venturi mask with FiO_2 60%.

Anesthesia registrar started BiPAP. He explained her condition to her younger son and the medical registrar and outlined all future prospects of treatment and their outcome. He also discussed the condition of the patient with the consultant on call in ICU as there was no bed available in e tICU. After being familiarized with the patient's condition, the consultant intensive care decided to examine the patient in the medical ward. He had discussed with the patient the possibilities of her treatment and their outcome earlier and she had agreed not to proceed for aggressive treatment (intubation, ventilation and in the event of cardiac arrest, resuscitation). But presently the patient was not in full control of her senses and was incapacitated. So the consultant called over the primary clinician and her family members to discuss her fate and further management. The two consultants differed in opinion regarding the patient management. Then a conflict arose in between the family members; the patient's daughter supported her mother's desire not to be aggressively resuscitate in case of serious illness; while the son wanted his mother to go all out in favor of full resuscitation against the wishes of his mother. The patient was incapacitated and had not appointed a surrogate decision maker or given an advance directive. In that way it developed significant ethical dilemmas and resolution of this issue became difficult. After prolonged conversations and exchange of arguments between family members, the clinician in charge of the patient and the ICU consultant, it was decided to withhold the treatment, to honour patient's autonomy and wishes and to let the nature decide the fate of the patient.

DICUSSION

We usually come across some difficult ethical dilemmas in our day to day practice in an acute care set up. This ethical dilemma is a result of conflicts between principles of ethics described by Beauchamp and Childress.[5] There may be a dispute between patient's autonomy and family's wishes, between autonomy and beneficence, autonomy and nonmaleficence, withholding of treatment and DNR issues. In our case, all these ethical conflicts intermingled and made this a complex ethical dilemma. The patient had wished not to be given aggressive treatment in case she got terminally sickl. But since there was no written advance directive, it gave rise to quarrels between family members. However, the patients do have a right to self determination and should give informed consent for their medical procedural treatment. The patient's dignity should be maintained during the whole course of his or her medical management and the ultimate fate of the illness. Individual self-determination is highly valued, and rightly so. Patients should have the right to accept or refuse treatment. If he chooses to let nature take its course, it should be allowed. It is important to remember that one must respect autonomy as long as we live in harmony with the first principle of our moral law and the sanctity of life.[5,6] Most conflicts involve issues of autonomy and beneficence principles. The patient's right to refuse therapy must be protected, recognizing that most patients are concerned about their families and do not wish to have family members undergo unnecessary burden or hardship. Physicians should be sensitive to such family concerns, but in the end, it is the patient's wish that must prevail.[5-7] In principle, families do not have the right to reverse patients' advance decisions when the patient loses consciousness and no longer able to make wilful decisions. Physicians may concede to the family's demands for aggressive therapy after the patient loses decision-making capacity regarding the withdrawal or withholding treatment when end of life issue arises. If the patient is not competent enough to make his own decisions, and has not appointed a surrogate decision maker or made an advance decision, then the senior clinician in charge of the patient's care must take the decision, based on the patient's best interests (principle of beneficence).[5,7] The health care professionals must remain engaged and supportive of the patient even if a conflict does arise. So affective communication and discussions amongst multidisciplinary teams of physicians taking care of the patient, as well as amongst the patient's family is utmost important; it may provide required information and allay fears to resolve many of the problems.[8,9] Resuscitation has the ability to reverse premature death. However it can also prolong terminal illness, increase discomfort and consume resources.[10] This might create unwanted difficulty for families. Effective communication resolved the issue in this particular case and ultimately decision reached among physicians and family members was not to go for aggressive resuscitative treatment and to respect the patient's autonomy as this was in the best interests of the patient.

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Professor Takrouri Joined APICARE

We proudly announce that Professor Mohamad Said Ahmad Maani Takrouri, Consultant and Chairman Neuroanesthesia as well as Resedency Programe Coordenator at Department of Anesthesia, King Fahad Medical City has joined Editorial Board of 'Anaesthesia, Pain & Intensive Care'.

Professor Mohamad Said Ahmad Maani Takrouri was born on May 16, 1946 in Damascus (Syria). He qualified MB, BCh in 1970 from College of Medicine, Alexandria University, Alexandria, Egypt, and FFARCSI in 1978.

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Professor Takrouri has played active role in World Federation of Societies of Anesthesia activities in various capacities. He has been associated with editorial boards of many of the national and international medical and anesthesia journals.

He is the proud author of more than one hundred publications in academically recognized or indexed scientific journals, as well as books, including 'Principle of First Aid', 'Analgesia and Anaesthesia in Labour', 'Ibn Al Nafis Contribution to Science' (arabic) and 'Historical Survey of Arabic-Islamic Medicine'. he has extensively contributed in many of the internet scientific publications as well as Saudi Anaesthetic Association's newsletters.

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We heartily welcome him on board.