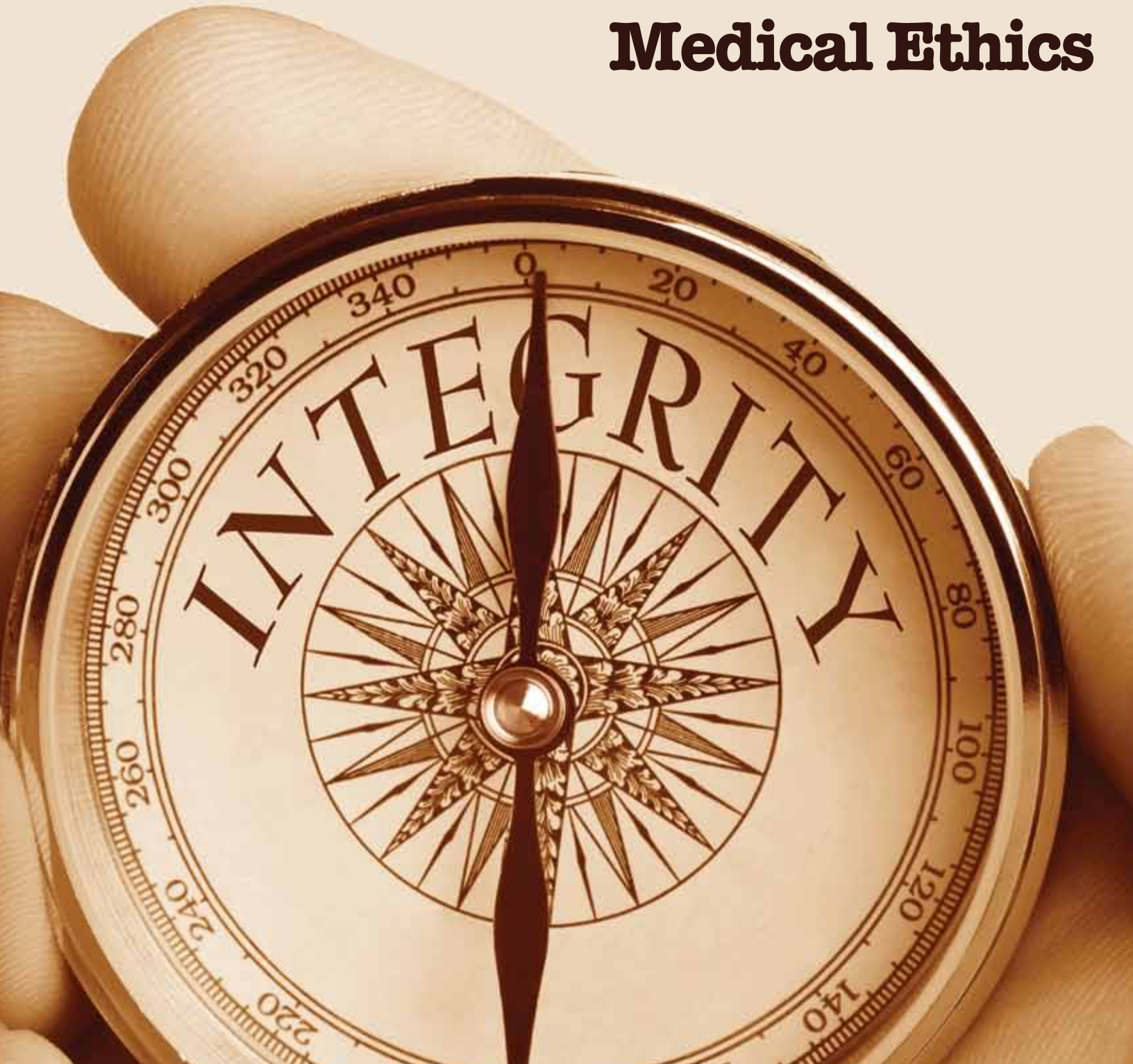
VOL.83 NO.6 July/August 2010

SAN FRANCISCO MEDICINE

JOURNAL OF THE SAN FRANCISCO MEDICAL SOCIETY

The Evolution of Medical Ethics



The Unbefriended Adult Patient

The San Francisco General Hospital Approach

Eric D. Isaacs, MD, and Robert V. Brody, MD

Clint Johnson's friends have not been back to the hospital since the first two days of his admission. A fiercely independent homeless man who has lived in and around Golden Gate Park for fifteen years, Clint was always willing to help his friends but rejected any help from others. His friends couldn't bear to see him in his current state. Admitted six weeks ago due to a devastating stroke, Clint was unable to communicate and needed around-the-clock skilled nursing assistance. The team was at the crossroads of a disposition. Yet there were no family, friends, or documented advanced directive. Who should make this decision? At San Francisco General Hospital, the attending physician makes the final decision.

The issue of care for the unbefriended adult has recently received increasing attention from the ethics and legal communities. Caring for patients who cannot make decisions for themselves and lack a surrogate decision maker is not an uncommon occurrence in hospitals, and it is seen frequently in the indigent community served by San Francisco General Hospital (SFGH). These are the patients who may have led a solitary existence, perhaps their family and closest friends have died, and now there is no one to speak for them when making medical decisions. There is little literature documenting care and decision making for these patients, but a review of the small literature base shows that incapacitated patients who lack a surrogate decision maker or advanced directive account for 5 to 10 percent of ICU deaths. Even among patients with identified surrogates, physicians had trouble contacting the surrogate in approximately 20 percent of the cases, and nearly three-fourths of physicians surveyed had made a major medical decision for a patient who lacked decision-making capacities in the past month.

In California, the official legal statute mandates that all patients in this situation should be assessed by the probate court both to determine their decision-making capacities and to authorize recommended medical care in the case that the patient is deemed incapable. Individual counties may implement this statute through their probate courts and health departments in a variety of ways, depending on the number of hospitals, size of the county, political environment, and leadership decisions. This process may work for many elective procedures or chronic care decisions, but it is not practical in the critical care environment or with many end-of-life decisions.

Interestingly, little agreement exists between specialty societies and the "House of Medicine" with regard to how medical treatment should be conducted with regard to the unbefriended adult. For example, the Ethics Committee of the American Geriatrics Society states that the group of individuals caring for the patient, usually a multidisciplinary health care team, should determine appropriate treatment goals. In contrast, the AMA Ethics committee put forth a policy in 2004 stating that an ethics committee or judicial review should be used in all cases, and the policy of the American College of Physicians is that all cases should be subject to judicial review. Documentation regarding hospital policy is limited, but information from selected hospitals around the country reflects a similar variation in the presence and character of policy to specifically address how decisions for such patients should be made.

It makes sense that decision making for these patients may be less than formulaic. While the SFGH Ethics Committee encourages consultation at any time, the hospital has implemented a system that allows the attending physician to make decisions for the unbefriended adult patient. Such a system causes angst for the greater ethics community. Many feel that "doctors should not be making these decisions." But the question remains whether other systems of mandatory review would result in a different decision, or a "better" decision. Bringing in ethics committees, independent committees, or judicial review creates monetary burdens, time burdens, potentially prolonged suffering, and no guarantee that decisions would be different or better. To put the question in the context ethicists create, would another system of care for the unbefriended adult create more benefit than burden? The burdens are real, but the benefits are really only theoretical.

While many attending physicians take advantage of the Ethics Committee consultation service, some do not. Why do we think this works? Ironically, the typical hierarchy experienced at many other hospitals does not influence the working environment as deeply at this teaching hospital. SFGH endorses a culture in which anybody involved in the care of the patient can refer a case to the Ethics Committee, not just the attending physician. In addition, nurses and social workers, in fact any staff member, are empowered to exercise this right to call for an Ethics Committee consult when they feel more information is needed, or they perceive the wrong decision is being made. Ethicists and others

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would argue that ethics committees are consulted so there is a "moral" community to assist with decision making. The environment of teamwork, structure of the care team at SFGH, and the softening of traditional hierarchy is allowing this to happen for individual patients in real time.

There is no legal basis for anyone making a decision for the unbefriended patient except for the judge or a conservator appointed by the judge, whether it is a layperson committee, ethics committee, or attending physician. Other entities, like Santa Clara County, working with the bar association and medical associations, have a system in place allowing independent citizens to come in and act as medical decision makers for these patients, with the idea that such a system is better than allowing the attending physician to make decisions. The concern is that leaving the decision to an attending physician, who may be operating in the vacuum of a passive and unempowered staff, would lead to an action based on a subjective application of the physician's ideas and ideals without taking into account an individual patient's preferences when they differ from our own. The argument is that an "independent" committee would be able to apply institutional values, where appropriate, in a consistent manner through a systematic process to discover an individual patient's preferences for care in a specific situation. One might use the analogy of our society's negative view of a provider caring for a family member, suggesting it is more important to take an unbiased view of a case, considering a wider differential diagnosis and asking tougher questions unhindered by an emotional attachment. Certainly, the physician who has invested time, resources, energy, and worry on a patient's behalf may have difficulty letting go, and this difficulty may stand in the way of timely end-of-life decisions.

However, we count on the intimate knowledge and emotional investment of family and surrogate decision makers to make these difficult decisions. These decisions require the same consideration and attachment from physicians. We are up to the task. It seems contradictory that an ethics subcommittee or a special group that has no particular knowledge of this patient's values, and which adds a layer of bureaucracy and extra time, would be preferable when there is no probability that they would make a different decision or the "right" decision.

It is interesting to remember that the attending physician is trusted to make decisions in the best interest of the patient every day, some without our overt consideration. We focus on providing the patient autonomy to make a decision between the options presented to the patient by their provider. However, no one questions the decisions by providers not to offer treatments to patients they feel will not result in any benefit.

It is perceived by some that there is a problem for the attending physician in making this decision for the patient, yet there is no documentation that a problem exists. Anecdotally, there are stories from community hospitals where the attending physician makes a decision for the unbefriended patient based on his own values, not that of the patient. There is always that possibility at San Francisco General Hospital, but the culture of this hospital makes that less likely. The system at SFGH seems to be working; exhaustive searches for surrogates and corroborating information are taking place without any outside committee influence. There is no sense that the wrong decisions are being made. But there is angst in the ethics community that such an unstructured and subjective process does not meet necessary standards. There are some attending physicians who say they do not want to make these decisions alone, and, in fact, if the attending requests (or if anybody requests), the Ethics Committee to get involved, we do. In fact, this is a large part of what we do. In the end, the Ethics Committee acts as any other consultant does; we provide information and point out nuances of individual cases, while leaving the final care decision up to the attending physician primarily responsible for the patient. sfm

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