Ethical Scenarios

You are the junior doctor in A+E when a 73 year old man is brought in vomiting large amounts of blood. He is in hypovolaemic shock which you initially triage with fluids, and you are about to call for urgent blood when the family arrive and let you know their father is a practising Jevohah's Witness, and they refuse for him to have blood.

What are the ethical issues involved in this scenario?

What are your options, going forward?

You have an acutely unwell patient who is going to die if he is not transfused bloods. His family say he would refuse the treatment (which he is legally allowed to do) if he were able to.

As the patient advocate, ideally you need proof of this from the patient before it can change you intended treatment plan.

There are ways that the patient could have proof. This can either be in the form of an **advance directive** or an **advance statement**.

The advance directive is a legally binding document that lets healthcare staff know what the patient would refuse in case of admission. They cannot be used to ask for specific treatments, except in specialised cases beyond this scenario.

How must you see an advance directive before you can act on it?

Similar to DNACPR or Respect forms, the original has to be seen before it can be acted on. This can cause problems if, for example, the gentleman has an advance directive, but it is at home.

How does an advance statement differ from an advance directive?

An advance statement is statement of **intent** and is **not legally binding**. That does not stop them from being useful. A statement is written and signed by the person, saying what they would like/not like, in the event that capacity is lost. This can inform the team, but if time allows, family members should also be asked what their relative would have wanted.

With the absence of either, it is, unfortunately, a case of family vs. healthcare on the decision. Evidence in many forms (e.g. personal communications) may guide the decision.

In summary:
Advance directive → advance statement → any documented patient wishes → family's wishes.

You are an FY2 on Medical Assessment Unit. A 78 year old lady has been referred from ED with probable CAP and sepsis. The sepsis bundle has been completed. Her CURB Score is 4. She is requiring 8L of oxygen. You look through their notes and find they have had a previous TIA, an MI, CKD Stage 4, and peripheral vascular disease. They do not have a DNACPR in place.

What are the ethical issues involved in this scenario?

What are your options, going forward?

You have an unwell patient with a high risk of mortality who may deteriorate at any point. A decision is needed to place a DNACPR on this patient.

As a patient advocate, you must ensure the patient does not suffer unnecessarily.

Deciding to put a DNACPR in place is always a difficult choice, and many different people will have their own internal reasons or thresholds to meet before they place a DNACPR. As a junior doctor, you are not making the decision – your consultant has the final say and has to counter-sign the document to make it valid.

Do you think this patient warrants a DNACPR? What reasons are against her having one?

Mortality statistics are all based on **Bayesian probability,** so there is always the possibility of someone surviving against the odds. Most recent examples are of elderly patients in Italy 'surviving the odds' against COVID. This becomes a complicated ethical challenge in a resource-limited environment when providing beds for all may prevent those who have a greater probability of success from having a bed.

The person who gets to decide if they should be resuscitated is the patient themselves.

Does she have capacity? How does one assess a patient's capacity?

The scenario has not said if she is confused or not (despite the high CURB65 score, they could be due to raised urea, respiratory rate, blood pressure and age). However, with a history of cerebrovascular and cardiovascular disease, there may be a chance of chronic mind or brain impairment. The next step would be to assess if she has capacity:

- Can she understand information given to her?
- Is she able to retain the information in a meaningful way?
- Is she able to weigh up positives and negatives of the decision?
- Based on the weighing up, is she able to communicate a definite decision?

If she lacks capacity at any stage, then the decision may be aided by her family (as per the first scenario).

You are the FY2 in intensive care. You are currently looking after a 51 year old man who was admitted to hospital after falling off a ladder at home. Unfortunately, he fell awkwardly and suffered a catastrophic intracerebral haemorrhage, and is now comatose. The prognosis is bleak and there is a decision to palliate the patient. His daughter, who lives in Australia wis hes to see him as soon as possible, but her flight is in three days.

What are the ethical issues involved in this scenario?

What are the options, going forward?

Firstly, this would not be a decision that you, even as an FY2, would have to make; it will involve the whole multi-disciplinary team and expert advice to ensure the best agreed decision is made.

There are many ethical problems here, and this is a complex case. You have to consider the family, the staff, and other patients.

As the patient advocate, you must ensure that the patient does not suffer unnecessarily.

The challenge in comatose patients is where prognosis is described as bleak, but death is not certain. We have to consider that he could be kept alive indefinitely with a ventilator, and given enough time, may recover some function (although what function and whether it is conscious remains to be seen). Rarely, patients can have significant head injury but remain wholly conscious. Unfortunately, the prognosis is described as bleak with a very poor neurological outcome.

In the decision to palliate a patient, the decision involves the family. While all agree, the daughter wishes to see their father – but in doing so, risks burdening the ward with a patient whose treatment is futile. There is strong evidence of the moral injury to staff caused by prolonging patient death. Resources are also spent keeping a patient in an ICU bed, which may be best suited to a patient with a better prognosis.

There is no obvious answer to this scenario, and there are multiple paths going forward. It is absolutely essential to ensure all parties agree to the best cause of action for the patient. This can mean stressing the suffering caused with prolonging life to the daughter. It could also mean providing a side room and a safe space for the family for the daughter to arrive in time.