NETWORK NEWS

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CASE PRESENTATION AND BIOETHICAL RESPONSE

This case study was submitted by **Judy Gygi, LCSW,** Director/Social Work, West Florida Medical Center, Pensacola. It is presented with comments and considerations from various health professionals for your review.

Background Information

Mr. B. is an eighty-four year old male referred by the Neurology Department for a history of blackouts. The initial history was obtained from the daughter as the patient denied having any blackout spells or even that anything was wrong with him in the past. The daughter states that three weeks ago she received a call from a neighbor stating that Mr. B. was found in the house passed out. He had been noted to be out walking, went to sit in a chair and was slumped unconscious with no report of movements, urinary incontinence, or stiffening. At least thirty minutes elapsed before the daughter was able to arrive and lift his chin, wash his face, and then noticed that the patient gasped and regained consciousness which took approximately four minutes. He was taken to the Emergency Room, examined and discharged. This was the second episode. The initial one occurred some three weeks before with similar type symptoms. Each time the patient was noted to have lost consciousness. History is also positive in the past for having fallen from a chair hitting his right chest and reported cracking some ribs. There was no head trauma noted. No falling during ambulation or walking. Recent memory loss was also noted in that the patient was unable to remember where the bathroom was, was found getting lost near the home, unable to manage finances, unable to account for what happened to his monthly income check.

Past Medical History From 1988 To 1993:

Patient was seen by Urology for recurrent urinary tract infections, bi-lateral renal cysts, acute cystitis, elevated PSA levels, and hypertension. He was treated in 1950 for what appears to be positive TB. Mr. B. has had unexplained episodes of weight loss and folate deficiency.

Past surgical history was significant for cancer of the throat for which surgery was done but no follow-up radiation, nephrolithotomy and a full mouth extraction. There were no known drug allergies and the patient appeared only to be taking multi-vitamins and occasionally has had episodes where he has taken a folate.

Family History:

Patient is known to be a widower for a number of years, living with his daughter. He is a retired plumber with a fourth grade education. He is a non-drinker noted to have been a smoker of cigars up to twenty years ago. It was noted that up to seven years ago Mr. B. was living by himself and was quite functional and only recently has developed these problems over the last year or two and has had to live with his daughter.

Because of the presentation of the symptoms, he was seen in consultation by Neuro-Surgery. At that time, an MRI of the brain was done and showed a pituitary macro adenoma with cellular extension and dis-placement of the optic chiasm. Due to the type of pituitary tumor, Neuro-Surgery recommended that formal visual fields and endocrine workup be done.

The endocrine workup was pursued and the patient seemed to be intact from an endocrine point of view and there were really not any significant adrenal insufficiency or hyperthyroidism. The problem at this point was whether a decision should be made to follow the patient medically due to his problems with dementia and the slow growth presentation of his tumor or whether they should go ahead surgically and do a transphenoidal resection of the adenoma.

Nursing Considerations

From a nursing standpoint, several questions immediately come to mind. The information provided indicates a diagnosis of dementia. Prior to the onset of the dementia, did the gentleman have a reasonable understanding of his multiple diagnoses and had he ever discussed outcomes with his family? If he had expressed his wishes with regards to further surgeries, life support, death and dying, we might possibly have a clue as to how to proceed. If this type of discussion had not occurred, then options need to be addressed and investigated with the patient and his daughter (and any other children). The primary question in my mind is his quality of life. The dementia would not change with either medical or surgical intervention, therefore, his quality of life probably would not improve (he would not be able to live independently). What would surgery achieve? This is a slow growing tumor, so at 84 years old, how many more years would we give him? What are the risks of surgery? One noted risk is blindness. This certainly would not improve his quality of life. What is the family, specifically the daughter, capable of handling at home? It sounds as though the daughter works and at present, if necessary, he could function in an ACLF, but if complications arose from surgery, are they prepared for home care or nursing home?

Susan A. Blackburn, RN, CRRN
Skilled Nursing Facility Coordinator
West Florida Regional Medical Center

Chaplain Perspective

My primary concern as Chaplain and part of the Bioethics Committee would be:

1) the choice of the patient, if he is able to make an informed decision; 2) the appropriate surrogate decision maker deciding for the patient based on her/his understanding of what the patient would decide, and on what outcome would best enhance the patient's quality of life.

I would want to determine whether he has a particular faith background. Oftentimes, the faith perspective of the patient will influence decisions regarding medical care. What his faith community believes and teaches about issues, such as quality of life, suffering, and God's will, may be an important link in health care decisions. Even though Mr. B. may not currently be able to express these beliefs and values, his daughter may understand his wishes in connection with his faith experience and history.

More broadly, I would want to talk with Mr. B.'s daughter regarding her father. I would want to seek to understand what kind of life he has led, has he been active and independent (the case study seems to imply he has been), what are his values and priorities? I would want to discuss with her

the life of her father in connection with the perceived outcomes of both treatment choices. In this way, the dignity and autonomy of the patient are kept at the highest level of priority. Maintaining this priority helps to assure spiritual/faith integrity based upon my theological understanding of the worth and value of life (creation and autonomy). I would attempt to guide Mr. B.'s daughter to think in terms of what her father's choice would be, and what outcome would best reflect his wishes in light of the quality of life he could expect at his advanced age.

In doing all of this, it would be important to assure, assuming Mr. B. does not have a spouse, that his other adult children (if any) are being consulted, in addition to his daughter.

Bob Jones, Chaplain
West Florida Regional Medical Center

<u>Social Worker Issues</u>

One can suffer from dementia and still be able to participate in making some decisions. Have any attempts been made to determine what the patient's wishes would be in terms of treatment? If the patient is not competent, has he completed any advanced directives or has he indicated his wishes through conversations with family members? What benefits would be accomplished with surgical intervention? Do the risks outweigh the benefits to the patient?

Cathy Randolph, BSW
Social Worker
West Florida Regional Medical Center

<u>Physician Perspective</u>

There are benefits in being the last for input! All of the pertinent issues seem to have been raised. They are summarized by focusing on three basic ethical principles:

1) <u>Autonomy</u> - Though demented, does Mr. B. still have the capacity to give informed consent himself? (Has the diagnosis of dementia been made with thorough evaluation? Might he have a reversible progress or a dementia <u>not</u> of the progressive Alzheimer's-type? Is his current cognitive ability made worse by a delirium - from the prolonged period of unconsciousness, from the stress of hospitalization or medication effects?) If he cannot give informed consent now, has he given advanced directives, written or oral, to direct his health care surrogate? Do his physicians consider any of his conditions "terminal" - that is, without treatment, death is expected? Has he made prior decisions that might guide the surrogate? If he has given no clear-cut directives, then his surrogate would make a "substituted judgment," acting in a manner best thought to represent what Mr. B. would wish, <u>not</u> what the surrogate would wish personally.

2) <u>Beneficence</u> - Would further evaluation and intervention for the pituitary adenoma "benefit" Mr. B.? Would it add to the quality - or quantity - of his life? (Were the syncopal episodes explained? What would life expectancy be with his dementia and other health problems if there was no pituitary tumor?) Would treatment of the pituitary tumor have consequences that might lesson the quality of Mr. B's life? Will treatment or complications cause discomfort or disability?

3) <u>Justice</u> - This principle is more difficult to engage but may become

more prominent as society tries to deal with controlling health care costs. At 84, with dementia, hypertension, syncopal episodes of a serious nature, weight loss, and history of carcinoma of the throat (do we know the status of these latter problems, too?), should resources be expended for treatment of what's stated to be a slowly-progressive tumor? Is it "fair" to Mr. B. not to offer such treatment? Should such treatment be considered "futile" in his particular case?

Even with all of these questions answered, decisions will still be difficult. The final decision reached in Mr. B.'s case may not be the same as what you would make in your patient "C" with the same tumor but a different set of circumstances and life values. Though like principles apply, each case is unique and may not fit the confines of a commuter program or "practice parameter!"

Donna J. Jacobi, M.D.
Assistant Medical Director
Senior Health Services

MESSAGE FROM THE PRESIDENT

. . . Esther Sangster.

As the outgoing President of Florida Bioethics Network, this is my last message to you. Over the past year, our membership has continued to grow. We have a unique professional membership group in FHA that represents all of the disciplines in health care. Our growth and cross-functional representation continues to indicate a need for a supportive network to provide assistance to all of us as we grapple daily with the grayness that we refer to as ethics. The conference brochure was designed to reflect ethics as gray -- not black or white -- not crystal clear. There are no clear-cut answers that always work. Instead, we have ragged edges, slippery slopes and untested ground. The planning committee has put many hours into developing an outstanding conference which touches on many of these issues.

I hope you are making plans to attend this year's conference. I know I look forward to meeting new friends and reconnecting with old ones. If you have not received a flyer for the conference, contact the FHA office. Whether we are working on an ethics committee, teaching ethics, or practicing within our profession, we all need support. I hope you look to this conference for that support.

WELCOME NEW MEMBERS!

The Florida Bioethics Network welcomes **Jacqueline Byers,** Education Specialist, Oviedo, 407/841-5111 b2164; **Rebecca Cooper,** Clinical Assistant Professor, Wolfson's Children's Hospital, Jacksonville, 904/390-3113; **Jerry Griffin,** Director/ Chaplaincy Services, Lee Memorial Hospital, Fort Myers, 813/432-3293; **Paula Morton,** Director/Social Services, West Volusia Memorial Hospital, Deland, 904/734-3320 x1123; and **Glennys Ulschak,** Chaplain, Tampa General Hospital, 813/251-7063.

BIBLIOGRAPHIC RESOURCES

Enclosed is a listing of journal articles submitted by **Glenn R. Singer, MD,** FBN Board Member, and **Mary Lou Jones, Phd(c),** FBN Secretary.

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