The Lone Ranger is Dead

William Andereck, M.D.

“Who was that masked man? Don’t worry; we’ll get there.”

Every year, about this time, I look over the ethics consultations that were requested in the previous year by the doctors, nurses, social workers, and patients at CPMC and other West Bay Hospitals. Several years ago our team noted a lot of cases in which patients, or their surrogates, had unreasonable expectations about how much the best medical treatments could achieve. Responding to physician requests for support in these difficult clinical situations, we began a series of onsite training sessions with our ICU team in communication skills and trust building. We also developed a hospital policy that provided guidance for future situations.

In 2013, we recognized a spike in requests to help make medical decisions for patients who have no one to represent them. This year, the Program in Medicine and Human Values is focusing on this vulnerable population as a part of our Neuroethics Initiative, launched thanks to the partnership of our generous individual supporters and Sutter Health.

Today I see something new. It’s been around for a while, but always in the background. Now it is becoming the elephant in the room. The issue I am grappling with has not been well defined. It is like a smell, a fragrance even, something distinct and new, but uncharted. It shows up something like this:

The patient is a seventy-eight-year-old gentleman, with a past history of outstanding health, who suffered a severe heart attack while walking in the park. Subsequently, he has developed kidney failure and lung failure requiring support with a respirator and dialysis machine. His family is gathered outside the intensive care unit. They understand the seriousness of his condition but are fixed on any positive news. Each day there is a parade of specialists. Kidney doctors, lung doctors, cardiologists, neurologists, hospitalists, and intensivists all weigh in. Each doctor puts a slightly different spin on the discussion, often times dependent on the organ they are representing. How can the family make any decisions about the treatments being offered to our patient if they can’t seem to get a consistent message from the myriad caregivers each expressing their independent opinion? Someone suggests the ethics consultation service be called to help the family understand their situation.

Fortunately, this case is not typical of the modern hospital experience. Most people enter the hospital, have a particular treatment or surgical procedure, and go home better for it. American hospitals have become incredibly organized and complicated places. They require the cooperation of a number of agents, from admissions clerks, to radiology technicians, to doctors, and beyond. Things work as expected in this complicated care environment…until they don’t. It is that one or two percent of the admissions that don’t go as planned, despite the finest of effort and experience, that leads to what I smell.

In situations like the case described above, the first goal of the ethics consultant is to bring the multiple specialists into the same conversation about what is the best approach for this particular patient. This shared conversation usually results in a unified treatment plan, which is agreed to, at least in part, by all members of the medical team. When all is going well, a single physician will step up to become the primary spokesperson for the medical team, relaying information from all specialists through one source.

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Mr. O is a 76 year old man with advanced Alzheimer’s disease who was admitted to the hospital from his nursing home for treatment of pneumonia. Although confused and disoriented, Mr. O is mostly pleasant and welcoming of care during the day. At night however, he becomes combative and agitated, pulling out his IV lines and attempting to get out of bed. The nursing staff has taken to putting Mr. O in physical restraints every evening to keep him from harming himself. Several nights later, a new nurse takes over Mr. O’s care. Despite her reservations, she follows the previously established practice and places Mr. O in restraints. Throughout her shift, she hears Mr. O calling out for his late wife and son asking for help. She checks on Mr. O multiple times and finds him physically well. In the morning, she calls the hospital ethicist to discuss her distress with placing her patient in physical restraints.

Ethicist:
The use of physical restraints in the care of geriatric patients is not uncommon. Restraints can be understood as any measure used to restrict a person’s ability to move his body, or any part of it, which cannot be controlled or removed freely. Limb ties, body straps, bedside rails, and wheelchair bars are some frequently used methods of physical restraint. The use of physical restraints is considered a medical intervention; therefore the benefits should outweigh the burdens for the practice to be ethically appropriate. Mr. O’s nurse understands that physically restraining Mr. O helps optimize his care, but she does not believe this benefit justifies causing Mr. O distress.

Among health care providers, nurses have been identified as the main initiators of physical restraints according to an article by the American Association of Critical Nursing. Their attitudes towards restraint use are divided. Most believe the practice helps maintain order, reduces chaos, and eliminates the need for close patient supervision. Some however express frustration, ambivalence, and guilt about having to physically restrain their patients.

The most common indications for physically restraining patients are facilitating care and ensuring patient safety. Routine, convenience, lack of experience, and fear or dislike of the elderly have also been reported as factors. Many of the patients who are restrained are disoriented and distressed. They hit at staff, try to remove catheters and tubes, and attempt to get out of bed, interfering with treatment and risking injury. Like Mr. O, some become noticeably more agitated and confused in the evenings. This is known as “sundowning”, a common phenomenon in patients who have dementia. Patients experience trouble sleeping, become anxious, and tend to wander during the night. While little is understood about the exact mechanism of sundowning, new or noisy environments, medications, and infections tend to exacerbate symptoms. Mr. O is in an unfamiliar place recovering from an infective process and being taken care of by strangers. His nighttime agitation and confusion is not unexpected.

The use of restraints is not without negative outcomes. Bruising, nerve injury, aspiration, asphyxiation, and feelings of shame, powerlessness, and isolation are some of the reported effects. In addition, research has not shown that the use of restraints has any significant therapeutic benefit. There are several substitute methods to using physical restraints including lowering beds and placing mattresses on the floor, designating volunteer workers to watch patients, minimizing noise and light over stimulation, allowing patients to wander under supervision, and providing continuity of care through the same care providers.

Despite the reported harms, unclear benefits, and available alternatives, physical restraint use remains a part of daily medical practice. The crux of the issue of restraint use lies at the intersection of two important ethical principles: beneficence and non-maleficence. Medical professionals have long justified the use of physical restraints as a way to maintain patient safety and optimize treatment (beneficence). However, considering the questionable benefits and reported burdens, refraining from restraint use can be seen as part of an ethical duty to protect
patients from harm (non-maleficence). In this situation, it may be difficult to favor one principle over the other. It is helpful to consider another important principle of health care ethics: autonomy.

Patient autonomy has long been the principal value of western medical practice. It assumes that patients have absolute control over their own bodies and a right to refuse any treatment, even if that choice results in significant harm. Respecting one’s autonomy includes obtaining their consent before performing any treatment or procedure. However in situations when it is not possible to obtain consent like emergencies, care providers may give life saving treatment without a patient’s consent. In an emergency situation, it is reasonable for care providers to assume that a patient would want life saving treatment. It is difficult to apply that same reasoning to physical restraints. Most people would not want to be physically restrained in order to receive treatment. Physically restraining someone without their consent can be considered a violation of their autonomy. Therefore, the use of physical restraints without prior patient consent is difficult to ethically justify.

It can be argued that it is not Mr. O who is fighting off the nursing staff and pulling at his tubes, it is his illness, and his actions are not a true manifestation of his wishes. It is important to remember however that respecting Mr. O’s autonomy includes respecting his bodily integrity even in times of illness and handicap.

There are however circumstances when the use of physical restraints may be appropriate. Instances such as: in order to prevent serious harm to the patient or others when other methods have failed, when specific benefits are anticipated through their use, and when no other alternatives are available.

Before using restraints, care providers should consider all alternatives and choose the least limiting option in order to preserve patient dignity. It is important not to use restraints indiscriminately or for convenience. Care centers should have policies underlying appropriate restraint use and promoting respect for patient autonomy. Regardless of the issue, it is always essential for care providers to exercise caution and act carefully before infringing on anyone’s autonomy and dignity.

Ethics Fellow

Ruaim Muaygil, M.D., joined the Program in Medicine & Human Values last October as this year’s Clinical Ethics Fellow. Ruaim received her medical degree from King Saud University in her native Saudi Arabia, and completed a Masters of Bioethics at the University of Pennsylvania before joining our Program. She is interested in ethical issues as they relate to women and moral distress. Ruaim will be pursuing a doctoral degree in healthcare ethics, and hopes to subsequently establish the first clinical ethics program at her alma mater in Saudi Arabia.

In her free time, Ruaim enjoys reading, writing, and going to Spin class.
Innovation in Ethics Education - PMHV Starts Web-based Education

Our Program prides itself in our efforts to be a local and international leader in organizing and sponsoring education activities in bioethics. In addition to conferences, workshops, ethics committee trainings, and nursing education classes, we have kicked off our foray into web based ethics education. Today’s technology – software and computers (sometimes more than one) in everyone’s office provides the perfect platform for launching web conferencing activities. PMHV welcomes these new platforms and is beginning a series of web-based educational programs. The programs will be called webinars, descriptive of web-based seminars. The webinar format offers real time, point to point communication with the instructor and student. It can be equally engaging as a face-to-face education event since it offers video interaction as well as power point slides, and the ability for participants to ask questions of the presenters.

PMHV kicked off its first webinar education this year with a one hour conference on January 14 titled ‘Whose Decision Is It? Guidelines for Health Care Decision Making’. The presentation discussed the professional standards relevant to patient and surrogate decision making. Who decides about a patient’s care when they do not have the capacity to make their own medical decisions? The faculty presenters were Dr. William Andereck and Dr. Ruchika Mishra. Nearly seventy people signed up online and virtually attended the seminar.

This webinar, Whose Decision Is It?, was recorded and can be viewed on the PMHV website. http://www.cpmc.org/services/ethics/

We are excited about moving into the future with web based ethics education and plan to offer several more webinars in 2015. If you have suggestions for topics, comments or questions contact Linda Hummel, Ph.D., at hummell@sutterhealth.org.
I am proposing a new moral responsibility for doctors: to act as members of a team rather than as autonomous agents.

We have found that ethics consultations don’t just end with the initial recommendation. Forging a consensus for treatment of this difficult patient can be just the beginning. That smell I was talking about begins to crop up on Friday morning and becomes more noticeable as the day wears on. The best laid plans of doctors and surrogates are about to be thrown in the tumbler and reanalysis is in order. Next week, a different set of doctors will take over the management of the case. This new cast is equally bright, well intentioned, and communicative, but in being so, they also immediately launch into their own treatment plans, often disregarding the difficult decisions hammered out last week. Imagine the old standard transmission cars. Sometimes when the gears are out of sync you only get a bump and a grind, but sometimes you blow the engine.

Now I get it, that smell is the lack of continuity inherent in a complicated medical situation involving multiple decision makers, especially when different individuals are stepping in and out of critical roles.

When I started my career at CPMC, things were different. Think back to the old times, Marcus Welby or Hawkeye. There was always the “Attending” - that senior physician who had known the patient for years and was trusted by the family, a physician who took “ownership” of the patient. All big decisions were deferred to the physician who took ownership.

Currently, we are all having trouble figuring out among the many names in the record, who the “Attending” really is. Is it the hospitalist who admitted the patient through the emergency room, the head of the ICU who is now rounding on the patient, the cardiologist who has managed his heart condition? No one seems to have known the patient before they were admitted, and, since that moment, the patient’s life has been dramatically different than it was before.

Two things have happened. First, the doctor whom the patient has seen as an outpatient is missing from the scene during hospitalization. Relegated to the derogatory term of PCP (primary care provider), the outpatient doctor is invited to observe, but not direct, or bill for any time spent. Few doctors take the hospital up on this offer.

Secondly, physicians, called hospitalists, are now directly responsible for your hospital stay. They are well trained in disease management and treatment. They are hampered, however, by their lack of knowledge of each individual’s personal perspective. Some are masters at quickly making a personal connection, others less so. The nature of their job at the hospital allows them to rotate on and off service. To the patient, this means a different doctor can take over at any time.

Each well-meaning doctor feels a responsibility to do his or her best for the patient. But, I contend that the individual doctor assuming the care of a complex case must assume the previous decisions made by the treatment team which preceded them.

The days when the patient’s personal physician would march into the hospital in the morning like the Lone Ranger, writing orders to be carried out while the doctor went back to the office, are long gone. The current level of sophistication in the modern hospital is far too advanced to think you can manage it on horseback. Cooperation and teamwork are necessary to make it work in the hospital of the 21st Century.

This brings me back to that smell. It is the smoke, if you wish, emanating from an important change in how we conduct ourselves. There is a new responsibility for physicians and other medical professionals, something to be valued and promoted, arising from our new methods of healthcare delivery. That responsibility needs to be articulated. I am proposing a new moral responsibility for doctors, working in hospitals, to act as members of a team rather than as autonomous agents. This is a fundamental shift in what most of us, as physicians, think of as our primary duty. How can we think that what we see as best for the patient could become subservient to the goals already established by the physicians who came before?

Giving up our rescue mentality and the aura of the Lone Ranger will not come easily. The complexity of the task will make it necessary, however. The challenge ahead is to maintain a level of personal continuity that maintains patient trust in the treatment team as a unit. To our fiercely independent medical practitioners, there is a lesson to be learned from the National Basketball Association. No matter how many superstars you have on your side, you cannot win unless they all work together as a team.

Once we have a team in place, it is still necessary to identify the coach who leads and takes personal responsibility for making the best medical decisions consistent with the patient’s goals. This is the future. “Hi, Ho Silver, away…..”
THANK YOU!

We are excited to announce that we surpassed our Sutter Health Matching Fundraising Goal of $100,000! We exceeded our fundraising goal by raising $117,098.50 in support of PMHV’s Neuroethics Program Development. The original goal amount of $100,000 will be matched by Sutter Health. We are grateful to the many donors who participated, and for the time and contributions of the CPMC Foundation Board and staff who all played an important role in our success.