Disentangling Ethical and Psychological Issues

A Guide for Oncologists

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The rapid growth of bioethics has injected a new style of analysis into medicine. It requires philosophical rigor, yet is deeply embedded in human situations that frustrate abstract thinking and are laced with subjective factors. These interlaced ethical and psychological components can lead to conflicts and dilemmas. Doctors, as experts and decision-makers, play a key role, but will benefit from additional skills to disentangle these situations. This paper notes ways in which patients, families and caregivers are newly vulnerable and delineates how ethical dilemmas and psychological issues mold or frustrate decision-making. To help physicians manage such cases, a method of systematic analysis, the 'situational diagnosis', and a related hierarchy of interventions, is described and illustrated with case examples.

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The higher the utility of a science or intellectual discipline, the more its abstract concepts are wedded to local contingencies. Medical bioethics is a branch of applied philosophy with one foot in its academic birthplace and the other in the stormy hub of medical care delivery. Its practical deliberations are complicated by subjective and psychological factors that are integral to personal illness. Oncologists, faced with multilayered problems, are well suited by their medical expertise and authority to manage most of them. But some situations present a simultaneous burgeoning of ethical dilemmas and psychological conflicts which doctors are not trained to resolve. The blend must be systematically analyzed if optimal decisions and valid interventions are to be constructed. The challenge is to design responses that are both ethically well argued and psychologically well grounded. A lack of either one may doom the intervention to fail and generate more distress. This article describes a method of systematic analysis and its related interventions to guide the physician at the bedside, illustrated with case examples drawn from patients receiving end-of-life care. But first, it is necessary to set the stage by reviewing recent developments that make greater demands on patients, families and caregivers.

THE CONTEMPORARY FACE OF CANCER: I. PATIENT DILEMMAS

The burdens of freedom placed by the era of autonomy on cancer patients have been called 'the perils of modern patienthood (1). With a longer, more arduous course as the price for prolonged survival or cure, more decisions need to be made in the face of greater uncertainty. Patients experience severe anxieties as they struggle with decisions they know to be at the limits of medical knowledge. The terminal care period, in particular, has become one of intensely painful decision-making, instead of a time for life review and leave-taking. In developed countries, spearheaded by The Netherlands, consumer fears of prolonged death have led to increasing public acceptance of physician-assisted suicide, especially among educated and privileged groups (2, 3). In a related development, lack of adequate pain control and/or aggressive palliative care is eliciting legal and ethical challenges (4).

THE CONTEMPORARY FACE OF CANCER: II. FAMILY TRIALS

However, patients are rarely alone. Their families' emotional involvement needs no emphasis, but the well-documented, negative, long-term impact of illness on family members is less obvious even as it makes them interested parties in ethical conflicts surrounding patient care (5).

Among worsening family stressors is the expanding array of available treatments that drain family finances even in countries where socialized medicine provides major shielding (6–8). The cutbacks occurring in many European

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healthcare systems are less a saving so much as a shifting of costs from the system to the consumer, i.e. the family system. Financial burdens are compounded by the rising medical expenses that have been documented in all family members, for up to three years following the index patient's illness (9). An equivalent psychological burden is borne by relatives whose emotional supplies and life options are shrunken by the illness (10–13).

Interdependence and the willingness to support one another are the glue that holds families together and gives members the moral grounding and resiliency to participate constructively in the larger world. It is society's basic building block and a crucial resource for oncologists, since social support is one of the most solidly documented psychosocial factors associated with improved treatment outcomes (14). Further support comes from several lines of research demonstrating the bi-directionality and correlation of reactions, affects and coping behaviors that yoke patients and family members to each other (15, 16). Some fare psychologically worse than the patient whose emotional well-being usually improves with his physical status. Primary caregivers may remain depressed or worsen, as their careers falter or grind to a halt due to absenteeism or lowered performance. Spouses and parents have also shown the same consequences, independent of caretaking role (17–19). Studies of family units in the performance of their myriad nurturing, educational and socializing functions have shown that as many as 25% of cancer survivor families are sufficiently traumatized that they function more poorly compared to control families in their communities, even a year or two after the treatment (20–22). More disturbingly, family dysfunctions do not improve over time. They may stabilize, but often worsen (18).

Bereaved families demonstrate the same dynamics (23, 24). The sturdiest family survivors describe the terminal period in vivid, often anguished terms, for years, if not forever. A capable woman who had adjusted well to widowhood 12 years before, said that her husband's last days were still etched in her memory, 'as if it happened yesterday', and she still continued to draw comfort from the fact that he had been able to make his own decisions until the end. Unfinished business or a sense of guilt and failure looms very large and haunts individuals or family units more fragile than this woman.

Families and treatment decisions

Family members care intensely and often do much of the research needed for informed decision-making, becoming vulnerable to guilt when the option fails (10). Many parents who agreed to bone marrow transplants or experimental protocols feel intensely helpless when their child suffers and even more so if the child dies. In a flight from parental guilt, irrational or unconscious though it is, they recast events, accusing the medical staff of using their child as a guinea-pig or worse, despite having received full information, excellent care and warm support (25). Deep down, parents always feel guilty that they were not invincible enough to shield their child from pain and tragedy. Without some awareness of that instinctive response, they blame others to escape their pain, often as an alternative to self-blame and depression.

Often asked to decide how much or what kind of care their dying relative should receive, family members feel a level of anguish which has been underestimated (26, 27). Many relatives go away convinced they gave permission for death to occur. To the health professional well aware of the outcome, imminent or not, these family treatment decisions seem to be 'pseudo-decisions', generated by current social mores and legal regulations. But the widow above remarked that her husband had made his own decision to die. By this she meant that he had agreed to the discontinuation of vasopressors two hours before his death. This was the 'decision' that brought her comfort over the years. During intense interpersonal confrontations, objectively trivial events have powerful emotional and symbolic significance.

But if the world celebrates the radiant private language of lovers, most people, doctors included, prefer to glide past the intensity of tragic moments.

THE CONTEMPORARY FACE OF CANCER: III. CHALLENGES FACING STAFF

Issues for the physician

The post-modern era has brought discomfort to physicians as well. The concept of patient autonomy, resisted by some and faithfully respected by many, stigmatized the paternalism that used to stand for patient trust and physician dedication to patient welfare. Doctors are not immune to pain, grief and wounded self-esteem. Their professional self-control, micro-optimism and continued activism are a constructive response against the urge to flee the repeated emotional wounds inherent in their work. But despite their knowledge and discipline, doctors often fall prey to painful self-doubt or relentless hyperactivity, when they must witness the death of a loved one. This extends to their work life. Doctors' treatment decisions are shaped by personal factors even when patients have left advance directives (28–30). Doctors' judgments in extreme human situations will be more reliable if they remain aware of their everpresent non-medical self.

Professional versus clinical ethics

An awareness of layered roles also affects professional ethics, i.e. the values governing performance of duties independent of any specific case (31). Social and philosophical controversies are repeatedly played out at the bedside, putting doctors in potential conflicts between their medical duties and individual beliefs or compliance with social norms. These become more frequent in times of financial cutbacks. All physicians are affected by political and financial constraints in delivery of care, but how much personal exposure does each doctor incur in attempting to obtain more care for patients than the system is willing to fund (32)? Rigid rules may provide some guidelines in solving dilemmas, but in the shifting arena of contemporary medical care, they cannot be blindly relied upon and personal factors again come to the fore.

Outside observers should not be judgmental. Doctors cannot be expected to jettison their human responses in existential dramas that extend far beyond clinical expertise (33, 34). Doctors do benefit from understanding their feelings better, and from better recognizing their patients' feelings. Therefore, programs have been developed to help doctors hear patients more effectively, break bad news less traumatically, prognosticate more comfortably and recognize their own biases more naturally (35–37).

The patient/doctor interface

The interface of patient and families with medical caregivers is especially important in conflictual situations (10). The intensity of family and patient feelings about their treating physicians surprises caregivers. Contented patients and families wax euphoric; angry ones lash out; propitiating ones are over-cooperative, frightened families run away, sometimes taking the patient with them. All of them share a rational desire for emotional support, alongside an unexamined belief that a special relationship with the oncologist will alter case management for the better, or provide some kind of semi-magical protection. To a lesser degree, this involves other staff members. Both professional distancing and over-involvement lead to disagreement among team members about what is best for the patient, or who is best at doing it. Patients and families intuit this and often play on it, complicating the situation even further.

Physicians are best positioned to help their staff understand their responses, and decrease tension and conflict as they face situations that are complex at best, and chaotic at worst. Analytic skills are required, as well as a method of bringing order and developing interventions in these demanding situations.

MAKING A 'SITUATIONAL DIAGNOSIS': A GUIDE TO COMPLEX CASES

Stressful clinical situations and their psychological and ethical components are in a constant state of flux, as depicted in Fig. 1. When the mix is sufficiently complicated or upsetting, all participants including medical staff can become uncertain about what is primary and what is derivative. Staff members may define the problem as ethical when it is a disruptive psychological reaction, or psychological when an underlying ethical question has been obscured by too much emotional heat. In these pseudo-psychiatry and pseudo-ethics stalemates, accurate redefinition may be enough. But many cases need a more systematic approach to identify the driving factors and suggest interventions (38). The components of the 'situational diagnosis' and its interventions are described below. (see Table 1).

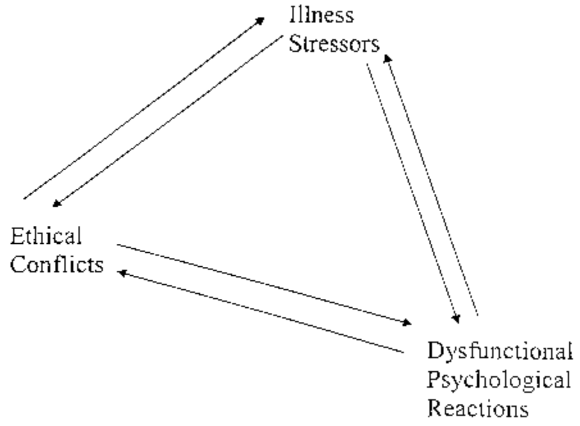

Fig. 1. State of flux between stressors, psychological and ethical components in complex cases. Adapted from reference (38).

I. Patient/family factors

1. What are the patient/family's understanding of the medical facts and the prognosis? How realistic are they? What is driving the distortions?
2. Are patient and family members communicating amongst themselves? Are there major 'secrets'? Are some members excluded from the information flow?
3. Are family conflicts affecting the patient's treatment? If so, whom do they involve, and what is their effect?
4. Are there severe psychological problems or treatable psychiatric disorders impacting on case management?
5. Are there religious or cultural factors discrepant from the ambient medical culture? (These are becoming more important as the size of ethnic minorities expands in many countries.) If so, what are possible consequences?

Interventions. Patient and family factors contributing to the impasse must be recognized, information gaps must be corrected and information flow facilitated. Providing clear information and improving communication are the most powerful positive factors in helping family systems function well (10, 23). Relevant authorities should be called

Table 1

Components of a situational diagnosis

I.	Patient/family factors
II.	Staff factors
III.	Staff/family interface
IV.	Legal/regulatory constraints
V.	Ethical dilemmas

when religious or cultural issues create distance or misunderstanding, mental health professionals called to mitigate obstructive psychological problems. Major crises create windows of opportunity during which families are unusually accessible to intervention which the physician is uniquely positioned to implement. Meetings with the oncologist, or conferences that include physician and a judicious mix of patient, family members and other staff such as nurses, social workers or a mental health consultant, can be remarkably effective (10, 39).

II. Staff factors

1. Is there any controversy or disagreement among the staff about the patient's medical management? If so, what is it about?
2. Are there other staff problems, such as interstaff conflicts, or collective concerns that could be affecting staff behavior?

Interventions. Staff concerns may be so covert or pervasive as to be unnoticed if not directly sought. The medical staff's own reactions must be scrutinized since their impact is disproportionately great. Team members can interfere with effective conflict resolution if over-involved or making inaccurate assumptions about the family. Case-specific controversies or broader differences of therapeutic philosophy may be in play, as well as personality conflicts, unacknowledged social biases, or inescapable organizational changes. Some of these problems may need to remain unaddressed, others may warrant overt, non-judgmental acknowledgement, but should be referred to a later conference or seminar. Rules of professional behavior that prevent discourtesy, passive interference or acting-out of personal feelings should be emphasized. Again, the physician as team leader must make these observations and decisions, after reviewing his own possible involvement.

III. Staff/family interface

1. How are the staff and the patient/family getting along? Are the patient/family hostile? Difficult? Intimidating? or unusually close to staff? Does the staff find them 'strange', unlikeable or unreasonable? Do they have a special affection for them?
2. How do the patient and family feel about various caregivers?
3. How do all the participants conceptualize and label the main issues both about the problem at hand and about each other?
4. How are they communicating with each other?

Interventions. The all-important staff/family interface can be improved by simultaneously 1) helping the staff to be accurately empathic toward the family, without over-idealization or condescension, and 2) helping the patient and family to feel heard and respected. These tandem goals are often achieved while carrying out the interventions described in the two previous sections, but still need to be independently identified and evaluated.

IV. Legal/regulatory constraints

1. Are there laws or regulations, federal, state or local, which impinge on the case?
2. Are there institutional constraints affecting the case? Are they overt rules or implicit expectations?
3. Do any of them have the potential to create a conflict? If so, what is the nature of the conflict?

Interventions. Legal and regulatory constraints are often unclear to participants. The physician must be familiar with them and should explain them to everyone. Discussion should be encouraged, not only for better learning, but to promote more thoughtful, flexible attitudes and improve communication. Legalities loom large in terminal care, with its controversies around pain management, terminal sedation, cessation of treatment, of life supports and nutrition/hydration, as well as terminal sedation, the 'double effect' (the unintended shortening of life), and lastly physician assisted-death in all its forms. These questions touch providers as well as patients and families. They call upon our deepest beliefs about the meaning of life and the limits of social constructs. It has been the author's experience that even when law or customs are quite clear, staff and families can be deeply troubled about stopping life supports or giving morphine for terminal respiratory distress. It is crucial for physicians to recognize their own responses and help their staff do the same, so they can help patients and families negotiate decisions without an unnecessary, lifelong residue of guilt and anguish among the survivors. But laws are social attempts at resolving ethical issues, so their examination often leads to defining ethical dilemmas.

V. Ethical issues

1. Are there remaining conflicts of values that cannot be reduced to any of the problems outlined above?
2. How should they be prioritized?
3. For each one, to whom is the duty owed? Who are the other actors? What are the available options? What are the consequences of each option?
4. How can this analysis be carried out in an open, non-judgmental way that involves and enables all the appropriate participants?

Interventions. The nature of these questions makes it evident why the preceding components of a case must be clarified, and often altered, before it is possible to frame the ethical questions. At that point, ethical dilemmas stand out naturally as the remaining conflicts requiring analysis. By definition, a dilemma does not have an obvious 'right' answer, but after available options are dissected, certain courses of action may be agreed upon. If not, the participants will at least have become better informed moral agents in their dealing with appropriate consultants.

CASE EXAMPLES

The use of the situational diagnosis method will be illustrated by two examples: a social worker could have helped the oncologist handle the first case, and the presence of a familiar, stable physician might have prevented the crisis in the second one.

Case 1

A psychiatry consult was called to rule out delirium in a 69-year-old widower with advanced multiple myeloma. Started on dialysis secondary to renal failure, he had become suddenly labile, irritable and negativistic.

Situational analysis

I. *Patient/family factors*. The interview revealed a lucid, severely ill man, with an adjustment disorder precipitated by an acute struggle with his only son, a single man of 33, who had always lived at home and never held a job. After the father announced his wish to stop treatment, the young man escalated his already significant anger at his father, and aggressively demanded that the latter continue dialysis. When directly queried, the patient dismissively said he was experiencing some pain and post-dialysis nausea and malaise, adding that they were not important and far less painful than the conflict with his son.

An interview with the son was colored by the latter's abrasive and hostile manner, his lack of minimal social graces, and a total resistance to discussing any aspect of the situation. Even without a formal evaluation, it was clear that the young man had long-standing life difficulties that would not yield easily to intervention. There were no other family members.

II. *Staff factors*. There was no staff disagreement or underlying conflict around this case.

III. *Staff/family interface*. The staff had previously found the patient easy to care for, and had accommodated to his son's lack of interaction. As the patient became more difficult, frustrated nurses began to wince at having to deal with him and his unfriendly son. Unaware of the father–son struggle, they were confused by the patient's contradictory behavior, manifested by marked anger about dialysis while still requesting it.

IV. *Legal/regulatory constraints*. There were no legal or institutional constraints. The patient had been told he could discontinue dialysis at any time.

V. *Ethical issues*. The patient was the main protagonist in one fundamental conflict. This father felt trapped in a cruel dilemma as he weighed his son's desperate need for him against his own desire to let himself die. The difficulty of it was worsened by his pre-existing irrational guilt about the inexorable abandonment that would come with his death, whatever the cause. Under this lay a yet earlier guilt at having fathered a disabled son in the first place. If the patient insisted on stopping dialysis, he would die with the acute feeling of having put his own desires first and having deserted his child, even while knowing that death was inevitable. Yet if he continued dialysis, he would endure an indefinite period of discomfort and suffering without being able to prevent the day when he would indeed 'abandon' his son. While it could be said that the son's undiagnosed psychiatric illness, which left him pathologically dependent on his father, was the real driving factor, it was a pre-existing condition, would not yield to acute intervention and had to be taken as a given.

Interventions. A social worker was asked to address the son's vulnerability and need for long-term support. A joint meeting was arranged with father, son, physician and social worker. The son was gently confronted with the reality of his father's imminent death whether dialysis was continued or not, and the depth of their mutual pain and fear was verbalized. The son was advised of his father's right to stop dialysis if he wished, and of the staff's obligation to honor his request. Lastly, he was offered help in planning to meet his own needs after his father was gone. The patient had the opportunity to hear these messages and observe his son's ability to tolerate them. He was told that the staff took his physical symptoms seriously, even if he, himself, did not.

The staff was told about the family conflict. This made the patient's recent behavior more understandable, and enabled them to develop a more focused supportive stance in dealing with father and son while they treated his symptoms. It was verified that the staff understood the patient's right to refuse life-saving treatment, and would have no difficulties accepting discontinuation of dialysis.

Outcome and ethical resolution

The patient announced he would continue dialysis 'for now'. He was relieved to have seen his son tolerate direct confrontation without decompensating and to know he was being referred to the social service for help. The son remained poorly related and abrasive, but his most hostile behavior toward his father abated, and grudgingly he became willing to talk with the social worker. The father's irritability abated, while he continued to discuss the meaning of his choices. He focused on talking to his son, and when he announced, two days later, that he was refusing any more dialysis, the son tolerated it without a scene. The patient died three days later, his son at his side, with extensive staff support available to both of them.

Discussion

In this example, a clear moral dilemma, one that only the patient himself could define and resolve, lay at the core of the situation. The fact that he was soon going to leave his son anyway might lessen the objective weightiness of the decision in the eyes of others, but leaving his son against the latter's grief-stricken, angry wishes was a massive emotional and moral trauma for this father, and would be for the son as well. From the staff's point of view, it was crucial to help him come to some resolution before he died. In moral terms, addressing an ethical dilemma that was more painful to him than his myeloma pain and dialysis nausea put together was as urgent as addressing the symptoms themselves.

Case 2

A 23-year-old unmarried man dying of non-Hodgkin's lymphoma and a pulmonary fungal infection was permanently respirator-dependent in the SCU (Special Care Unit). He had previously been admitted to several hospitals, and was non-compliant in all of them. As a result, he had never developed a stable relationship with any oncologist. His parents had always displayed hostility, now compounded by acute grief.

In talks with the attendant SCU staff, following a psychiatric decision-making capacity evaluation, the patient had agreed to extubation and to a 'Do-not-Resuscitate-Order'. He had asked not to be sedated, wishing to remain conscious for as long as possible. The SCU staff were accustomed to such requests and to offering prompt sedation when patients developed respiratory distress. They did not confront the unrealism of his plan, feeling that forcing him to face the certainty of severe dyspnea was a brutal exercise in depriving this moribund young man of his last illusion of control and his last hope for a little more time.

Transfer to an open ward was set into motion following the new directive. After a telephone conversation between the SCU and ward staff, the patient was accompanied by his SCU nurse who brought his chart and transferred him directly to his floor nurse. Shortly after extubation, the patient became dyspneic and his frantic parents demanded re-intubation. The beleaguered nurse, privately uneasy about which terminal sedation, responded with a certain relief to their suggestion. By the time the ward attendant arrived on the scene, he was told that the patient had agreed to re-intubation.

This entailed a return to the SCU whose attendant staff called an ethics consultation, asking for a discussion on how to deal with such a change of directive from a patient whose acute emotional and physical condition could be said to preclude the possibility of making a meaningful decision.

Situational analysis

I. *Patient/family factors*. By the time of the ethics consultation, the patient had become somnolent, confused and could not be re-interviewed. His parents' behavior had been consistent throughout and originally shared by the patient. His desperate condition, and total dependency on caregivers whom he had come to trust, had dissolved the young man's aggressive behavior, but not that of his parents.

II. *Staff factors*. There were overt and covert disagreements within and across services. The SCU team, accustomed to extubations and sedation, felt the patient had been inappropriately re-intubated and that further treatment would go against his previously expressed wishes. The open ward team, meeting a desperate, hostile family and a dyspneic, exhausted patient for the first time, felt their situation was not appreciated. Significant unease emerged among some of them, about terminal sedation and the 'double effect', (the unintended hastening of death). Several individuals admitted to personal anxiety when asked to administer it, recognizing the inconsistency between their formal obedience to hospital policies and their private moral concerns.

III. *Staff/family interface*. Both services recognized that family intimidation had complicated delivery of care, making difficult decisions even more difficult. The absence of an attending physician with an established relationship to the patient and family was less noticeable on a small referral unit, but it contributed to the crisis in the open ward. Standing up to disruptive families, arbitrating disputes and making necessary medical decisions are best done by a well-informed, well-known physician. This one first met the patient after the latter had already decided on re-intubation.

IV. *Legal/regulatory constraints*. In this unusual jurisdiction, resuscitation was mandatory unless explicitly abjured by the patient or a family surrogate. Hence, they had a legal right to insist on it, and the staff were obliged to perform it. The patient right to discontinue treatment was clear to all staff members. Legal and ethical policies were well promulgated as were hospital guidelines about the care of terminally ill and dyspneic patients. Yet none of this had resolved unspoken staff discomfort about the double effect, one of the ethical issues these guidelines were designed to address.

V. *Ethical issues.*

Hierarchy of issues

1. There were many moral questions in this case, but, as identified by the SCU staff, those affecting the patient have first priority. How do caregivers deal with a patient who rescinds a decision under conditions of diminished or possibly absent decisional capacity? Does the content of the decision affect the response? Does the urgency of the decision, or its life-threatening aspect affect it? If so, how and why?

Buttressed by the requirement for informed consent, there is no legal or ethical question about a competent patient's right to refuse any treatment, life-threatening or not. The companion right to rescind a decision at any time is equally important, for without it, self-determination would be a charade and patients would be fearful of agreeing to anything. In the individual case, these principles remain binding, despite philosophical and societal discussions about the overvaluing of autonomy, the importance of family/community interests, distribution of scarce resources and the like.

But questioning the patient's decisional capacity opens a different area of concern. The basic components that go into defining 'competence' have included the ability to 1) understand and communicate, 2) reason and deliberate, and 3) connect to a set of personal values (40). Psychiatrists do not refer to competency and prefer the term 'decision-making capacity' for several reasons: first to differentiate the legal from the psychological determination; second to differentiate a categorical yes/no distinction from a continuum-based dimensional one. The latter is more compatible with two other aspects of consent doctrine. First, it is decision-specific, i.e. it applies only to the decision at hand, and decisional criteria may vary according to the risk/benefit ratio involved. Secondly, it has a subjective component that no single 'test' can capture. Rather, it seeks to establish a sense of inner coherence whereby the patient demonstrates some remaining constancy of awareness and consistency with his previously known self.

This elastic definition means that biases and personal pressures can de facto play a larger role than was intended in philosophical and legal discourse. It also means that the burden of proof is on the physician who refuses to accept a change of opinion, even when events carry such an aura of helplessness and necessity as did this desperate second decision.

2. The parents are the next protagonists to be considered. Should they be given any standing or should only the patient's desires be considered? Should the nearness of death make any difference? Should it alter the management of disruptive behaviors?

The patient is the doctor's primary responsibility, but as long as that responsibility is discharged, family members are an appropriate source of concern. They often make demands contrary to patient wishes, demands which become more difficult to deny as death approaches. Their stake increases, extending as it does into an emotionally scarred and indefinite future, while the patient's energy is gradually withdrawn. Nevertheless, patient wishes continue to receive priority, avoiding the abuses of earlier eras, even if creating new moral ambiguities.

The parents' belligerence had made it difficult to feel much natural warmth toward them, but there was no doubting their grief and no mistaking their need for understanding and compassion as their loss drew near. This gave support to affirming the re-intubation decision reached on the ward, and sustaining it after re-admission to the SCU, especially given that the young man's course was going to be a short one. But truly disruptive behaviors require limit-setting under any conditions, for the sake of patient, parents, staff and other patients. Good medical care cannot occur in a climate of fear. Gratuitous intimidation has never been included among the professional risks medical staff are expected to assume.

3. Staff issues are the last group to be considered. They are multiple, and the most difficult to isolate as pure ethical problems, independent of patient requirements and distinct from practical and procedural issues since caregivers exist to serve patients' legitimate needs. Furthermore, the patient and family's psychological problems were written in broad strokes, while staff issues were more subtle. The ethics committee and its psychiatric consultant convened a meeting for medical, nursing and social work staff from both services, to discuss all aspects of the case.

The ethical aspects of patient decisional capacity were explored, but for the SCU staff, it was inseparable from concerns about whether they should have predicted that the transfer would not go smoothly; whether they should have insisted on making the patient accept sedation; whether their judgment was skewed by discomfort with the family; whether the patient's young age had touched them in ways of which they were not aware.

The ward staff could not separate the second decision from some resentment toward the SCU for what they perceived as 'blindsiding' them, and from resentment toward the family and patient for having always refused to comply with treatment only to reappear late in the day with their desperate demands. The ward attendant initially felt defensive about having been unable to prevent the problems, and protect his staff. He was also defensive toward the SCU attendant who had called the ethics consultation. The ward nurse was embarrassed and unwilling to discuss her feelings about terminal sedation until several colleagues shared their own discomfort and the extent of staff emotions about it became more obvious. It was acknowledged that their concerns reflected an on-going, heated societal controversy (41).

When the discussion finally returned to the original question of what to do next, the mood had changed and both services felt they were being heard and were able to be supportive of each other's problems. The attendants realized they had no substantive disagreement, and the question of how to manage the re-intubated patient seemed self-evident and uncontroversial. The patient was to be left intubated, but that no other measures would be taken. The SCU staff would work closely with the parents to contain them and help them accept this policy and their imminent bereavement.

This seemed to be the best compromise between, first, honoring the patient's intent(s); next, sparing the parents unnecessary pain; and, last, minimizing any violation of staff professional and personal values. The ethics committee's interest in exploring the full range and ethical consequences of available options (from full support measures to immediate extubation) was heard politely but had become academic once an ethically and pragmatically viable solution had emerged.

Outcome

The patient never regained consciousness and died on the third day. After two days of extensive involvement, the parents began to make their peace with the care their son had received. They became slightly less hostile, no longer threatened various forms of retribution, but refused any bereavement counseling.

Over the next few days, an ethics committee member contacted the most involved staff members to offer more closure if needed. At the next meeting of the full Ethics Committee, the ethical questions around patient directives were parsed again, but intertwined with action-oriented concerns, constantly referring to previous cases and their consequences. Systemic issues around patient transfers were scrutinized and judged to be adequate. Hospital regulations giving staff members the option of recusing themselves from a case as long as it did not interfere with patient care were reviewed. It was agreed that ethical scruples about the "double effect" warranted repeated education and ventilation sessions, as did the management of chronically hostile patients and families. The tendency of such families to create splits within and between treatment teams and to play staff members against each other was highlighted as a needed part of the training, as well as methods of dealing with it.

CONCLUSION

Both examples demonstrate how ethical and psychological problems wind their way in and around medical decisions. In the first, the ethical conflict was buried in a psychological conflict. In the second, several issues, involving patient, family and two treatment teams, were tied in a Gordian knot that reached crisis dimensions in large part because the patient and family had not permitted any physician to develop a consistent relationship with them. The examples also illustrate how solutions are a mix of practical compromises, which, when they are discovered and implemented, appear deceptively simple. Yet, in the absence of unquestioned sources of authority, and without a systematic exploration of all facets of each case, resolutions are often elusive.

These clinical moments carry with them a great richness and intensity of human meaning that affect not only patients and their loved ones, but staff members as well. Thorough analyses and thoughtful responses sustain staff morale. The large majority of these problems will continue to be managed by internists, geriatricians and oncologists who must negotiate ambiguities their predecessors never faced. It is easy to declare each case is too insignificant to warrant close analysis, but analytic skills are needed and can only be learned by practicing them. The situational diagnosis method of analysis will be useful as doctors and their patients navigate post-modern waters.

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