CHA
Catholic Health Association of the United States

# Understanding and Applying the *Ethical and Religious Directives for Catholic Health Care Services:*

AN EDUCATIONAL RESOURCE FOR THE CATHOLIC HEALTH MINISTRY



## *Part Three - The Professional-Patient Relationship*

# *Part Three - The Professional-Patient Relationship*

## CASE STUDY

### CASE #1: INFORMED CONSENT OR MISINFORMATION?

Susan Smith, a 59-year-old female is admitted through the ED with severe headaches, nausea/vomiting, vision problems, and other persistent symptoms. After conducting a neurological exam, the ED physician orders a contrast CT, which reveals Susan has a relatively large tumor that appears to be malignant. A neurosurgeon is consulted and he meets with Susan to inform her of the probable diagnosis, pointing out that the only way to be absolutely sure if the tumor is cancerous is to examine surgical specimens. He mentions that without surgery, she would likely die within six months. However, with surgery, and assuming malignancy, radiation and chemotherapy, there is about a 10 percent chance of surviving five or more years, depending on the precise makeup of the tumor. The neurosurgeon also notes that the operation carries a 5-10 percent chance of mortality or serious disability. After thinking about it for some time, Susan decides not to undergo surgery. In describing why, Susan talks sadly about her sister-in-law's long terminal illness, and about a friend's daughter who lived her life completely dependent on others — both situations she would rather avoid. Just to be sure that Susan is fully competent to make this decision, the neurosurgeon asks for a psych consult. The psychiatrist finds that Susan is fully rationale and very capable of making treatment decisions for herself.

Not happy with Susan's decision, the neurosurgeon appeals to her family to help change her mind. Though everyone in the family agrees, with the exception of Susan's sister, that Susan should pursue the surgery, Susan remains adamant. Within four weeks after being admitted, Susan returns to the ED unconscious and unresponsive. It is determined that her condition is due to the enlargement of the tumor. This time an MRI with gadolinium is performed to determine the exact status of the tumor. Shockingly, the radiologist reading this scan questions the original diagnosis: the tumor on the present scan lacks characteristics of the type of malignant tumor it had previously been thought to be. Its homogenous appearance leads him to suspect a meningioma — usually a benign tumor. If true, this would change the likelihood of survival. More than 60 percent of patients with meningioma survive at least ten years after surgery. However, Susan's only hope of survival still depends on surgical removal of the tumor, and the risks of surgery — including cognitive disability — remain the same given the placement of the tumor. The neurosurgeon again approaches the family and, despite

Susan's verbal statements about surgery, tries to get them to provide their consent for it. Again all are in agreement, but Susan's sister who insists that the surgery not be done because that is not what her sister would have wanted and she made that very clear. The neurosurgeon protests saying that Susan made that decision with the wrong information and since she is no longer competent and without an advance directive, her previous decision does not stand. (Courtesy of Dr. Michael Panicola, SSM Health Care, St. Louis, Mo.).

# *Part Three - The Professional-Patient Relationship*

## CASE RESPONSE

### CASE #1: INFORMED CONSENT OR MISINFORMATION?

**1. What ethical issues do you see here?**

- ✦ Informed consent.
- ✦ Patient self-determination.
- ✦ Decision-making capacity.
- ✦ Best interests.
- ✦ Refusal of treatment.
- ✦ In the absence of an Advance Directive, who is an appropriate surrogate?

**2. Which Directives apply to the case?**

- ✦ 23, 26, 27, 28, 32, 33

**3. How might the Directive(s) help address the case?**

- ✦ As with other cases, the Directives here do not contribute to an easy resolution of a very difficult situation. What they do is highlight important considerations — self-determination, informed consent, the need for appropriate information and counseling to form one's conscience, the use of ordinary and extraordinary means, the fact that the well-being of the whole person must be taken into account in making treatment decisions.?

# *Part Three - The Professional-Patient Relationship*

## CASE STUDY

### CASE #2: THE DUTY TO TELL

Mr. Johnson, a man in his late 70s, is brought to his physician by his son, who is concerned about his father's apparent problems in interpreting and dealing with what used to be normal day-to-day activities. He worries that his father might have Alzheimer's disease, but asks the physician not to tell his father if Alzheimer's disease is confirmed as the diagnosis. The son expresses strongly how devastating such a diagnosis would be for his father, an independently-minded person. After the appropriate tests, the physician believes she has a reasonably firm diagnosis of Alzheimer's disease, and discusses with a nurse and social worker the son's "impassioned plea" not to tell his father the diagnosis. The nurse notes that a strong consensus has developed over the last twenty-five years about disclosing the diagnosis of cancer to patients, and wonders if the same reasons apply to patients with Alzheimer's.

The physician responds that the arguments in favor of telling patients about cancer assume relative accuracy of diagnosis, existence of therapeutic options, and competency of patient. However, in the case of Alzheimer's, diagnoses are not certain, there are limited therapeutic options, and the patient generally suffers from an erosion of decision-making capacity and often has limited coping skills. In this case, the physician knows the family well, and knows that the son is devoted to his father's well-being and would care for him. The physician thinks patient autonomy is important, but wonders if, in this case, she should tell the son but withhold the diagnosis from this patient -- at least until a later date, when the diagnosis might be made with more certainty. (Courtesy of Dr. Michael Panicola, SSM Health Care, St. Louis, Mo.).

# *Part Three - The Professional-Patient Relationship*

## CASE RESPONSE

### CASE #2: THE DUTY TO TELL

**1. What ethical issues do you see here?**

- ✦ Respect for human dignity.
- ✦ Truth-telling.
- ✦ Do no harm.
- ✦ Patient best interests.
- ✦ Informed consent.
- ✦ Patient self-determination.
- ✦ Confidentiality.
- ✦ To whom is the physician responsible? The father? The son?
- ✦ Are there HIPPA issues?

**2. Which Directives apply to the case?**

- ✦ 23, 26, 27, 33, 34.

**3. How might the Directive(s) help address the case?**

a. Here again, there is no easy resolution to this case based on the Directives in Part Three. The Introduction to Part Three, however, does offer a view of the health professional-patient relationship that might be of some assistance: this relationship "requires mutual respect, trust, honesty, and appropriate confidentiality."

b. The emphasis on respect for human dignity in Directive 23 and on informed consent in Directive 26 and the need for reasonable information in Directive 27 all have some bearing on approaching and addressing the case. Directive 33 reminds us that the well-being of the whole person must be taken into account.

# *Part Three - The Professional-Patient Relationship*

## CASE STUDY

### CASE #3: PATIENT SELF-DETERMINATION, INFORMED CONSENT, AND PATERNALISM

N.L., a 56-year-old female with no close relatives, is a patient at St. Agatha's Hospital. She has no medical insurance. She has ovarian cancer that has spread to other parts of her body. She has a guarded prognosis and has been told she has, at most, one to two months to live. She is experiencing a good deal of pain and discomfort despite her physician's efforts at pain management, and this is expected to get worse.

A common side effect of ovarian cancer is the development of blood clots in the legs. N.L. is now experiencing a pulmonary embolism. The embolism will soon be fatal if not repaired. N.L. is conscious and competent to make treatment decisions. The physician in charge of her case has spoken with the surgeon, who says that surgery to remove the clot is possible. The surgeon and N.L.'s physician agree, however, that such surgery would not be a good choice in this case. The patient's cancer has already spread to many other parts of the patient's body, so the surgery, at best, would only extend N.L.'s life by a month or so. Furthermore, N.L. would be facing a poor quality of life during that time from the advancement of the cancer, in addition to recovery from major surgery.

N.L.'s physician is also very aware that the proposed surgery is much more expensive than the palliative care he thinks is best for the patient, and that there are limited charity care funds and that a good number of other patients could better benefit from these funds. Instead of presenting the options to the patient without recommending any option, N.L.'s physician is considering recommending only palliative care to N.L., and attempting to dissuade her from requesting the surgery option. (Source: Unknown)

# *Part Three - The Professional-Patient Relationship*

## CASE RESPONSE

### CASE #3: PATIENT SELF-DETERMINATION, INFORMED CONSENT, AND PATERNALISM

**1. What ethical issues do you see here?**

- ✦ Full disclosure
- ✦ Patient self-determination
- ✦ Informed consent
- ✦ Truth-telling
- ✦ Justice/equity
- ✦ Stewardship of resources
- ✦ Care for the well-being of the whole person

**2. Which Directives apply to the case?**

- ✦ 23, 26, 27, 33

**3. How might the Directive(s) help address the case?**

- ✦ The Directives in Part Three do not prescribe what to do in this case. As with other cases, they point to relevant considerations such as the mutuality of the health professional-patient relationship, respect for human dignity, care for the well-being of the whole person, sufficiently informing the patient for good decision-making, and fairness. While not part of this section, what was said earlier about stewardship of resources is also important. Some of what is said in Part Five ("Issues in Care of the Seriously Ill and Dying") would also be helpful in approaching this case.

# *Part Three - The Professional-Patient Relationship*

## CASE STUDY

### CASE #4: SURROGACY, PRIVACY, AND NON-BENEFICIAL TREATMENT

John H., a 28-year-old truck driver, was admitted to the ED by his girlfriend (whom he had named his durable power of attorney for health care about six months earlier). He was confused, incoherent, his movements were uncoordinated, he was jaundiced and had an acutely distended abdomen. John had a 10-year history of very heavy drinking.

John was taken to surgery in a metabolic coma. Surgery found that the small bowel and colon were densely matted to one another and to the abdominal wall. In all areas, there was acute and chronic inflammation. There was persistent oozing from all surfaces with no apparent surgically amendable area. Given these findings, John's abdomen was packed tightly with pads and closed with large sutures. He was sent to the ICU in critical condition on a ventilator with a diagnosis of multisystem failure, septicemia, cirrhosis of the liver and coagulation defect.

After surgery, the surgeon informed John's mother (John's girlfriend had run home to check on her two children) that John's prognosis was bleak and his chances of survival were "minimal." John's mother said she wanted all treatment stopped. When John's girlfriend heard about this several hours later, she was furious, and insisted on aggressive treatment and a second surgical opinion.

John continued to bleed and generally deteriorate over the next several days, but his girlfriend continued to demand that everything be done, including administration of blood products, dialysis, and CPR in the event of a cardiac arrest. She claimed that stopping treatment would be immoral and against the tenets of her Catholic faith. John's mother continued to vehemently oppose treatment.

The physicians caring for John agreed with the mother (with the exception of the nephrologist who agreed with continuing dialysis). The primary physician avoided John's girlfriend and spoke almost exclusively with his mother about John's medical condition and prognosis. However, because of the conflict between the mother and the girlfriend, and the fear of a lawsuit, the primary physician opted to continue treatment. He didn't "want to end up in a courtroom over this case." Aggressive treatment continued. John died two-and-a-half weeks later, never having regained consciousness, after a 45-minute attempt at resuscitation. (Source: Unknown).

# *Part Three - The Professional-Patient Relationship*

## CASE RESPONSE

### CASE #4: SURROGACY, PRIVACY, AND NON-BENEFICIAL TREATMENT

**1. What ethical issues do you see here?**

- ✦ Privacy and confidentiality.
- ✦ Who is the appropriate surrogate?
- ✦ Non-beneficial treatment.
- ✦ Stewardship of resources.
- ✦ Withdrawing life-sustaining treatment.
- ✦ Benefitting the patient/doing no harm.
- ✦ Status of the Advance Directive.

**2. Which Directives apply to the case?**

- ✦ 23, 24, 25, 26, 27, 28, 32, 33, 34, 37

**3. How might the Directive(s) help address the case?**

- ✦ The Directives shed light on the appropriate role of the surrogate and also emphasize the importance of privacy and confidentiality which may have been violated in this case.
- ✦ Directive 24 speaks about the right to execute an Advance Directive and the importance of following the Advance Directive so long as it is consistent with church teaching.
- ✦ Directive 28 speaks to the need for access to medical and moral information in order to form one's conscience prior to making a decision. The surrogate in this case has misinformation about the Church's teaching on end-of-life care. She is not making informed decisions.
- ✦ Directive 33 points to the importance of benefitting the person as a whole in making decisions about treatment.
- ✦ Directive 37 underscores the importance and role of an ethics committee. Such a committee might have been of value in this case.
- ✦ There may have been an important role for pastoral care to play in this case (Part Two).
- ✦ Part Five sheds light on the Catholic approach to end-of-life care.

# *Part Three - The Professional-Patient Relationship*

## CASE STUDY

### CASE #5: ADVANCE DIRECTIVES IN LONG TERM CARE

JTed Reed recently retired from twenty years of teaching math at Elkhorn Community College. In retirement, he has remained so active that his friends joke that he has "flunked retirement." Ted reads avidly, has resumed playing the piano, volunteers, and travels around the country attending Elderhostel programs.

Over the past year, Ted has also spent a fair amount of time with his good friend, Jim, who was diagnosed with cancer. Ted watched him undergo chemotherapy and multiple hospitalizations, and eventually lose his battle to cancer, a mere shadow of his former self.

Jim's death caused Ted to wonder what would happen to him if he were diagnosed with a terminal illness. He wouldn't want to have his life prolonged if he were no longer able to engage in those activities that gave his life purpose. To avoid a prolonged and difficult dying that Jim experienced, he decided to complete a living will and a durable power of attorney for health care. Ted was unmarried but had two sisters and a younger brother. Ted named his brother as his proxy decision maker.

One morning, Ted began to experience severe chest pain. He was taken to the ED of the local hospital, where he was diagnosed as having suffered a severe heart attack. His physicians, in fact, are surprised that he even survived. After a week of hospitalization, Ted was sent to Mount Mary Home for further recuperation.

After three weeks at the home, Ted developed pneumonia. Ted's physician believes that Ted should be transferred to the hospital and placed on a ventilator to assist his breathing until antibiotics could clear up the pneumonia. Medications for his heart condition as well as the pneumonia have left Ted disoriented. His physician does not believe that he has the capacity to make decisions about his care. The physician contacts Ted's brother to authorize the hospitalization and treatment.

Ted's brother produces the advance directive and says that nothing should be done for Ted's pneumonia. "Ted would never want to live like this," his brother states, "where he can no longer do anything that he used to enjoy."

Ted's physician disagrees with the brother. He disapproves of advance directives and does not believe that Ted is terminal. Ted can recover from this bout of pneumonia, though his heart problems will leave him with a very restricted life style. But he is not terminal. Ted's two sisters also disagree with Ted's brother. They believe everything should be done to save Ted's life.

The chaplain at the Home is approached by the facility's administrator about mediating the dispute. While she has encountered similar disputes in the past, this is the first time she has encountered a conflict where the patient's life is at stake. She herself wonders who is right. (This case has been adapted with permission from Janine Idziak, Ethical Dilemmas in Long Term Care, Dubuque: Simon & Kolz Publishing, second edition, 2002, pp. 115-117).

# *Part Three - The Professional-Patient Relationship*

## CASE RESPONSE

### CASE #5: ADVANCE DIRECTIVES IN LONG TERM CARE

**1. What ethical issues do you see here?**

- ✦ Patient autonomy.
- ✦ Respect for an advance directive and the decision of a legal surrogate.
- ✦ The obligation to accept ordinary means, but not extraordinary means.

**2. Which Directives apply to the case?**

- ✦ Directives 25, 26, 27, 28, 32, 33.

**3. How might the Directive(s) help address the case?**

- ✦ Directive 25 speaks to the patient's right to appoint a surrogate decision maker to make decisions for him or her in the event he or she loses decision-making capacity.
- ✦ Directive 28 emphasizes that a patient's or surrogate's decisions should be respected so long as they do not conflict with Catholic moral principles.
- ✦ Directive 32 is crucial to dealing with this case. It deals with ordinary and extraordinary means and the moral obligation to employ the former, but not the latter. The significant question here is whether the use of a ventilator in a situation of pneumonia is ordinary or extraordinary. The ventilator in the case of pneumonia is usually temporary.
- ✦ But also very important is Directive 33 which states that the well-being of the whole person must be taken into account when deciding about any therapeutic intervention or use of technology. The pneumonia occurs in the context of an individual who has suffered a severe heart attack. What will be the impact of the pneumonia on the patient's overall condition and what will be the impact of the patient's heart condition on the pneumonia? How these questions are answered will help determine whether the ventilator in this case is ordinary or extraordinary.
- ✦ In order to make these judgments, the surrogate will need adequate information (Directive 27) and possibly also some moral guidance (Directive 28).

# *Part Three - The Professional-Patient Relationship*

## DISCUSSION/REFLECTION QUESTIONS

- What is the foundational ethical principle upon which care of the patient rests? How do the bishops express this in Directive 23?

- How is this operative in your facility?

- Review your facility's policies and procedures regarding patient rights, medical decision-making, and advance directives. How do these reflect the spirit of the Directives?

- Is the Directives' view of professional-patient relationship similar or dissimilar to the general understanding in society? The general understanding in health care? In your organization?

- What is meant by the terms "ordinary and extraordinary means" in Directive 32? See also Directives 56 and 57. How does your facility educate patients and families regarding these directives? How does your facility educate staff, including medical staff?

- How is Directive 33 implemented in your organization?

- What policies and procedures does your facility have in place to ensure patient confidentiality?

- How does one access your ethics committee for a case review or assistance?

# *Part Three - The Professional-Patient Relationship*

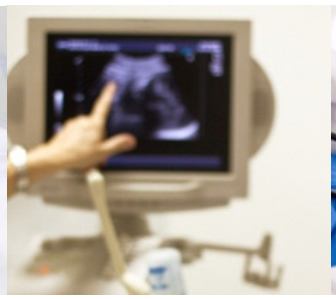
## PRAYER RESOURCE

### OPENING PRAYER

O God, creator and sustainer of all, you call us to participate in your healing ministry and delegate to us a sacred trust, that of meeting you in the person of everyone who comes into our care. Grant us a spirit of respect and integrity, of honesty and truthfulness. Guide us to ask in each situation, "What is for the good of this patient?" Support us in the difficult decisions we make on your behalf. We ask all these things in your Holy Name. Amen.

### READING

There was a woman afflicted with hemorrhages for twelve years. She had suffered greatly at the hands of many doctors and had spent all that she had. Yet she was not helped but only grew worse. She had heard about Jesus and came up behind him in the crowd and touched his cloak. She said, "If I but touch his clothes, I shall be cured." Immediately her flow of blood dried up. She felt in her body that she was healed of her affliction. Jesus, aware at once that power had gone out from him, turned around in the crowd and asked, "Who has touched my clothes?" But his disciples said to him, "You see how the crowed is pressing upon you, and yet you ask, 'Who touched me?'" And he looked around to see who had done it. The woman, realizing what had happened to her, approached in fear and trembling. She fell down before Jesus and told him the whole truth. He said to her, "Daughter, your faith has saved you. Go in peace and be cured of your affliction." (Mark 5:21-34)


# *Part Three - The Professional-Patient Relationship*

## ADDITIONAL RESOURCES


*Austriaco, Nicanor Pier Giorgio, "Scientific Certitude, Moral Certitude, and Plan B," *National Catholic Bioethics Quarterly* 11, no. 4 (Winter 2011): 623-27.

_____, "Special Section: Person-Centered Care," *Health Progress* 93, no. 2 (March-April 2012): 4-55.

Davis, Thomas J., "Plan B Agonistics: Doubt, Debate, and Denial," 10, no. 4 (Winter 2010): 741-772.

deBlois, Sr. Jean and Rev. Kevin O'Rourke, "Safeguarding Patients' Dignity," *Health Progress* 76, no. 5 (June 1995): 39-43, 48.

Hamel, Ron, "Thinking Ethically about Emergency Contraception," *Health Progress* 91, no. 1 (January-February 2010): 62-67.

Hamel, Ron and Michael Panicola, "Emergency Contraception and Sexual Assault," *Health Progress* 83, no. 5 (September-October 2002): 12-19.

Hilliard, Marie, "*Dignitas* Personae and Emergency Contraception," *Ethics and Medics* 34, no. 2 (February 2009):3-4.

Reznik, M.D., Sandra, "'Plan B': How Does It Work?" *Health Progress* 91, no. 1 (January-February 2010):59-61.

Yeung, Patrick, Erica Laethem and Joseph Tham, "Argument against the Use of Levonorgestrel in Cases of Sexual Assault," in Edward Furton, ed., *Catholic Health Care Ethics: A Manual for Practitioners* (Philadelphia: National Catholic Bioethics Center, 2nd edition, 2009): 143-150.


*The debate about the mechanism of action of Plan B continues. For that reason, both positions are represented in the selections included here.