Risk-Benefit Evaluation for Surgery in a Patient with Psychiatric Complications

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THE CASE

Our patient was a 56-year-old woman with bipolar disorder and chronic obstructive pulmonary disease who continued to smoke, and who presented to the ER with intermittent substernal chest pain. In the last year, she had had several similar episodes, with multiple presentations to the ED. Each time, she refused further evaluation and left the hospital against medical advice, reportedly "to smoke cigarettes." At this visit an electrocardiogram revealed an inferior non-ST elevation myocardial infarction. She was admitted to the CCU for cardiac angiography, which revealed multi-vessel coronary artery disease. The cardiologists recommended coronary artery bypass graft (CABG) surgery.

During medical rounds, the cardiology team presented the results of the angiogram and treatment recommendations to the patient and her boyfriend. The team also discussed the risks and benefits of the CABG procedure, including medications the patient would start and continue daily, such as dual antiplatelet therapy and other important medications. She also declined nicotine replacement therapy, while becoming aggressive towards medical staff because she was not allowed to leave the hospital to smoke.

As she became increasingly agitated, she stated she was not reliable enough to take the daily medications after surgery and refused the surgery until she could go outside to smoke. Her agitation escalated into violent behavior towards staff and she began pulling out her intravenous lines. In response, the cardiac team called hospital security as well as a psychiatric consult to evaluate her capacity. The psychiatric team determined that she lacked capacity to make medical decisions due to her agitation, inability to make rational decisions, and behaviors that necessitated sedation. While she was sedated, discussions with her family revealed their anxiety about her prognosis and their strong desire for her to undergo CABG.

THE ETHICS DILEMMA

Should the physicians perform CABG or pursue optimizing medical treatment of the patient's heart disease and psychiatric disease?

STUDENT ANALYSIS: (TT, AT, JM, YS)

In this case our patient has stated her clear refusal of CABG surgery. It may be argued that the care team should heed both her aversion to surgery and her refusal to adhere to the post-operative therapy prescribed. Although surgery may be indicated for this medical condition in an ideal candidate, the ethical principle of physician non-maleficence might prevent the physicians from taking this patient to surgery. She is a poor candidate for surgery due to her many risk factors, history of medical non-adherence, and significantly, her expressed intent to stop post-operative medications. In this instance, the anticipated harm of surgery, including significant morbidity or death, could outweigh the potential benefit of improved life expectancy, and surgery could easily be construed as causing harm.

The ethical principle of justice further supports not operating on this patient. Operating on this patient may well deprive others of needed care.[1] Surgical supplies, operating room time, and support personnel required to pursue this operation are expensive. The current healthcare landscape demonstrates that the number of patients with surgical needs will continue to rise while the pool of surgeons trained to treat them will fail to keep pace.[2]

There are, however, many arguments in favor of performing the surgery. It is the nature of medicine that some patients will respond to treatment more poorly than others. This is not, and has never been, a justifiable reason to withhold treatment from patients who do not or potentially will not respond as well. Researchers have rigorously studied the short- and long-term risks of CABG, resulting in many models to predict a patient's risk based on individual characteristics.[3,4] That the surgery was offered at all indicates this patient could benefit from CABG even with her mental health comorbidities.

To respect patient choice, physicians have a duty to offer care that may reasonably improve patient health, even in the context of risk. A patient with decision-making capacity may decline the intervention. However, in this patient without decision-making capacity, the physician must work with a surrogate decision-maker when one is available.

The American Medical Association's Principles of Medical Ethics states that physicians are responsible for helping surrogate decision makers use the "standard of substituted judgment" in medical decision-making. The standard obligates

the surrogate to mirror the patient's desires, including "the patient's views about life and how it should be lived," as well as "the patient's attitudes towards sickness, suffering, and certain medical procedures."[5] When our patient was previously thought to have capacity, she had explicitly stated that she was incapable of adhering to complicated treatment plans. Her surrogate decision makers have an obligation to adhere to these "attitudes towards sickness," despite their trepidation with the prognosis.

While the patient's family desires surgery to potentially prolong her life, she has proven time and time again to be non-compliant with physicians for evaluation and treatment of her heart disease. Again, many of these scenarios occurred when the patient was felt to have capacity for medical decision-making. The family argues that the patient's non-compliance is founded on her anxiety and that she would comply with treatments if given the opportunity. The patient, however, has not demonstrated this in past interactions with the healthcare system, specifically in her numerous departures from the Emergency Department against medical advice.

While physicians often determine optimum treatments based on risk-benefit modeling in complicated patients, these determinations are neither static nor permanent. Over time, physicians may get to know their patients and form different opinions of prognosis based on personal expertise with prior cases. In no way does a physician's past offer of a procedure remain open out of principle, especially if new information comes to light that negates the prior risk-benefit assessment. In this case, it behooves the treatment team to focus on optimizing medical and psychiatric treatment of the patient's heart disease and psychiatric comorbidities, before any attempt at surgical intervention.

ETHICS COMMITTEE ANALYSIS #1 (SM)

Analyses of these difficult cases benefit greatly from discussions among diverse members of the Hospital Ethics Committee. As Director of Risk Management, I tend to view ethical dilemmas in terms of risks and benefits.

It is not uncommon for patients to be noncompliant with care; patients have the right to make testing and treatment choices, even if these choices appear poorly considered to the medical team. In this case, the team has determined that the patient does not possess the capacity to make her own medical decisions at the moment of crisis. While the psychiatric diagnosis of bipolar disorder may be clouding her ability to do so, at that moment it is the sedatives that are impeding her most. When a patient is deemed to lack capacity, a surrogate decision maker is needed. One of the health care team's jobs is to look for someone who is best positioned to know what the patient would have wanted if she could choose for herself. In cases involving chronic diagnoses, we would first inquire about an advance directive created during previous periods of lucidity. Absent that, in Rhode Island, there is no law determining who can make decisions for the patient and function as a surrogate. In this case, it may be helpful to follow the guidance of the Rhode Island General Laws Uniform Anatomical Gift Act in determining who may act as the surrogate decision maker.[6] Not infrequently, there are situations in which a friend or clergy member may know the patient's wishes better than family. The surrogate decision maker must be informed that treatment should conform to what the patient would want based on written or oral advance care planning if available. If these preferences are not known, care preferences should be founded on evidence of what the patient would have chosen based on the patient's values, previous choices, and beliefs (substituted judgment) or, failing that, the best interests of the patient.[7]

Patients with psychiatric disorders that directly affect cognition may benefit from both a period of treatment and more intensive efforts at education, in order to optimize understanding of relevant information. Introducing a known and trusted confidante may also help the patient to make decisions consistent with his or her best interest(s).[8]

In this case, the "evidence" known thus far includes the fact that the patient chooses to live her life without pills. These have been seen as decisions on her part worthy of respect (did anyone try to compel her to take her outpatient medications?) and may represent her true wishes. At the same time, she has not expressed suicidal ideation. Other critical questions to ask include: "What is the bigger risk for the patient, not proceeding with the surgery or having it and taking anticoagulant medications inconsistently?" "Is there time to delay the surgery to allow her psychiatric medications to help her gain a more solid capacity?" The health care team's short-term solution of sedating her to avoid her leaving against medical advice is only that. Taking advantage of these chemical restraints to allow family to override a consistently expressed desire to forego surgery by the patient would be similarly difficult to defend from an ethical perspective. (Our Risk Management opinion in such a case would also suggest that such an approach carries significant legal risk.)

If there is time to delay the surgery, the clinical team should continue to work with the patient, the trusted patient confidante and the patient's outpatient providers, while continuing to educate her about the risks of avoiding surgery and the benefits of having it, seeking her consent.

ETHICS COMMITTEE ANALYSIS #2 (CR)

The patient in question is having an NSTEMI and CABG surgery is indicated. Without this surgery, she has a very high risk of severe morbidity and death. It has been determined that she lacks capacity for medical decision-making and her family would like her to undergo CABG.[9] However, all parties are concerned that she will be noncompliant with

her anticoagulant medication and continue to smoke. The question of whether to move forward with surgery will be based on the team's concern for noncompliance, essentially their assessment of her ability to care for herself. They must decide whether her noncompliance is of greater risk than forgoing the surgery altogether.

To perform a surgery and put her at risk for clotting raises the specter of violating the principle of non-maleficence even though serious clotting is not an inevitability. We don't know if or how often she will neglect to take her pills.

We have many other patients who end up in the cath lab after decades of artery hardening smoking, neglected diabetes, etc., yet we continue to provide treatments from of our duty of beneficence.[10] It would be neglectful to deny her the standard of care that we would provide to another patient who simply didn't declare as stubbornly and honestly about the likelihood of noncompliance. Doing so violates our obligation to beneficence as well as the principle of justice. Unlike transplant recipients, our patient does not have to prove herself to be capable of compliance.[11] Though cardiac surgery is expensive, her receiving a CABG does not mean someone else will not. She has been declared to lack capacity to decline care and CABG is the standard of care.

It is also quite possible that her mental health will improve and that she will become more capable of keeping up with daily medication. Perhaps an unjust distribution of resources left her incapacitated by psychiatric illness; and now facing denial of lifesaving surgery because she doesn't have the coping skills to take a daily medication. We can attempt to address the broader psychosocial context at play and mitigate her noncompliance with wrap-around services at discharge. It is our ethical obligation to serve and not abandon our patients, to perform the standard of care when possible, and to provide the opportunity for patients to recover from ailments of the body as well as the mind. For these reasons, the most ethically defensible course is to perform the CABG with the valid informed consent of her surrogate decision-makers, and to then work with the patient upon discharge to give her the best chance for health through her surgical recovery and beyond.

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