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Case Study

Do you have a right to decide? Or do we have a right to acquiesce?

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ABSTRACT

Clinicians make decisions about patient management on a daily basis and are required to act in a way that is both legally and ethically correct. To act legally requires compliance with a set of rules which reflect the values and interests of society. Ethical decisions are based on what we believe as a group to be morally right. Morals are, however, unique to the individual. Balancing the legal, ethical and moral dimensions of clinical decisions has the potential, therefore, to generate conflict for the individual practitioner.

In this paper we report a case study of a patient with a high cervical spine injury resulting in quadriplegia, without prospect of a ventilator independent life. The patient, who was assessed as having capacity to make decisions, subsequently elected to have treatment withdrawn. In this case, withdrawal of treatment constituted removal of mechanical ventilation which ultimately resulted in death. The patient also requested for his organs to be donated after he was deceased. This case study, to our knowledge, is the first report of donation after cardiac death following a high cervical spinal injury in a cognitively intact patient. As such, this case study allows us to discuss the moral, ethical and legal implications of donation after cardiac death following withdrawal of medical treatment.

1. Introduction

> "I disapprove of what you say, but I will defend to the death your right to say it."[1]

Critical care is an area of clinical practice that provides a constant intersection of the law, ethics and individual morals. Clinicians make decisions about patient management on a daily basis and are required to act in a way that is both legally and ethically correct. To act legally requires compliance with a set of rules which reflect the values and interests of society, that is, what society as a whole deems right and wrong.[2] Ethical decisions are based on principles of what we believe as a professional group to be morally right.[3] Morals are, however, unique to the individual.[4] Balancing the legal, ethical and moral dimensions of clinical decisions has the potential, therefore, to generate conflict for the individual practitioner. Thus one can act legally, indeed be compelled to do so, but at the same time have an internal moral conflict. This conflict can result in moral distress,[5,6] a concept that has been associated with end-of-life decision making in the intensive care unit.[7] In this case study we discuss the moral, ethical and legal implications of withdrawal of medical treatment and donation after cardiac death.

2. Case history

A 59 year old male was admitted to an Intensive Care Unit (ICU) in southeast Queensland after experiencing salt water immersion followed by five minutes of cardiac arrest. At the scene, cardiopulmonary resuscitation was initiated. After return of spontaneous circulation, ineffectual respiratory effort necessitated intubation and ventilation. This was performed with full cervical spine precautions.

Examination at the receiving tertiary ICU revealed a Glasgow Coma Score of 10/15. The patient was awake, and able to obey com-

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mands with facial movements. Neurological examination revealed intact cranial nerves with complete quadriplegia at C3 motor and sensory level. A computed tomography scan of the patients' cervical spine revealed a posteriorly displaced fracture of the odontoid process with moderate posterior subluxation of C1 on C2. He was fully ventilator dependent. A magnetic resonance image scan confirmed the type III C2 odontoid process fracture with posterolateral displacement and evidence of cord laceration at this level – see Figs. 1 and 2.

Communication was established and the patient was able to respond to questions through blinking and tongue movements. On day two the patient expressed his wish for the withdrawal of life sustaining ventilation. His family confirmed this was consistent with what he had previously stated over his lifetime. Neurosurgical and intensive care specialists were consulted, and a consensus of opinion was for a period of time to be allowed to pass so that the extent of his injury was fully clarified, and his decision verified.

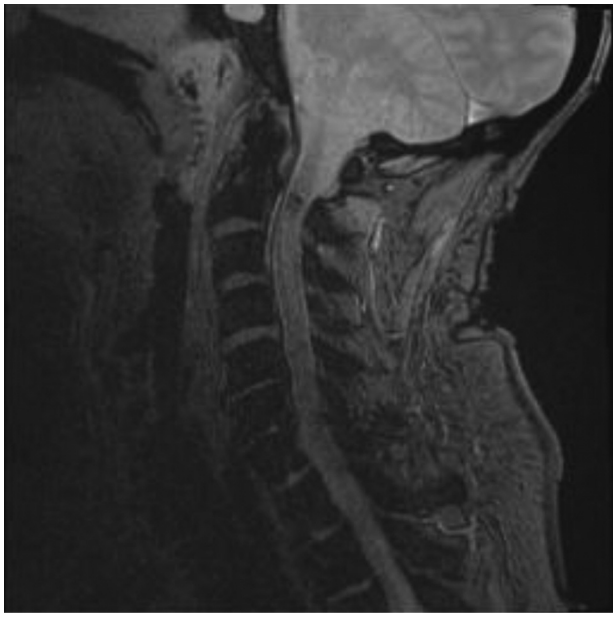

Fig. 1. Extensive cord oedema with in the upper cervical cord to the level of C4.

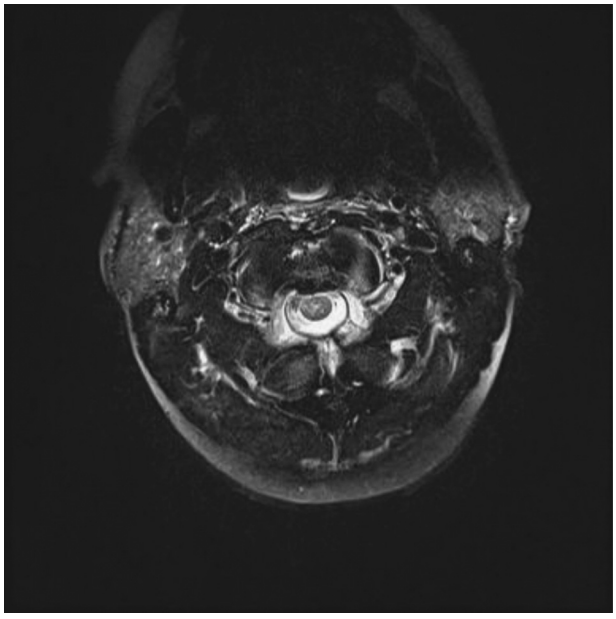

Fig. 2. Cord haematoma at level of C2.

Another seven days from the time of injury was negotiated with the patient for assessment of any signs of recovery to be seen, and to allow for a further period of time for the patient and family to consider the implications of his request. There was no evidence of recovery evident by day eight, and the patient remained steadfast in his wishes.

Multiple discussions were held with the patient, his family and the patient's solicitor. It was unanimously agreed that withdrawal of treatment was appropriate given the patient had capacity to make the decision. The patient also indicated at this time that he wished to donate his organs. All discussions and decisions were made in the absence of the effects of narcotic analgesia and sedative medications. In consultation with the patient and family, the decision was made to palliate via removal of the life support with concomitant sedation, then proceed to organ donation after cardiac death.

3. Discussion

Clinicians working with critically ill patients are often faced with moral, ethical and legal dilemmas, many of which relate to end-of-life care.[8] This case highlights several pertinent questions when systematically addressed. These help to guide collaborative decision making and clinical practice. These questions serve as the focus for this case study discussion.

3.1. Can a patient refuse therapy?

In the context of life sustaining medical treatment, two broad situations arise. The competent patient who refuses treatment or the competent patient who demands what is considered medically futile treatment. The current case falls into the former situation. The law has consistently recognised such a refusal to be lawful. This is also consistent with the autonomy model of decision making, which is based on informed consent and the ability of patients to make choices about treatment alternatives.[9] An adult who has the requisite capacity may choose not to receive medical treatment – even if that treatment is needed to stay alive.[10] This raises the question as to how a patient's unequivocal right to refuse medical treatment can be assessed.

The House of Lords – the highest appellate English Court was involved in a similar case to the one we describe here where a patient experienced spinal cord haemorrhage resulting in quadriplegia and subsequently requested the withdrawal of artificial ventilation.[10,11] The court, citing similar decisions, determined that the following principles applied to the making of this decision: (1) The patient's capacity needs to be high where the decision is particularly grave.[10] (2) The decision is made by the patient alone, not via outside influence.[11] (3) The right to refuse life sustaining therapy may also operate even if the refusal is given in advance of the medical situation.[11–13] (4) The patient has all relevant information when refusing treatment.[13]

Recognition of a patient's right to refuse treatment is essential. To treat a patient against their stated wishes is, in itself, a harm to the patient and may be viewed by the courts as a form of assault. For example, if a patient wishes to withdraw life sustaining treatment, but the treatment is not withdrawn, the patient is likely to experience severe physical and emotional suffering from the continuation of such treatment. Thus where the patient is competent, to refuse to cease therapy can constitute assault in the same fashion as commencing therapy against the competent patient's wishes.[14,15]