Ethics in the Setting of Burned Patients

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KEYWORDS

• Informed consent • Surrogate decision making • Substituted judgment • Best interests • Beneficence • Autonomy • Ethics

KEY POINTS

- Surrogate decision makers must make decisions based on substituted judgment (what patients would want for themselves, not what the surrogate wants for the patient).
- Stopping an intervention is morally equivalent to not starting it (eg, removing the ventilator vs not putting someone on the ventilator).
- Informed refusal is as important as informed consent.
- Respect for patient autonomy requires working to restore patient autonomy (which is weakened in an acute trauma/burn), which requires working through issues such as refusals of interventions.

INTRODUCTION

Charles Bosk,[1] the noted sociologist who studied surgeons, pointed out in his seminal work *Forgive and Remember* that "the postgraduate training of surgeons is above all things an ethical training… The moral and ethical dimensions of training are not bracketed from all other concerns but are instead built into everyday clinical life." By that he meant that surgical decision making entails not only making a diagnosis and considering treatment options but also making a host of other judgments that require the prudential weighing of values. If ethics is defined as "disciplined reflection on moral ambiguities"[2] then surgeons do not engage in much of the reflection, because they are actively sorting through the ambiguities of complex situations in pursuit of doing the right thing for their patients. What then can ethics offer surgeons who are taking care of burned patients? Fundamentally it represents a large body of literature that has taken a principled approach to closely examining the conflicts in values that clinicians experience as ethical dilemmas. Knowledge of the content and process of ethical deliberation can help clinicians to navigate these situations.

The issues of informed consent, surrogate decision making, and withholding or withdrawing interventions at the end of life are commonly encountered in burn practices. The following 3 cases examine practical solutions to these issues. Burn surgeons also must be familiar with the ethics of innovation and research in the surgical setting, what to do with a do-not-resuscitate (DNR) order in the operating room (OR), and what to disclose to the patient when a harm-causing error occurs.

CASE 1

A 48-year-old man is admitted to the burn intensive care unit (ICU) with a 30% total body surface area (TBSA) full-thickness flame burn and inhalation injury. During his resuscitation he develops respiratory distress and requires ventilator support. He

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requires extensive debridement and split-thickness skin grafting, and you approach his wife for her signature on the consent form. She states that she will consent to the operations, but refuses to accept any blood transfusions because they are Jehovah's Witnesses. You decide to stage his excision and grafting to minimize blood loss. After surgery his hemoglobin level is 5 g/dL and you are concerned that his unexcised burns are making him septic but that he cannot tolerate further excisions without a transfusion. The patient's son arrives from out of town and informs you that the patient is not a Jehovah's Witness and that he will accept a blood transfusion. It seems that the patient's wife and he are recently married and she has been trying to convert him; however, per report of the son, your patient is not a practicing Jehovah's Witness. The son demands a blood transfusion and excision and grafting as soon as possible, despite protests from the patient's wife.

What is the Appropriate Next Step?

A. Have the son sign the consent for blood transfusion, transfuse the patient, and proceed with excision and grafting.
B. Follow the wishes of the patient's wife, because she is the legal health care decision maker, not the son.
C. Consult the hospital ethics committee.
D. Because no clear consensus exists among the family members, transfuse the patient based on the notion of best interests of the patient, which you are sworn to always pursue.

DISCUSSION

There are several issues at play in this case that intertwine to make it more difficult than usual. One issue is a religion-based refusal of a lifesaving medical intervention.[3] The second is a conflict between family members about the appropriate course of action. The third issue, which relates to respect for patient autonomy, is the concept of surrogate decision making.[4]

In this case the patient is intubated and sedated, and therefore cannot express his wishes relative to his care. Therefore, someone has to make decisions on his behalf. The standard that must be applied is called substituted judgment; what the person would choose for himself if he was able. Some patients have appointed a durable power of attorney for health care to make these decisions for them. Most patients, especially those who have traumatic injuries, have not executed such documents and surgeons routinely turn to next of kin for guidance. Some states have laws and some hospitals have policies that delineate the hierarchy to be followed; for example, court-appointed guardians, spouse, partner, adult children, parent (if living), and close friend. The overriding principle is that the person who speaks on behalf of the patient should have demonstrated an intimacy with the patient to know what the patient would want to be done.

Patients generally have the right to refuse treatment, and Jehovah's Witnesses have had a long and well-defined refusal of blood transfusions based on their interpretation of certain passages in the Bible. Although many surgeons disagree with their interpretation of these passages, or disagree with religion-based decisions in medicine generally, they accept the refusal of blood out of respect for the patient's autonomy. A different standard is used in children, in whom, rather than substituted judgment, a notion of best interests is followed. A court order is obtained to transfuse these children. Simply put, society's interest in the flourishing of children overrides the parent's religious convictions to make martyrs of their children. Because this patient is an adult, the best-interests standard is not invoked, so answer D is incorrect. In emergency situations in which the patient lacks decision-making capacity and there is no surrogate decision maker available, it is ethically permissible for surgeons to treat the patient with presumed consent using a reasonable-person standard. The idea is that a reasonable person would choose to undergo a life-sustaining intervention, and delaying implementation of the intervention while trying to get consent would render the intervention ineffective.[5] This standard does not apply in this case, because 2 potential surrogate decision makers are readily available.

In this case, answer C is the most prudent choice. The hospital ethics committee may be more familiar with state laws or hospital policies on surrogacy. The committee may also be equipped to facilitate a family meeting and be able to arbitrate between family members. The right course of action in this case depends on several details that are not readily available. Specifically, the claim that the patient is not a practicing Jehovah's Witness needs to be investigated. If the patient is not a Jehovah's Witness, then the wife's refusal of a blood transfusion for him is not ethically permissible. She is imposing her values onto him and potentially risking his life. Even if state law or hospital policy indicated that the patient's spouse should be the surrogate decision maker, the deviation from making the decision according to the substituted-judgment standard weakens the spouse's authority. In that case option A would be the correct course of action. Option B is only the right answer if, after further investigation, the son's claims are found to be

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