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Commentary on "The Case of Mr. A.B.": Dilemmas for a Reason

G. Caleb Alexander

G. Caleb Alexander, MD, MS, is an Assistant Professor of Medicine, General Internal Medicine, Center for Advanced Medicine, University of Chicago Medical Center, *galexand@uchicago.edu*.

Ethical dilemmas are called *dilemmas* for a reason. Unlike some cases in clinical ethics, which can ultimately be resolved with the gathering of additional facts or the facilitation of greater communication among affected parties, in the article "The Case of Mr. A.B.," we face a true dilemma: should the staff not tell Mr. A.B. about the tragic loss of his daughter prior to a planned bypass surgery, as his family asks? The authors of the case, Peter Sloane and Evan G. DeRenzo, should be commended for highlighting that "refined ethical analysis rarely results in a neat division between what is clearly ethical and what is clearly not."[1]

There are many important dimensions of the problem of truth-telling in medicine (for example, Is lying different than deception?), most of which are far beyond the scope of this commentary.[2] Nevertheless, a few observations follow.

First, the facts are clear, as are the competing principles at stake. Mr. A.B.'s family and the medical team must grapple with a classic tension between beneficence and patient autonomy. Unfortunately, part of what complicates the picture in this setting is the difficulty of knowing how the timing of the delivery of the daughter's death will impact Mr. A.B. The physiologic consequences of grief in the context of his critical illness are not clear, and, of course, given its rarity, this is not the sort of topic that lends itself to rigorous scientific study.

The real crux of the issue here, as with many cases of delivering bad news, is not whether or not the truth should be told, but how it should be told. Respecting Mr. A.B.'s autonomy does not necessitate the delivery of sensitive information without consideration of timing, and a whole host of other contextual factors. Patients don't need to be "hit over the head" with information, and just as with disclosing a terminal diagnosis, clinicians should skillfully deliver information with careful consideration of not only *what* is communicated but *when* it is communicated, *how* it is communicated, *who* is present, and the like.[3] In this case, one helpful consideration to guide when disclosure should take place is how elective the bypass surgery truly is. The less elective the surgery, the less any news of the daughter's death seems material to the decision of whether or not the surgery should be pursued.

The main argument to support postponing disclosure of the daughter's death is Mr. A.B.'s own precarious state. It may be safe to assume that if any patient were to be at increased risk of poor outcomes triggered by acute grief, Mr. A.B. would be the one. Even without news of his daughter's death, his comorbid conditions and current clinical instability already put him at serious risk from his bypass surgery. Going into the operating room on a ventilator is never a good prognostic sign, and even Mr. A.B.'s "peak physiologic state" is tenuous.

(As an aside, despite the hardship and grief that this patient will necessarily undergo, how fortunate that he has a family and that they are all on the same page. This consensus is invaluable in helping to negotiate these clinical settings. Nevertheless, the clinician has shared responsibility for the situation. Responsibility for withholding news of the daughter's death cannot be abandoned by the healthcare providers and left to the family alone,[4] even if the patient's children, as Sloane and DeRenzo stated, are "adamant that they would take responsibility for such outcome and would be clear with their father that the decision to delay disclosure was theirs.")

This is a tricky clinical case, and one could argue that there may be more than one ethical resolution to the dilemma that the team and patient's family face. Is it possible that the morally defensible course lies as much in the process that is taken as in the outcome that is reached — a procedural argument that recognizes the vagaries of clinical decisions that at times must be made? Here, the team reached a decision through thoughtful deliberation and careful consultation with the affected parties. True, it is a decision about which reasonable people will disagree. However, this is what characterizes dilemmas in the second-best world in which we live.

EPILOGUE

Although tempting, the ethical standing of the decision to withhold news of the daughter's death should not be judged based on the follow-up to the case that is provided. This follow-up, and the outcome of other similar cases, may be of interest and utility in informing how *future* cases should be navigated. However, whether or not the decision reached in *this* case was an ethical one should be judged based on the information that was available to the decision makers at the time the decision was made. Hindsight is, after all, better than foresight, if not 20/20.

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NOTES

1. P. Sloane and E.G. DeRenzo, "The Case of Mr. A.B.," The Journal of Clinical Ethics 18, no. 4 (Winter 2007), 399-401.

2. M. Sheldon, "Truth telling in medicine," *Journal of the American Medical Association* 247 (1982): 651-4.

3. R.D. Truog et al., "Sudden Traumatic Death in Children: 'We Did Everything, but Your Child Didn't Survive'," *Journal of the American Medical Association* 295 (2006): 2646-54.

4. A. Torke et al., "The doctor-surrogate relationship," *Archives of Internal Medicine* 167 (2007): 1117-21.