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Application of Systems Principles to Resolving Ethical Dilemmas in Medicine

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INTRODUCTION

Ms W, a 23-year-old woman, was hospitalized in the intensive care unit (ICU) of a large urban teaching hospital with a diagnosis of metastatic sarcoma that was considered terminal. Two years earlier, Ms W had had a sarcoma surgically removed from her left thigh. She was feeling well until four weeks before this hospitalization, when she developed night sweats and difficulty breathing. At the time her symptoms appeared, Ms W was engaged to be married and was preparing to graduate from college. She had no history of mental illness, and had a high-functioning and intact family.

Ms W was a highly intelligent individual who was an accomplished collegiate athlete and leader on her college campus. Her family described her as open and approachable, and part of a tightly knit family who was always able to "talk things out." When the sarcoma recurred, a great change took place in Ms W. To her family's surprise, she became uncharacteristically withdrawn and sullen. She ceased open communication with family members, and soon withdrew into silence. While her family initially tried to engage Ms W in conversation about her disease, this failed to alter her mood, and the family soon joined her in silence.

When Ms W was admitted to the hospital, she was told that there was no cure for her disease, and she was offered palliative care to treat her symptoms and to help keep her comfortable. In the ICU, the staff quickly became invested in her care. Although death is a common occurrence in any ICU, there was something about Ms W that drew people to her in a way that surprised even the experienced ICU staff. She was a promising young woman who was liked and admired by those who knew her (the dean of her college appeared in the ICU in full academic regalia to award Ms W her diploma), but her life would be prematurely ended.

During the initial stage of her hospitalization, Ms W remained withdrawn and uncommunicative, refusing to take the medications that her nurses and physicians believed to be important. With time however, she began to express herself, making statements that the ICU staff found disturbing, such as: "How many of these pills do I need to take to kill myself? Can you give me enough medicine to end this? What's the quickest way to die?" While the ICU staff was deeply moved by Ms W's plight, they felt it was wrong to participate in assisted suicide, and they struggled to find an appropriate way to respond. As the requests for

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assisted death continued, the ICU staff became increasingly frustrated; they felt powerless to change her condition and were frightened by her statements. Eventually, in an effort to "get her to stop saying those things," the ICU staff requested a consultation from a hospital-based psychologist who was also a member of the hospital's ethics committee.

When the consultant visited Ms W, she was sitting up in bed with her eyes closed. She was ashen-looking and had a nasal cannula delivering oxygen. She appeared to be air hungry and her speech was barely audible. Her mother and brother stood in a corner of the room with their arms folded. Ms W motioned for the consultant to come closer and whispered, "Will you please shoot me tonight?"

ANALYSIS

Ms W's case raises a number of important issues relevant to the care of terminally ill patients. Foremost is how to deal with requests for assisted death. Sometimes the primary issue is a moral one—for example, should physicians or other healthcare providers aid patients who request help with dying? In such cases, the methodologies of bioethics are well-suited for addressing the issue, with an emphasis on fact gathering, determination of competency, delineation of the ethical issues and competing ethical claims, and then moving toward resolution.[1] Other well-suited models that are useful for addressing ethical conflicts include mediation,[2] mediation combined with a medical advisory panel,[3] and facilitation.[4] But in some cases, the moral issues are secondary, such as when requests for assisted suicide are not really genuine expressions of a wish to die, but instead are about something altogether different, such as a conflict in relationships or a breakdown in effective communication. In these cases, the compelling nature of the life-and-death situations can so impair communication that people are distracted by the "ethics," to the exclusion of the relationships. Then, the traditional or well-suited approaches to resolving ethical dilemmas in medicine are less helpful, because their narrow focus on normative issues provides little guidance for addressing the impasse in relationships.[5] Since ethical conflicts in medicine are often laced with such interpersonal dimensions, clinical ethicists can benefit from broader approaches that explicitly address the role of the interpersonal aspects of ethical dilemmas.

So, when faced with a patient's request for assisted death, how can one know whether this is a genuine moral issue, or if the patient's plea is driven by other psychological forces?[6] These are not mutually exclusive.[7] The moral issues raised by assisted death have been dealt with extensively elsewhere.[8] To further the discussion of the influence of psychological issues on ethical dilemmas, this article proposes a systems-based model that focuses on building collaborative relationships as a means of resolving ethical dilemmas.

What was conspicuous in Ms W's case was her inability to express her needs effectively and maturely. Concurrently, the ICU staff was distracted by the intense emotions generated by Ms W's provocative statements. They heard only what she said, not what she needed. By applying "systems principles" that help to identify a person's underlying needs in the context of intra- and interpersonal relationships, this article proposes a strategy for broadening the scope of ethics interventions.

A SYSTEMS FRAMEWORK

A systems framework can be helpful for understanding the complex relationships involved in many cases for which ethics consultations are sought. For the purposes of this article, systems principles posit that families are social units in which relationships are interlocking and interdependent, in which an ongoing tension exists between the individual's longing for communion and struggle for agency.[9] Individuals in families face an ongoing tension trying to balance feeling close and connected to family members (communion) and needing to establish an identity separate from one's family of origin (agency). Consequently, when one person changes, all family members are affected.

When serious illness strikes a family and life-and-death decisions need to be made, the family's ability to adapt to adversity is typically challenged. During times of crisis, instability in family systems may impair

the ability to respond to and resolve conflict. In this case, Ms W's family was impaired in the sense that they went from being communicative and connected to being fragmented and disconnected. When people cannot resolve conflict, the anxiety created by the unstable relationship may drive one or both parties to seek support from a third party, a situation that family therapists call triangulation.[10] Although this triangle temporarily reduces tension, it obscures the conflict, and, as the conflict grows, people feel misunderstood and cut off from one another. The parties then become more entrenched in their positions and start believing that the solution lies in the other party (that is, "If she would just stop saying these things, it would be OK") rather than in the relationship itself ("How can we find a solution we both find acceptable?").

An impasse in a relationship (defined simply as a relationship being developmentally "stuck") can develop between clinical staff, patients, and families in the face of medical adversity.[11] During such an impasse, despite attempts to move the process forward, the outcome remains unchanged. In Ms W's case, the staff expended extraordinary efforts to get Ms W to stop requesting assisted death; they talked at length with the patient, they discussed the matter among themselves, and they expended a great deal of emotional energy in trying to figure out how to "fix" the problem. Yet, despite such efforts, the outcome was unchanged, and Ms W continued to ask for assisted death.

As this impasse became more entrenched, the physicians and nurses became increasingly frustrated with their attempts to help the patient and family. The medical staff framed the issue in terms of a request for physician-assisted suicide, a request that made them feel uncomfortable. What the staff failed to see, however, was the underlying distress that was driving the requests. Of course there are cases in which a request for death is simply that: a genuine expression of a desire to die. But in Ms W's case, it wasn't so clear, and framing the issue in terms of physician-assisted suicide, while helping to clarify ethical issues, did not break the impasse.

A broader approach is the model of the symptomatic cycle.[12] This model helps to clarify interpersonal conflicts by providing a map for understanding how instabilities in human systems can escalate out of control (see figure 1). This model shifts the emphasis from *symptoms* to *relationships.* Micucci argues, "Symptoms in families evolve in a context of interpersonal isolation, characterized by conditional acceptance and efforts to control one another."[13] The attempts to control others escalate the presenting symptom, which can narrow everyone's focus to the presenting problem, and important relationships deteriorate. Consequently, people feel an increasing sense of isolation, which in turn fuels further distress. The focus then moves onto *fragments* of behavior ("Get her to stop saying those things!") rather than more meaningful *patterns* of behavior ("She is becoming alone and isolated").

Framing the case of Ms W in terms of the symptomatic cycle, the "symptoms" were her suicidal statements and requests for staff assistance in her death. The more that the ICU staff and Ms W's family tried to get her to stop making disturbing statements, the more the symptoms increased. This pattern was frustrating for the ICU staff because they believed they were doing all they could to be helpful to the patient and family. When their efforts were met with anger, hostility, or opposition, the staff wondered what was wrong with this patient and family. A common response to the frustration generated by these situations is to seek a psychiatric consult. While rendering a psychiatric diagnosis such as depression, psychosis, or even a personality disorder is potentially helpful to patients, doing so may lead staff to wrongly conclude that the problem and solution lie solely within the patient. In contrast, systems ideas frame a conflicted situation in relational terms, and provide an opportunity to bring people together in a way that facilitates a meaningful and productive outcome. In this case, viewing Ms W's requests for death as purely an ethical dilemma blinded the staff to a broader way of approaching the impasse. The net impact of separating the ethical dilemma from the interpersonal aspects of the case was to further entrench the impasse.

BASIC PRINCIPLES REGARDING FAMILIES WHO FACE MEDICAL ADVERSITY

In an effort to address the underlying causes of interpersonal conflicts in cases such as Ms W's, four basic principles apply.

ALL PARTIES BRING COMPETENCIES

All patients, families, and medical staff bring a pre-existing set of competencies—defined as one's sense of mastery over a given task—to the illness experience. This differs from the traditional notion of competence in ethics, which is a legal determination of a person's decision-making capacity. Competency for a patient and family can include many things, among them being a successful student, parent, or professional. When illness strikes, however, unfamiliarity with the role of patient may undermine existing competencies. In the case presented here, Ms W was a competent college student, daughter, sister, and fiancée. She was successfully navigating the developmental challenges of young adulthood. When her cancer recurred, her sense of competence was undermined and was expressed in an uncharacteristic wish for death.

ISOLATION + DISCONNECTION = PSYCHOLOGICAL DISTRESS

Isolation and disconnection from important relationships breed conflict and lead to psychological distress. As mentioned earlier, people strive toward communion, yet also need agency. In times of illness, individuals' different coping styles can create conflict. Ms W was coping in a manner that clearly lead to isolation from her family and the medical staff. Paradoxically, her provocative statements drew attention to her, but because the statements were so frightening, people began to withdraw, thereby increasing her isolation. As Ms W's important relationships deteriorated, her "symptomatic behavior" escalated in the form of making increasingly graphic and provocative statements about her death. As a result, the impasse was solidified. Feeling powerless, like the staff, the family was paralyzed in their attempts to help because of the horror of hearing Ms W's request for death.

BLIND SPOTS FUEL CONFLICT

The intense emotions generated by the life- and-death drama of serious illness can distract people from existing competencies. While Ms W was successful academically and socially, her current strategy for dealing with distress was ineffective, and resulted in isolation. There is nothing wrong with an ill person wanting to be alone. Indeed, being alone can provide an opportunity for healthy reflection. However, Ms W was *isolated*—that is, she lacked meaningful connection to others around a difficult issue.

INCLUDE STAFF IN PROBLEM SOLVING

These first three principles apply to patients, families, and medical staff. It is common for medical staff to put the onus of change on the patient and family. When medical staff feel incompetent, isolated, and disconnected, psychological distress can develop in them as well. In Ms W's case, the staff felt powerless because, despite their best efforts, Ms W continued to make clear, stark, and disturbing statements about her desire to die. Their feeling of powerlessness led to anger, and they began to feel incompetent, which furthered their isolation, not just in relation to the patient, but also with each other.

INTERPERSONAL DIMENSIONS OF ETHICAL DILEMMAS

How does one broaden her or his awareness of the interpersonal aspects of an ethical dilemma? Here are some of the signs that an interpersonal impasse is contributing to an ethical dilemma.

ANGER

Doctors and nurses feel anger toward the patient and family. The anger is driven by a sense of powerlessness in relation to the patient and family. This is not the same as a difference in moral beliefs. It is possible to work with patients who have different moral beliefs and find common ground in the relationship. People do not feel powerless when they have expressed their position on an issue: for example: "Ms W, I respect your wish to die. However, I'm unwilling to help you die. However, I believe that I can help to relieve your pain or other troubling symptoms."

URGENCY

There is a global sense of urgency around the case. This is different than a medical emergency; the urgency is around a need to "fix the problem," often identified as the disturbing symptom. The desire for the problem to "go away" is driven by the anxiety and sense of powerlessness produced by the symptom.

SENSE OF FAILURE

There is an impending sense of failure that fuels the urgency to fix the problem. This feeds the symptomatic cycle in that the harder people try to fix the problem, the worse it gets.

BLAME

Those involved with the case start to assign blame. Blame is often the final stop in clinical medicine before the patient receives a psychiatric diagnosis. Blame protects against feelings of failure and shifts the burden of responsibility for change to the patient. Blaming the patient also insulates the staff from examining how they contribute to the impasse. In Ms W's case, the ICU staff viewed her as a person who wanted them to kill her. As a result, they isolated themselves from her, and their interactions with her became defensive.

WHAT TO DO

When confronted with an impasse involving a patient and family, a clinician or consultant can take concrete steps using systems principles to help resolve the conflict.

FOCUS ON COMPETENCE

A good place to start is to highlight the competence of those present: "Ms W, I'm very sorry that your disease has come back and that you see death as your only option. I can see that your family cares deeply about you and you about them. One of the things that troubles me is that it appears that you are facing this challenge in your life alone." Starting the conversation by highlighting competencies enables the physician or consultant to: (1) convey a sense of respect and trust to the patient, (2) directly validate the expressed concerns of the patient, and (3) shift the viewpoint from blame and a sense of powerlessness to one of hope. This contrasts with a less effective approach, such as: "Ms W, physician-assisted death is against the law and we won't participate in it," which suggests that the physician is about to abandon the patient and does not provide the patient with choices. Emphasizing competencies initiates the process of reframing the dilemma from a conflict to a collaborative process in which all parties feel heard and understood.

In the present case, the intervention began by highlighting the competencies of all of the involved parties (patient, family, and staff). This took the form of first talking with the patient about why she was requesting help with her death. She replied, "I can't breathe!" This presented an opportunity to both advocate for the patient and appeal to the competencies of the staff. When this was explained to the staff, they were able to quickly relieve Ms W's respiratory distress. Treatment of respiratory distress is a relatively straightforward intervention in an ICU. Why then did the ICU staff miss something so simple? The answer may lie in the power of Ms W's requests for death. The emotional upheaval generated by her requests was so distressing that it distracted staff from their primary role of providing competent medical care.

CLARIFY ROLES

Clarifying roles is another step in helping patients, families, and staff resolve a dilemma. This is accomplished by asking the referring parties: "How can I be helpful?" While it may sound simplistic, the question gets people thinking about what they need. This is an important component in guiding staff in their efforts to help patients and families. If the patient and family request more than the medical staff can provide, the intervention can be broadened by including other professionals (that is, chaplains, social workers, or other consultants). This approach allows the staff to view a request for help as a successful intervention, not a personal failure. For Ms W's case, the consultant also met with the ICU staff to discuss their feelings about

the case. They expressed frustration and a global sense of powerlessness over "not knowing what to do." While well-intentioned, the staff was at a loss as to how they could effectively respond to Ms W's requests for death. They were adamant that they would not participate in assisted suicide, but felt shame over avoiding her. A part of the conversation was to help the ICU staff clarify their role in Ms W's care. They knew that what they did best was to take care of critically ill patients. They helped patients live, not die. Ms W, even though dying, was not technically critically ill. In short, she was in the wrong place. This realization lifted the staff's burden of guilt and feelings of having failed the patient. Ms W was transferred to an oncology floor of the hospital, where staff was better trained for the types of medical and psychological problems she was experiencing.

FOCUS ON RELATIONSHIPS

Focusing on relationships is more difficult than clarifying roles. The first task is to tolerate the intense emotions surrounding the conflict. When we feel powerless, we tend to act in ways that instill a sense of control. The net impact may be a well-intended but misguided attempt to control others. The resulting pressure may distract the individual from the critical work of concentrating on competencies, which shifts the frame of the relationships from control to collaboration. In the face of the intense emotions that can accompany conflicts, asking oneself these simple questions might prove helpful in defusing conflict: "If this were a collaborative relationship, how would I behave? What would I do?"

As the distance in Ms W's relationships increased, so did her desperation. By emphasizing the loving and supportive relationships in the family, the consultant began a conversation about death that was tolerable for the family and allowed Ms W to serve as a guide. Ms W's two biggest fears were suffocating to death and dying alone. Once her family understood how they could be helpful, they could access their pre-existing competencies (that is, organize around-the-clock schedules to be with Ms W). This was also the beginning of a painful family discussion about where Ms W would like to die (at home versus in the hospital).

KEEP THE CONVERSATION GOING

Pulling away from disagreements about medical adversities can lead to an impasse. Demonstrating to the patient and family that the medical staff will not abandon the relationship is critical for any progress to occur. This is particularly relevant when the patient rejects attempts to move forward and break an impasse. In these situations, the focus needs to remain on validating the patient's concerns, even when there is disagreement. It is also crucial that caregivers demonstrate an ongoing commitment to the relationship with the patient. Offering something like, "Ms W, I won't kill you. But I can still be of some help to you. I'm willing to keep talking about this until we find common ground," sends a clear message that the patient and family will not be abandoned or isolated. This can help to move forward. It is also critical to convey such a message to clinical staff. Inevitably, there will be divisions and differences of opinion among staff, and between them and families, regarding ethical conflicts. However, highlighting the competencies and roles of the staff can be helpful in moving people toward developing a broader view of the presenting dilemma. It creates the possibility of collaboration, rather than control; for example: "If she would just do this . . . then we wouldn't have this problem."

During Ms W's two-week hospitalization, her medical management was stabilized, and she became increasingly articulate about her wishes for the end of her life. Her family, while grief stricken, was able to reframe their contributions. Instead of viewing themselves as powerless to alleviate her suffering, they recognized that they had an important role to play in her death. Family members remained close to Ms W despite the intense feelings that death can generate. Ms W was discharged to her home and received hospice care, and she died six weeks later, at home, surrounded by her family.

CONCLUSION

The case of Ms W illustrates how interpersonal aspects of an ethical dilemma can be an integral part of resolving the conflict. In Ms W's case, the ethical dilemma of physician-assisted suicide was a mask for the

struggle of a patient to get adequate palliative care and find a different way to relate to those she loved as she was dying. By shifting toward building relationships and away from exhibiting controlling behavior, the medical staff was able to concentrate on delivering medical care and being supportive, while family members became actively involved in caring for Ms W at the end of her life. The process proposed here is not about trying to "get patients to change their minds." The systems approach is an attempt to frame the engagement of ethical dilemmas as a concurrent process of building collaborative relationships while exploring the salient moral issues. In this case, the request for assisted death was driven by the patient's fear and isolation. If Ms W actually wanted help in dying, the systems-based approach used here would have revealed that at some point. Although the initial response of the ICU staff was to frame the problem as an ethical dilemma, blind spots around the interpersonal aspects of the conflict led to an impasse. A systems framework that emphasizes the competence of the patient, family, and medical staff, combined with efforts to build collaborative relationships to decrease everyone's isolation, helped move the dilemma to a more satisfactory conclusion.

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