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

The Case of Mr. A.B.

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Mr. A.B. was a 70-year-old Caucasian male referred to our institution for coronary artery bypass graft (CABG) surgery. His past medical history included hypertension, diabetes mellitus, peripheral vascular disease, and chronic obstructive pulmonary disease. Three days before Mr. A.B. was transfered to our institution, he had presented to an outside institution with a non-ST elevation myocardial infarction (MI) and mild congestive heart failure. A coronary artery stent was placed, and Mr. A.B. was discharged to home the following morning. On the day before he was transfered to our institution, he presented to the same outside institution with recurrent substernal chest pressure, severe congestive heart failure, and acute respiratory failure requiring intubation and placement on mechanical ventilation. Mr. A.B. underwent repeat coronary arteriography, which confirmed severe multi-vessel coronary artery disease, and the following morning he was transferred to our hospital for consideration of CABG surgery.

After initial evaluation at our hospital, the consensus recommendation by our cardiologists, intensivists, and cardiac surgeons was to target a surgical date for CABG on approximately hospital day three to allow time to stabilize the patient on the ventilator and aggressively treat the congestive heart failure. The patient showed significant improvement by hospital day two and was posted for CABG surgery, as previously planned, for the following afternoon. The patient was assessed to be sufficiently capacitated to consent for his own surgery and signed the surgical consent form after discussion of the risks and benefits of the planned procedure. The family was supportive of the patient's decision to proceed with surgery.

The next day, four hours prior to the planned surgery, the Critical Care Unit (CCU) attending physician (the first author) was informed by the patient's nurse that the family had called the nurse to notify our staff that the patient's daughter had died unexpectedly that morning. This daughter had been living with the patient and his wife for some time because she was impaired, but ambulatory, from previous cardiac events. According to the nurse, the family requested that news of the patient's daughter's death be delayed until after the patient's recovery from surgery.

DISCUSSION

The medical team, composed that day of the CCU attending (the first author), residents, medical students, nurses, and a bioethicist (the second author), immediately recognized the ethical complexity of con-

sidering the request from the family to delay notifying the patient about his daughter's unexpected, but not surprising, death. The initial opinion of the CCU attending and the bioethicist was that the patient should be told of his daughter's death prior to proceeding with CABG surgery. This judgment was based on the ethical justification that the information was sufficiently material to the patient's ability to make an informed decision about whether or not he wanted to have the surgery at the time presently scheduled.

A counter argument was immediately raised in the general discussion among the team members that delaying surgery might not be in the patient's best medical interest. The team had worked diligently over the days leading to the surgical date to get the patient into a physiological state that would maximize his chances for surgical success. The team felt that proceeding with the surgery at the scheduled time would provide the patient with the maximal chance of a good outcome and that, because of his precarious clinical condition, any delay past his peak physiological state might result in the window closing on providing him the best outcome. The team was particularly concerned that coupling a delay in surgery with the potential for deterioration that such sad news might be expected to trigger in the patient could be factors supporting a sufficiently strong argument for withholding of the news of the daughter's death until after surgery (based on the principle of the primacy of beneficence) rather than proceed with pre-surgical disclosure (based on the principle of autonomy).

Although both positions were argued vigorously, the attending physician and bioethicist continued to believe that the patient should be told.

Shortly after these discussions it was learned that the family was expected in momentarily. The attending physician felt it would be prudent to interrupt rounds to meet with the family when they all had arrived. In preparation for this family meeting, he contacted both the chair of the hospital's ethics committee, also an intensivist practicing in the hospital's CCU, and the CCU chief. These two physicians both advised the team that it would be ethically permissible to withhold the information of the daughter's death from the patient on the basis of prioritizing the patient's immediate medical best interest as overriding disclosure on the basis of patient autonomy. That the family was reported as not wanting the hospital to disclose prior to surgery was, for these two, not governing but certainly a consideration. Disclosing news of the patient's daughter's death to the patient, over the family's objection, would cause additional distress and upset and could only be expected to contribute negatively to the patient's well-being and the morale of the medical team. Nonetheless, the attending and the bioethicist continued to hold their bias towards disclosure.

OUTCOME

A meeting with members of the family, critical care team, nursing staff, and medical ethicist was convened to confirm the family's wishes and resolve the issue of whether or not to disclose news of the death of the patient's daughter. The family included the patient's wife, their two adult daughters, and one surviving adult son. The patient's wife and one of the daughters sat through the meeting quietly, with their only verbal contribution being an indication that they were in agreement with the plan put forward by their son and other daughter. Although the daughter spoke the most and was quite vocal in her opinions, it was clear that all family members were in agreement to withhold the news until after recovery from surgery. The family also requested that the family would be the ones to tell their father of the death after recovery from surgery.

When an attempt was made to discuss the possibility that withholding this information until after the surgery had a chance of hindering post-surgical recovery (if the patient would exhibit profound sadness over the news or anger at the family for withholding the news), the son and more-verbal daughter were adamant that they would take responsibility for such outcome and would be clear with their father that the decision to delay disclosure was theirs.

In the end, the attending physician weighed the conflicting precedent of autonomy at our institution to inform a capacitated patient of the death of a close family member against the principle of beneficence regarding the family's concern about the patient's emotional fragility, the concern about the patient's medical instability, and the family's resolve that they were acting in the patient's best interest. The attending

physician informed the family that the medical team would follow their request to withhold news of the daughter's death from the patient until after surgery and that the family would be the ones to inform the patient at that time.

By post-operative day three, the patient was doing quite well medically and was informed by the family of the death of his daughter. The patient's grief was felt to be appropriate and the patient displayed no anger towards the family or medical staff for withholding the news of his daughter's death until his post-operative convalescence.

EPILOGUE

Although the team was, and continues to be, in agreement that the ethically optimal decision was made at the time it had to be made, for some there are lingering discomforts. It is unclear whether the concerns about the potential negative effects of providing the information pre-surgery are based on emotions and myth or sound medical outcomes data. It is unclear whether or not the inclination to weight the potential harm of disagreeing with the family springs from altruistic concern for avoiding family, patient, and/or medical team moral distress, or whether these concerns are inordinately influenced by fears of increasing the hospital's and the physicians' risks of legal liability.

Today, more than two years since the case occurred, this case has become a teaching tool at our institution. It continues to produce vigorous debate, with no reduction in the lingering discomforts some feel about its outcome. Perhaps the case is most instructive in its illumination that refined ethical analysis rarely results in a neat division between what is clearly ethical and what is clearly not. Rather, perhaps the most important lesson to be learned from this case is that resolution of ethical problems in the everyday clinical care of patients most often results in some ethical principles being infringed on more obviously than on others, and that the moral discomforts this phenomenon produces is merely another dimension of the ambiguities and uncertainties inherent in the art of practicing medicine.

Would your institution have handled this case any differently?

MASKING OF THE CASE

The authors have changed details of the case to protect the identity of the patient and the patient's family.