The Cura Personalis of Healthcare Delivery: Ethical Reflections on Internal Medicine

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THE CURA PERSONALIS OF HEALTHCARE DELIVERY: **ETHICAL REFLECTIONS ON INTERNAL MEDICINE**

INTRODUCTION

Everything and everyone in internal medicine moves faster: the time, the diagnoses, the proposed remedies, the clinicians themselves (experienced speed-walkers, no doubt), and, lastly, the patients, the majority of whom actively communicate and deliberate alongside the medical team.

When I first imagined what the clinical world would look like to the ethicist, this was it – or so I thought. The patients admitted to the intermediary care units, significantly ill but not critically so, typically present with pneumonia, c-difficile, an immediate need to be dialyzed, withdrawal symptoms from drugs or alcohol, or something of the like. Their needs are hardly of the sort encountered in critical care, but they are undoubtedly as diverse as the patients themselves. These units – each with their own particularity – are the medical epicenter of the homeless: homeless in the literal sense of not possessing a permanent residence, and “homeless” in the darker, existential sense, a subjective experience that often accompanies individuals who, for reasons physical, emotional, and/or socioeconomic, find it difficult, if possible, to feel at home in any environment, let alone with themselves.

THE INTRACACIES OF INTERNAL MEDICINE

The practice of internal medicine seems to be a lost art. It seeks, in one sense, to remedy those less than visible problems – be they overlooked complications produced by competing medications, the inability of most clinicians to meet patients where they are, or the consistent failure to ask probing questions that get to the heart of the patient’s situation, both biological and biographical alike. In another sense, internal medicine aims to provide those essential but “boring” care items that patients so desperately require: an updated sleep study, new blood pressure medication, wound care, still another x-ray, a few minutes holding hands and ascertaining fears. Further, it is the lot of the Internist, paired with the case manager, to discern the location to which patients are likely to receive the best care once hospitalization can no longer provide any substantive benefits: one’s own home, a nursing home, a daughter’s house, perhaps.

According to the clinical team, the primary ethical issues facing Internists include, but are not limited to: (1) ascertaining decisional capacity, particularly in geriatric populations; (2) end-of-life decision making (particularly for individuals who do not meet the formal medical criteria for admission to any of the specialty units); (3) truth-telling (veracity) and disclosure of medical diagnoses and/or prognoses to patients for whom decisional capacity is variable (consider, for example, the individual with “sun-downer’s syndrome,” who possesses capacity by day and loses it by night); and (4) adequately palliating the marked pain of individuals who suffer from addiction.

“YOU’RE TALKING AS IF I’M NOT HERE. ASK ME, DAMNIT!”

During my rounds on a sunny Friday morning, I visited a 90-year-old gentleman, Mr. R., who had been hospitalized with co-morbidities for approximately one week at the time of our meeting. I stood in the semi-circle of medical professionals who surrounded his bed and listened closely to ascertain any value conflicts that might fall upon my ears. (I had by now become relatively bored. Was there anything for me to do? Almost every patient would be discharged that day – a wonderful thing, indeed. While there are several pressing issues encountered daily in the practice of internal medicine, it is assuredly no intensive care unit. The moral distress here is much less visible, almost too small to be seen. It exists, no doubt. But it does not have the flashing signs above it as do many of its peers.) In standard fashion, the medical team introduced themselves to Mr. R., informed him that they would deliberate about the case in medical jargon first, and thereafter explain to him the medical course of action necessary to remedy his ailment in terms of the layman – “something you can understand.” (Since it was mid-July, there were many first year residents on the team. As Dr. M. remarked, “such a teaching opportunity is, of course, bar none. But it is also, if one is not careful, a recipe for disaster,” as one resident would quickly find out.)

Following formal deliberation, the presenting resident addressed Mr. R. by his given name. This would mark the first strike. Mr. R. fired back: “You’re my physician, not my friend. Call me ‘Mr. R.’ and I’ll call you ‘Dr.’” The resident, now slightly shaken, continued with his prognosis. For the medical team, the immediate plan included urological surgery to remedy a bladder issue that was causing kidney malfunction. The resident then revealed his plan of approach: “Mr. R., we are going to operate on your bladder today to fix the problem with your kidneys. After that. . .” Growing increasingly agitated, Mr. R. immediately expressed his concern: “Slow down, chief! You’re *telling* me what I need to do. Don’t you get it? I don’t *need* to do anything at all. You’re talking *at* me as if I’m not here. Ask me, damnit! Present me with my options, and ask *me* what I am willing to do to treat my problem.” As my the pace of my head-nods grew more rapid and focused (in vigorous agreement with Mr. R.’s sentiments), the medical team became visibly distressed at “his attitude.”

COMPASSION AS MEETING THE PATIENT AT THE “SUFFERING POINT”

The freshly-minted resident had overlooked something vital to the physician-patient relationship. Upon Mr. R.’s visible irritation, which bordered on the furious, the attending physician (Dr. M.) dismissed the residents to leave the room, petitioning me to stay behind with her. She profusely apologized to Mr. R. for everything wrong with the prior interaction, and maintained that his care – *his* wishes, *his* values, *his* biography – were of utmost importance. Mr. R. broke into tears. As I went to comfort him, he told me that his trust in the medical profession was already weak, and that this was his breaking point. I assured him that I would be his advocate, along with Dr. M., and that nothing would be done that he did not explicitly consent to. This was *his* care, and *he* was in control. This much was our mutual promise.

Upon leaving Mr. R.'s room, Dr. M. mentioned that her patient "suffered temporary delirium" for the past several days, and was therefore not at all convinced that he was capable of making a good decision. I explored her concern by ascertaining the nature of the delirium and asked whether Mr. R. was able to (1) understand the relevant information pertinent to his medical diagnosis, prognosis, etc.; (2) evaluate the relevant information in light of his idiosyncratic values; and (3) reason about various courses of action (e.g., if he chose not to have the surgery (x), then he well may end up back in the hospital with further acute issues (y)). Dr. M.'s primary "ethics question" concerned what to do if/when Mr. R.'s delirium, which was due in large part to his medical condition, continued. At what point, if ever, does the diminishment of decisional capacity extinguish the moral obligation of the clinician to follow the patient's (present) wishes?

MORAL OF THE STORY

In the few days that followed Mr. R.'s eventual urological surgery, his decisional capacity ebbed and flowed. The original consensus to perform surgery regardless of Mr. R.'s wishes (since, as one resident put it, "his feelings and thoughts are irrational [due to delirium] – and that won't change") had by now been reevaluated. I twice approached the incapacitated Mr. R. in the days leading up to his eventual surgery. He would repeat (up to a fourth time) that he had "absolutely no desire to die," stating that "only a fool would [choose to die] when he had the chance to [reasonably and comfortably] avoid it." Mr. R. eventually disclosed to me that he "wouldn't blink at the thought of surgery; I know I need it to live, and that's what I want." His problem was not, as the team originally thought, his ability or even his willingness to consent. His problem was rooted in the experience of being ignored – "the only thing worse than being hated," he told me. What Mr. R. wanted was to be heard. To have his thoughts count. He wanted a say in his own care. He wanted control. In short, he wanted to feel compassion; he wanted his person, not merely his physiology, to be cared for.

I took this opportunity to educate the clinical team on the inner-workings of capacity as a relative notion, particularly its fundamental nature as a decision-specific faculty that concerns the ability to make an informed, evaluative, and rational decision in the moment. The team would finally welcome the idea that patients like Mr. R. might be capable of deciding what they want for lunch without, in the same moment, being capable of deciding in favor of life-prolonging surgery. Mr. R. would indeed come to the latter decision – but in his own time, when both his voice and values had been acknowledged.

My experience with the internists and my conversations with Mr. R. taught me many lessons about the need for prudence in bioethics. It is not enough to do the good thing. In Mr. R.'s case as in any other, the good thing must be done in the right way and at the right time, too.