The Moral Obligation of Bearing One Another's Burdens: Ethical Reflections on Surgical Intensive Care

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THE MORAL RESPONSIBILITY OF BEARING ONE ANOTHER'S BURDENS: **ETHICAL REFLECTIONS ON SURGICAL INTENSIVE CARE**

INTRODUCTION

Clinical rounds in the surgical intensive care unit (SICU) begin at the ungodly hour of 0600. Here, the stakes are higher than anywhere else in the hospital. The patients, torn to shreds by poor choices – either their own (consider the reckless motorcycle operator who drives intoxicated and helmet-less into oncoming traffic) or those of others (consider the careful motor vehicle operator who is harmed at the hand on the reckless motorcycle operator) – are mended together by the unspeakably steady hands of the finest of surgical artists.

While the vast majority of patients in the SICU are adults, they are often incapacitated, and as such require surrogate decision makers. Although surrogate decision makers enjoy a broad range of moral and legal authority for making medical decisions, their authority is, of course, limited to only what is in the best interests of the patient. However, when a surrogate's decision appears contrary to the previously expressed wishes or best medical interests of the patient, clinicians have a moral responsibility to challenge the decision and, if necessary, remove the decision-making authority of the surrogate. This unfortunate circumstance was, according to the SICU clinical team, "more often present than absent," causing both moral distress and perplexity surrounding the best methods of communicating such an ethical onus.

QUALITY OF LIFE: A STILL MORE DIFFICULT DISCERNMENT

Determinations over quality of life for patients who require surgical intervention to maintain physiological structure (never mind function) is no easy task. Yet it has remained the arduous burden of trauma surgeons such as Dr. G. for the past 25 years. He put it well: "Since the beginning of time, people have needed to be put back together. Today, we are privileged to have the technology and technique enough to do so. What remains, however, is a foundation to ensure that we are making the right decisions for patients – which is why I imagine you're here!" As he would want to be, Dr. G. was spot on. Patients have long necessitated the skilled hand of trauma surgeons, but they have also required a voice – one both reasonable and compassionate – to ensure that decisions place them in the driver's seat, even if they lack the awareness to appreciate it at the time.

Particularly in the evening of life, conflicts about care often have multiple causes. Patients, surrogates, and even clinicians may not understand the capabilities or limitations of contemporary medical technology, and so may base decisions on false information. Due to the debilitating nature of guilt, grief, fear, denial, and suspicion, patients and surrogates may refuse to accept the fact that further intervention promises no more benefit than burden. Because of the disparateness of beliefs, attitudes, and values between patients, surrogates, and clinicians, each may engender a different notion of the good in relation to care at the end of life. In a unique way in the SICU, the bioethicist must

familiarize himself/herself with the treatment options, the common dilemmas in sorting through them, and practical, compassionate approaches to analyze and resolve them.

THE REQUEST FOR UNREASONABLE MEDICAL CARE

Decisions about forgoing life-sustaining medical treatments typically arise when death is imminent and continuing treatment will result in intensified and prolonged suffering rather than improved clinical status. Due to the sensitivity of the decision under consideration, framing the issue carefully is critical. On the one hand, deciding to forgo life-sustaining treatment may be viewed as depriving the patient of needed care; on the other hand, it may be viewed as protecting the patient from the burden of ineffective and perhaps even harmful treatment. Framing the concerns appropriately is further complicated when surrogates request aggressive and invasive treatment – the “do everything mode,” as Dr. G. put it – in spite of the fact that such interventions are both therapeutically inappropriate and medically contraindicated.

“What’s the best way you know of to resolve these sorts of things?” Dr. G.’s question was a pressing one – one, I imagine, many clinicians across various disciplines must, at some time or another, struggle to answer. Little did we know that just a few days later, we would sit side by side with a surrogate to resolve just such a challenge. Christina, a 40-year-old Hispanic mother of two, presented on Wednesday with post-operative multi-system organ failure and gross septicemia. Three days prior, she was awake, alert, and interacting with her family. Suddenly, she had become severely neurologically devastated, and would never open her eyes again. Her hands and feet, each blackened to the point of looking charred, indicated severe circulatory death. She would experience five cardiac arrest episodes over the next two days. Surprisingly (though understandably), her husband would maintain her full code status. He wanted aggressive treatment, for “everything to be done.” “But what,” Dr. G. asked, “are the limits of such a request? I mean – I know *my* answer, but what would *you* say?”

MORAL OF THE STORY

Dr. G.’s question is, again, an excellent one: What, if anything, is the moral justification of medical futility? As I explained to Dr. G. and, ultimately, to Christina’s husband, medical professionals have an obligation to provide treatment that they discern to be in the best interest of their patients. To do otherwise – that is, to provide treatment that is not in the best medical interest of patients – would, of course, be morally irresponsible, particularly if it would only cause more harm and suffering to the patient. In the midst of grief, this was something the husband understood – but he needed something more.

Previously, the clinical staff gave Christina’s husband the option of discontinuing treatment. “But who would willingly make that decision?” he would ask me. He was, and is, absolutely right: no one would. With my assistance, Dr. G. and the clinical team came to understand more deeply their indispensable role in helping Christina’s husband out of such a terrible position by absorbing the decision on his behalf. Together, we would

explain that what was no longer reasonable was no longer in the best interests of his wife, and that we could, in good conscience, discontinue nonbeneficial treatment. This would prove an essential lesson at the heart of bioethics: that healthcare professionals should never be slow to enter into the chaos of another and help to bear (if not remove) the burden of something too heavy to be borne alone.