Ethical Dilemma in the Intensive Care Unit at a Military Hospital

CPT Jeffry Thomas Negard

Uniformed Services University of the Health Sciences

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While working in a trauma ICU at a Military Medical Center in 2009, a shooting occurred at a nearby military installation. We were expecting numerous casualties, but only one arrived: the shooter himself. The patient was admitted to one of our ICUs and the issue immediately arose of whether or not to allow active duty military to take care of him as tensions and emotions were elevated since he was also active duty and there had been several casualties. Should the patient die, his death may raise speculation of improper medical care and spark an investigation into care specifically done by military members. Initially, only civilians were allowed to provide nursing care, but eventually, any nursing staff that volunteered to care for him, including military, were allowed to do so.

After a few weeks, the patient was conscious and able to be removed from the ventilator, yet he remained a paraplegic. He was arrested and put under MP supervision but remained hospitalized for several months. During his hospital stay, he requested to be able to observe his religious beliefs, which required washing of his hands, genitals, and feet four times per day. This request created arguments as it became a question of whether he should be provided this extra care or whether the attending nurse could refuse, as it actually did not fall under “necessary care”.

Two dilemmas are presented here and I have chosen to analyze them by applying the tools provided by Jonsen, Siegler and Winslade (2010) in respect to the Four Topics model they created. The model is built around the ethical principles of beneficence, nonmaleficence, respect for autonomy, justice and fairness, and incorporates them into the four headings of medical indications, patient preferences, quality of life, and contextual features.

Medical Indications

The patient suffered an acute and critical life-threatening injury that took a couple of weeks to stabilize. During the time he was ventilated and sedated, he had the right to be treated as any other patient. The immediate goals were to return him to as normal as a life as possible that could be achieved in light of his injury. With a spinal injury, there is always the possibility of life-long disabilities, but the outcomes take many months or even years to determine. Because the patient was an active-duty service member, he was provided the highest level of care possible and there were no circumstances in which medical treatment was not indicated. His injury was not high enough to cause quadriplegia or permanent ventilator dependence, though I am unaware if there was complete severing of the spinal cord that would prevent him of ever walking again, so the probabilities of success of treatment options cannot be addressed in this writing. Despite his status as a "blue-on-blue" attacker and reports of a possible terrorist link, there was never any reason to withhold care and the patient was at a Level 1 trauma center and was so benefited by advanced and life-saving medical and nursing care.

Patient Preferences

The patient was informed of benefits and risks of care once he regained consciousness, but until then, implied consent was assumed. I was not privy to whether he declined treatment, but once he regained consciousness, there was no longer a danger of death. Additionally, because he was an active duty service member and under investigation for the shooting (but not under arrest at this point) I am not sure he would have been allowed to decline care. He was assumed to be mentally capable and legally competent to make his own decisions, and a psychological evaluation was conducted at some point during the investigation to determine his mental competence.

The component of care that came into question was his preference to have his hands, face, feet and genitalia washed four times per day so that he could pray in accordance with his religious beliefs. The discussion and debate among caregivers was whether those wishes should be granted. I was asked, “Would you do it for any other patient?” After considerable thought and personal reflection, I determined that it depended on the priorities each day brought.

Bathing a patient once per day and then as necessary (i.e.: patient soiling) is a part of routine nursing care. However, a daily bath must occur once every twenty-four hours, not when a patient demands. Additionally, in a busy Surgical/Trauma ICU, nursing and medical staff cannot always afford to adjust their care of other patients around the requests of just one. For me, this was not a decision motivated out of hatred or disrespect, but it came after evaluating the larger scope of nursing care. The patient’s requests were a personal desire of his and not something nursing or medical staff was required to do as part of daily care.

Quality of Life

With or without treatment, the patient would never be able to return to life as he had formerly known it as his is injuries left him a paraplegic. He was facing a life of numerous physical deficits. Though there are many arguments regarding quality of life that come into play daily in the medical field, especially in the ICU environment, there was never to my knowledge the question of whether to withhold treatment of this patient based on the outcome he would have to deal with later in life. Biases, such as the beliefs a provider might have about his own care should he be in the same position as this patient will always come into play and it is impossible to remove those thoughts completely. The challenge in medical care is to set aside one’s own biases and provide the best care possible without personal influence.

Additionally, I do not belief anyone has the right to judge whether a patient might find life created by a medical condition undesirable unless they are provided with that patient's wishes. Without a Living Will, I believe all life-sustaining efforts must be made on an incapacitated patient without judgment, unless the efforts are deemed futile. This is a gray area that is debated often among ethics committees, and I believe no answer will ever be 100% correct. We do our best in making these decisions and hope we make a correct an unbiased decision.

Ethical issues are also a concern in improving or enhancing a patient's quality of life and are hotly debated as our technology has allowed us to provide better treatments year-after-year. One of the biggest questions surrounding health care is if we should provide certain levels of care just because we can. For example, would it be reasonable to provide life-saving heart surgery or even a transplant on a ninety-five year old man? Would he even survive the surgery or the months of rehabilitation afterwards? We may have the skills and technology to perform the treatment, but should we?

For the patient discussed in this paper, there were no ethical issues regarding improving his quality of life. Additionally, suicide was not a factor, though "suicide by cop" could be considered in that he was shot by a police officer while conducting a mass shooting. As a former police officer, I was aware early in my career of this mentality among suicidal individuals who would perpetrate acts of violence with the desire to have their own life ended by law enforcement because they did not want to take their own lives. One cannot rule out this as a possibility for this patient, though I am not aware that he made any such statements at any point in time prior to or after his injury.

Contextual Features

The main professional interest that created conflict in the treatment of this patient came from the fact that he was an active duty soldier who had been injured while in the act of inuring and killing numerous other soldiers during an act of violence he had intentionally committed, and was then treated at a military hospital. This is not to say that any care was withheld. Rather, it created inter- and intrapersonal conflict as each provider struggled with the situation itself and his or her own emotions. Additionally, as mentioned earlier, his religious preferences may have influenced clinical decisions as providers struggled with how to work with and around the patient's requests while still withholding judgment.

Legal issues of care had to be considered from day one. Because this patient was most likely going to be involved in a lengthy court proceeding, every aspect of his life came until intense scrutiny. Therefore, his medical care was carefully monitored so it would not become a factor in the eventual legal trial. The administrative staff was adamant in making sure that the care he was given would not come under question later on as being insufficient or lacking in any way, and so biases of medical staff were also carefully monitored. Staff who voiced their displeasure with caring for this patient was not allowed to do so.

Because the patient was active duty and under investigation for a crime, none of his family members were allowed to influence decision making for his care while he was sedated and incapacitated. There were no problems of allocation of scare resources that might affect care, and third party interests were not a factor, nor were conflicts of interest within the institution. Financial factors were also a non-issue in that the patient was an active duty service member and was therefore provided with every resource the hospital had or could obtain with disregard for cost. Public safety was a minor issue only in that the hospital was put on lock down for several weeks until public anger regarding the incident the patient was involved in had subsided. Until

then, everyone who entered the hospital had their bags searched by security and the ICU the patient was in became a “no-access” floor to any personal who were not on a daily-approved list. Finally, clinical research and education did not factor into patient care.

Conclusion

Ethical dilemmas are a difficult piece of medical care and every case brings something new that must be discussed. Recently, a case in Texas once again put patient and family wishes regarding the right of whether or not to choose life-sustaining care back into the spotlight. Marlise Munoz suffered a suspected pulmonary embolism in November 2013 and had been on life-support while the family battled Texas law for the right to remove her per her wishes. The issue was that Marlise was pregnant and the Texas Advance Directive act states, “A doctor may not withdraw or withhold life-sustaining treatment from a pregnant patient” (Advance Directive Act, 1999). This case was debated in the courts and in the press as answers were sought on just what the right thing to do was, and the fact that the fetus was still alive was the driving force. On January 26, 2014, Marlise was removed from life support after the courts ordered the hospital where she was to do so (Mohney & Lupkin, 2014)

After analyzing the case presented at the beginning of the paper using the Four Topics model created by Jonsen, Siegler and Winslade (2010), and carefully evaluating the two dilemmas presented, I believe the active duty patient was cared for properly without violating his own rights. In fact, he was provided the best possible care, as he was treated at a leading Level 1 hospital, and his care was in no way detrimental to his outcome. To my knowledge, his request to have his body cleansed four times daily for religious purposes was not always met. Even when he was transferred to a private unit built just for him, his requests were instead incorporated into his own physical and occupational therapy rehabilitation.

I have no doubt that others may look back at the case I have analyzed here and judge the actions of the nursing staff for their refusal to provide the care the patient requested, but that is precisely the type of conversation that leads to one's personal reflection of how they handle ethical dilemmas they encounter in the future.

References

Advance Directives Act, Texas Health and Safety Code, Title 2, Subtitle H, Chapter 166, Subchapter A. (1999). Retrieved from http://www.statutes.legis.state.tx.us/Docs/ HS/htm/HS. 166.htm

Jonsen, A. R., Siegler, M., Winslade, W. J. (2010). *Clinical ethics: A practical approach to ethical decisions in clinical medicine* (Seventh edition). New York: McGraw-Hill Medical

Mohney, G. & Lupkin, S. (2014, January 26). Pregnant texas woman taken off life support. *ABC News.* Retrieved from http://abcnews.go.com/Health/pregnant-texas-woman-off-life-support/ story?id=22041878