

The Unrepresented Patient: Pitfalls of Decision Making by Committee

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Disclosures

- No financial disclosures

The Unrepresented Patient

- Who is the unrepresented patient?

The Case of Ms. M

- 69 year old female living in a board and care facility brought to the ED after she was found to be altered in her room by staff
- Imaging revealed a large stroke → admitted to ICU
- Intubated, GCS 5T, otherwise stable

The Case of Ms. M

- 69 year old female without decision making capacity
 - No family – never married, no children, no known relatives
 - No written wishes – no advance directive or living will, no POLST
 - Few friends – one name of a friend given to the social worker by staff at the board and care
- What is the best way to make decisions for Ms. M?

The Case of Mr. S

- 59 year old male who was admitted with septic shock
- Intubated in the ED, transferred to the ICU
- Now with renal failure on hemodialysis, extubation failure x 1
- Intermittently follows commands, does not appear to have decision making capacity

The Case of Mr. S

- 59 year old male without decision making capacity
 - Advance directive in EMR from a previous hospitalization signed 3 years prior stating, “I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits”
 - No family immediately available, brother possibly living in Arizona
 - Acquaintances state they did not have much knowledge about the patient
- What is the best way to make decisions for Mr. S?

The Unrepresented Patient

- Who is the unrepresented patient?
 - Moral unrepresentation – unavailability of a person to ***translate*** the patient's wishes
 - Legal unrepresentation – unavailability of a person with the ***legal authority*** to speak on the patient's behalf
 - Moral – legal incompatibility – the person with legal authority to speak does not have the knowledge required to translate the patient's wishes

The Case of Mr. S

- 59 year old male without decision making capacity
 - Advance directive in EMR from a previous hospitalization signed 3 years prior stating, “I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits”
 - No family immediately available, **brother possibly living in Arizona**
 - Friends state they have some knowledge about the patient
- Who speaks?

The Unrepresented Patient

- Who is the unrepresented patient?
- Is there a way to make decisions for these patients?



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OPERATING POLICY

CATEGORY: PATIENTS' RIGHTS

SUBJECT: HEALTHCARE DECISIONS FOR
UNREPRESENTED PATIENTS

CODE: P-23

EFFECTIVE: 06/2016

REPLACES: ---

PAGE: 1 of 5

LLUH Policy P-23

- Interdisciplinary ad hoc committee
- Establish goals based on the diagnosis and prognosis
- Best interests standard in evaluating burdens / benefits of treatment
- Decision making power includes withdrawal / withholding of life sustaining therapy
- Disagreement → continue current level of therapy while conflict resolution process occurs
- Court mandates as a last resort
- Only good for current hospitalization

LLUH Policy P-23

- Pros
 - Defined process
 - Encourages inclusion of multiple perspectives
 - Avoids hasty decisions
- Cons
 - Can be unwieldy / time consuming
 - **Presumes the use of commonly accepted norms in determining goals**
 - Process can be subjected to bias
 - Tendency to use “medical indication” as justification

The Case of Ms. M

- 69 year old female without decision making capacity
 - No family – never married, no children, no known relatives
 - No written wishes – no advance directive or living will, no POLST
 - Few friends – one name of a friend given to the social worker by staff at the board and care
- How should the committee set treatment goals without first knowing the Ms. M's lived and stated values?
 - Quality of life
 - Subtle influence of concerns for distributive justice
 - Is limitation of treatment appropriate because it is medically indicated or there is an absence of a personal request for treatment continuation?

The Unrepresented Patient

- Who is the unrepresented patient?
- Is there a way to make decisions for these patients?
- Is this legal?

DEFAULT SURROGATE CONSENT STATUTES

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Explanation: The descriptors in the chart are generalizations of statutory language and not quotations, so the statutes must be consulted for precise meaning. The default surrogacy statute language varies from state to state and the listed descriptors generally hold the following meanings:

- Adult includes any person who is 18 years of age or older, is the parent of the child, or has married;
- Close friend (Adult friend) is one who has maintained regular contact with the patient as to be familiar with the patient’s activities, health, and religious or moral beliefs.
- **Provisions in red** are those addressing patients with no available qualified surrogate.

CAUTION: The descriptions and limitations listed in this chart are broad characterizations for comparison purposes and are not precise quotations from legislative language.

State & Citation	General Type of Statute	Can Patient orally name a Surrogate?	Priority of Surrogates (in absence of an appointed agent, surrogate, or guardian with health powers)	Limitations on Types of Decisions	Provides Standard for Decision-Making	Disagreement Process Among Equal Priority Surrogates
1. ALABAMA Ala. Code 1975 §§22-8A-1 to -14 (2017). Specifically, see §22-8A-11	Comprehensive Health Care Decisions Act		<ul style="list-style-type: none"> ▪ Spouse (unless legally separated/divorcing) ▪ Adult child ▪ Parent ▪ Adult sibling ▪ Nearest adult relative ▪ Att. physician & ethics committee 	Patient must be in terminal condition or permanently unconscious. Certification requirements.	Yes §22-8A-11(c)	Judicial recourse, §22-8a-11

The Unrepresented Patient

- Who is the unrepresented patient?
- Is there a way to make decisions for these patients?
- Is this legal?
- How does this policy work?

The Case of Mr. A

- 68 year old male with history of congestive heart failure admitted for pneumonia
- No advance directive, no surrogate decision maker, requested full code status at admission but stated to the admitting MD “but don’t try too hard”
- Now requiring BiPAP, intermittantly lucid, heading towards intubation

The Case of Mr. A

- Ad hoc committee
 - Diagnosis
 - Prognosis – reversibility?
 - How much weight to give verbal declarations?
 - How to account for biases?

The Case of Mr. A

- Committee decided based on diagnosis (poor heart function and pneumonia severity) and prognosis (unlikely to be successfully extubated if intubated) to do the following:
 - DNAR code status
 - Limitation of treatment including no intubation based on burden / benefit
 - Maximize current treatments including escalation of BiPAP settings as needed until burdens exceed benefits
 - Appropriate treatment of pain / relief of suffering
 - Did not tolerate increased BiPAP settings (increased agitation)
 - Died the next day from respiratory insufficiency

The Unrepresented Patient

- Who is the unrepresented patient?
- Is there a way to make decisions for these patients?
- Is this legal?
- How does this policy work?
- Practical tips
 - Check the legal status in your state
 - Recognize different types of patient unrepresentation
 - Ensure intradisciplinary participation
 - Preventive ethics

Pitfalls of Decision by Committee

- Bias
 - Cannot prevent bias
 - Need to recognize bias to mitigate it



Decision-making and safety in anesthesiology

Marjorie P. Stiegler^a and Keith J. Ruskin^b

Purpose of review

Anesthesiologists work in a complex environment that is intolerant of errors. Cognitive errors, or errors in thought processes, are mistakes that a clinician makes despite 'knowing better'. Several new studies provide a better understanding of how to manage risk while making better decisions.

Recent findings

Heuristics, or mental shortcuts, allow physicians to make decisions quickly and efficiently but may be responsible for errors in diagnosis and treatment. Using simple 'decision-making checklists' can help healthcare providers to make the correct decisions by monitoring their own thought processes.

Anesthesiologists can adopt risk assessment tools that were originally developed for use by pilots to determine the hazards associated with a particular clinical management strategy.

Summary

Effective decision-making and risk management reduce the risk of adverse events in the operating room. This article proposes several new decision-making and risk assessment tools for use in the operating room.

Keywords

cognitive errors, heuristics, medical errors, risk assessment, safety

Table 1 Cognitive error catalogue

Cognitive error	Definition	Illustration
Anchoring	Focusing on one issue at the expense of understanding the whole situation	While troubleshooting an alarm on an infusion pump, you are unaware of sudden surgical bleeding and hypotension
Availability bias	Choosing a diagnosis because it is in the forefront of your mind due to an emotionally charged memory of a bad experience	Diagnosing simple bronchospasm as anaphylaxis because you once had a case of anaphylaxis that had a very poor outcome
Premature closure	Accepting a diagnosis prematurely, failure to consider reasonable differential of possibilities	Assuming that hypotension in a trauma patient is due to bleeding, and missing the pneumothorax
Feedback bias	Misinterpretation of no feedback as 'positive' feedback	Belief that you have never had a case of unintentional awareness, because you have never received a complaint about it
Confirmation bias	Seeking or acknowledging only information that confirms the desired or suspected diagnosis	Repeatedly cycling an arterial pressure cuff, changing cuff sizes, and locations, because you 'do not believe' the low reading
Framing effect	Subsequent thinking is swayed by leading aspects of initial presentation	After being told by a colleague, 'this patient was extremely anxious preoperatively', you attribute postoperative agitation to her personality rather than low blood sugar
Commission bias	Tendency toward action rather than inaction. Performing un-indicated manoeuvres, deviating from protocol. May be due to overconfidence, desperation, or pressure from others	'Better safe than sorry' insertion of additional unnecessary invasive monitors or access; potentially resulting in a complication
Overconfidence bias	Inappropriate boldness, not recognizing the need for help, tendency to believe we are infallible	Delay in calling for help when you have trouble intubating, because you are sure you will eventually succeed
Omission bias	Hesitation to start emergency manoeuvres for fear of being wrong or causing harm, tendency towards inaction	Delay in calling for chest tube placements when you suspect a pneumothorax, because you may be wrong and you will be responsible for that procedure
Sunk costs	Unwillingness to let go of a failing diagnosis or decision, especially if much time/resources have already been allocated. Ego may play a role	Having decided that a patient needs an awake fiberoptic intubation, refusing to consider alternative plans despite multiple unsuccessful attempts
Visceral bias	Counter-transference; our negative or positive feelings about a patient influencing our decisions	Not trouble-shooting an epidural for a labouring patient, because she is 'high-maintenance' or a 'complainer'
Zebra retreat	Rare diagnosis figures prominently among possibilities, but physician is hesitant to pursue it	Try to 'explain away' hypercarbia when MH should be considered
Unpacking principle	Failure to elicit all relevant information, especially during transfer of care	Omission of key test results, medical history, or surgical event
Psych-out error	Medical causes for behavioural problems are missed in favour of psychological diagnosis	Elderly patient in PACU is combative—prescribing restraints instead of considering hypoxia

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Anchoring	<p>Focusing on one issue at the expense of understanding the whole situation</p> <p>Premature closure Accepting a diagnosis prematurely, failure to consider reasonable differential of possibilities</p> <p>Feedback bias Misinterpretation of no feedback as 'positive' feedback</p>	<p>While troubleshooting an alarm on an infusion pump, you are unaware of sudden surgical bleeding and hypotension</p> <p>Assuming that hypotension in a trauma patient is due to bleeding, and missing the pneumothorax</p> <p>Belief that you have never had a case of unintentional awareness, because you have never received a complaint about it</p>
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Pitfalls of Decision by Committee

- Bias
 - Cannot prevent bias
 - Need to recognize bias to mitigate it
- Empower members to speak up
- Time consuming
 - May discourage clinicians from activating the process
 - Administrative support
 - Proactive ancillary staff

The Case of Mr. Doe

- 32 year old male involved in a witnessed auto vs pedestrian
- Admitted to the ICU → severe traumatic brain injury, right leg / pelvis injury
- No friends / family on scene, no ID, no identification through criminal fingerprint database