

CASE 14: Mr. Simpson's Clinical Decline

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On Friday morning, Dr. Waverly, the physician director of case management, calls to make a request for a clinical ethics consultation on behalf of nursing staff. The nurses were experiencing moral distress about providing patient care that might be contrary to patient wishes. Dr. Waverly had gotten a call from the bedside nurse, Penny Wilcox, and charge nurse, Diane Reilly, who reported two closely related concerns: first, that the patient, Ben Simpson may be nearing the end of his life with no clear plan of care; second, because Mr. Simpson's primary physician, Dr. Timothy Adler, had a close relationship with Mr. Simpson and "was too emotionally involved to see he was dying." In addition to the distress about Mr. Simpson's care, Dr. Waverly also notes that the nursing staff is worried about raising these questions with the physicians involved – so worried, in fact, that they were hesitant about requesting clinical ethics consultation directly because they feared rebuke or retaliation from those physicians.

The Department of Case Management is well familiar with Mr. Simpson from multiple admissions. According to Dr. Waverly, Mr. Simpson is a 38-year-old man with end stage renal disease who had been on hemodialysis in the past. In more recent years, he has been on continuous, ambulatory peritoneal dialysis (CAPD). He also has diabetes, peripheral vascular disease and chronic gangrene, and has lost multiple digits to amputation, as well as both legs below the knee. He was admitted for possible infection of his left knee stump, as well as possible peritonitis, and had been in the hospital for over a month this time.

Mr. Simpson's code status was DNAR/DNI, based on his own clearly stated wishes, as documented in physician notes and in a DNAR order in the electronic medical record. Mr. Simpson reportedly told Ms. Wilcox and other nursing staff that it had taken a great deal of effort for him to convince Dr. Adler to write the order in the first place. Additionally, Mr. Simpson had been asking for information about and expressing interest in palliative care and hospice with Ms. Wilcox and other bedside nurses. The nurses had relayed those desires to the physicians caring for Mr. Simpson, without, they felt, much of a response.

The report of Mr. Simpson's wishes and *his* conversations with Dr. Adler came from Ms. Wilcox and Ms. Reilly because now, when Dr. Waverly is calling to request ethics consultation, Mr. Simpson is no longer able to communicate. He had returned from the GI Lab in respiratory distress and with seizures, after a follow-up EGD procedure. Dr. Adler is out of town at this time, and today, the covering physician, Dr. Richardson, wrote orders to change Mr. Simpson's code status to Full Code and transfer Mr. Simpson to the ICU. When Ms. Wilcox asked why the code status had changed, Dr. Richardson said that Dr. Adler had asked him to do so. Dr. Adler explained that he had talked to Mr. Simpson a week prior and Mr. Simpson had revoked his request for DNAR/DNI code status. According to Dr. Adler, Mr. Simpson also said that he wanted all aggressive measures, though Dr. Adler "hadn't gotten around to documenting that conversation" before he left town. Based on this discussion with Dr. Adler, Dr. Richardson changed Mr. Simpson's code status. Dr. Richardson also told the nurses that with Mr. Simpson's history of ambivalence towards his medical condition and treatment, it made sense to continue aggressive measures, including ICU admission and CPR if he arrested. Mr. Simpson might change his mind again, but if his code status was DNAR, then it would be too late.

Ms. Wilcox and Ms. Reilly are very distressed by what they see as a shift in the focus of Mr. Simpson's care that seems based on Dr. Adler's emotional reaction to his long-time patient's deteriorating condition, rather than Mr. Simpson's stated wishes. They thought Dr. Adler's claim to have discussed change in code status with Mr. Simpson was questionable – if they had this conversation a week earlier and Mr. Simpson had wanted a change in his code status, why didn't Dr. Adler document it then and write new orders? Learning about such a major change from Dr. Richardson added to their frustration, because it came second-hand and they couldn't reach Dr. Adler to get more details. Further, Ms. Wilcox and Ms. Reilly saw Dr. Richardson's focus on past ambivalence as disregarding the nursing reports, consistent throughout this hospitalization, of Mr. Simpson's discomfort, recognition of his own dying, and desire to focus on palliative care. They hinted at their suspicions that Dr. Richardson's decision to change the code status to full code and write transfer orders may also be motivated by his personal religious commitments (as an Orthodox Jew) to "preserving every last breath in a patient." Because of these religious concerns, and because Dr. Richardson "hadn't listened" to Ms. Wilcox's reports about Mr. Simpson's requests for palliative care, Ms. Wilcox and even Ms. Reilly were afraid to question Dr. Richardson's orders for Full Code status and ICU transfer.

Questions:

1. What are the primary ethical or moral concerns that the clinical ethics consultant must consider in this consultation?
2. How would you, as the clinical ethics consultant, respond to the moral concerns in this case?
3. In this case, would a clinical ethics consultant need to give the perspectives of the nurses more weight than the perspectives of the doctors in trying to determine the most ethical treatment for Mr. Simpson? Why or why not?

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<http://nubc2014.files.wordpress.com/2014/01/bb-case-packet-20141.pdf>