Rationality of Refusing Treatment: Clinical Ethics Conference at the Department of Emergency Medicine

Motomu SHIMODA, Ph.D.

Professor, Osaka University Graduate School of Medicine, JAPAN

Introduction

The number of hospitals in which clinical ethics conferences are being held besides medical conferences has been increasing recently in Japan. Either the four-quadrant method by Albert R. Jonsen et al.[1] or the communication process sheet by Tetsuro Shimizu [2], a Japanese philosopher, is used for decision making or problem solving regarding ethically controversial issues among medical staff, patients, and their family members. The participants include doctors, nurses, ethicists, lawyers, and psychologists.
In this paper, I examine the major points to consider and tasks to undertake based on the discussion of the clinical ethics conference held at the Department of Emergency Medicine of Osaka University Hospital. The central topic is how to cope with cases of patients such as suicide attempt survivors who refuse the proposed treatment, in which most medical staff members usually find various difficulties.

1. Case presentation

The following two cases related to attempted suicide are to some extent arranged based on the actual cases that we discussed in line with the Sheet for Case Examination in Clinical Ethics by Shimizu.

Case 1

A man in his 40s was sent to hospital because of the serious injuries caused when he set fire to himself. He has been in and out of hospital for the treatment of schizophrenia and has taken drugs for several years. After emergency intervention, he recovered from a critical condition and was managed by respirator. He refused such treatment and asked to go home immediately; however, since there was no one to take care of him, the medical staff were concerned about the possibility of suicide attempt recurrence.

Case 2

A woman in her 20s who repeatedly took overdoses due to panic disorder was taken to hospital and treated immediately. As medical staff members had experienced problems with the woman several times before, e.g., making a noise and shouting, as well as violent conduct and language toward them or other inpatients, they are frustrated both by not giving adequate care and wanting her to leave at the same time. The patient refused a psychiatric examination and left the hospital.

In both cases, medical staff found some difficulties in terms of how to provide adequate care for the patients and felt that care had been insufficient after their discharge. This is why some medical staff members raised these cases as topics of the clinical ethics conference.

2. Sheet for Case Examination in Clinical Ethics

There is a strong necessity for an effective method of discussion among medical staff coping with clinical ethical issues. The sheet proposed by Jonsen et al., a so-called quadrant sheet -- medical indication, patient preferences, quality of life, and contextual features -- has been widely used around the world including among Japanese medical staff. However, this sheet often indicates that the communication process and the general Japanese relationship between the patient and his/her family members are not considered sufficiently. That is why Shimizu and his group have proposed their own sheet.

Basic features of the Sheet for Case Examination in Clinical Ethics by Shimizu are as follows:

(1) Examination is conducted in line with the communication process for decision making or problem solving.
(2) Both the patient and his/her family members are regarded as almost equal stakeholders.
(3) Filling in the sheet is either for ongoing cases or for already-finished cases in order to pass on the knowledge learned from such cases.

The outline of the Sheet is as follows.

0-1 Patient profile

0-2 Summary of the patient's medical history

I. Analysis and sharing of information

A. Medical information:

Possible choices of treatments, their merits and demerits/risks; social issues; explanation by the medical staff to the patient and to the patient's family

B. Life and will of the patient and family:

The patient's understanding and will; the family's understanding and will; the patient's life and values

II. Examination and orientation

A. Finding the problem:

Individualized judgment by the medical staff; consensus among the people involved regarding the best choice

B. Analysis of the problem and how to solve it:

Causes of divergence/impediment and possible ways of solving it; how to promote communication between the patient and the medical staff in order to reach a consensus

III. Process of communication aiming at consensus

(1) Communication with the patient and his/her family
(2) Social arrangement
(3) Conclusion and/or decision
(4) Follow-up

This sheet can be used for both ongoing and just-finished cases, and is sometimes used for public workshops by persons working in the clinical setting while protecting personal information.

3. Discussion: Major Points to Consider

The decision-making process is based on such factors as "medical indication," "will or preference of the patient and his/her family members," "evaluation of quality of life including risk-benefit analysis," and "familial and social support." By taking these factors into consideration "the best interests of the patient" can be made clear.[3] However, we find some difficulties in the case of suicide attempt survivors.

(1) Rationality of Refusing Treatment

Conflicts of opinion among persons involved often occur concerning refusal of treatment by patients who are suicide attempt survivors. Some claim the will to refuse should be respected, whereas most Japanese medical staff members tend to regard such will as irrational due to the lack of competence and to deal with the patient in a paternalistic way. We need to assess the decision-making capacity of the patient instead of legal competence.[4,5] In some cases, however, life-saving treatment is withheld because of its medical futility.

(2) Care and Support for Patients after Discharge

Although hospital medical staff have not formerly been involved in patients' lives after discharge, it is required nowadays for them to connect and cooperate with the local government, health center, and psychiatrists for welfare services or psychiatric care for patients who are suicide attempt survivors. As the patients are likely to be shunned or excluded by those around them, even their family members, as well as being isolated from their community and family, some medical staff provide support for the patients after discharge in order to prevent recurrence.

(3) Japanese Cultural Attitude to Suicide

Japanese cultural tradition has a tendency to condone suicide instead of assigning blame for it. However, suicide attempt survivors are often looked down upon for causing disruption to others. While we can find the norm of valuing one's life and the idea that "suicide is a sin" and "never kill yourself" in Japanese culture, these values seem to be less among the general public, which is shown in such phenomena as the double suicide of a mother who kills her child, the prevailing method of suicide among young people, and the high suicide rates of the population (the highest for advanced countries according to a WHO report).[6] We need to conduct the comprehensive survey to get the basic data concerning attempted suicide and to cope with it in Japan as in the US.[7,8]

Conclusion

The major issues emerging from the clinical ethics conference on patients who are suicide attempt survivors refusing treatment are as follows:

(1) Is it valid for medical staff to disregard the will of a patient to refuse treatment as rational and conduct life-saving treatment against the patient's will?
(2) Is it the duty of medical staff to arrange to provide support for the patient after discharge?
(3) Is it necessary for medical staff to consider the tendency toward condoning suicide and isolation of survivors in Japan?

In my view, the positive involvement of medical staff with suicide survivors is justified from the viewpoints of the social mission of emergency and preventive medicine, public health, and the sociocultural circumstances in Japan.

References

1. Jonsen, Albert R., Siegler, Mark, Winslade, William J. Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine, 6th Edition, 2006, McGraw-Hill.
2. Shimizu, T., Principles in Clinical Ethics: With special reference to Palliative Medicine. http://www.l.u-tokyo.ac.jp/~shimizu/papers/pr-cleth.pdf
3. Motomu Shimoda, "Respecting Patient's Dignity in Emergency Medical Care: Drawing from the Experience of Clinical Ethics Case Conferences in Japan." http://www.med.osaka-u.ac.jp/pub/eth/English/paper30.pdf
4. Larkin, G.L., Marco, C.A., Abbott, J.T., Emergency determination of decision-making capacity: balancing autonomy and beneficence in the emergency department. Acad Emerg Med 2001 Mar; 8(3): 282-4
5. Isaacs, E., D'Souza, P., Ethics in Emergency Medicine. http://andrewta.net/webdocs/vol4/emed_htm/ER/topic692.html
6. World Health Organization, Suicide rates per 100,000 by country, year and sex (Table).
7. Birkhead, G.S., Galvin, V.G., Meehan, P.J., O'Carroll, P.W., and Mercy, J.A., The emergency department in surveillance of attempted suicide: findings and methodologic considerations, Public Health Reports, 1993;108(3): 323-331.
8. US Department of Health and Human Services, Suicide Prevention in Emergency Medicine Departments (U01), Feb. 2009. http://grants.nih.gov/grants/guide/rfa-files/RFA-MH-09-150.html

Correspondence

Motomu SHIMODA, Ph.D.

Professor

Osaka University Graduate School of Medicine

2-2 Yamadaoka Suita, Osaka 565-0871, Japan

E-Mail : shimoda@eth.med.osaka-u.ac.jp