

Case Study Application of an Ethical Decision-Making Process for a Fragility Hip Fracture Patient



Lynn Haslam, RN(EC), PhD(C), Vincent DePaul, BHSc(PT), PhD

Department of Rehab Science, Aging & Health Program, Queen's University, Kingston, ON

DOI:<https://doi.org/10.5770/cgj.22.272>

ABSTRACT

In Canada, up to 32,000 older adults experience a fragility hip fracture. In Ontario, the Ministry of Health and Long Term Care has implemented strategies to reduce surgical wait times and improve outcomes in target areas. These best practice standards advocate for immediate surgical repair, within 48 hours of admission, in order to achieve optimal recovery outcomes. The majority of patients are good candidates for surgical repair; however, for some patients, given the risks of anesthetic and trauma of the operative procedure, surgery may not be the best choice. Patients and families face a difficult and hurried decision, often with no time to voice their concerns, or with little-to-no information on which to guide their choice. Similarly, health-care providers may experience moral distress or hesitancy to articulate other options, such as palliative care. Is every fragility fracture a candidate for surgery, no matter what the outcome? When is it right to discuss other options with the patient? This article examines a case study via an application of a framework for ethical decision-making.

INTRODUCTION

Every year, over 30,000 Canadian older adults experience a fragility hip fracture. The Ministry of Health and Long Term Care of Ontario has promoted best practice recommendations which advocate for immediate surgical repair, within 48 hours of admission, in order to achieve optimal recovery outcomes.^(1,2) The majority of patients are good candidates for surgical repair; however, given the risks of anesthetic and trauma of the operative procedure, surgery may not be the best choice for all. The patients at higher risk of poor outcomes perioperatively deserve the opportunity to explore options and articulate their values. Unfortunately, as a short pre-operative interval predicts the best outcomes, patients and families face a difficult and hurried decision, potentially with limited time to voice their concerns, and little to no information on which to guide their decision.

From a systems perspective, quality of care and health outcomes have not always incorporated the patient-centred perspective.⁽³⁾ Patient-centred care is “a moral concept and philosophy, considering it to be the right thing to do when designing and delivering respectful, humane, and ethical care”.^(4,5) Patients and families have reported in the past that they feel left out of crucial conversations and decisions surrounding care,⁽⁶⁾ and that relevant information is not always provided.⁽⁷⁾

To better understand the underlying ethical complexities which arise from critical decisions in the acute care setting, this paper will examine a case study to demonstrate application of the Corey *et al.*⁽⁸⁾ 8-step framework (see Appendix A) for ethical decision-making.

Case Study

Ms. Jones is 93 years old and lives in a Long Term Care residence. She was admitted to hospital with a fragility hip fracture after being found on the floor in the middle of the night. Ms. Jones has dementia and is unable to make her own decisions. She has limited mobility, previously used a walker. Her two daughters are at her bedside. They state her health has been declining over the last few weeks, with increasing confusion and she now rarely leaves her room.

On admission, the team discovered a pleural effusion, taking up much of her right lung. Her pre-operative assessment also revealed a heart murmur; the resulting echocardiogram demonstrated a heart in very poor condition, with significant valve issues. Between her cardiac and pulmonary function, the surgery poses an increased risk of perioperative complications—she may never survive the surgery, or come off of the ventilator once she is intubated.

Interprofessional teams (surgery, anesthesia, nursing) are of differing opinions. The issue at hand is very difficult. The family is informed that the risk of not having surgery will likely result in death, yet in this patient's case, proceeding with surgery carries its own risk. The family is left with an hour to think things over. Should they pursue the palliative care route or proceed with surgery?

Step 1. Identify the Problem or Dilemma

In our case study, 93 year old Ms. Jones is admitted to hospital with a fragility hip fracture. As a first step, we must recognize that there is actually an ethical dilemma; in this case, the dilemma is whether the patient should proceed with surgery or not, given her underlying medical conditions and potential for perioperative complications. We also need to acknowledge that there is an underlying assumption from all involved (staff, Ms. Jones' family) that surgery will occur, and that health-care providers (HCPs) may not clearly articulate the option of 'no surgical intervention'. The stakeholders who are required to proceed through the decision-making process include the patient and family, the surgical team, anesthesia, nursing staff, social work, and potentially the palliative care team and bioethics team.

Step 2. Identify the Potential Issues Involved

There are several assumptions made when a patient presents to the hospital with a fragility hip fracture: a) the fracture will be repaired; b) the patient will recover; and c) the patient will eventually go home or to rehabilitation. With a critically ill, frail, and/or previously compromised patient, this standard trajectory should be questioned. Barry and Edgman-Levitan⁽⁹⁾ promote an ideology of patient-centredness, with the argument that an intervention should only be considered standard if there is 'virtual unanimity amongst patients about the overall desirability... of the outcomes'.

The first potential issue is the 'standard' intervention of surgical repair—the assumption to proceed with the surgery, as directed by best practice recommendations. Is this standard intervention appropriate in all patients with a fragility hip fracture? A second potential issue arises with the patient and their family—the presumption that the acute medical issue will be resolved and the patient will eventually return home. Given her underlying health, this concept is in jeopardy. To add to the complexity, Ms. Jones is likely not able to articulate her wishes and values, as she has dementia. Finally, there is the potential issue of moral distress experienced by health-care providers (HCPs) who feel uncomfortable with the expectant surgical trajectory of this patient, and may feel they are not empowered to advocate for the wishes of the patient.

As health-care professionals, we are guided by moral principles in our decision-making process, namely, autonomy, non-maleficence, beneficence, justice, fidelity, and veracity.⁽¹⁰⁾ A focused examination and application of the principles to the case study will help to support potential resolutions for the identified issues.

Autonomy

The spirit of 'patient-centred care' endorses that patients should be involved at their level of choice to make an autonomous decision.⁽¹¹⁾ However, it is important to recognize that no decision is made in isolation.⁽¹²⁾ The decision at hand is

not a simple or straightforward one; literature demonstrates that patients and families have a difficult time with making decisions at time of a critical illness, identifying fear, worthlessness, and a lack of autonomy within the hospital system.⁽⁷⁾ Differing levels of patient and family participation requires an individualized approach to convey meaningful, accurate, and timely information.⁽⁸⁾ Older adult patients tend to take a 'non-participative' stance in their care. They often have limited participation in the process for decision-making for a variety of reasons, thereby increasing the risk of their inability to understand or find value within the end decision.^(6,7,13)

Non-maleficence

Hospitalization can cause the patient to experience "needless mental and physical suffering"⁽¹⁴⁾ in any number of ways (i.e., pain, waiting for surgery, uncertainty of outcomes, patient/family relationship stress). Evidence indicates that the number of different HCPs involved causes immense anxiety to the family, especially when they do not hear the same message from all members of the team.^(13,15) HCPs must ensure that they are not withholding information, or are untruthful as to the options in order to expedite a decision. A study by Ekdahl, Andersson, and Friedrichsen⁽¹³⁾ found that physicians perceive they are 'too short' of time for patients to participate in the decision making process, that decisions were 'too complex' and 'time consuming' to fit into the schedule. Ekdahl et al.⁽¹³⁾ also found that physicians feel frustration with the 'health-care production machine', especially in those older adult patients with multiple co-morbidities.

Beneficence

Beneficence promotes wellbeing; or is an action that is carried out to benefit another.⁽⁸⁾ The hospitalization 'process' promotes assessment of a patient, treatment of the illness, followed by a physical approach to recovery (allowing recovery to be measured against specific milestones), and discharge in a timely manner.^(15,16) This 'process' may promote beneficence in an overarching global perspective of the system; however, on an individual level, it often falls short. On an individual level, key actions that have been found to be beneficial and meaningful are open communication and sharing of information.^(6,7,14,17)

Justice

"Practitioners have a responsibility to provide appropriate services to all clients"⁽⁸⁾ Older adult patients may not receive information about options available, especially if the HCPs feel that it would take too much time to thoroughly explain, or if HCPs assume that patients are too ill to participate in the decision-making process,⁽¹³⁾ or if the assumption is made that all patients want to proceed with surgery. Focusing on each older adult's individual health goals is time-consuming—in this case, the patient has dementia, and a family meeting would be required. The concept of patient-centred care revolves around patient and HCP partnerships, yet older adult patients face unique problems with hospitalization—a slower

communication process, a decreased level of functioning, and a degree of family involvement.⁽¹⁴⁾ Can we provide this type of relationship and communication effort equally for every patient? Or only for those patients who may be at higher risk of negative outcomes?

Fidelity and Veracity

Fidelity involves fulfilling ones' professional roles, creating a trusting relationship, and veracity ensures that we are truthful and honest to the patients. How do we ensure that as a HCP we are providing an unbiased opinion? Do we take the same amount of time to present patients with the option of conservative, non-surgical treatment, including palliative care, as we take to advocate for surgery? The HCP team assumes that patients will commit to surgery; however, a patient often displays a suboptimal understanding of the risks and benefits of surgery.⁽¹⁸⁾ Similarly, there is the very real risk of bias towards an argument of palliative care in those frail patients or those with dementia. HCPs must return to the voice of the patient through their family, to understand that patients' identity, their meaning of life, and desired goals which emphasize the patients' dignity.⁽¹²⁾

It is important to acknowledge assumptions that the patient and family may have made upon admission to hospital—that surgery will occur and the patient will recover. Have we presented the patient and their family with as much information as they need to make a decision in a clear format (without medical jargon)? In addition to understanding risks of surgery, it is paramount that the family understands the non-surgical option may result in death or decreased function (if any functional ability returns). It is in an acute situation such as this that families require truthful and open communication with physicians, nurses, and other members of the health-care team.⁽¹¹⁾

Self Care (HCPs)

Can we consistently provide care that prioritizes a patient's values? HCPs are not always able to preserve all of the values and interests at stake.⁽¹⁹⁾ We know that the most common cause of moral distress in nursing is prolonged, aggressive treatment which we do not believe will be likely to have a positive outcome.⁽²⁰⁾ As a HCP, we must look to root causes operating within the larger system, to prevent and/or respond to feelings of moral distress.⁽¹⁹⁾

From a systems perspective, does the hospital provide an avenue for exploration of patient values within a timely fashion? Is there a framework in place to enhance the HCP's understanding of moral distress and provide strategies for coping with situations such as these (i.e., an opportunity for a team debriefing with the entire team, or opportunities for learning how to deal with situations that may cause moral distress)?

Step 3. Review the Relevant Ethics Codes

The philosophy of patient-centred care within the hospital encourages active listening, respect, and an attempt to understand

individuals. The Canadian Medical Association (CMA) supports "practicing the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect".⁽²¹⁾ The College of Nurses of Ontario (CNO) supports the view that nurses "must use the client's views as a starting point".⁽²²⁾ Across all HCPs is the similarity of the need to listen, understand, support, and advocate for a respect of patients' values with the expected course of treatment.

The importance of collaboration with the patient and respecting a patient's values are highlighted within similar statements: "...it is the patient who ultimately must make informed choices about the care he or she will receive".⁽²¹⁾

Step 4. Know the Applicable Laws and Regulations

In Ontario, legislation and common law require that the wishes of patients or substitute decision-makers be respected.⁽²²⁾ However, in many systems, health care is not truly patient-centred; rather, patients are required to adapt to the system.⁽¹¹⁾ A number of initiatives have been undertaken in the last few years in an attempt to improve the focus of patient-centredness, with the principle assertion that patients should be involved at the level of their choice.⁽¹¹⁾

Step 5. Obtain Consultation

It is important to realize that we bring our own biases to the decision-making process, making it difficult to view the current patient/family's situation objectively. As an individual HCP, our previous experiences will have an impact on the messaging that we provide. From a systems perspective, we are likely to pose a 'knowledge' bias towards meeting treatment based outcomes—for example, surgery within 48 hours, immediate post-operative mobility, and the expected length of stay for this type of patient.

Inter-disciplinary consultations with patients and their families ensure review of unbiased information about the risks and benefits of proceeding with surgery, allowing for a fully informed decision. In addition to discussing the operative plan with the surgical team, there is an opportunity to provide Ms. Jones' family with other options that may be available to her. Consultation with extended family members, clergy, social workers, or an ethics team may help the family to reflect on the patient values; what this illness means to them as a family unit, and how best to proceed. A discussion with palliative care may help the family to better understand what symptom management consists of for their mother. Social work may also be able help explore community services available to the family in this situation—for example, is the patient able to return to home with the future of wheelchair dependence? Are there any other options which may be available to this patient and her family that were not originally considered? How do we, as HCPs, ensure that the family is afforded the opportunity to obtain all the necessary information from differing disciplines to make an informed choice?

Step 6. Consider Possible and Probable Courses of Action

In order to fully understand the options, it is helpful to outline all the possible and probable courses of action that are open to Ms. Jones and her family.

1. Surgical team offers a ‘purposeful pause’ to discover Ms. Jones’ core values; to discuss the consequences of a) delaying surgery, b) proceeding with surgery, and c) the non-surgical intervention. From an ethical and legal perspective, this may meet the concept of patient-centred care, but does not likely provide the patient and her family with all the information they need to make an informed choice. They may have more questions that the surgical team may not be able to answer, or they may request more time to consider. Additionally, the patient and her family would still be expected to adapt to the system in place in order to make a decision within the proposed wait time frame (admission to surgery less than 48 hours).
2. Advocate for a family meeting with the primary nurse, social work, palliative care team, clergy, internal medicine, in addition to the surgical (surgeon, anesthesia) team, to fully explore both options, and to explore what the ‘non-surgical’ option would mean. From a legal and ethical perspective this embodies the concept of patient-centred care, with as many members of the health-care team at the table to help Ms. Jones’ family fully explore their options.
3. Apply the current standard of care recommendations to Ms. Jones’ situation, without consideration of the patient’s needs, values, or preferences. From an ethical and legal perspective, this approach does not represent patient-centred care.

Step 7. Enumerate the Consequences of Various Decisions

With the first option, the surgical team takes a ‘purposeful pause’ to discover the patient’s core values and discusses pros and cons of a surgical intervention. Often, this may be most ‘efficient’ way to deal with the situation at hand. It may also be the preference of the patient; some patients have reported that they value this limited level of involvement—“I get a description of what is going to happen”.⁽¹³⁾ As a consequence, there will be a number of patients who will want to have a greater sense of involvement other than a simple description of planned events. The first option does recognize the principle of autonomy, but does not follow the principle of justice; practitioners have the responsibility to provide information about other options which may be available. The principles of beneficence and non-maleficence are not completely met, as the team approaches the solution primarily to benefit the system (i.e., efficiency). The principles of fidelity and veracity are also partially met, as the surgical team provides an honest perspective, although it may be biased towards proceeding with surgery.

The second option, offering the patient and her family a meeting with all stakeholders, strongly aligns with the fidelity and veracity principles. The information offered is truthful and complete, and is in Ms. Jones’ best interest, as it attempts to discover her values that will affect the family’s final decision. Principles of beneficence and autonomy would be met with patient empowerment through information sharing, and secondly, by allowing the patient and family to arrive at their own decision with that information. As a consequence, taking the time to arrange for a family meeting with all stakeholders may not be possible for all patients, and the principles of justice and non-maleficence are brought to the forefront for future patients. A potential consequence could be harm to the patient, as the time it takes to arrange a meeting could push the time to surgery beyond the recommended 48 hours post-admission, placing the patient at greater risk of negative post-operative outcomes.

The third option is one of passive action, with a lack of communication and recognition of patient-centred care values. Ms. Jones would be placed on the operating room list, and the surgical repair will occur. Consent must legally be obtained for the surgery; however, the family may not think of key questions to ask that may be relevant in this situation. The onus remains on the HCP to provide a full explanation of all options to the family. The only benefit would be to the system, as the procedure will be carried out in a timely manner. Ms. Jones may benefit from the surgery; we cannot assume that surgery is a negative option. As a consequence of this option, HCPs do not explore patient values, and this option is against almost all of the ethical principles. Additionally, this option is likely to cause the highest moral distress amongst staff, as they are unable to meet the unique needs of Ms. Jones and her family.

Step 8. Choose what Appears to be the Best Course of Action

Virtue ethics asks us if we are doing the best action for our patients, and compels us to be conscious of our behaviours.⁽⁸⁾ We need to take the necessary time to discover the patient’s values within the unique situation they are now experiencing. Simply stated, we need to remember that they are a person, with feelings, emotions, past experiences, future hopes/plans, and usually an element of fear and anxiety. The goal is to work with Ms. Jones and her family to decide together on the current care plan and the best plan for action (or inaction), a plan that truly aligns with the patient’s values.

From an ethical perspective, the best course of action is to hold a family meeting with all stakeholders to discover Ms. Jones’ values about a meaningful life and a meaningful death, and come to a consensus as to what the right decision is for this patient.⁽¹²⁾ The team must ensure that the patient and the family have all the necessary tools in which to make this decision. Have we provided them with all the information required? Do they understand the information?

Do they understand the consequences of their decision? From a systems perspective, we need to continue to strive towards engaging patients and family members more fully and consistently in care and decision-making processes.⁽⁶⁾ Dissemination of lessons learned from assisting patients and families through difficult decision-making may be helpful to other health-care teams experiencing similar moral conflicts.

As a next step, the HCP team may consider development of an educational reference for future patients to assist with similar decisions, including promotion of an advanced care plan to help communicate goals and concerns to HCPs.^(12,18) Additionally, decision aids, such as videos and brochures, can help deliver information to patients and their families.⁽⁹⁾ The use of readily available technology, such as iPads and cellphones, means that families are better able to access these materials at any time of day. A recent Cochrane Review demonstrated that, in comparison to usual care, decision aids can increase knowledge, resulting in a higher proportion of patients choosing the option which most aligns with their values.⁽²³⁾ Providing patients with information that outlines potential options with risks and benefits clearly explained can also meet many of the ethical principles that are to be considered with ethical decision-making.

CONCLUSION

The in-depth review of the case study has helped us to examine the underlying issues that come into play when helping this patient and her family to make a critical decision. Although each patient is an individual, literature tells us that many perceive the concept of patient-centredness to represent an ‘involvement in their care’. The level of involvement may vary from person to person, but all patients want the care they receive to reflect their values and preferences, and to make them feel that they have been treated as a whole person.⁽²⁴⁾

Clinicians also like to believe that they deliver patient-centred care, yet the characterization of the concept will vary with the health-care provider, their relationship with the patient, and the circumstances surrounding the admission to hospital. Recognizing that there is potential for an ethical dilemma when patients present with a critical illness is important to ensure that we continue to act upon the key concept of understanding a patient’s values and proceeding to align provision of care with those values.

ACKNOWLEDGEMENTS

The author wishes to acknowledge Dr. Tracy Trothen (Queen’s University) for her time and expertise as a ‘practical ethicist’.

CONFLICT OF INTEREST DISCLOSURES

The author declares that no conflicts of interest exist.

APPENDICES

Appendix A: Framework for Ethical Decision-Making (Corey *et al.*, 2014)

1. Identify the problem or dilemma
2. Identify the potential issues involved
3. Review the relevant ethics codes
4. Know the applicable laws and regulations
5. Obtain consultation
6. Consider possible and probable courses of action
7. Enumerate the consequences of various decisions
8. Choose what appears to be the best course of action

REFERENCES

1. Health Quality Ontario. Quality Standards: Hip Fracture Care for People with Fragility Fractures. Toronto, ON: Health Quality Ontario; 2017.
2. Brener S. Optimal Timing for Hip Fracture Surgery: a Rapid Review. Available from: <http://www.hqontario.ca/Portals/0/Documents/evidence/rapid-reviews/hip-fracture-surgery-optimal-timing-130419-en.pdf>
3. Reuben DB, Tinetti ME. Goal-oriented patient care—an alternative health outcomes paradigm. *New Eng J Med.* 2012;366(9):777–79.
4. Duggan PS, Geller G, Cooper LA, *et al.* The moral nature of patient-centeredness: Is it “just the right thing to do”? *Patient Edu Counsel.* 2006;62(2):271–276.
5. Edvardsson D, Innes A. Measuring person-centered care: a critical comparative review of published tools. *Gerontologist.* 2010;50(6):834–46.
6. Toscan J, Manderson B, Santi S, *et al.* “Just another fish in the pond”: the transitional care experience of a hip fracture patient. *Int J Integrat Care.* 2013;13(2).
7. Bridges J, Flatley M, Meyer J. Older people’s and relatives’ experiences in acute care settings: systematic review and synthesis of qualitative studies. *Int J Nurs Stud.* 2010;47(1):89–107.
8. Corey G, Corey C, Corey MS, *et al.* Issues and Ethics in the Helping Professions, 9th ed. Stamford, CT: Brooks/Cole Cengage Learning; 2014.
9. Barry MJ, Edgman-Levitan S. Shared decision making—the pinnacle of patient centered care. *New Eng J Med.* 2012;366(9):780–81.
10. Beauchamp TL, Childress JF. Principles of Biomedical Ethics, 5th ed. Oxford, UK: Oxford University Press; 2001.
11. Ontario Medical Association. OMA Policy Paper: Patient Centred Care. Toronto, ON: OMA; 2010.
12. Holstein MB, Parks JA, Waymack MH. Ethics, Aging, and Society: the Critical Turn. New York: Springer Publishing Company; 2011.
13. Ekdahl AW, Andersson L, Friedrichsen M. “They do what they think is the best for me.” Frail elderly patients’ preferences for participation in their care during hospitalization. *Patient Edu Counsel.* 2010;80(2):233–40.
14. Huckstadt AA. The experience of hospitalized elderly patients. *J Gerontological Nurs.* 2002;28(9):24–29.

15. Lilley EJ, Bader AM, Cooper Z. A values based conceptual framework for surgical appropriateness: an illustrative case report. *Ann Palliative Med.* 2015;4(2):54–57.
16. Healee DJ, McCallin A, Jones M. Older adult's recovery from hip fracture: a literature review. *Int J Orthopaed Trauma Nurs.* 2011;15(1):18–28.
17. Eldh AC, Ekman I, Ehnfors M. A comparison of the concept of patient participation and patients' descriptions as related to healthcare definitions. *Int J Nurs Terminol Classificat.* 2010;21(1)21–32.
18. Murthy S, Hepner DL, Cooper Z, *et al.* Controversies in anaesthesia for noncardiac surgery in older adults. *Br J Anaesthesia.* 2015;115(S2):15–25.
19. Varcoe C, Pauly B, Webster G, *et al.* Moral distress: tensions as springboards for action. *HEC Forum.* 2012;24(1):51–62.
20. Epstein EG, Hamric AB. Moral distress, moral residue and the crescendo effect. *J Clin Ethics.* 2009;20(4):330.
21. Canadian Medical Association. CMA Code of Ethics. Ottawa, ON: Canadian Medical Association; 2012. Available from: <http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>
22. College of Nurses of Ontario. Ethics. Toronto, ON: CNO; 2009. Available from: http://www.cno.org/globalassets/docs/prac/41034_ethics.pdf
23. Stacey D, Legare F, Col NF, *et al.* Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev.* 2014;CD001431.
24. Laupacis A, Gibson J. “Patient-centred”—what does it mean and how achievable is it? [Healthydebate.ca](http://healthydebate.ca) [website]; 2015 Available from: <http://healthydebate.ca/opinions/patient-centred-mean-achievable>

Correspondence to: Lynn Haslam, RN(EC), PhD(c), Department of Rehab Science, Aging & Health Program, Queen's University, Louise D. Acton Bldg., 31 George St., Kingston, ON K7L 3N6

E-mail: lynn.haslamlarmer@queensu.ca