

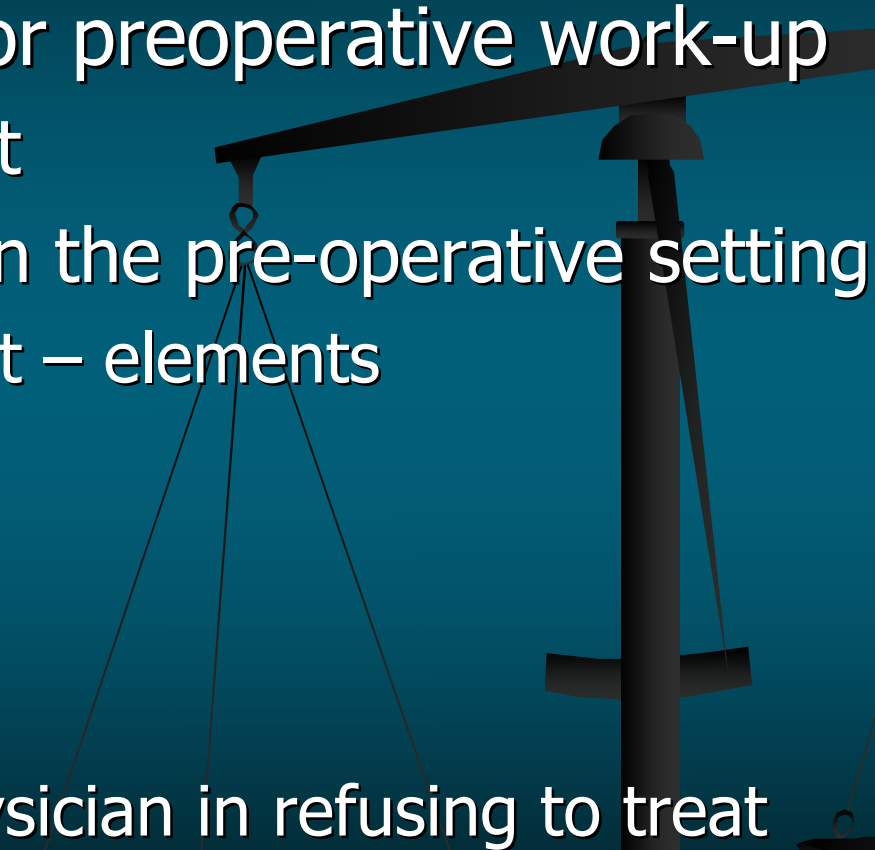


POS teaching 9

March 2011

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Stony Brook University Medical Center – Home of the best ideas in medicine.

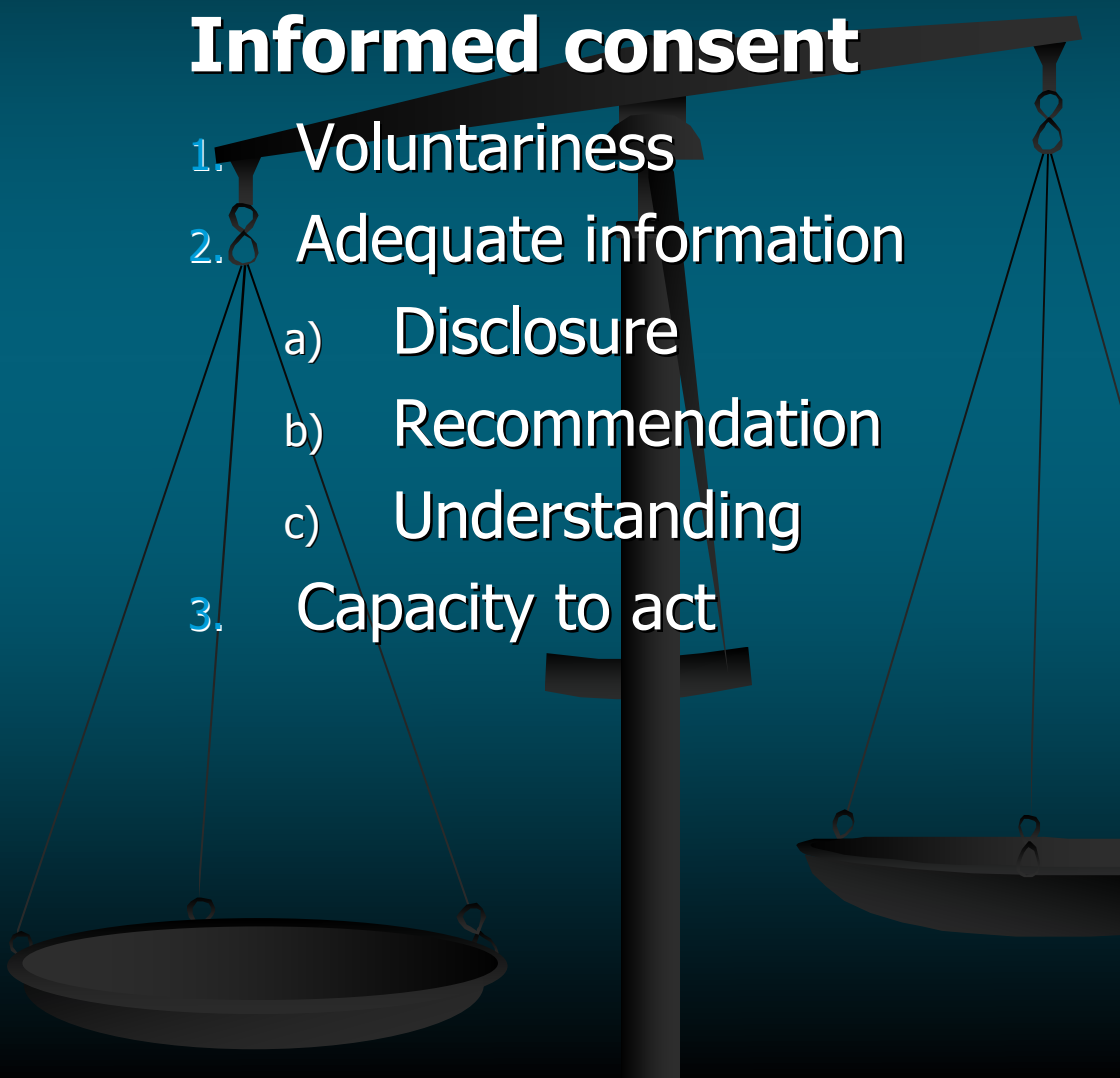
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- AHA guidelines for preoperative work-up
 - Airway assessment
 - Ethical dilemmas in the pre-operative setting
 - Informed consent – elements
 - Voluntariness
 - Information
 - Capacity
 - Informed refusal
 - Rights of the physician in refusing to treat

Review of last week

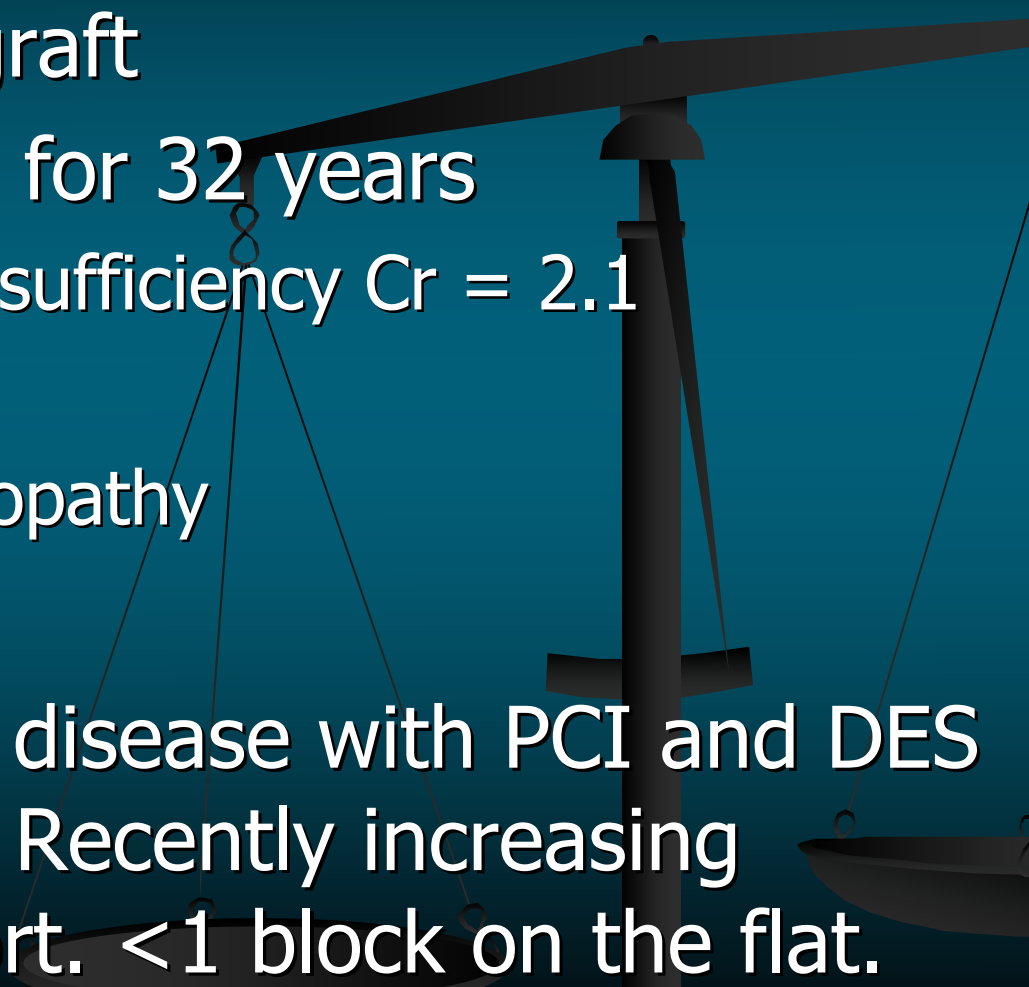
Ethical Principles

- Autonomy
- Beneficence
- Non-maleficence
- Justice

Informed consent

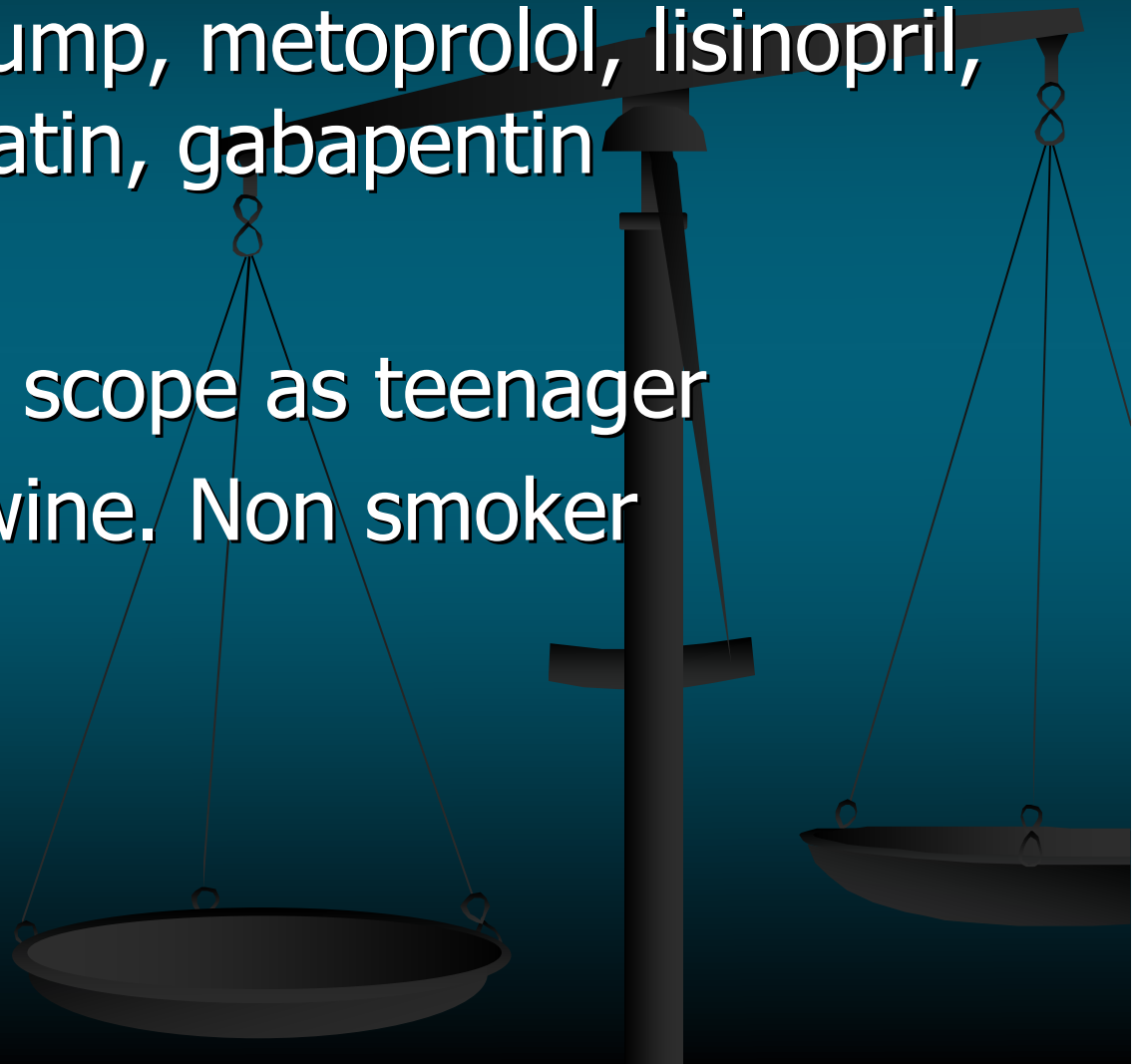
1. Voluntariness
 2. Adequate information
 - a) Disclosure
 - b) Recommendation
 - c) Understanding
 3. Capacity to act
- 

Case 2

- 58 yr old physician presents for removal of infected aortic graft
 - Type 1 diabetes for 32 years
 - Chronic renal insufficiency Cr = 2.1
 - Gastroparesis
 - Peripheral neuropathy
 - HTN
 - Coronary artery disease with PCI and DES 22 months ago. Recently increasing dyspnea on effort. <1 block on the flat.
- 

History (cont)

- Meds: Insulin pump, metoprolol, lisinopril, aspirin, simvastatin, gabapentin
- Penicilin allergy
- PSH: AAA, knee scope as teenager
- Social glass of wine. Non smoker



Exam:

- Ht 5.9, Wt 180lbs
- BP 125/70, P 62
- No edema, JVD or crackles in lungs.
- S1S2
- Abdominal scar – no organomegaly
- Diminished pedal pulses, trophic change on legs

MP 2, ant upper caps, FROM, thyromental distance > 3 finger breadths, interincisor distance > 2 finger breadths

Airway Exam

- C-spine
- Neck – soft tissue (profile)
 - Short
 - Thick
 - Masses
 - Compliance
- Beard
 - Mask ventilation
- Teeth
 - Buck
 - False
 - Loose/decaying/missing
- Tongue
 - Relative
- Mallampati

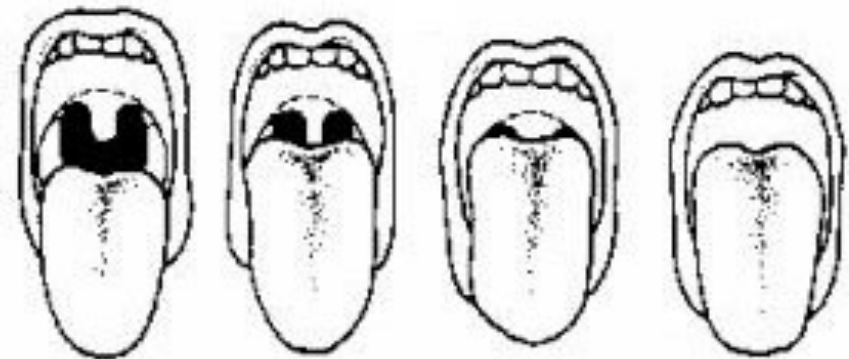


Mallampati classification

(Mallampati et al, CJA 1985)



Figure 2: Mallampati views

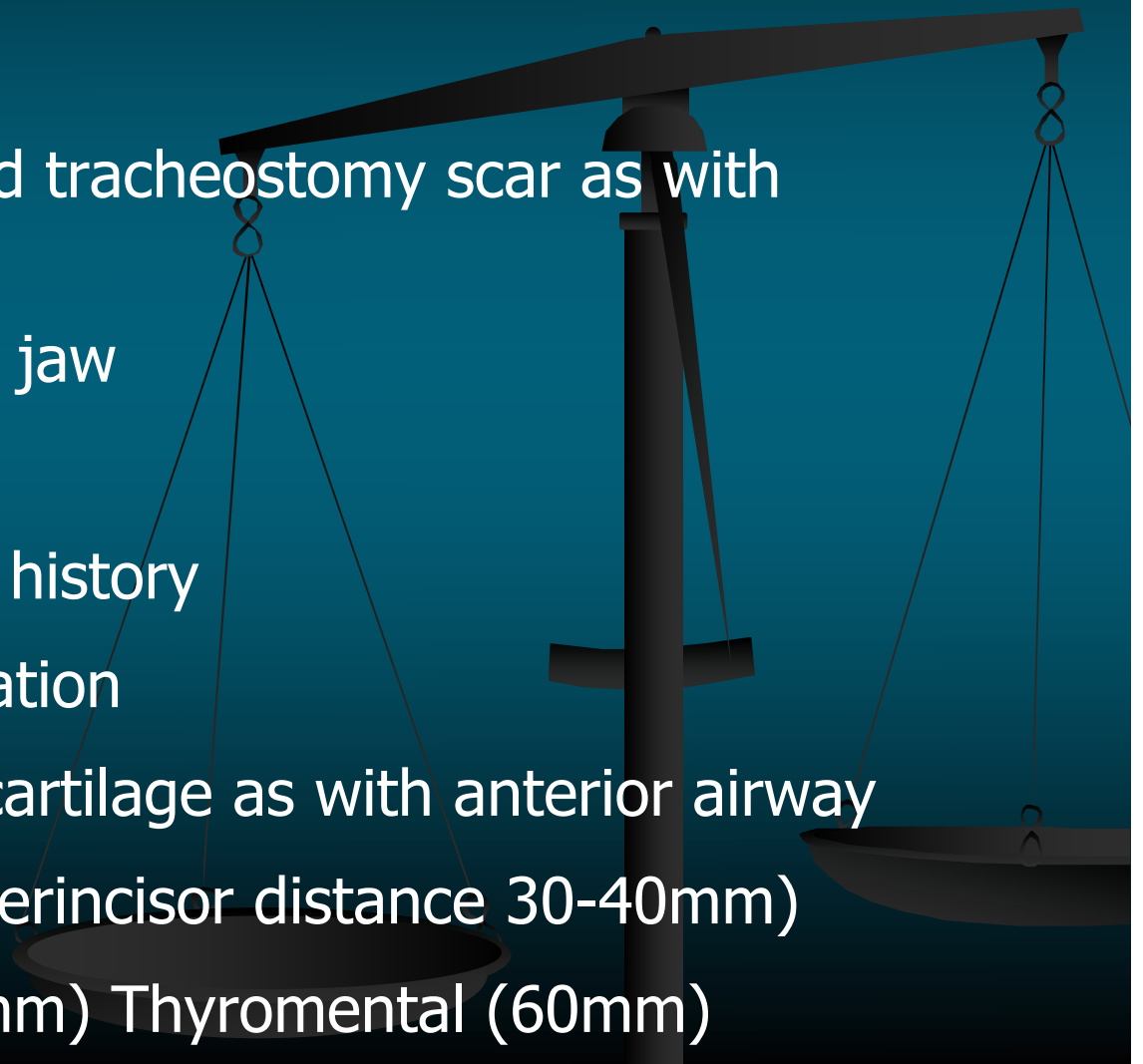


Class 1 **Class 2** **Class 3** **Class 4**

Class I: soft palate, fauces, uvula, pillars
Class II: soft palate, fauces, portion of uvula
Class III: soft palate, base of uvula
Class IV: hard palate only

Airway Exam

- Jaw
 - TMJ disease
 - Receding mandible
- Scars such as an old tracheostomy scar as with tracheal stenosis
- History of fractured jaw
- Hoarseness
- Previous intubation history
- External beam radiation
- Prominent thyroid cartilage as with anterior airway
- Mouth opening (Interincisor distance 30-40mm)
- Hyomental (30-40mm) Thyromental (60mm)



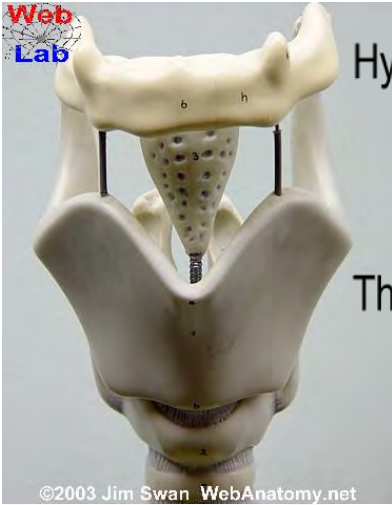


Micrognathia



Prominent / anterior larynx

Web
Lab



Hyoid bone

Thyroid cartilage

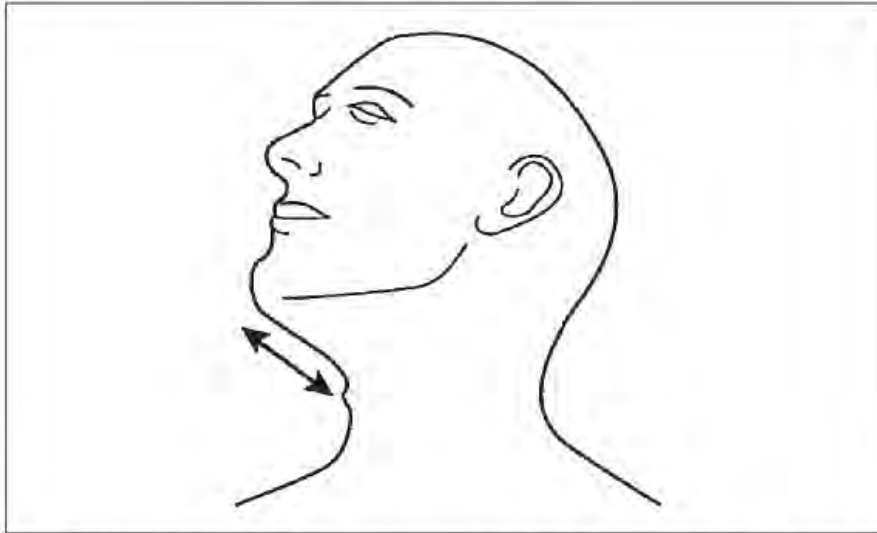


Figure 1.2 Line shows the thyromental distance from the thyroid cartilage to the tip of the chin.

Thyromental distance
(>3 finger breadths)

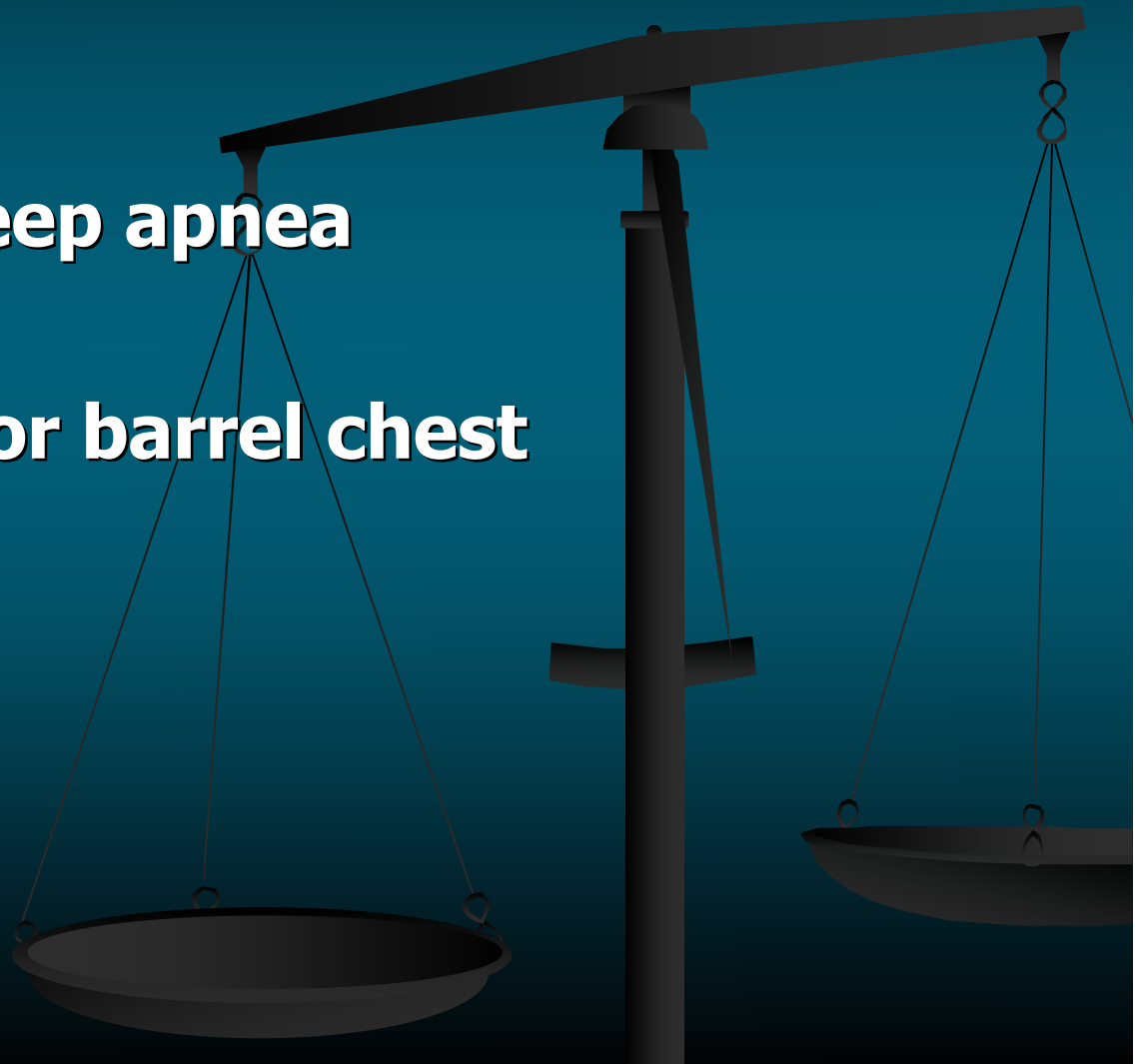
Distance from the thyroid cartilage to the mental prominence when the neck is extended fully.

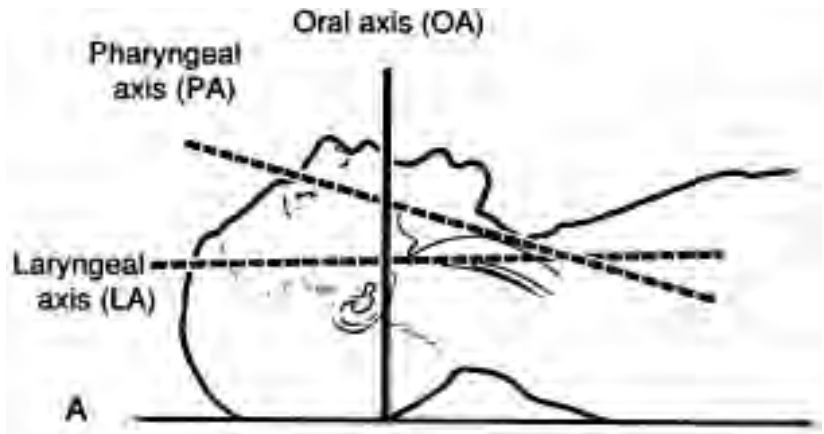


Interincisor distance
(>2 finger breadths)

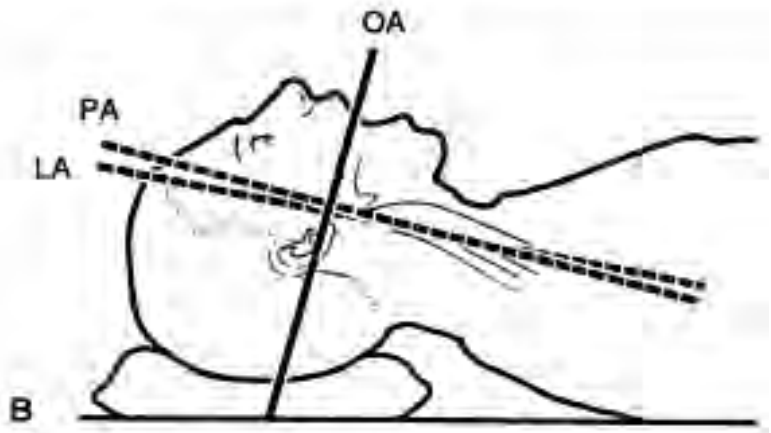
Airway Exam

- **Obesity**
- **Reflux disease**
- **Obstructive sleep apnea**
- **Syndromes**
- **Large breasts or barrel chest**

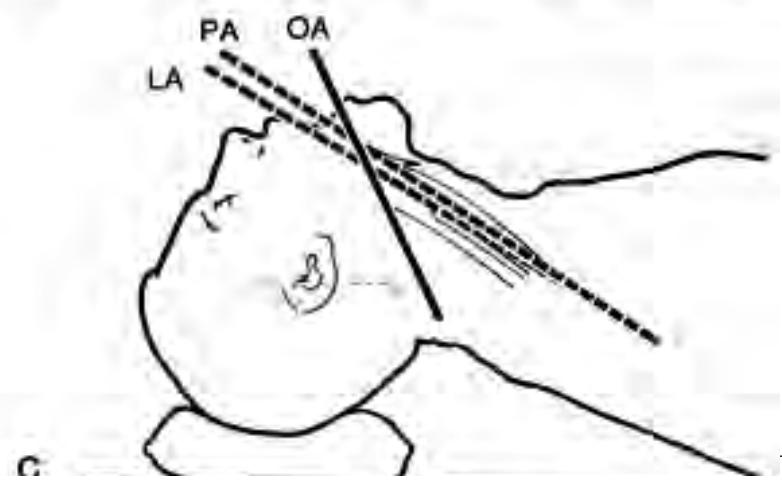




A



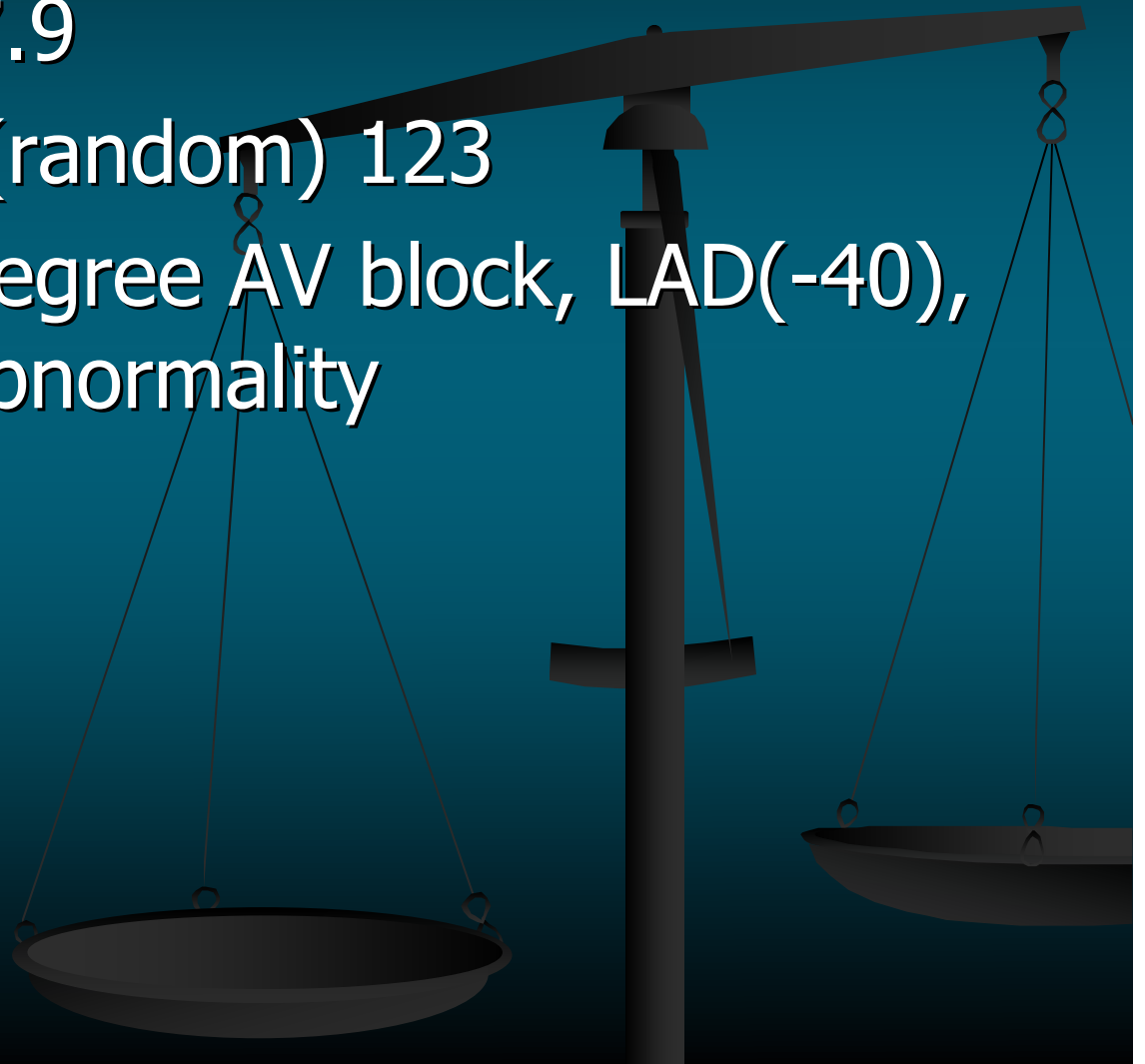
B



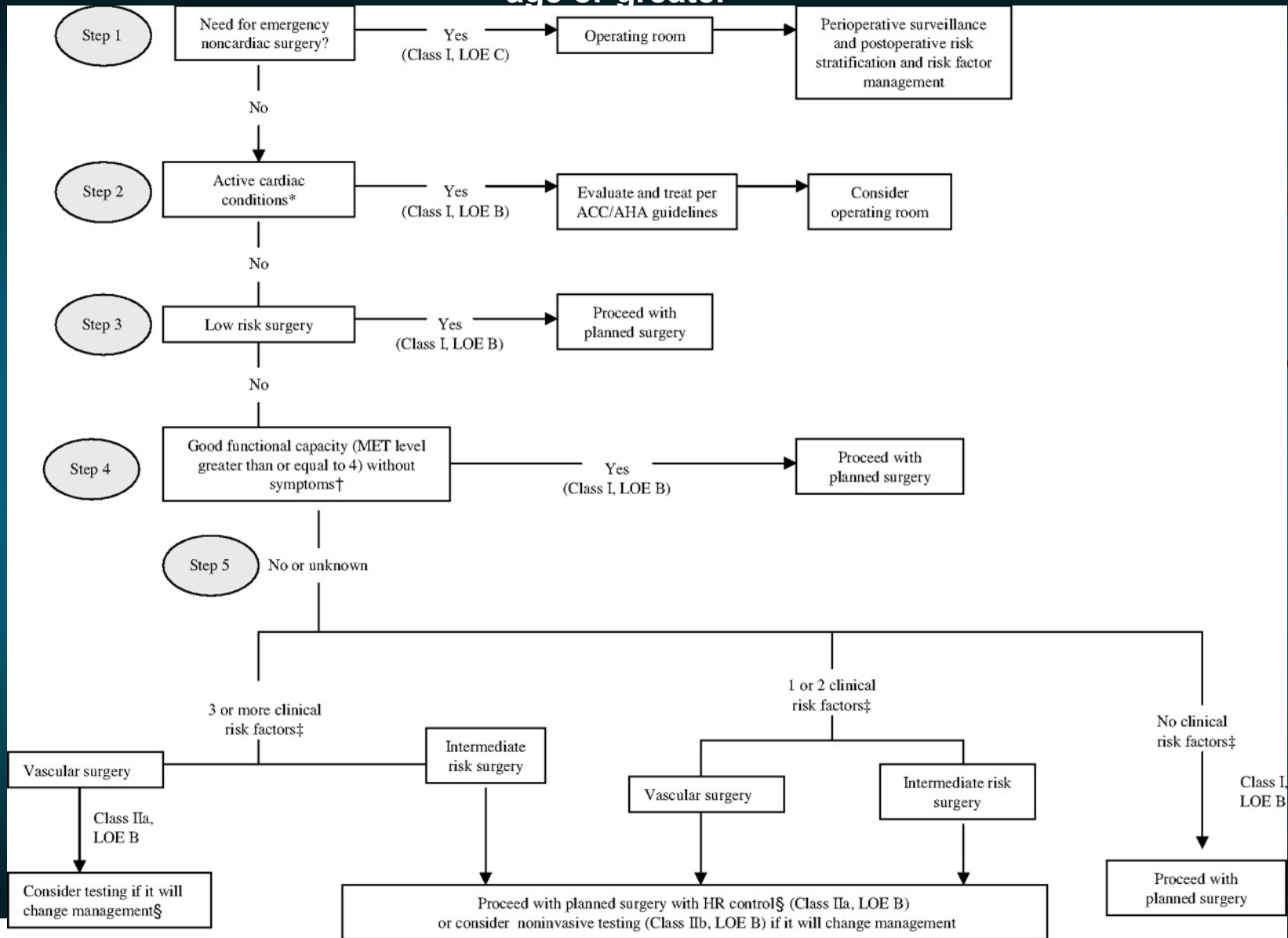
C

Labs

- Hb 11.8, WCC 7.9
- Cr 2.1, Glucose(random) 123
- ECG: NSR, 1st degree AV block, LAD(-40), no Q's, no ST abnormality



Cardiac evaluation and care algorithm for noncardiac surgery based on active clinical conditions, known cardiovascular disease, or cardiac risk factors for patients 50 years of age or greater



***Active Cardiac Conditions for Which the Patient Should Undergo Evaluation and Treatment Before Noncardiac Surgery (Class I, Level of Evidence: B)**

Condition

- Unstable coronary syndromes
- Decompensated HF
- Significant arrhythmias

- Severe valvular disease (progressive dyspnea on exertion, exertional presyncope, or HF)

Examples

- Unstable or severe angina* (CCS class III or IV) †
- Recent MI‡

- (NYHA functional class IV; worsening or new-onset HF)

- High-grade atrioventricular block
- Mobitz II atrioventricular block
- Third-degree atrioventricular heart block
- Symptomatic ventricular arrhythmias
- Supraventricular arrhythmias (including atrial fibrillation) with uncontrolled ventricular rate (HR greater than 100 beats per minute at rest)
- Symptomatic bradycardia
- Newly recognized ventricular tachycardia

- Severe aortic stenosis (mean pressure gradient greater than 40 mm Hg, aortic valve area less than 1.0 cm², or symptomatic)
- Symptomatic mitral stenosis

*According to Campeau.⁹

†May include "stable" angina in patients who are unusually sedentary.

‡The American College of Cardiology National Database Library defines recent MI as more than 7 days but less than or equal to 1 month (within 30 days).

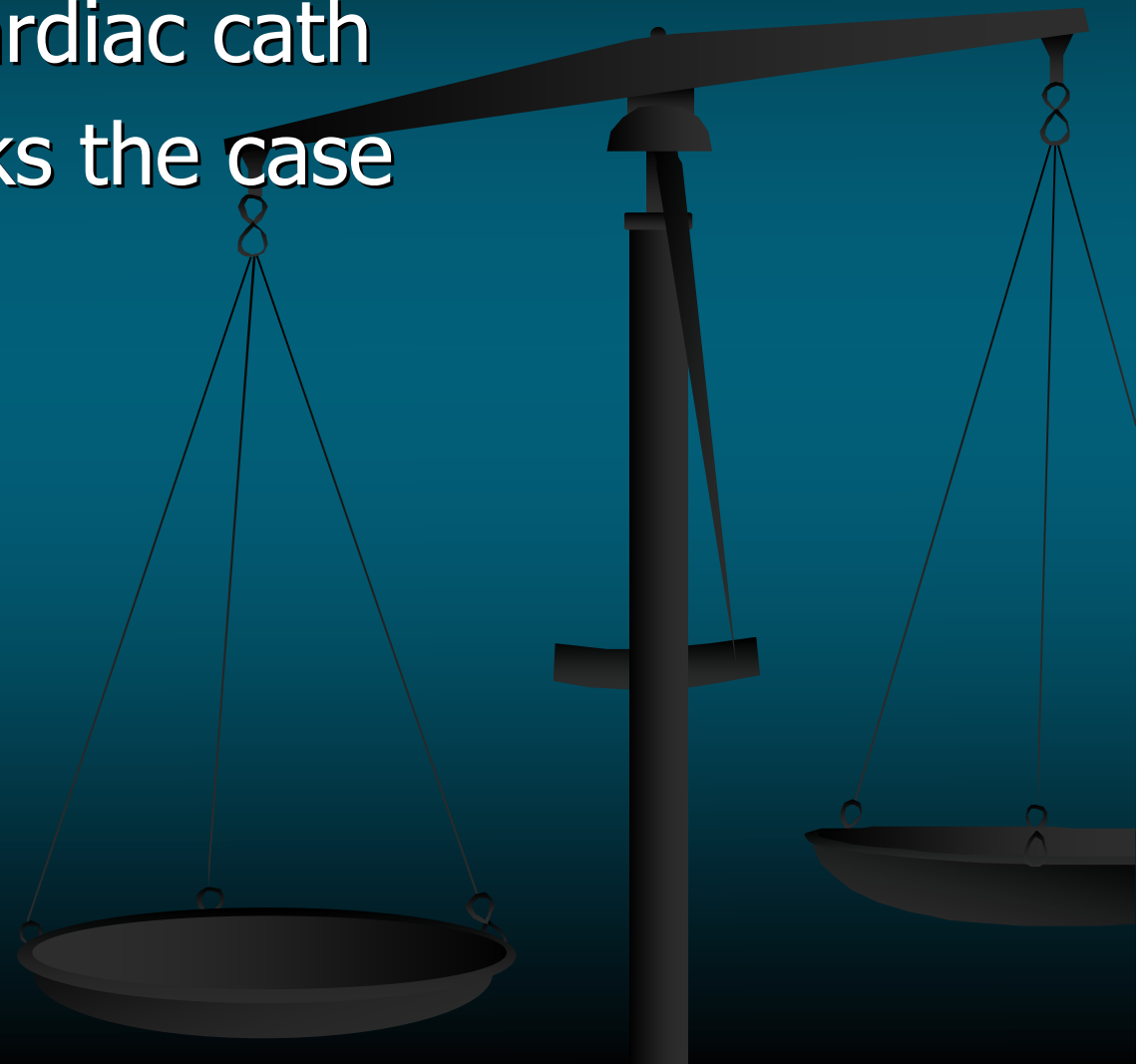
•CCS indicates Canadian Cardiovascular Society.

Assessment

- Active cardiac condition
- For vascular surgery
- Stress or cath?
- ASA 3



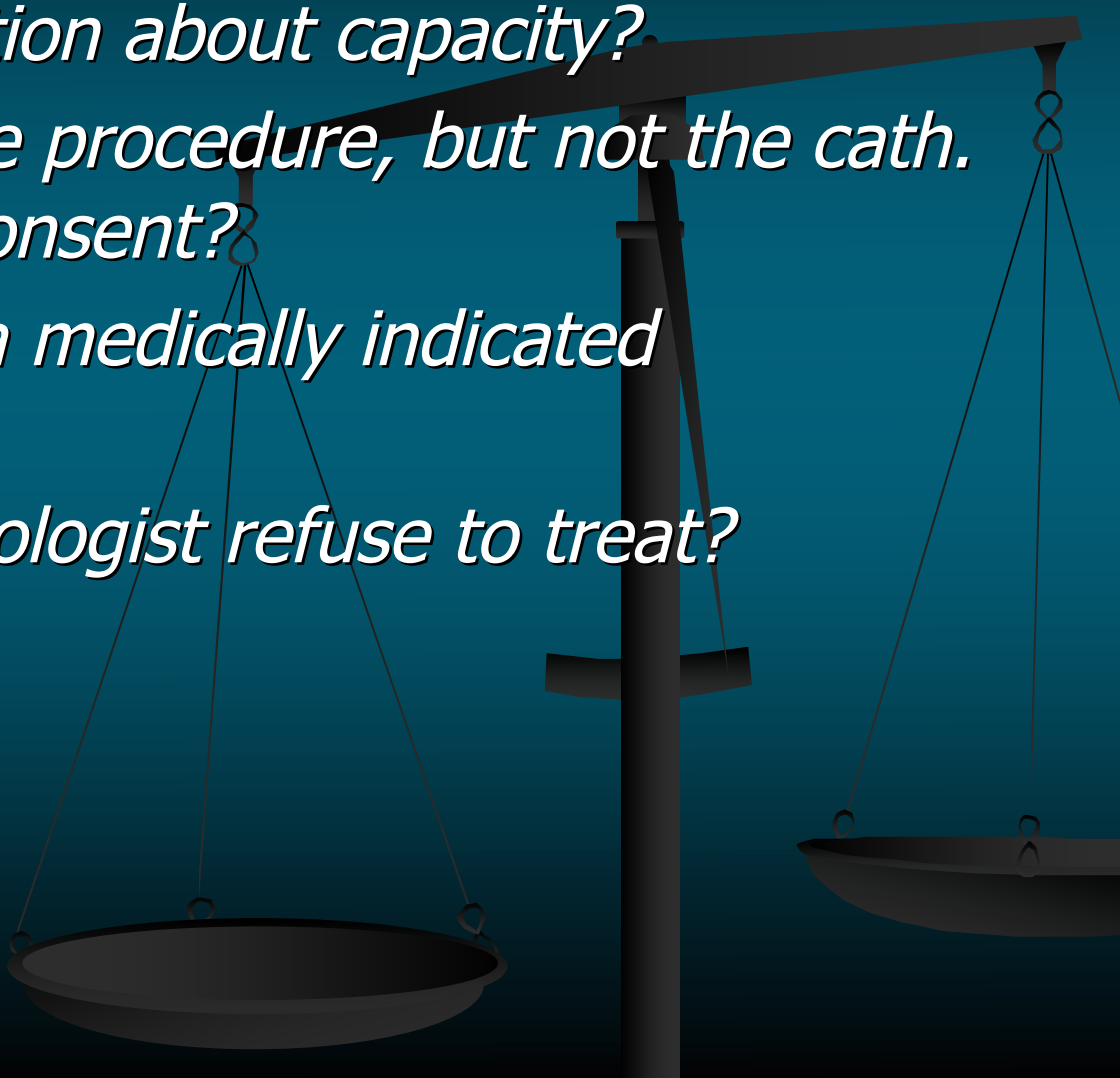
Patient refuses cardiac cath
The surgeon books the case





The assigned anesthesiologist reviews the chart the night before surgery, and citing his high cardiac risk and inadequate pre-op evaluation:

He cancels the case.

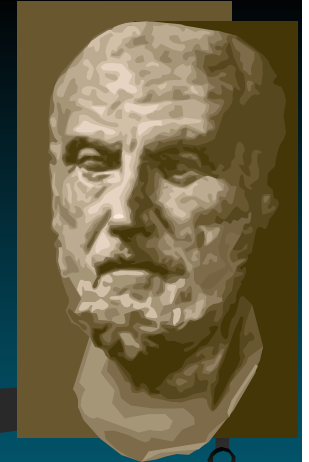
- 
- *Is there any question about capacity?*
 - *He consents to the procedure, but not the cath. Is this informed consent?*
 - *Can he refuse to a medically indicated catheterization?*
 - *Can the anesthesiologist refuse to treat?*

Informed consent

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body."

New York Supreme Court Justice Benjamin N. Cardozo
in response a medical malpractice suit 1914

What ethical principle is this?



1847 Code of AMA: "when pestilence prevails, it is [physicians'] duty to face the danger, and to continue their labors for the alleviation of the suffering, even at the jeopardy of their own lives."

1986 Code Principle VI: "A physician shall ... be free to choose whom to serve...."

May a physician refuse to treat?

- In an emergency – No
Treat to best of your ability

Principle – people have a right to health care

Physicians have a monopoly on providing health care

Therefore physicians have a moral duty to provide health care

Was the anesthesiologist acting legally and ethically when canceling the case?

Legal



- Emergency Medical Treatment and Active Labor Act (EMTALA 1986)
- Section 504 of the Rehabilitation Act of 1973 prevents a physician from excluding someone with a disability
- Americans With Disabilities Act of 1990
 - Specifies contagious disease
 - Asymptomatic HIV is a disability
 - *Bragdon v. Abbott* 1998

Ethical



The American Medical Association Council of
Ethical and Judicial Affairs

May refuse if:

“A specific treatment sought by an individual is incompatible with the physician’s personal, religious, or moral beliefs.”

May a physician refuse to treat?

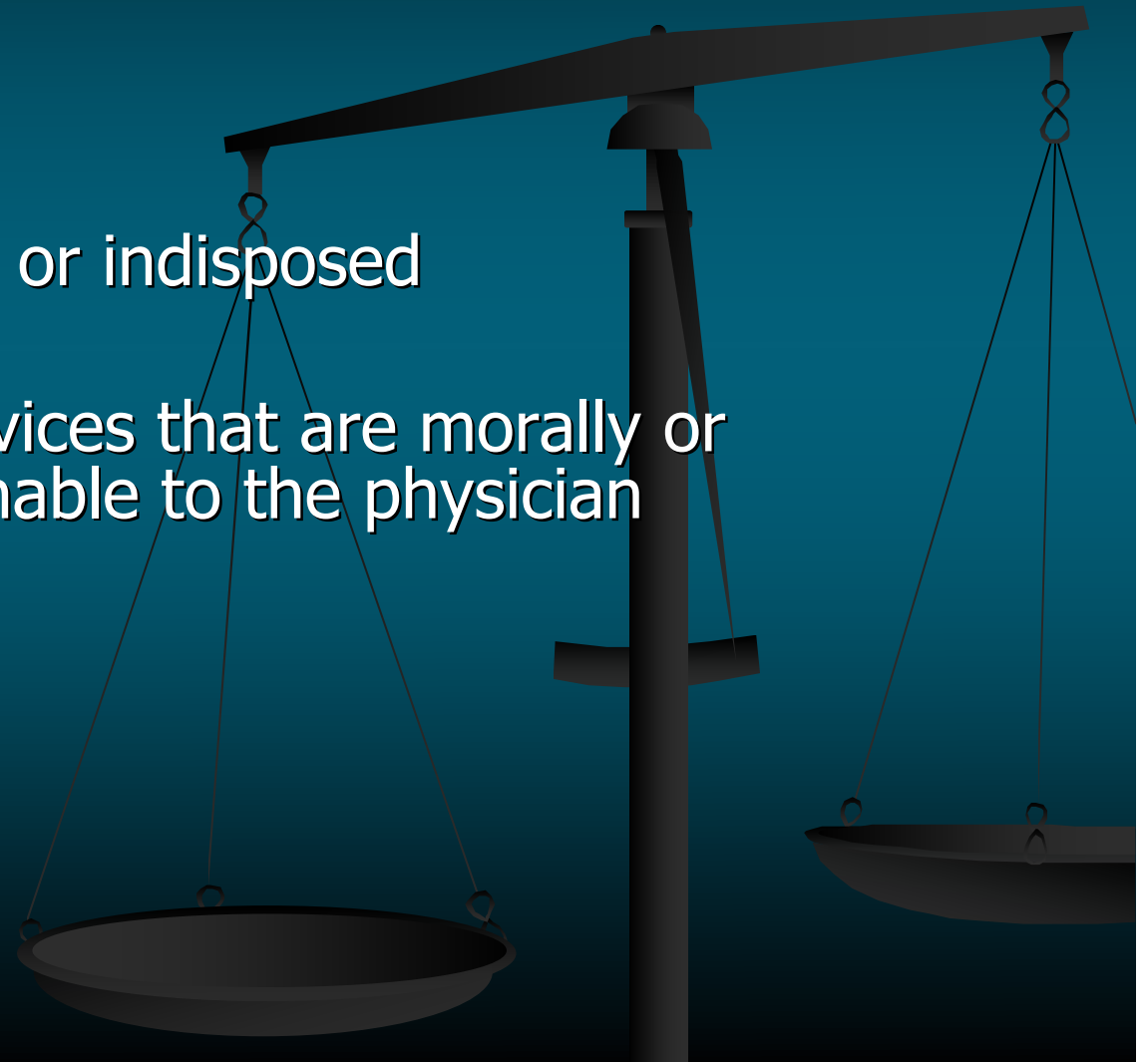
Is there an established relationship?

- If yes – obliged to treat otherwise can be considered abandonment
 - Ethically wrong
 - Illegal
- If no – do not have to initiate care, but unethical to refuse to treat on basis of bias against protected minorities

When is it acceptable to terminate a relationship with a patient?

Physician factors:

- physician is retiring or indisposed
- patient seeking services that are morally or religiously objectionable to the physician

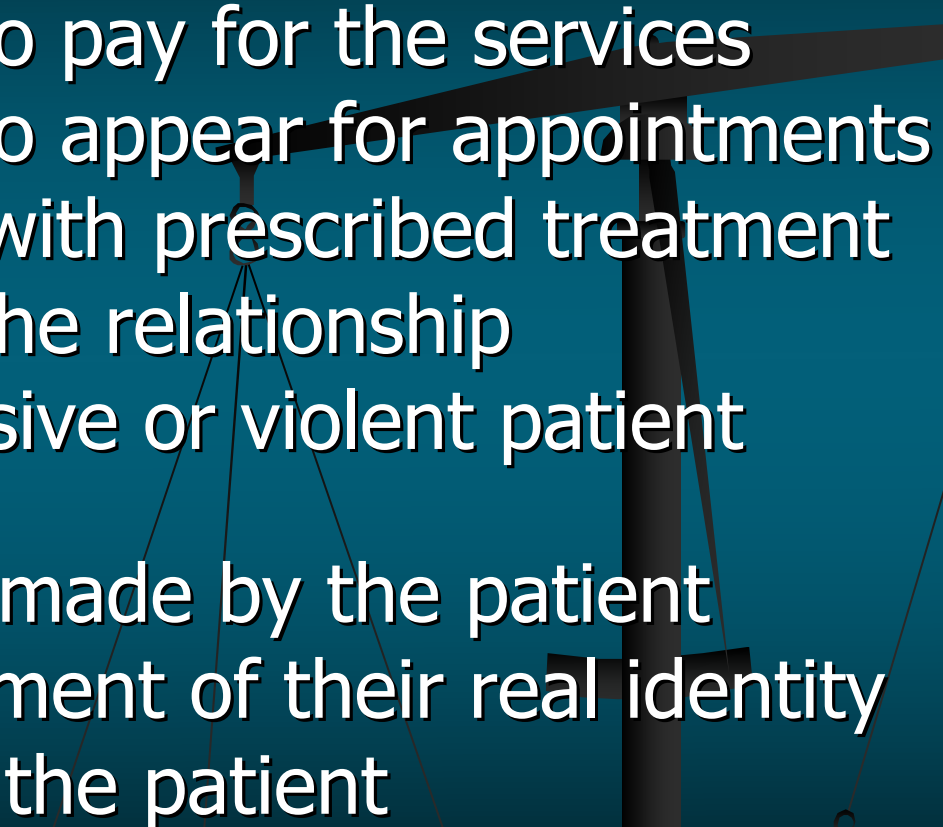


When can a physician refuse to treat?

Patient Factors:



The drunken or drugged patient

- 
- patient's failure to pay for the services
 - patient's failure to appear for appointments
 - non-compliance with prescribed treatment
 - a breakdown in the relationship
 - threatening, abusive or violent patient behavior
 - sexual advances made by the patient
 - patient's concealment of their real identity
 - fraud or theft by the patient

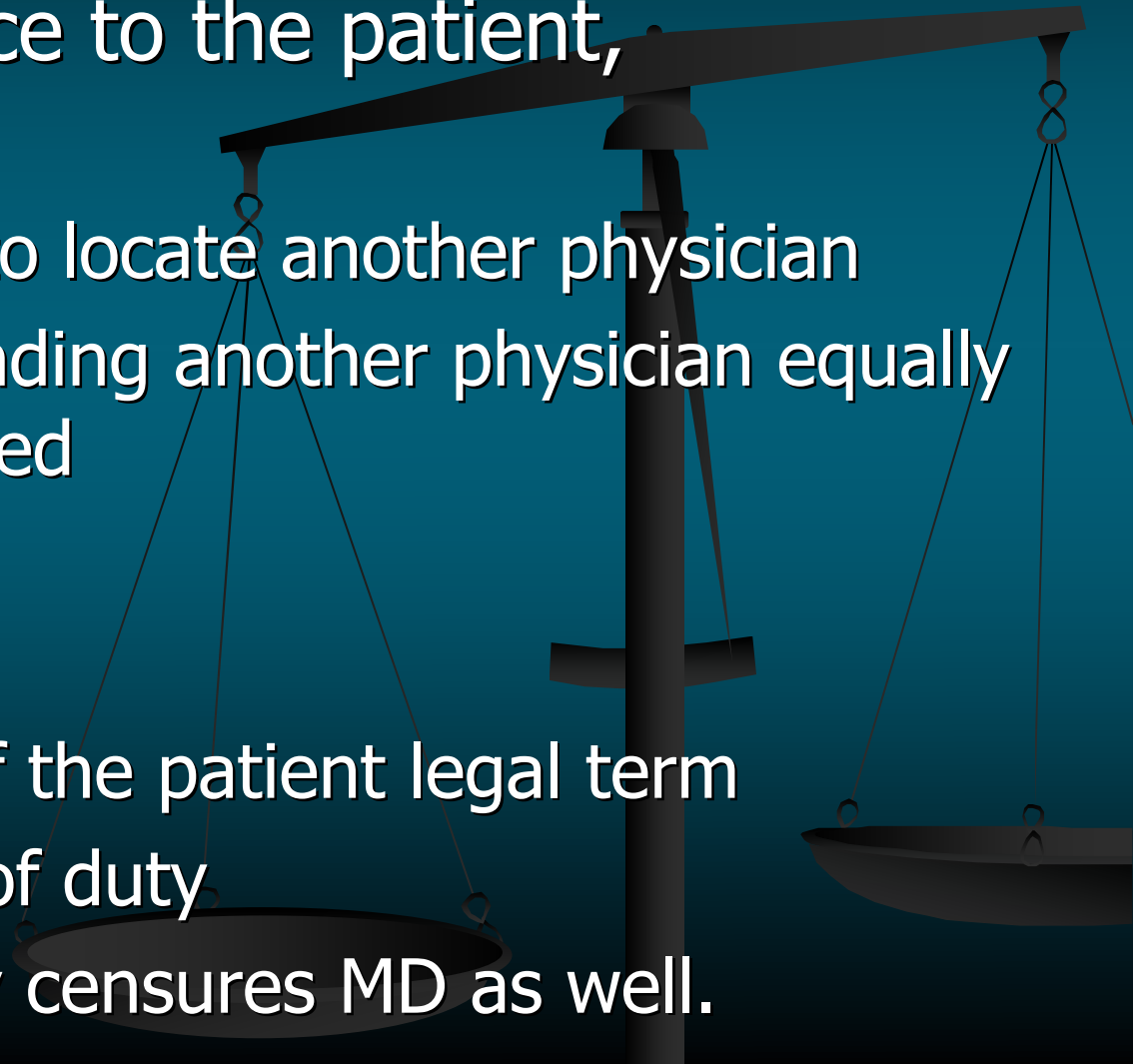
Ending relationship

- reasonable notice to the patient,
 - in writing
 - sufficient time to locate another physician
 - assistance in finding another physician equally or better qualified

'Abandonment' of the patient legal term

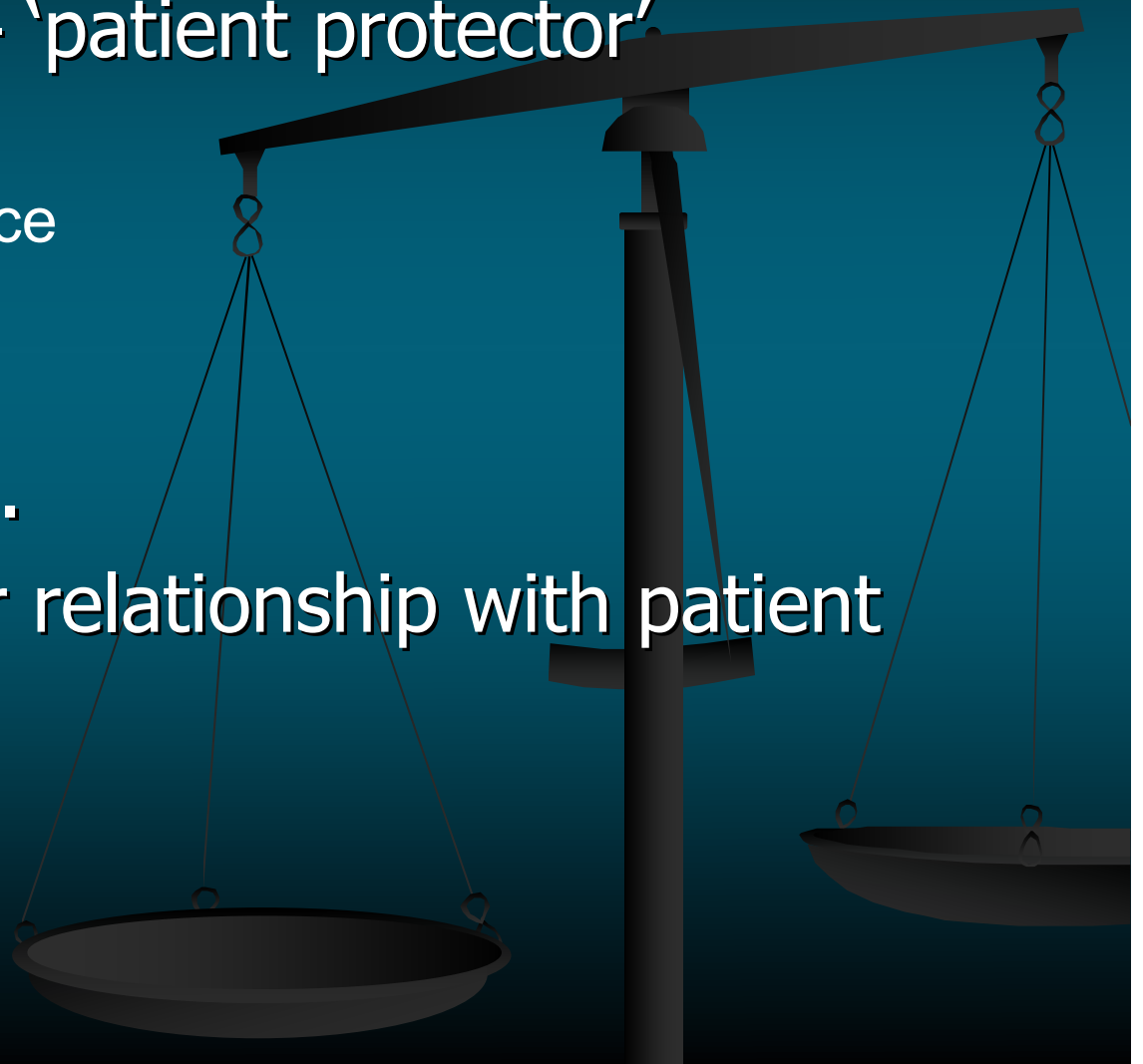
Ethical – breach of duty

Professional body censures MD as well.



Anesthesiologist

- Traditional role – ‘patient protector’
 - Beneficence
 - Non- maleficence
 - Autonomy
 - Justice
- Stopping the line.
- Typically no prior relationship with patient



Anesthesiologist

One time event

Needs to be made clear

No further obligations



Anesthesiologist



- Hospital employee.
- Assigned to provide a professional service

In this case, the surgeon and the patient have already agreed to accept a substantial surgical risk, for the benefit of infection control. Can the anesthesiologist-employee refuse to participate on the grounds of "riskiness" alone, without being paternalistic?

An argument can be made that the anesthesiologist in this case has a **contractual obligation** to treat this patient.

Refusing to anesthetize under these circumstances is considered misconduct by some institutions.

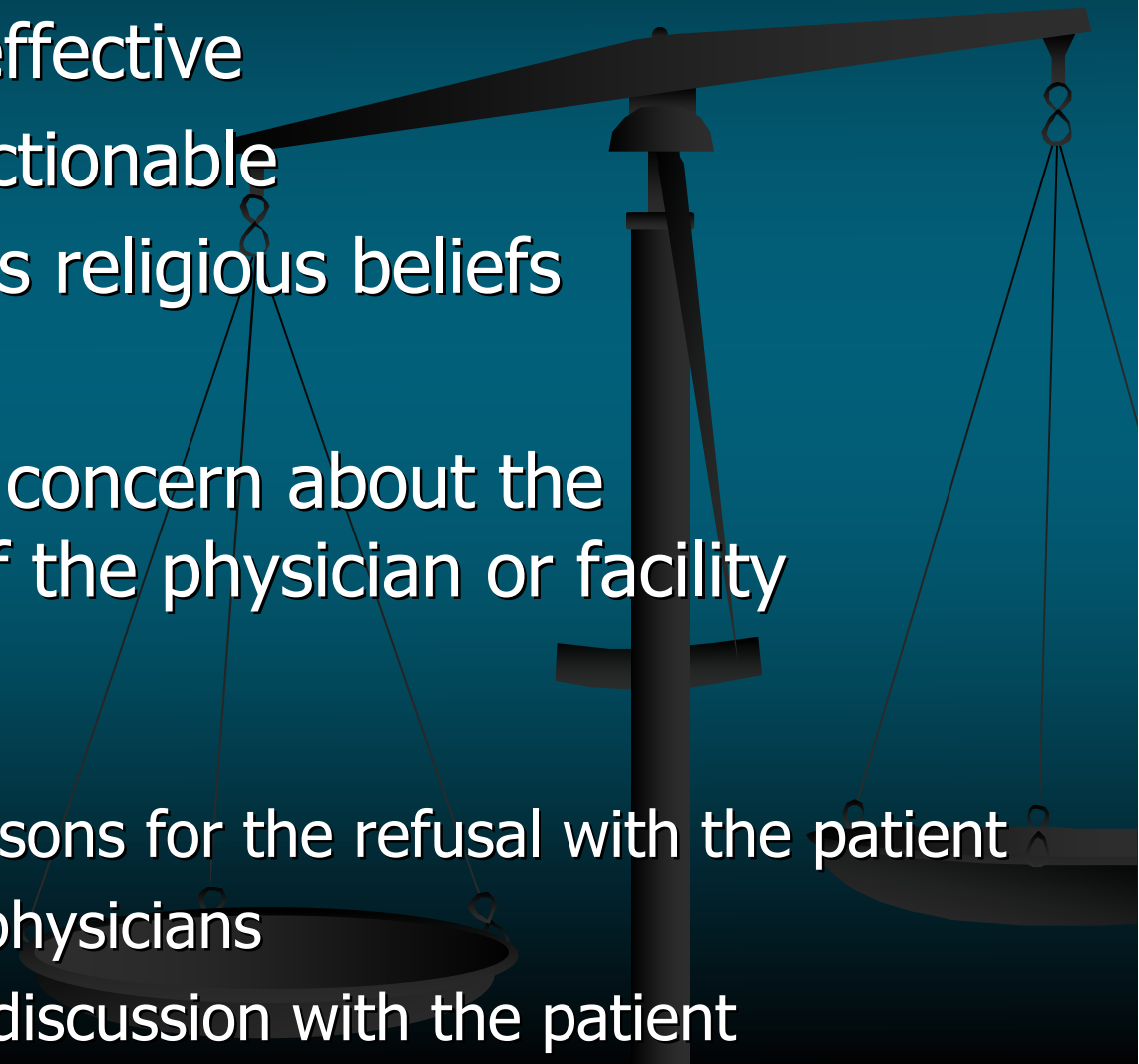
Physician is not required to provide treatment that

- Is ethically inappropriate
- Is medically ineffective
- Is morally objectionable
- Goes against his religious beliefs

Or when there is concern about the qualifications of the physician or facility

In such cases:

- discuss the reasons for the refusal with the patient
- refer to other physicians
- document the discussion with the patient



Anesthesiologist

AMA:

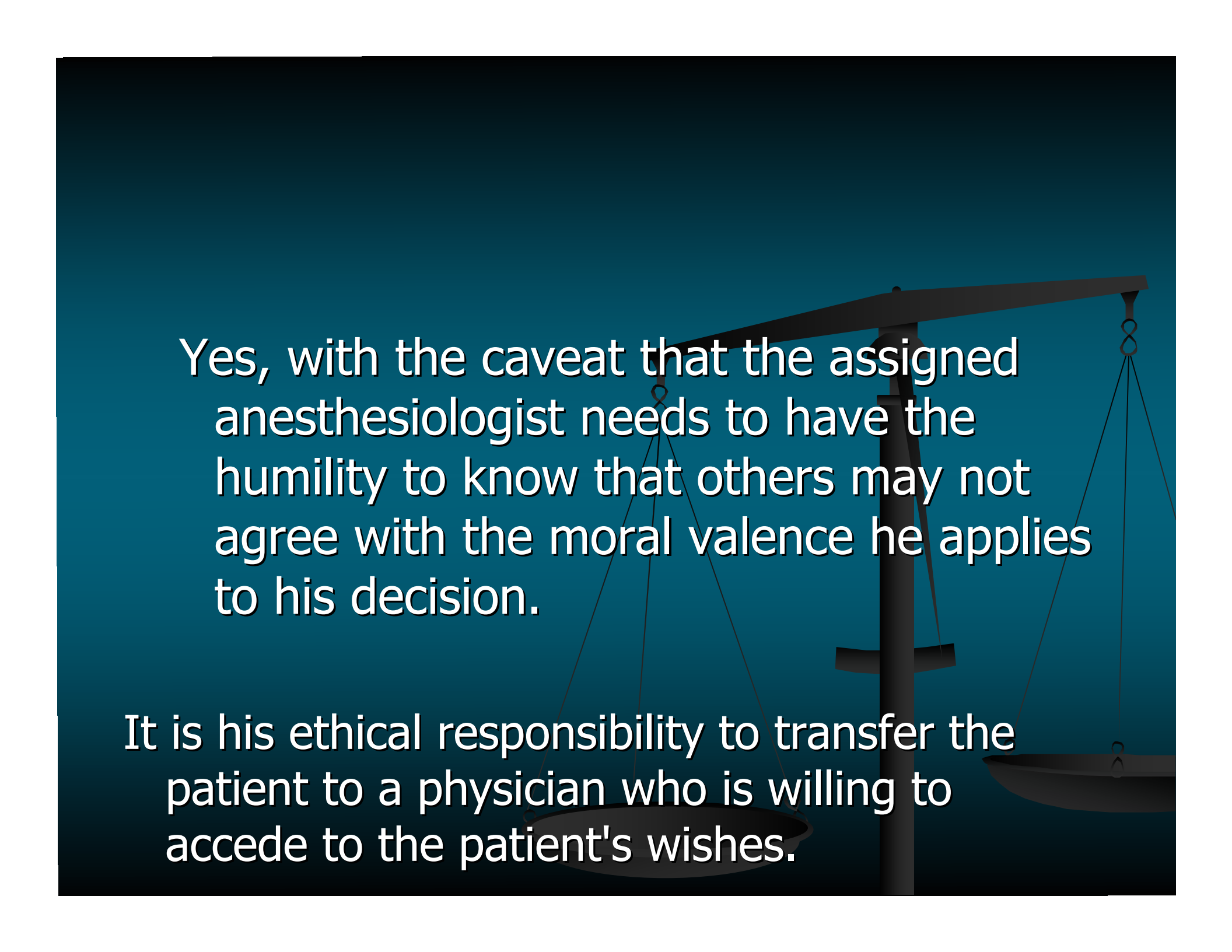
The anesthesiologist can only “opt out” in the case of a procedure that goes **against his personal, religious or moral values.**

Rationale for canceling:

- Do no harm – non-maleficence
- Unsafe, substandard, harmful
- Legal concerns
- Peer opinion

Is this OK?

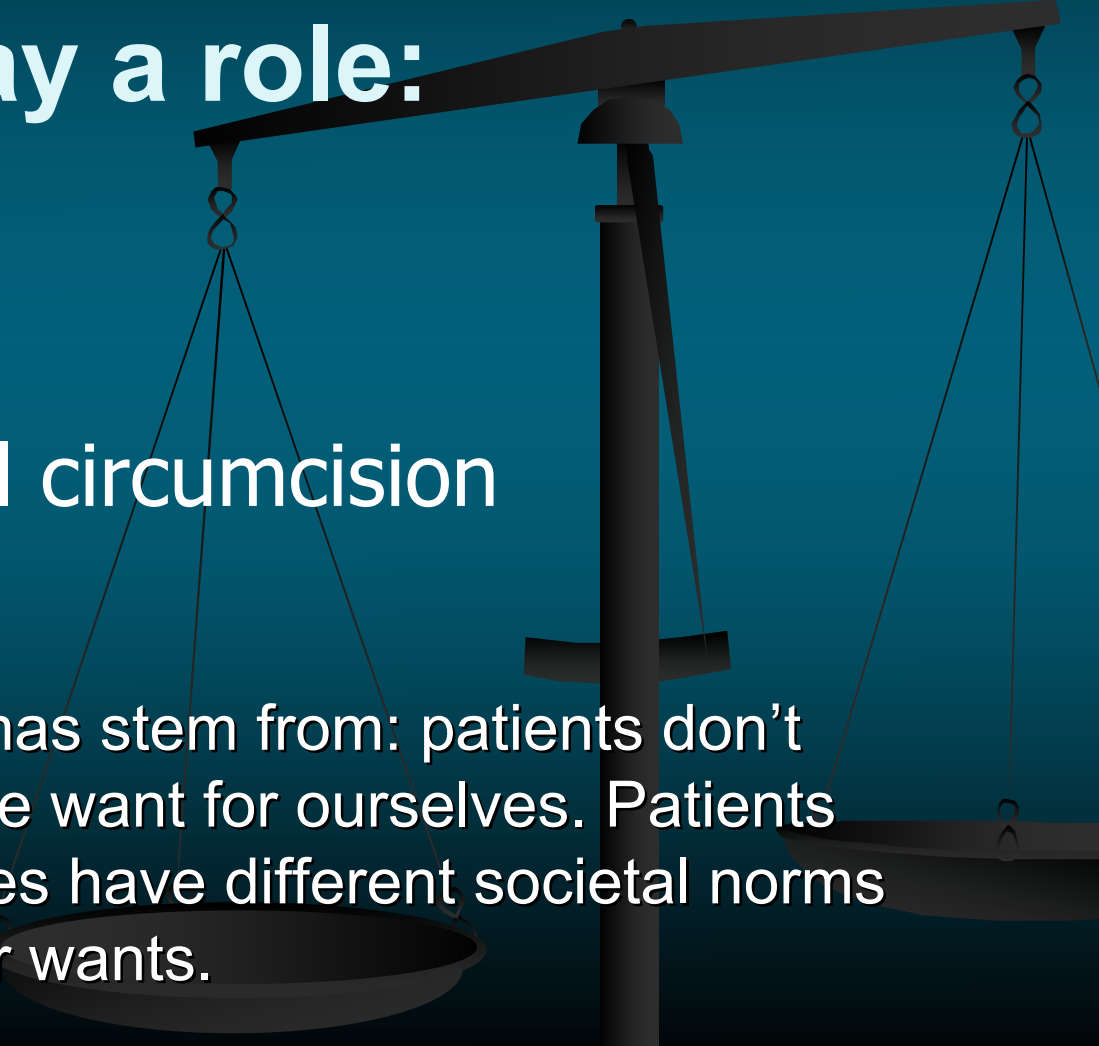




Yes, with the caveat that the assigned anesthesiologist needs to have the humility to know that others may not agree with the moral valence he applies to his decision.

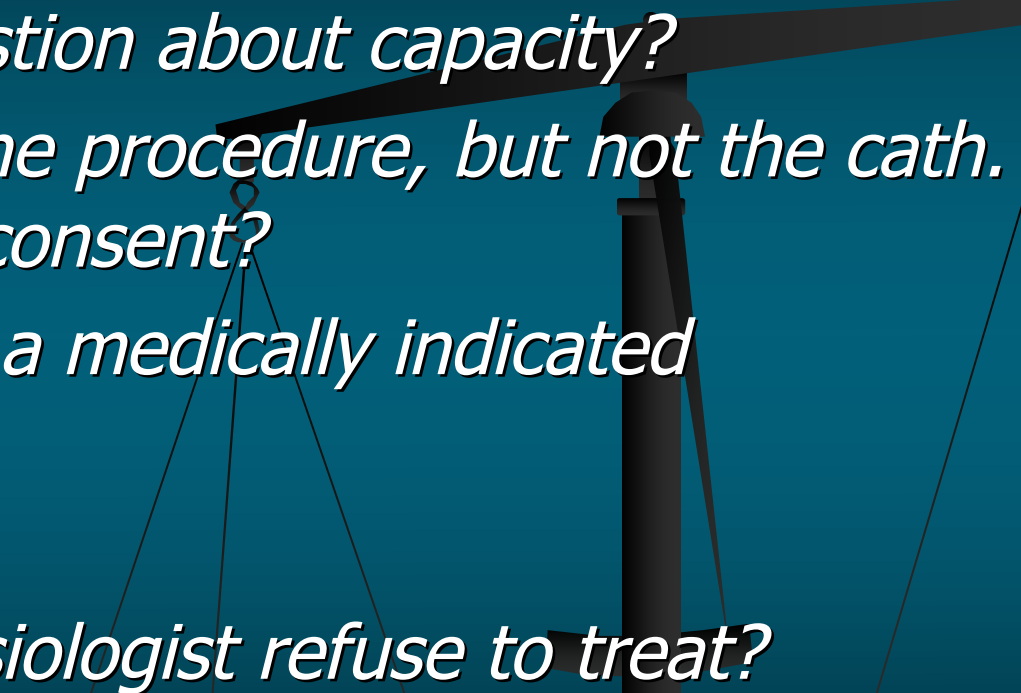
It is his ethical responsibility to transfer the patient to a physician who is willing to accede to the patient's wishes.

Examples of where personal, religious or moral values may play a role:

A stylized illustration of a balance scale, symbolizing ethical dilemmas and the weighing of values. The scale is dark brown and is positioned on the right side of the slide. The beam is tilted, with the right pan being lower than the left pan, suggesting an imbalance or a leaning towards one side. The background is a dark teal color.

- Abortion
- Routine neonatal circumcision

Many ethical dilemmas stem from: patients don't always want what we want for ourselves. Patients from different cultures have different societal norms which influence their wants.

- 
- *Is there any question about capacity?*
 - *He consents to the procedure, but not the cath. Is this informed consent?*
 - *Can he refuse to a medically indicated catheterization?
informed refusal*
 - *Can the anesthesiologist refuse to treat?*

Case 2



Suppose you were asked to perform a procedure with no recognized medical value, a procedure that may harm the person undergoing it.

Suppose the person requesting is asking for their minor child to undergo the procedure.

WHO:

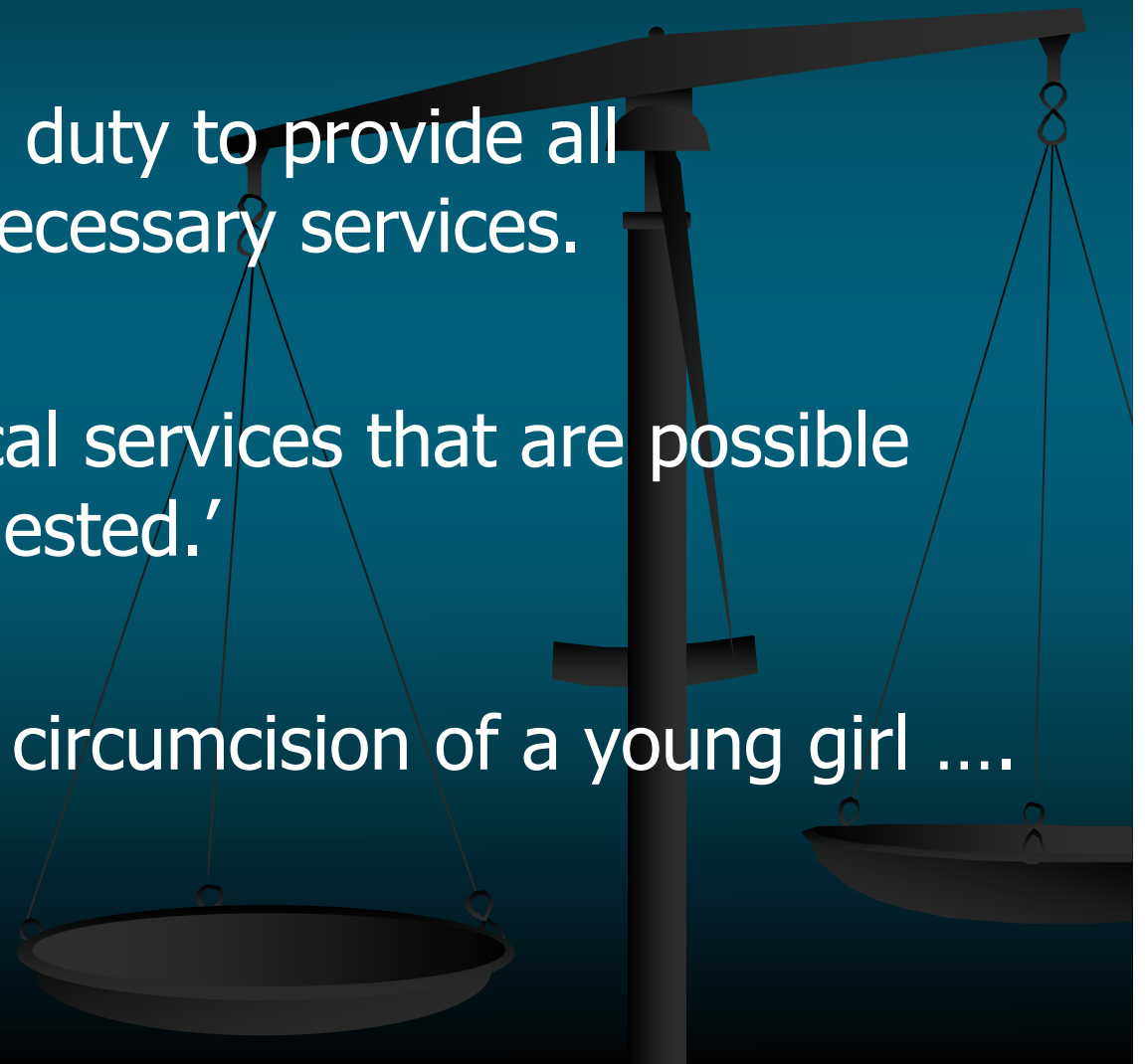
- *health 'includes the notion of social wellbeing'*

Physicians have a monopoly on medical services.
People have a right to *health* vis-à-vis medical services.

Physicians have to a duty to provide all appropriate and necessary services.

This is not 'all medical services that are possible and could be requested.'

The request is for circumcision of a young girl



- Ethical dilemmas solved by:
 - communication
 - Ethics consult(page – institutional ethics consult service)



Summary



- Airway assessment is more than Mallimpati.
- Patient autonomy allows refusal of treatment or test.
- Physician has moral and legal duty to treat if:
 - Preexisting relationship
 - Contractual relationship
 - Emergency
- May refuse if it is against personal, moral or religious values.