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Article abstract

This case study illustrates how principles and approaches from trauma-informed care can be used in a setting where a family is requesting the medical team not to share bad news out of fear of re-traumatization. A trauma-informed ethics consultation acknowledges how unresolved trauma may obstruct open and ethical communication. Effective facilitation of ethical dialogue is only possible once underlying trauma affecting communication is acknowledged and addressed.

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ÉTUDE DE CAS / CASE STUDY

The Influence of Trauma on End-of-Life Decision-Making

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Résumé
Cette étude de cas montre comment les principes et les approches issus de la prise en charge tenant compte des traumatismes peuvent être mis en œuvre dans un contexte où une famille demande à l'équipe médicale de ne pas lui communiquer de mauvaises nouvelles par crainte d'un nouveau traumatisme. Une consultation éthique tenant compte des traumatismes reconnaît que les traumatismes non résolus peuvent entraver une communication ouverte et éthique. Une facilitation efficace du dialogue éthique n'est possible qu'une fois que le traumatisme sous-jacent affectant la communication a été reconnu et pris en compte.

Mots-clés
sensibilisé au traumatisme, consultation éthique, prise de décision, décisions de fin de vie

Abstract
This case study illustrates how principles and approaches from trauma-informed care can be used in a setting where a family is requesting the medical team not to share bad news out of fear of re-traumatization. A trauma-informed ethics consultation acknowledges how unresolved trauma may obstruct open and ethical communication. Effective facilitation of ethical dialogue is only possible once underlying trauma affecting communication is acknowledged and addressed.

Keywords
trauma informed, ethics consultation, decision-making, end-of-life decisions

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CASE STUDY

Ms. B was admitted to the hospital after presenting to the emergency department (ED) with fever, abdominal cramping, vomiting, diarrhea, and tachycardia. She had previously been diagnosed with acute leukemia and hemophagocytic lymphohistiocytosis (an overactive immune system attacking its own blood cells), not having achieved remission. Upon further workup in the ED, it was determined that Ms. B had pneumonia as well as a distended colon and persistent ileus.

During her hospital stay, Ms. B became weaker with increased difficulty breathing and was transferred to the intensive care unit (ICU), where she was intubated and started on a vasopressor (medication to keep her blood pressure up). Ms. B's medical status continued to worsen, and she was eventually determined to be in multi-organ failure. A goals-of-care conversation was held with the ICU attending, Ms. B's primary oncologist, and Ms. B's children. Though the children understood that there were no more cancer treatments available, and that Ms. B was in multi-organ failure, they asked the ICU attending to continue with aggressive intervention and focus only on sharing positive news. This request caught the ICU attending off-guard, as they were not sure how to proceed with engaging with the patient's children as her condition progressively got worse, and good news was not to be had. A request was placed for an ethics consultation.

During the initial phase of fact gathering, the ethicist met with the patient's children to get better clarity on their request. The children's father, the patient's husband, had passed away traumatically 4 months prior and the children were still attempting to make sense of his death.

ETHICAL PROBLEM

This case raises the ethical issue of disclosure, truth-telling, and respect for autonomy. A physician is obligated to disclose sufficient information about a patient's condition to the decision-maker, either patient or a surrogate, as part of the informed consent process (1,2). A barrier to addressing this ethical issue is the patient's children's previously experienced trauma.

TRAUMA-INFORMED ETHICS CONSULTATION

Traumatic events can upend an individual's life, leaving them wary of themselves, others, and the world around them. Trauma is the result of an event that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being (3). In this case, the children receiving news about the patient's medical condition can be a potential trigger that may re-traumatize them. The concept of re-traumatization has been defined as:

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> Traumatic stress reactions, responses, and symptoms that occur consequent to multiple exposures to traumatic events that are physical, psychological, or both in nature. These responses can occur in the context of repeated multiple exposures within one category of events (e.g., child sexual assault and adult sexual assault) or multiple exposures across different categories of events (e.g., childhood physical abuse and involvement in a serious motor vehicle collision during adulthood). (4, p.2)

Facilitation of ethical communication, like in traditional ethics consults, can only be accomplished if prior trauma that impedes communication is first addressed. Trauma-informed ethics consultation (TIEC) acknowledges how trauma may be impeding ethical communication and allows parties to arrive at an ethically appropriate resolution while mitigating risk of re-traumatization. TIEC applies principles of trauma informed care (TIC) into standard ethics consultation processes (5). TIC is an approach to healthcare that aims to promote a safe environment, trustworthiness and transparency, collaboration and mutuality, peer support, empowerment of voice and choice, and recognizes the impact of culture, history, and social identities on experience and daily interactions (6). The principles and approaches from TIC are not meant to be applied in a direct clinical sense by the ethicist, to treat or diagnose patients or family members, but are aimed to inform and orient communication with these individuals.

First, an ethicist can acknowledge the impact of trauma on decision-making by being an active listener, normalizing grief associated with trauma, and assessing social support and resources for the family. They can draw on their skills of mediation and effective communication to encourage patients and families to voice both internal and external physical and emotional losses they have experienced due to trauma (3). This would promote a safe environment and aid in building trust and transparency.

Once the impact of the trauma on decision-making has been acknowledged, the clinical ethicist can work towards identifying any trauma-related triggers by eliciting the similarities and differences between the past traumatic event and current situation (7). One likely trigger in this case would be that of being in a hospital setting; the clinical ethicist could ask family members to articulate similarities and differences between their father and mother's admissions, drawing upon how individuals may have reacted differently to the admissions, and how these individuals may have different physical or emotional responses.

Finally, the clinical ethicist can aid in facilitating a conversation where the family members identify what unique choices can be made in this situation which were not able to be made in the past. Exploring choices available in the current situation can aid in managing triggers by giving family members a sense of empowerment with their voice and decision-making abilities (3).

ETHICAL RESPONSE

Supporting the needs of those who have suffered from trauma aids in building trust between individuals and can help encourage participation in decision-making and care (8). Once trust has been built by acknowledging trauma and identifying and managing triggers, it would be appropriate for the clinical ethicist to finally address the ethics issue. The clinical ethicist should explain to the family members that informed consent is not possible without a clear disclosure, both positive and negative, of the patient's condition; that the purpose of adequate communication and truthful disclosure is to empower them to make informed decisions pertaining to their mother's care (1,2); and that making decisions for their mother's care is voluntary. If certain family members do not want to hear the information necessary to make a decision, out of fear that hearing negative news would result in re-traumatization, those family members may waive their right to engage in the decision-making (2).

QUESTIONS

1. How does trauma informed ethics consultation differ from that of a typical ethics consultation?
2. What alternative strategies could an ethics consultant employ when engaging with a family or patient not affected by trauma who only want to hear positive news?
3. Should all ethics consults be trauma-informed?

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