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IN THE LITERATURE

How Situational Diagnosis Helps Disentangle Ethical and Psychological Features of Complex Cases

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Lederberg MS. Disentangling ethical and psychological issues—a guide for oncologists. *Acta Oncol.* 1999;38(6):771-779.

Abstract

We review Marguerite S. Lederberg's 1999 *Acta Oncologica* article entitled "Disentangling Ethical and Psychological Issues: A Guide for Oncologists," in which she introduces a method of analysis that facilitates clarification of ethical and psychological aspects of complex cases. Based on her understanding of the dynamics at play in patients', family members', and physicians' experiences, Lederberg formulated what she calls "situational diagnosis," a guide on how to distinguish ethical from psychological issues at the bedside or when an ethics consultation is requested. Here, we apply situational diagnosis to a case and consider whether and how Lederberg's guidance relates to current literature on how clinicians communicate with patients about serious illnesses.

Introduction

In a 1999 article in *Acta Oncologica* entitled "Disentangling Ethical and Psychological Issues: A Guide for Oncologists," Marguerite S. Lederberg describes dilemmas that patients, their family members, and physicians experience in cancer medicine [1]. Cancer patients can sometimes see autonomy as a burden when struggling to make decisions fraught with uncertainty. Such decisions can generate anxiety about both survival and managing side effects from treatments. Families suffer with increased financial burdens of medical expenses, and their careers might falter or their jobs disappear. They also struggle psychologically, as they tend to be critical resources for the patient's care. In this role, they collaborate with the patient on treatment decisions, make decisions when the patient lacks capacity, and often suffer from guilt and depression when the patient experiences unfavorable outcomes. Physicians struggle with their personal feelings, patient load, time constraints, and political and financial constraints in delivery of care. Finally, there can be dilemmas in the patient-physician relationship, such as those over appropriate professional boundaries. An example of such a dilemma would be whether to accept a gift from or dine with a patient, which could lead to expectations of special treatment.

These dilemmas motivated Lederberg to develop a method for separating out ethical issues from issues pertaining to the relational dynamics represented by four factors: "patient/family factors," "staff factors," "staff/family interface," and "legal/regulatory constraints." In her method, which she calls "situational diagnosis," each of these factors can be systematically analyzed to clarify a dilemma and decide whether a true ethical issue exists or not [1]. In this paper, we will discuss Lederberg's method of situational diagnosis and apply it to a case. We will then discuss the contemporary relevance of components of situational diagnosis and offer possible strategies for resolving stressful clinical situations involving these components.

The Method of Situational Diagnosis

Based on her understanding of the dilemmas at play in the patient's, the families', and the physician's experiences of cancer, Lederberg formulated the method of situational diagnosis, which is a guide on how to elucidate an ethical issue—either at the bedside or when an ethics consultation is requested—and identify possible interventions. As mentioned above, she described four components that that can be analyzed systematically to clarify an ethical dilemma: patient/family factors, staff factors, the staff/family interface, and legal/regulatory constraints [1].

Questions and issues arising from the first four components need to be addressed for an ethical dilemma—if there is one—to be unmasked. It is not uncommon for patients and families to have a distorted understanding of the patient's disease and prognosis. First, there can be cultural and religious issues, psychiatric problems, or a history of family conflict. Second, staff members can have differing opinions on medical management, or there might be inter-staff conflict. Third, relationships among staff and family members can be fraught, so those need to be analyzed as well, particularly when one party has strong negative or positive perceptions of the other or when there is poor communication. Fourth, laws or institutional constraints can be at play in a case. What remains after each of these factors has been clarified is a clearer picture of the actual ethical dilemma. Situational diagnosis thus facilitates clearer deliberation about what might constitute an appropriate response to the ethical issues and questions.

Situational Diagnosis Applied to a Case

Here we provide an example of how situational diagnosis can be applied to a case seen by one of the authors (JJI).

A 17-year-old Venezuelan woman had been diagnosed as a child with metastatic NUT midline carcinoma—a rare, aggressive, genetically defined, poorly differentiated cancer. The patient did not respond to several lines of chemotherapy. She was eligible for a clinical trial, which posed risk of harm from the experimental agent's side effects. However, the patient refused to allow any discussion of risks and didn't want to hear

anything "negative." When she was a child, she would defer to her parents, who would receive information and sign consent forms, but after she turned 18, she still declined to review risks and benefits. In fact, when the clinical team would discuss risks posed by the clinical trial or attempt to discuss her poor prognosis, she would cry to the point of nausea and, on occasion, vomit.

Using situational diagnosis to review this case, the apparent ethical issue (the patient's refusal to consider risks and benefits of clinical trial participation or to sign a consent form) was more complicated than it seemed. The patient's parents explained that, in their culture, children weren't "truly" considered adults until age 25, and when it came to illnesses and decision making, they would defer to parents. Because of the patient's emotional reactions to attempts to discuss risks and benefits of clinical trial participation, a psychiatric-psychological consultation was requested; consultants evaluated the patient and concluded that she was also suffering from an anxiety disorder that stemmed from asthma attacks when she was younger. (According to the situational diagnosis method, this would be a patient/family factor.) The staff had inadvertently increased the patient's anxiety by explaining risks and benefits of participating in the clinical trial when it was culturally inappropriate for her to consent for herself. (According to the situational diagnosis method, this would be a staff/family interface factor.) The apparent ethical dilemma was created by a hospital and government policy requiring adult patients to hear risks and benefits of clinical trial participation before giving consent. (According to the situational diagnosis method, this would be a legal/regulatory constraint.)

Is Situational Diagnosis Still Relevant?

The current literature seems to support the value of applying Lederberg's method of situational diagnosis for stressful clinical situations. A number of patient factors must be clarified before ethical issues can be framed and analyzed. Patients might demand what clinicians consider to be futile treatment because they misunderstand their disease status or prognosis [2]. In one study, 25 percent of cancer patients misunderstood the goal of their chemotherapy treatment, with age and language ability being significant predictors of misunderstanding of goals of care [3]. Some patients might be in a psychological state of denial about their illness, inhibiting discussion and understanding of care goals [4]. Others might refuse to "give up" because of religious beliefs, such as "putting everything in God's hands." Chevaux et al., for example, found that religious patients tend to desire aggressive measures to extend life [5]. However, one must be careful about making generalizations about specific religious groups; Chevaux et al. also found that Protestants tended to desire do-not-resuscitate orders by cardiopulmonary resuscitation [5].

Awareness and treatment of psychopathology is also of utmost importance before ethical issues can be analyzed, specifically when considering informed consent. Severe

mental illness, such as major depression, bipolar disorder, or schizophrenia, has been found to be associated with poor decision making [6]. And decision-making capacity can fluctuate in patients with bipolar disorder, being impaired when the patient is in a manic episode but returning with the patient's recuperation [7].

Sometimes communication problems between staff and family and patients can appear as ethical issues about treatment choices. For example, a clinician who tells a family member of an ICU patient with a poor prognosis that "his numbers look good" might mislead the family into believing that the patient is rallying. This could cause a patient and family to desire continuation of chemotherapy when it would be futile and could create a conflict of values between them and the staff. Primary care physicians can be overly optimistic about a prognosis with patients and families out of a desire not to destroy hope or because of the psychological stress of being bearers of bad news. For example, in one study, the primary physician was found to be the only significant factor in patients' continuation of chemotherapy during the last four weeks of life [8]. On the other hand, when physicians do deliver bad news, patients tend to view them with cynicism or mistrust [9].

It is important that interventions address these factors once they have been identified. These might include providing chaplains or mental health consultation. Good communication can also help clarify patient/family factors. For example, promoting effective communication can prevent conflict in discussions of prognosis and end-of-life care [10]. Part of effective communication is to ensure that the patient and family have correct information about the disease prognosis and interventions. This can be done by continually assessing patients' and family members' understandings about goals of care and trying to clarify discrepancies, thereby preventing the previously described issues [11].

Sometimes interactions between staff members can mask a possible ethical issue. For example, when a nurse perceives that a patient with advanced disease was not given an opportunity to discuss a desire to forego aggressive treatment, she might experience moral distress if she refrains from speaking up [12]. This situation raises the issue of whether it would be unethical for a physician to proceed with aggressive treatment in such a case. One solution might be for the nurse to request an ethics consultation. Another would be for the nurse to discuss the patient's wishes with the physician. One of the authors (WFB) and colleagues have described a six-step protocol called SPIKES for disclosing unfavorable information [13], which can help guide nurses to accomplish this communication task.

Finally, being aware of institutional and legal policy can be important to clarify if there truly is an ethical issue. The Texas Advance Directives Act of 1999 allows physicians to

remove a medically inappropriate intervention after giving the family and patient time to find an alternative facility that might administer the intervention [14].

Conclusion

In addition to the method of situational diagnosis, several methods have been discussed in the literature on how to approach an ethics consultation, including the "four quadrants" approach [15], the Montefiore model [16], and the CASES approach [17]. However, we believe that situational diagnosis provides an organized and systematic way to approach a stressful clinical situation by creating awareness of patient/family factors, staff factors, the staff/family interface, and legal/regulatory constraints. A clinician faced with such a situation can use the method of situational diagnosis as an algorithm to rule out and resolve issues related to the four (non-ethical) factors, possibly preventing the need for an ethics consultation. Ethicists, however, are usually trained to identify factors affecting patient care that are not true ethical dilemmas and to recommend other solutions.

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