Pharmacy 543 Ethics Cases – Cross-Cultural

Case 1

A twenty-seven-year-old female named YP arrives in the emergency department of a large teaching hospital at midnight. She has sickle cell anemia and is in the midst of a sickle cell crisis. She has severe pain in her thighs, arms, hands, and feet. She is dehydrated and anemic. An ED resident instructs a nurse to give her a shot of Demerol for pain and to start a normal saline IV. She is admitted to the hospital. In the hospital, she asks the nurses many questions about the pain medications she is receiving, and she continues to complain about her pain. The following day, two residents, a medical student, and the attending physician visit YP during morning rounds. Neither the physician nor the residents know YP or have seen her before. In the conversation, they discover that she knows a great deal about her disease. When she is not having a crisis, she is able to use a nonsteroidal anti-inflammatory drug, (usually Motrin) to manage her pain. She claims that during a crisis, intravenous morphine provides her with the most effective pain relief, and she asks whether she can be given this drug instead of Demerol (meperidine). She even suggests dosage levels and schedules. In the past, she says that she has used a PCA pump to administer morphine. The pump allows her to have a morphine drip on a "round the clock' (RTC) basis as well as extra morphine on a "prescribe as needed" (PRN) basis for breakthrough pain.

The medical team is somewhat dumbfounded by YP's request. The attending physician tells YP that they will consider this option, but that they would like to continue treatment with Demerol on a PRN basis. He also asks YP who has treated her in the past so that the team can talk to a physician who knows her well. YP says that she has no primary care physician, but she does name several hospitals where she has received treatment in the past few years. After leaving YP's room, the team discusses her case. One of the residents questions YPs request for a particular kind of pain medication. He is concerned that she may be an addict trying to get a fix and that she likes the euphoria from morphine. Another resident points out that Demorol provides a more euphoric effect than a morphine drip or another opioid, such as methadone.

Adapted from *The Hastings Center Report* 2001;31(3):29-30.

Case 2

Bishop P is a sixty-year-old man who suffers from quadriplegia and persistent infections. He is the retired prelate of a church that emphasizes faith healing. One year ago, he developed *Staphylococcus aureus* meningitis, epidural abscess, and pneumonia. During his hospitalization, Bishop P developed quadriplegia, respiratory failure, renal failure, and persistent fevers. After he returned home, his wife worked part time while also providing home care. His daughter stopped her graduate studies to devote herself to his care.

Ten months later, Bishop P was admitted with urosepsis with *Enterobacter cloacae*. His course was complicated by hypotension, respiratory arrest, stroke, and seizures. He was discharged, but returned to the hospital after three weeks because of persistent fevers. During a five-week hospital stay, he developed ventilatory and renal failure, which required intubation and dialysis. Despite multiple courses of antibiotics, his blood cultures remained positive for *Enterobacter cloacae*, which are resistant to all antibiotics. His ascites fluid cultures also remained positive for several organisms. As a complication of his antibiotics, he developed autoimmune hemolytic anemia and thrombocytopenia, which required daily

infusions of red cells and platelets. He also developed a total body rash, caused by a medication for his seizures. His skin sheared away around his bandages and electrocardiogram leads. The physicians predicted that he would not survive the hospitalization and that attempts at cardiopulmonary resuscitation (CPR) would be futile and disfigure his body. Bishop P could not state his preferences for care. His family insisted that everything be done, because he believed that all life was sacred.

Adapted from Alpers & Lo. *J Law Med & Ethics* 1999;27:74

Case 3

A fifty-five-year-old Native American man, Mr. B, presented with hypertension for a routine clinic appointment. On this visit, as on previous visits, the patient's blood pressure was elevated. In the past, the physician had devoted considerable energy to educating Mr. B about high blood pressure: its etiology, natural history if untreated, and the benefits of controlling it. In addition, he had stressed the importance of non- pharmacologic measures, such as restricting salt, moderating alcohol use, exercising appropriately and losing weight. At the time of this visit Mr. B was being treated with two drugs. The physician considered adding a third drug; however, he was concerned that Mr. B would not adhere to a new medical regimen. Mr. B had not followed the physician's recommendations pertaining to diet and exercise in the past, and the physician suspected that he had not taken medication with prescribed frequency. Despite the physician's efforts, Mr. B's blood pressure was elevated and he was at risk for stroke, renal injury and coronary artery disease.

Complicating the situation was the fact that the physician's ordinary manner of relating to patients involved disclosing negative possibilities and risks in order to inform and educate patients. In this situation, his inclination was to stress to Mr. B the negative risks associated with his refusal to follow medical advice. Mr. B, however, was a traditional ***** and his expectations reflected his culture's ideas about healing as a process of moving the patient from a negative state of illness or "imbalance" to a positive state of harmony and health. Hopefulness and positive thinking are perceived as integral to healing, while negative thinking is regarded as potentially deleterious. Thus, "***** emphasize that if one thinks of good things and good fortune, good things will happen. If one thinks of bad things, bad fortune will be one's lot." According to traditional *****, people can acquire disease through a process of "witching". Witching involves manipulating agents that produce disease, and can occur through explicit discussion of potential morbid events.

Adapted from Jecker NS, Carrese JA, Pearlman RA. Caring for patients in cross-cultural settings. *Hastings Cent Rep* 1995 Jan-Feb;25(1):6-14

Case 4

Ms. LF was a 50-year-old female nurse, who presented at a community hospital with lower extremity cellulitis and was found to have an excess of peripheral blasts. A bone marrow biopsy and aspirate confirmed a diagnosis of acute monocytic leukemia (AML). Her significant past medical history included node positive breast cancer, for which she received high-dose cyclophosphamide and doxorubicin sequentially, followed by tamoxifen, 2 years prior to her AML diagnosis. It was speculated that her AML was related to the previous chemotherapy, though her favorable cytogenetic profile confounded this speculation. Ms. LF stated that she was a Jehovah's Witness and asserted with an advanced directive that she did not want blood product support. Staff discussed this decision with Ms. LF and made it

clear that her refusal of blood products would adversely affect her chance of survival. Ms. LF maintained that she wanted to be treated but that she would not accept blood products.

Treatment was initiated, using erythropoietin and G-CSF to increase her blood counts, and aminocaproic acid to help prevent bleeding. [Several months of chemotherapy and post-remission treatment ....] With a hematocrit of approximately 20%, she experienced extremely symptomatic anemia. Two months after finishing post-remission therapy, a bone marrow biopsy showed no evidence of AML. Her hematocrit slowly returned to normal with a peak value at this time of 35.9% while receiving erythropoietin. Fourteen months later blasts were again found in her peripheral blood.

The risks and benefits of continuing therapy were discussed with Ms. LF. She remained adamant in her refusal of blood products and repeated that she wanted to continue treatment and to "die fighting" her disease. [Further chemotherapy ....] When her hematocrit dropped below 10%, she was treated with bovine hemoglobin. Initially, Ms. LF was reluctant to accept the bovine-derived product, but she eventually agreed to accept it after the elders from her congregation approved its use in her care. During reinduction chemotherapy, the lowest level that Ms. LF's hematocrit reached was 7.1%, partly contributed by free bovine hemoglobin.

After 2 weeks of hospitalization, she began a precipitous decline with severe anemia, renal failure, and pulmonary infiltrates of unknown etiology. Ms. LF continued to state that she wanted to "fight" her disease. She was moved to the medical intensive care unit (MICU) for dialysis and later intubated for respiratory distress. A final bone marrow biopsy confirmed persistent blasts. She died 3 days later.

Abstracted from Knuti KA et al. *The Oncologist*, 2002;7(4):371-380.

Case 5

Ying Chang Liang, age 43, developed a severe headache following the birth of her fourth daughter, now age 2. She was eventually diagnosed with adenocarcinoma metastatic to the brain. She has been in the United States for about 10 years, following a path from Southern China to Hong Kong to the United States. She has a junior high education and worked as a chef, providing a large part of the financial support of her family, prior to becoming ill. Her husband, who has some college education, has had a more difficult time maintaining steady employment.

Unlike Ms. Tai, who defers to her brother in decisionmaking, Mrs. Liang was described by herself, husband, and physician as the primary decisionmaker about her medical care. "I personally made the decisions about most things in my family. For my treatments, even for the Chinese medications (and I had several different kinds) I would take whichever I trusted more." Describing her discussions with her doctor about treatment, she said "If I did not feel good, I asked to stop, and the doctor would stop."

The interviews reveal striking mistrust of the western physicians involved in Mrs. Liang's care. She not only returned once to China for therapy with a"famous" doctor in Shanxi, but took traditional medicines provided by family members and friends remaining in China. Her husband believed firmly that his wife would have died if they had relied on western medicine, and complained, "I don't trust the doctors here; doctors here with an MD degree are not even as good as bare-foot doctors in China."

Fully in control, Mrs. Liang used western therapies when they suited her needs, and refused them when she found them ineffective. One of our researchers once observed a complex negotiation between patient and husband, interpreter, and physician, during which the patient requested a CT scan of the brain in order to determine whether the Chinese medicines she took were working. The physician—who was never informed about the patient's use of alternative therapies (and the interpreter was party to this miscommunication)— could not understand why she wanted a CT scan when she was refusing radiation therapy to further shrink her brain tumor. Dr. Ingle, her oncologist, described her as "clearly in control; she had no trouble speaking her mind." Nonetheless, he had lingering doubts about her understanding of her illness, complaining that she never understood the connection of her brain metastases to the primary tumor and that she was never "completely accepting" of her illness.

From Hern EJ, Jr. *et al.* *Camb Q Healthc Ethics*. 1998;7(1):27-40.