A few definitions of Autonomy:

- The right of competent adults to make decisions about their own medical care
  - This is the root of informed consent – what are we really asking someone when we ask for informed consent
- The Law: The right of choice is not limited to that which others might regard as sensible
  - This feels like a gray area in nursing, we often persuade patients into have a procedure they didn’t want
- Lessons from: Harvard’s annual bioethics conference: The Ethics of Making Babies
  - Autonomy does not exist in a bubble – it is influenced by cultural factors, family, spirituality, etc.
    - the role of the health care professional should be to use their professional experience and evidence to guide a patient in their decision-making process.
  - Just because a patient has been provided with all the information, doesn’t mean that they are “informed” for consent.

Autonomy in Mental Illness:

- Sarah C shared the story of a patient who was admitted with an infection, but her past medical history of schizophrenia seemed to change the attitude of nursing staff towards her.
  - The patient was very particular about her diet and very wary of taking in processed things, like medications. It was very difficult to convince the patient that the antibiotics she was being given were necessary. It became even more difficult to convince her to take an essential blood thinner, and nurses began to lie to her and tell her that it was an antibiotic. Doctors also indirectly encouraged her to lie to her patient. Sarah discussed her strategy for building trust with her patient and how she was able to successfully convince her to take her essential medications.
  - Our discussion focused on how trust is broken down when we lie to patients, and the disrespect it demonstrates for that person. We also discussed the argument that could be made that nurses are acting in the best interest of the patient when they lie to them about an essential medication in order to convince them to take it. The duty to protect patients from the risk of harm caused by not taking a medication is a strong argument, but flawed because it doesn’t respect the autonomy of a person.
  - We explored other reasons nurses might act this way:
    - Patient’s logic is dismissed as flawed due to mental illness
    - Nursing convenience – as the extra time it takes to work with this patient might take away from other patients
    - Doctor’s convenience – Other medications or therapies might work better for this patient, but doctors are trained to follow a specific order set and especially young residents are often unwilling to explore other options.
Solutions:

- Honesty. Being honest with a patient allows a bond of trust and respect to be formed/preserved.
- Interdisciplinary meeting – using social work, spiritual services, family, friends, etc. to help patient understand the recommended therapies.

Other issues related to mental illness during inpatient care:

- It seems that mental illness isn’t prioritized as physical conditions are when it comes to hospital care. Home medications for mental illness are often discontinued upon admission and are a secondary or even tertiary consideration when restarting home medications.
  - Often discontinued for good reason, but not restarted as a home cardiac medication would be – this is sometimes to help reduce sedation and reaction risk of new medications, but it also seems that the illness isn’t respected as it should be.

- Mental Illness itself isn’t discussed enough, or understood enough in bedside care.
  - A “grading” system would be very helpful. We can understand how well the heart functions with certain tests and lab values, but we don’t know how badly someone’s anxiety might be impacting their well-being.

Moral Culpability in Dementia Care:

- My intention of using the term “moral culpability” was to talk about the way that people with dementia can be let down by our health care system (and us!) It proved to be unnecessary to go into discussion about the paper examining nursing attitudes of pain relief for dementia patients because we already had a lot to talk about in what we see in society and on our units.
- The real subject here is the connection between nurses and patients that they may not be able to understand very well. We expanded on some of the difficulties we have making connections with people with severe mental illness, and some of the resolutions that we make to establish a connection despite that adversity.
  - Empathy and open-mindedness were emphasized as essential to building these connections and establishing trust and understanding

- Alzheimers is the 6th leading cause of death – it’s important that we expect it in our nursing practice and are prepared for it. The science behind it is still being worked on, and delirium remains without a good explanation for what causes it.
  - In Alzheimers, very healthy people decline and it seems that once the mind is gone, the body fails quickly
    - The phenomena of a stressful emotional state being linked to weakened cardiac output – Broken Heart Syndrome (Takotsubo cardiomyopathy)
  - We explored the mind-body connection and how we can use that in our nursing practice
  - Participants expanded upon a belief in transference of energy between people – and that this can be used to help establish a connection with patients

- We discussed social solutions to the problems with elderly care including shared living communities, retirement communities on college campuses and some cultures that coexist more communally, where grandparents and community members care for the
children. I think we briefly touched on the idea of what is American or un-American about those social models, but we didn’t get into detail.

**Miracle Care: Brain Death/Vegetative State**

- A definition: Brain Death – The irreversible loss of all clinical functions of the brain and is recognized in all 50 states as legally equivalent to death determined by other means, after which there is no legal obligation to continue interventions to sustain respiration or circulation.

- We discussed what we think “miracle care” means, and what a person who “expects a miracle” might mean:
  - Some brought up anecdotes about patients who were not expected to survive or it was unknown what their limitations might be, but ended up doing very well.

- Stages of mourning was discussed as part of what families go through and how a “miracle” might fit into those stages. We can also use this in our own practice to connect with patients and their families:

- Notes from Peter’s email:
  - Peter’s focus in ethics has been centered around neuro-ethics and particularly the moral metaphysics of hope (including ‘miracles’) in medicine.
  - There is a false dichotomy between belief in a miracle, on the one hand (which can be exceptionally rational and appropriate), and the conclusion that life-sustaining medical treatments (LSMTs) must therefore be continued (for which there is no logical or rational connection). Hence, it is completely compatible to believe in the possibility of a miracle and conclude that LSMT can/should be discontinued.
    - If a miracle is going to occur, and only a divine other can perform that miracle, then the divine miracle worker must transcend our capacity to effect/prevent the miracle ourselves. Therefore, it follows that nothing we do can possibly effect/prevent it, but only the divine other’s willful choosing.
    - Miracle stories in all of the major eastern and western religious traditions. None of them include ventilators, G-tubes, repeated CPRs, etc.
      - The story of Lazarus:
        - Does it say that Jesus entered the tomb, tripped over the Lazarus’ dialysis machine, slowly withdrew the ventilator, and raised him from the dead? Absolutely not.
        - Yet people of faith believe this is true, and with good reason. Therefore, they can come to the same conclusion in the clinical setting.
    - On a final note, why must miracles always include living? If the dead are ‘in a better place,’ how could this be so? Could endless LSMTs therefore be viewed as an artificial block to eternal beatitude?