Medical Ethics: Tough Issues!
Relationship of Physicians to the "Ethics Establishment"

- We do ethics everyday:
  - Deliver bad news
  - Guide pts/family through complicated/devastating decisions
  - Seek informed consent
  - Have trouble sleeping the night before
  - Daily enter the point of "no turning back"
Relationship of Physicians to the “Ethics Establishment” (cont.)

- Ethics establishment
  - Ethics committees – consult & adjudicate complex issues
  - Institutional Review Board
  - Teach principles to staff / students

- Not so much critical of the establishment, as of us!
  We should be there!
Current Threats to Cherished: Doctor-Patient Relationship

- Medicine is a business!
  - Time is money
  - Reimbursement down
    - need to see more to generate same income
- Can actually do more than ever before
  - So try to do it for as many as possible
Current Threats to Cherished: Doctor-Patient Relationship (cont.)

- Shift to “outpatient” treatment gives less time with patients and mentors
- We live in suspicious times
- Less time and identity with mentors
  - Presumably the previous source for learning ethical and compassionate care
Current Threats to Cherished: Doctor-Patient Relationship (cont.)

- The issues are more complex
  - Transplants
  - Genetic information
  - Preservation of life
    - issues of “futility”
  - Creation of life
    - stem-cell / cloning
Current Threats to Cherished: Doctor-Patient Relationship (cont.)

- Taking of life
  - physician-assisted suicide
  - euthanasia
- Rationing of limited health care resources
- AIDS/HIV
- Threat of unconventional acts of terrorism
“Clinical Ethics” Provides a Technique of Case Analysis to Resolve Ethical Problems

- Classical ethical principles:
  - Respect for autonomy
  - Beneficence
  - Nonmaleficence
  - Fairness
Practical case analysis by:
- Medical indications
- Patient preferences
- Quality of life
- Contextual features
  - social
  - economic
  - legal
  - administrative
**Working Relationship:**

<table>
<thead>
<tr>
<th>Medical Indication</th>
<th>Patient Preferences</th>
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<tbody>
<tr>
<td>- Principles of beneficence / nonmaleficence</td>
<td>- Principle of respect for autonomy</td>
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<td>- What is the pt.'s medical problem?</td>
<td>- Decision - making - capacity</td>
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<td></td>
<td>* Advance directives</td>
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<td>* Right to choose</td>
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<tr>
<th>Quality of Life</th>
<th>Contextual Feature</th>
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<td>- Principles of beneficence / nonmaleficence and respect for autonomy</td>
<td>- Principle of loyalty / fairness</td>
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<tr>
<td>- Prospects for “normal” life</td>
<td>- Issues affecting treatment plans</td>
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<td>* How much suffering to survive</td>
<td>* family</td>
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<td>* Plans to forgo treatment</td>
<td>* provider</td>
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95% of decisions in clinical care are made above the double line.
Quality of Life

- Raises issues clinicians confront
- Possibly a new way of considering decisions
  - When to treat
  - When not to treat
  - Meaning of “futility”
  - Who makes the decision?
A Case:

A 95 year old woman is transferred to your ER with a ruptured abdominal aortic aneurysm. She is hypotensive, but cognizant.

She is told she has a terribly serious problem and that if she has surgery, she may not survive.

She was taken to the operating room and died during the procedure.

What is the ethical problem?
Ethical Dilemmas Related to Quality of Life:

- Divergence between quality of life as assessed by physicians, nurses and the patient
- When patients are unable to express the quality of life they wish to have
- When the enhancement of normal qualities is set as a goal of treatment
- When quality of life is used as an objective standard for rationing care
When Using Quality of Life in Clinical Decision Making, Must Consider:

- Judgment of poor quality of life
  - Personal evaluation – the one who lives the life
  - Observer evaluation – what observers think is poor quality, may be lived quite satisfactorily by the one living the life

- Poor quality may mean:
  - Pain, loss of mobility, debilitation, loss of mental capacity & ability to enjoy human interaction, loss of joy in life
When Using Quality of Life in Clinical Decision Making, Must Consider:

- Evaluation of quality changes with time
- Evaluation may reflect bias and prejudice
  - Mentally retarded are said to have “poor quality of life” because our cultural bias favors intelligence and productivity
- Evaluation may reflect socioeconomic conditions beyond the experience of the patient
  - We must explain home care, rehabilitation, special education
Physicians Should Consider: When Do We Advise Not to Operate?

- The patient is old and senile
- The surgeon is old and wise
- Surgery would be futile
  - Can we use that word?
  - Ethical range is 0-15% survival
- Patient is “no code”
- Data speaks against improvement
  - ex. obstructed defecation
Case Considerations:

- Chances of return to acceptable quality of life
- Risk / benefit ratio for extensive surgery
- Dealing with the “unconscious” patient
- Who decides for minors?
- Ethics of “teaching service”
- Who supports the doctor?
Futility???