Surgeons and Ethics: You Bet!
It's early August in the surgical intensive care unit of a major teaching hospital. All of the surgery residents are either new interns or have just rotated onto the services involved. They are confronted with the problem of a 50-year-old woman with severe diabetes, who has been on renal dialysis for many years because of her end-stage renal disease. She is a "clinic patient" with little continuity in her care and the lowest level of economic reimbursement from the state for all of her care. There is no attending physician familiar with all aspects of her medical and living situation.
Almost three months ago a heroic attempt was made by the vascular surgery service to provide dialysis access using the femoral artery. The surgical site became infected, and one week after surgery she was admitted for debridement of the wound. While this was being done, she bled massively and remained in hypotensive shock for at least 30 minutes. Since that episode, she has been on a ventilator, unresponsive except to deep painful stimuli, septic, and sedated.
A Hypothetical Case (cont.)

- Her dialysis had been maintained through a subclavian line, which may be infected and is becoming ineffective because of clotting. If she is to be kept alive, the subclavian line must be replaced by interventional radiology. They refuse to do the procedure without "legal consent".

- Investigation by the new crew of surgical residents reveals that the patient has no "advance directive", and there is no designated surrogate decision maker.
• She has a "common-law" husband of 30 years, but his legality is not recognized in the state in which the hospital is located. The patient's sister has been signing most of the consent forms but doesn't wish to do it any longer.

• These forms include an undated "do not resuscitate" directive. The patient has eight adult children. Only one visits her mother, and she is described by the nurses as frequently "high on drugs".
A Hypothetical Case (cont.)

• The ethical questions facing this group of surgery residents are these:

1. Does the family know about the possible iatrogenic cause of the potentially fatal complication?
2. Who can make legal decisions for this patient?
3. Is it appropriate to continue dialysis and all other forms of aggressive life support?
4. What is the depth and cause of her "unresponsive" state?
A Hypothetical Case (cont.)

5. Can radiology really refuse to do an urgent, life-saving procedure because of lack of adequate "informed consent"?

6. Who, if anyone, in the hospital is designated to help resolve such complicated issues?
What About An “Ethics Consult?"
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!
So why is this such a big deal now?
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:**

**Medical Indication**
- Principles of beneficence / nonmaleficence
- What is the pt.'s medical problem?

**Patient Preferences**
- Principle of respect for autonomy
- Decision-making capacity
  - Advance directives
  - Right to choose

**Quality of Life**
- Principles of beneficence / nonmaleficence and respect for autonomy
- Prospects for “normal” life
  - How much suffering to survive
  - Plans to forgo treatment

**Contextual Feature**
- Principle of loyalty / fairness
- Issues affecting treatment plans
  - family
  - provider
  - economic
  - religious
  - research
  - teaching
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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 A.F.

- 20 year old woman in high speed auto accident had seat belt avulsion of anterior abdominal wall, fracture of shoulder, fracture of back, multiple internal organ perforations.
- Family described as hostile, unrealistic and impossible to work with.
Case A.F.

- Asked to consult for management of fistulas and stomas
- Initial encounter
  - On isolation
  - Dark room
  - Family and patient in tears
  - Patient somnolent and in pain
  - I offered transfer to C/R service and “total care”, not just “fistula consult”
Case A.F.

- Initial conversation with patient
- Meeting with parents next day
  - Young parents driving behind children and saw both of them critically injured as they watched
  - Child described as being in constant severe pain
  - No one doctor speaking to family
  - Probably abused on “teaching rounds”
Case A.F.

• Why I became her doctor
• Transferred to C/R surgery service with no abdominal wall and large cluster of small bowel fistulas beneath her right chest wall
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 surgeon?
Surgeons and Ethics

- We need the knowledge and skills to quickly and effectively deal with issues
  - We usually do so correctly and compassionately
- But, the game is constantly changing
- We deliver the news that a person has a serious problem, must undergo surgery (at our own hands) and the condition may change or shorten their lives
Surgeons and Ethics (cont.)

• We must guide them to the current decisions for surgery, post-op care and long-term implications (perhaps for generations if genetically based)

• No one else can understand the anxiety of going to bed at night and realizing what must be done in the morning
Surgeons and Ethics (cont.)

• No one else can identify with the situation in the OR when we “burn the bridge” and must go forward with no end in sight

• Yet we stand by, allowing the community, our students and our non-surgical colleagues to perpetuate the myth that we are only technicians
• Get involved – learn ethical principles

• Teach what we know and cherish

• Enjoy seeing our patients, their families and our students relish what we do so well!
Futility???