Medical Ethics: Origins, Principles and Case Studies

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No disclosures

Objectives

1.) Name and define 4 Common Ethical Principles

2.) Know components to assess capacity for medical decision-making

3.) Define: Principle of Proportionality

Ethics Everywhere

Bioethics/Clinical	Associations have Codes of Ethics: AMA, ANA, ADA	Organizational Ethics	Research Ethics
Business Ethics	Journalism Ethics	Legal Ethics	Computer Ethics
Religious Ethics	Transplant Ethics	Prison Ethics	Animal Ethics

Clinical Ethics

"Changes in modern medicine have created an unanticipated range of ethical dilemmas that demand justice and reflective **clinical** response."

Siegler, Mark 1979

Incompetent Patients PVS

1975 Karen Ann Quinlan, 22yo, (unconscious after consuming valium with alcohol in crash diet) persistent vegetative state for over a year, father was appointed her surrogate. Right to refuse respirator support? Hospital refused to remove ventilator despite parent's requests- euthanasia.

NJ Supreme Court ruled for the parents, ventilators and feeding tubes thought to symbolize "an oppressive medical technology , unnaturally prolonging dying".

PVS for 9yrs on feeding tube

Incompetent Patients PVS

1983 Nancy Cruzan 26 yo (anoxic injury auto accident) persistent vegetative state, parents court-appointed guardians, removal of artificial nutrition and hydration?

US Supreme Court stated that artificial nutrition and hydration, like respirators, are medical interventions that can be removed based on 'clear and convincing evidence' of patient's preferences

Start of patient wishes and values

Serious implications for the elderly

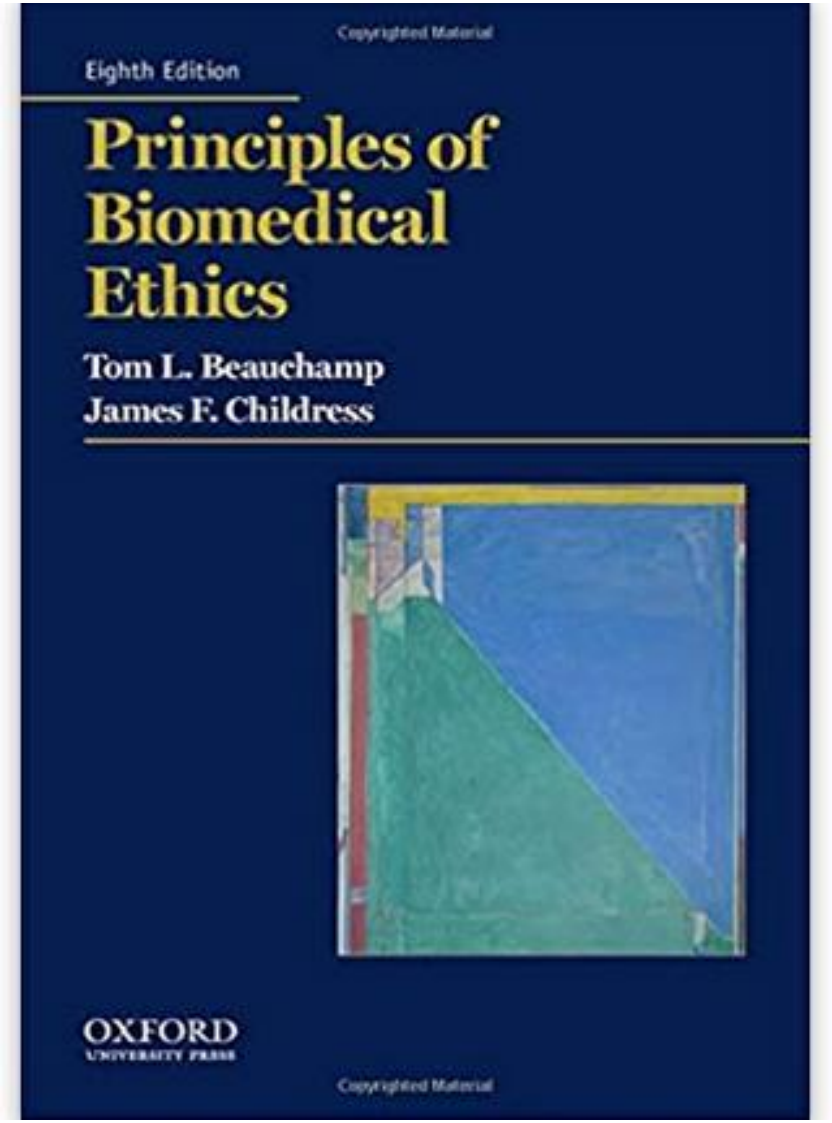
Incompetent Patients PVS

1990 Terri Shiavo, 41yo, (anoxic brain injury cardiac arrest K+ imbalance) irreversible persistent vegetative state. Removal of administered nutrition and hydration

Husband appointed legal guardian. Husband states she never would have wanted, parents challenged.

Feeding tube removed and replaced, 14 appeals, motions and hearings in Florida, states rights. Feeding tube removed last time March 2005 and she died.

Public opinion, husband should have the authority to make decision for wife – surrogate decision-makers



Origins of Principlism
Tom Beauchamp and James Childress

1970s

Advocated by National Commission for the Protection of Human Subjects of Biomedical Research

Belmont Report: principles and guidelines for research

1976 Autonomy, Beneficence, Justice

1979 added Non-Maleficence

4 principles are at the core of moral reasoning in healthcare

Principles of Biomedical Ethics: "Principlism"

fundamental bioethical concepts, most commonly taught

Autonomy: person rule of oneself; the capacity to make an informed, uncoerced decision.

Beneficence: do good; to act for the benefit of the patient

Non-maleficence: committing no harm; avoid disproportionate harm

Justice: fair distribution of resources, equality; equitable allocation of healthcare resources

Patient Self-Determination Act 1991

The purpose of the Self-Determination Act is to inform patients of their rights regarding **decisions toward their own medical care**.

Includes **Power of Attorney** should the patient become incapacitated

Goals were to prevent cruel over-treatment

Reduce costs of end-of-life care when **elderly would elect to refuse life extending or life saving treatments in order to shorten their suffering** unto a certain death.

Self-Determination Act (SDA)

Allows a patient to refuse treatment

There is no corresponding right that permit patients to demand treatment that is not medically beneficial

4 Principles adding

Veracity:

truth telling

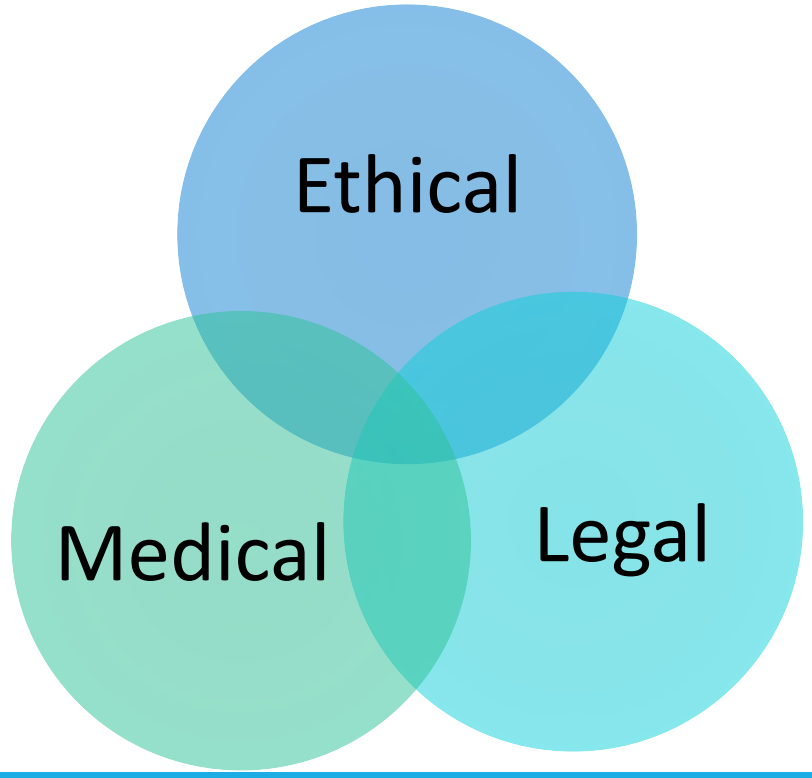
Compassion: concern for others' suffering

All are important, but some may take precedence over others at times.

Relationship of Ethical and Legal Issues with Medicine

Ethics interacts:

- With a variety of other disciplines and works closely with both the medical and legal teams.
- Examples:
  - Medical/Ethical- when is it ok to withdraw ventilator care?
  - Ethical/Legal – who gets to make the decision to withdraw medical care?
  - Medical/Ethical/Legal – why do we need a guardian to make decisions for Mr. Smith?



Capacity for Medical Decision-Making:
4 Key Components

- **Communication.** The patient needs to be able to express a treatment choice, and this decision needs to be stable enough for the treatment to be implemented.
- **Understanding.** The patient needs to recall conversations about treatment, to make the link between risk versus benefit.
- **Appreciation.** The patient should be able to identify the illness, treatment options, and likely outcomes as things that will affect him or her directly. Impact on daily life.
- **Rationalization or reasoning.** The patient needs to be able to weigh the risks and benefits of the treatment options presented to come to a conclusion in keeping with their goals and best interests, as defined by their personal set of values.

Questions to Assess Capacity for Medical Decision-Making:

- Tell me what you believe is wrong with your health now.
- I have shared the possible benefits and risks of XX procedure. How would it affect your everyday activities?
- Tell me how you reached your decision.
- Tell what makes XX procedure seem worse than the alternatives.

Capacity for Medical Decision-Making

Different than: being **Alert and Oriented**

Capacity can:

- Wax and wane
- Affected by illness
- Medications
- Psychiatric diagnoses/dementia do not rule out possibility of capacity

Ethical Dilemmas

If a patient/surrogate agrees to a recommended treatment that aligns with the provider, there is no issue.

If a person has *decision-making capacity*, they have the right to refuse recommended treatment.

Patient ideally speaks directly or through a surrogate decision-maker

Ethical Dilemma

An *ethical dilemma* is a situation where there is a major difference between family members, patient and family members, physicians and nurses, patient and physician, etc.,

-- about what "**should**", "**ought**", or "**ought not**" be done in a situation.

Recap: we've covered

Principles: Autonomy, Beneficence, Non-maleficence, Justice, Veracity, and Compassion

Self-Determination Act

Relationship: Medical, Ethical, Legal

Capacity

Case #1

20 yo college student presents to Emergency Department with unrelenting headache and fever. He appeared drowsy but was responsive. Neck rigidity on exam. Agreed to lumbar puncture. Spinal fluid was cloudy with increased white blood cells. Appropriate IV antibiotics were started.

Diagnosed with Bacterial Meningitis. Proceeded to admit him to the hospital.

Patient refused further treatment without giving any reason. He wanted to return to his dorm.

Provider gave explanation as to the seriousness of diagnosis and absolute need for continued treatment, including danger to life without treatment.

Ethical Principles Case #1

Autonomy

Pt making choice for no treatment with dire consequences

Can we treat against his will?

A clear determination of mental capacity cannot be made—presumed altered mental status due to infection

Patient would not give his rationale for declining treatment

Beneficence

Treatable condition

Severity of illness and urgency to treat to save his life --- supports treatment

Justice

Protecting others in the dorm

Best Interests

Best interests of the patient (what outcome would most likely promote the patient's well-being). Opinion 2.1.2 explains, "Best interest decisions should be based on …the pain and suffering associated with the intervention," "the degree of and potential for benefit," and "impairments that may result from the intervention"

Best Interests - providing care that when patient's direct values are unknown, would be what a reasonable person would choose among the options available to promote health and reduce burdens.

Case #2

Family does not want the patient informed of the diagnosis or prognosis

Cultural

Religious

Patriarchal

Translator if needed.

Ethical Principles Case #2

Autonomy

Capacity

SDA: Allows delegation decision-making authority to another person

Ask: Would you like to make decisions yourself or prefer family to decide?

Respect Cultural Values

Veracity

Truthful

Want patient fully informed

Ask the patient how much they want know. If decisions on treatment need to be made, who should we discuss this with?

What is the Goal of Medicine?

1. Cure disease
2. Improve quality of life through relief of symptoms, pain, suffering
3. Promotion of health and prevention of disease
4. Prevent untimely death
5. Improve functional status or maintain compromised status
6. Educate and counseling of patients regarding their condition and prognosis
7. Avoidance of harm in the course of care
8. Provide relief and support near the time of death

What is the Goal of Medicine?

1. Cure disease Beneficence
2. Improve quality of life through relief of symptoms, pain, suffering Beneficence/Compassion
3. Promotion of health and prevention of disease Autonomy/Justice
4. Prevent untimely death Non-Maleficence
5. Improve functional status or maintain compromised status Beneficence
6. Educate and counseling of patients regarding their condition and prognosis Autonomy/Veracity
7. Avoidance of harm in the course of care Non-Maleficence
8. Provide relief and support near the time of death Compassion

Principle of Proportionality

The **Principle of Proportionality** states that responses should be proportional to the good that can be achieved and the harm that may be caused.

Ethically, providers have no obligation to offer, recommend, or perform interventions or procedures that have no improvement in patient's health outcomes.

Considerations: Is the treatment being offered ***a perceived benefit to the patient*** or are we doing it for the family members?

The patient bears the burden

Case #3

76yo woman with advanced Alzheimer's dementia, alert, speech incoherent, bed bound, losing weight - had a previous PEG feeding tube placed. Pt was accepting some oral intake. Pt pulled out the PEG tube 2 weeks ago. Family did not worry because patient was eating orally.

Sudden change in mental status, admitted with UTI. Treated with IV antibiotics.

Family and medical team hopeful that pt would improve after antibiotic treatment.

Patient stopped eating, decline in cognition, not alert, cried out anytime she was touched, would not open her mouth.

Pt's sister was her guardian and wanted a new PEG tube placed.

Medical team thought infection tipped an already fragile patient and patient should start comfort measures.

Ethical Principles Case #3

Non-Maleficence

If Peg placed: risks aspiration, continue risk malnutrition, dislodgement, increased risk pressure wounds, hospital readmissions

Risk psychological harm with restraint use or sedation

American Geriatric Society Position Statement: feeding tubes are not recommended for older adults with advanced dementia

Autonomy

Sister was guardian and decision-maker

Sister said patient would have wanted tube feeding

Ethically, providers have no obligation to offer, recommend, or perform interventions or procedures that have no improvement in patient's health outcomes.

Consent versus Assent

Consent: *to grant permission for something to happen*

Must agree to accept risks versus benefit

Case #3 Patient does not have capacity to provide consent

There is no corresponding right that permit patients or families to demand treatment that is not medically beneficial or may cause more harm

Assent: means *to agree with an opinion, to express agreement or acceptance*

If patient does not accept treatment, tries to pull out the tube, in restraints, cries whenever she is touched--- she is not assenting

Causing harm to the patient?

Ought we provide the PEG feeding tube?

Case #4

89 yo woman wheelchair bound with significant pressure ulcer in the sacral area that was necrotic. Patient lived at home with a mildly cognitive impaired adult daughter. The daughter was able to help the patient with much guidance.

The stage IV pressure wound was debrided and the surgical team's recommendation was to perform a diverting colostomy to prevent fecal matter infecting the wound and to keep it clean.

The attending staff were concerned about patient's ***poor quality of life***.

Worsening wound that would never heal, wheelchair bound, would now have an ostomy to manage in her advanced age. Unlikely that daughter could manage ostomy care.

Patient had capacity.

Staff thought we should offer comfort measures versus aggressive surgery.

Quality of Life (QOL)

Definition: personal satisfaction expressed by individuals about their own physical, mental, and social situation.

Based on Autonomy

Determination of QOL is best made by the patient herself (perhaps with her family), not by the healthcare provider

Providers should therefore be very cautious in making judgments about QOL for their patients.

Ethical Case #4

Met with patient who expressed her values.

Willing to risk complications of surgery

Willing to endure the ostomy

Willing to perform care for the worsening wound

If patient had accepted comfort measures for end-of-life care—she would likely die soon.

**Patient was worried about where her daughter would live and who would care for her.

Patient was willing to have multiple procedures to stay alive for the benefit of her daughter.

Risks were worth her ***Quality of Life***

Medical Futility

Merriam-Webster: Futile: serving no useful purpose, completely ineffective, uselessness

Definitions of medical futility can sound like abandonment, can be inconsistent, controversial, and vague

Futility is often slanted to reflect the definer's point of view.

Invoking 'medical futility' is often a code-word for unilateral withdrawal of treatment

Medical Futility

When someone says, “Continuing treatment in this case would be futile,”

You should seek clarification, “Futile for what? For what treatment goal?”

This is where “proportionality” is helpful.

Recall the **Principle of Proportionality** states that responses should be proportional to the good that can be achieved and the harm that may be caused.

You might say, “Continuing this particular therapy might be disproportionate for our treatment goals”.

Medical Futility
Proportionate vs Disproportionate

An example “CPR would be futile in this elderly 85yo woman with heart failure.”

Consider: “CPR would likely cause more harm (or trauma) than benefit for the goal of discharging Mrs Jones from the CCU (Coronary Care Unit).”

“The potential side effects of another round of chemo could be severe and ***disproportionate*** to the goal of achieving a meaningful and comfortable prolongation of life.”

Case #5

75yo male severe COPD admitted to ICU with pneumonia, sepsis and respiratory failure.

Prior to admission, used oxygen at home and was short of breath with minimal exertion

2 previous admissions to ICU and intubated.

Despite multiple antibiotics, IV fluid hydration, vasopressors, his SBP is in the 70s, elevating liver enzymes, anuric with creatinine rising to 5, edematous, and mottling coloration of bilateral lower extremities.

Ethical principles Case #5

Compassion: Compassionate care for the dying

Withdraw treatment—but do not withdraw care

Non-maleficence: avoid harm in proportion to the good that can be achieved

Goals of Medicine

Family meeting for goals of discontinuing life-sustaining interventions: empathy, explanation multisystem organ failure, allow a natural death

Performing CPR

Physicians are not obligated to deliver care that, in their professional judgment, will not have a reasonable chance of benefiting the patient.

As a result, a physician has no ethical duty to perform CPR if it is determined to be ineffective and non-beneficial

Cause more harm and trauma

Will postpone natural death

Medical interventions are medical decisions, not a patient or family choice

Don’t give choices where none really exist! Many institutions have policies that support these medical decisions.

DNAR Against Surrogate Decision-Maker

2 physicians: one being the attending and the other in the same service or a consultant seeing the patient, can agree to change code status to DNAR with Ethics Committee support.

Pt has a guardian who cannot make medical decision for code status.

Surrogate decision-maker or next-of-kin cannot state “DNAR”, yet they agree.

Often family member will say, “It’s fine for you to change it, but I just cannot’.

Moral Burdens and the Choice of DNAR

Leaves the family with heavy responsibility

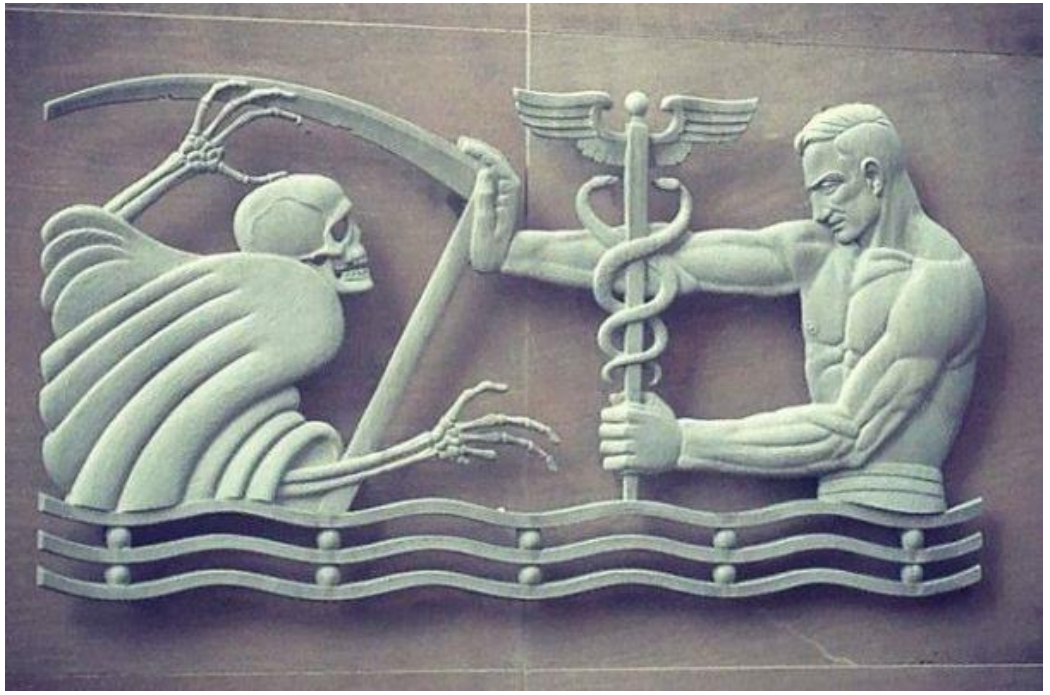
Family members agonized over the dilemma

Think they made the decision to end a loved one's life.

"Pulled the plug" and bear responsibility for death

If left on life support, believe they have forced ongoing suffering.

PTSD much higher even years later!



Organ Donation for Reduced Prison Time

Bill filed in Massachusetts's House of Representatives Jan 20, 2023

Allow prisoners who choose to donate organs or bone marrow for transplantation to be eligible for reduced sentences.

Reduce sentence at least 60 days - no greater than one year.

https://apnews.com/article/organ-donation-massachusetts-state-government-health-a11a7f93dd13ad018bbb1899dbb4623a

Organ Donation for Reduced Prison Time

First thought: Crazy! Induce incarcerated individuals to undergo an operation (with non-zero risk of death or lasting morbidity) to reduce prison term!

Shouldn’t a prisoner be able to donate a kidney just as healthy individuals who are not in prison?

Principles

Autonomy: Decision over own body

Beneficence: help a patient in ESRD

Justice: helping another,

debt to society,

reduce dialysis costs.

Non-Maleficence: surgery is not without risk, who will bear cost if poor outcome for the donor

Organ Donation for Reduced Prison Time

Incentive for the option: Bribe, coercive, exploitive

A ‘captive population’ at risk for exploitation? Exploitive if both parties benefit?

How free are prisoners to consent?

Is 60 days to 1 year sufficiently large enough to risk kidney transplant?

Donation carries risk for future health care.

Is the incarcerated population biased by structural injustices: majority black and brown people, some degree of mental illness or intellectual disability, socioeconomically marginalized

Federal law bans selling human organs. Is reducing a prison sentence in exchange for organ donation the equivalent of a payment?

Federal prisoners are allowed to donate organs, but only when the recipient is a member of the inmate’s family.

Organ Donation for Reduced Prison Time

Code of Ethics for Prisons:

The American Correctional Association expects of its members unfailing honesty, respect for the dignity and individuality of human beings and a commitment to professional and compassionate service.

When are Providers too Old to Practice?

Safety and Patient Care: factors associate with aging: analytical processes, working memory, declining visual acuity, slowing mental operations

Differences in performance may come after age 60

Commercial airline pilots screened after age 40 and retire by age 65 (used to be 60)

Mandatory retirement of air traffic controllers age 56!!

Principles

Autonomy: provider to decide for themselves

Professional organizations to self-determine competence

[Organizational ethics – are **the values, principles, and standards that guide the individual and group behavior of the people in an organization**.]

Beneficence: Experience and wisdom

Justice: patient safety

Ease shortage of providers by working into later years

Non-maleficence: prevent harm

When are Providers too Old to Practice?

Young providers doesn’t mean competent provider. Older does not mean incompetent.

Assessment by specialty or practice? Example surgeons cognitive and psychomotor testing at age 65?

Resistance to report impaired colleagues.

Mandatory retirement age does not account for older providers performing on par with younger or account for age related wisdom and experience

Who monitors solo practice providers?

How often to retest?

How are records maintained?

Top Ethical Issues Medical Students Should be Taught (AMA 2021)

1. Maintaining health and wellness
2. Using social media professionally
3. Reporting incompetent or unethical behaviors by colleagues
4. Accepting gifts from patients
5. Working with surrogate decision-makers
6. Addressing disparities in health care
7. Managing conflicts of interest

Ethical Decisions Everyday

Decide which blood pressure medication will provide greater benefit with less risk to kidneys

Decide which antidepressant will help and not impact seizure threshold

Discuss risk and benefit of cardiac procedure versus medical management and guide patient to make autonomous decision

Don’t offer non-beneficial treatment as an option

You are truth-telling when there are no additional treatments to offer and then provide compassionate care to manage pain

Reporting errors

Interest in Bioethics

ASBH American Society for Bioethics and Humanities

National Institute of Health

Professional Organizations Code of Ethics– Code of Ethics, then challenges

Review Objectives

1.) Name and define 4 Common Ethical Principles:

Autonomy, Beneficence, Non-Maleficence, Justice, Veracity, Compassion

2.) Know components to assess capacity for medical decision-making:

Communication, Understanding, Appreciation, Rationalization

3.) Define: Principle of Proportionality:

Responses should be proportional to the good that can be achieved and the harm that may be caused.

Thank you for your attention and participation!

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