FREQUENTLY ENCOUNTERED TOPICS IN MEDICAL ETHICS

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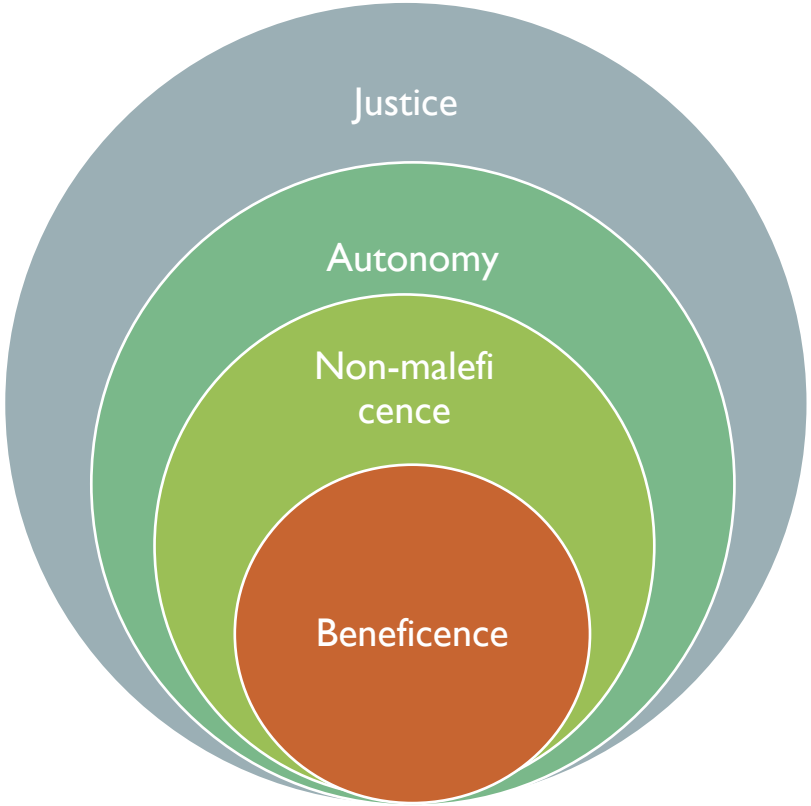
LEARNING OBJECTIVES

- Describe the four principles of medical ethics and how they were derived.
- Explain differences in withholding vs. withdrawing of life sustaining treatments and how this differs from physician aid in dying.
- Explain the difference between capacity and competence.

OUTLINE

- Principles of Medical Ethics
- Disclosure Medical Errors
- Nonabandonment
- Determining Capacity vs. Competence
- Surrogate Decision Makers
- Inappropriate Care or Care of Disputed Efficacy
- Withholding vs. Withdrawing Life-Sustaining Treatments
- Physician Aid-In Dying

PRINCIPLES OF MEDICAL ETHICS



1. Beneficence* – the duty to do good
2. Nonmaleficence – the duty to prevent harm
3. Respect for Patient Autonomy – the duty to respect persons and their rights of self determination
4. Justice – the duty to treat patients fairly

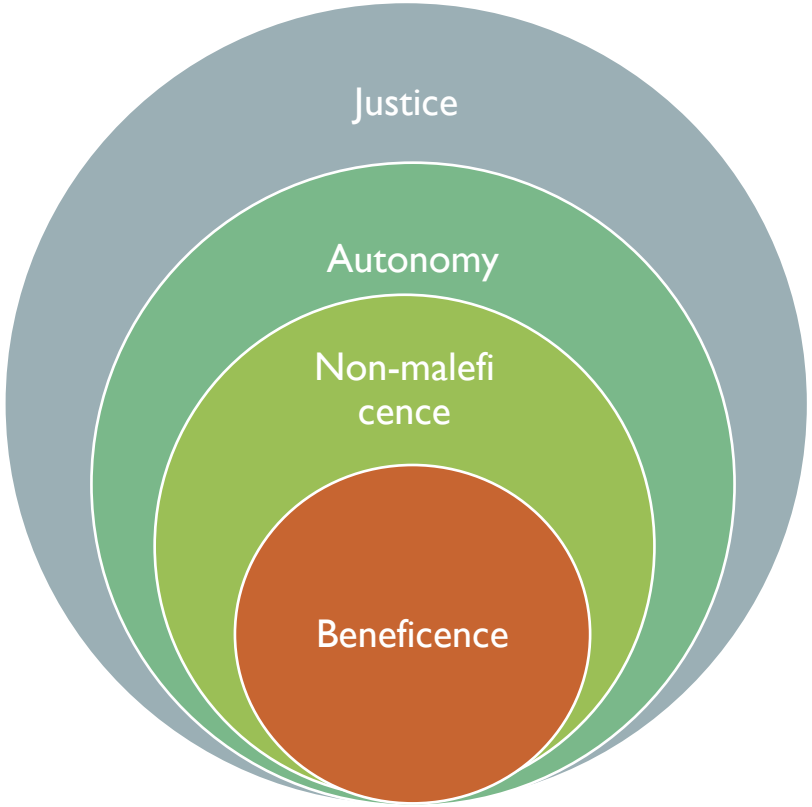
*primary motivating principle for most physicians

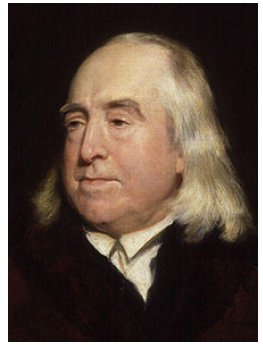
Principles are *prima facie*

WHY "PRINCIPLISM"?

Immanuel Kant
1724-1804

- Reason is the source of morality
- Categorical imperative





Jeremy Bentham
1748-1832

- Father of utilitarianism
- Greatest happiness of the greatest number

MEDICAL ERRORS

MKSAP 72

A 72 YOF is evaluated for 2-weeks of intermittent dizziness. She has had no falls. Medical history is notable for HTN and DM, for which she takes amlodipine, lisinopril, and metformin. Review of the patient's medical record reveals that the dosage of amlodipine was increased 3 weeks ago by a colleague's order. The patient's documented blood pressure was normal 3 weeks ago, and the care plan notes that the dosage of the antihypertensive agents should remain the same.

On exam, blood pressure is 115/70 mm Hg supine and 90/55 mm Hg standing, and pulse rate is 85/min supine and 105/min standing.

Which of the following is the most appropriate management?

A. Explain that a colleague made an error and steps will be taken to reduce the chance of recurrence

B. Explain the pharmacy committed an error by providing the incorrect dosage

C. Report the error to the National Practitioner Data Bank without further patient disclosure

D. Restore the dose of amlodipine without further patient disclosure

MEDICAL ERRORS

- Require full, honest disclosure
- Disclosure helps preserve/restore physician-patient relationship
- Patients more likely to pursue legal action if not informed
- Errors not necessarily improper, negligent, or unethical
- Failure to disclose is unethical if material to patient well-being

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NONABANDONMENT

MKSAP 115

A 52 YOM fails to attend a scheduled appointment. He was initially evaluated for bilateral knee OA 1 year ago, and treatment with weight loss, NSAIDs, and physical therapy was recommended. Over the past year, the patient missed 3 scheduled appointments, did not attend physical therapy, arrived for urgent care assessment twice with requests for stronger pain medications, and did not complete sufficient trials of oral nonopioid pharmacologic agents. Attempts to reach the patient by phone to discuss adherence to his care plan have not been successful. The visit today was scheduled to discuss the difficulties in his treatment and assess his barriers to care. Medical history is significant for bipolar disorder. In past visits, he has not appeared manic or suicidal.

Which of the following is the most appropriate management?

A. Refer the patient to a psychiatrist
B. Report the patient to the local mental health crisis team
C. Send the patient a letter that the relationship may be terminated
D. Terminate the relationship immediately

NONABANDONMENT

- Related to beneficence and nonmaleficence
- Fundamental to long-term physician-patient relationship
- Rarely physician may terminate, usually only if
  - Adequate care available elsewhere, and
  - Patient's health not jeopardized
- Nonadherence is not grounds for abandonment
- Must notify in writing
- Abandonment is actionable under the law

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INFORMED CONSENT & CAPACITY

INFORMED CONSENT

- Sufficient information on risks, benefits, and alternatives
  - Professional practice standard
  - Reasonable person standard
- Shared decision making - not a menu of choices
- Principle of implied consent
- Therapeutic privilege

MKSAP 89

A 70-year-old man is evaluated before discharge from the hospital after treatment for community-acquired pneumonia. Medical history is significant for mild dementia. The patient lives alone and has a daughter who lives nearby. Remaining in his home is very important to him.

The care team recommends that the patient be discharged to a short-term rehabilitation facility to gain strength and prepare him to safely return to his home. The patient refuses. Decision-making capacity is assessed; he is able to articulate the risks, benefits, and alternatives to short-term rehabilitation as well as an understanding of his current medical condition.

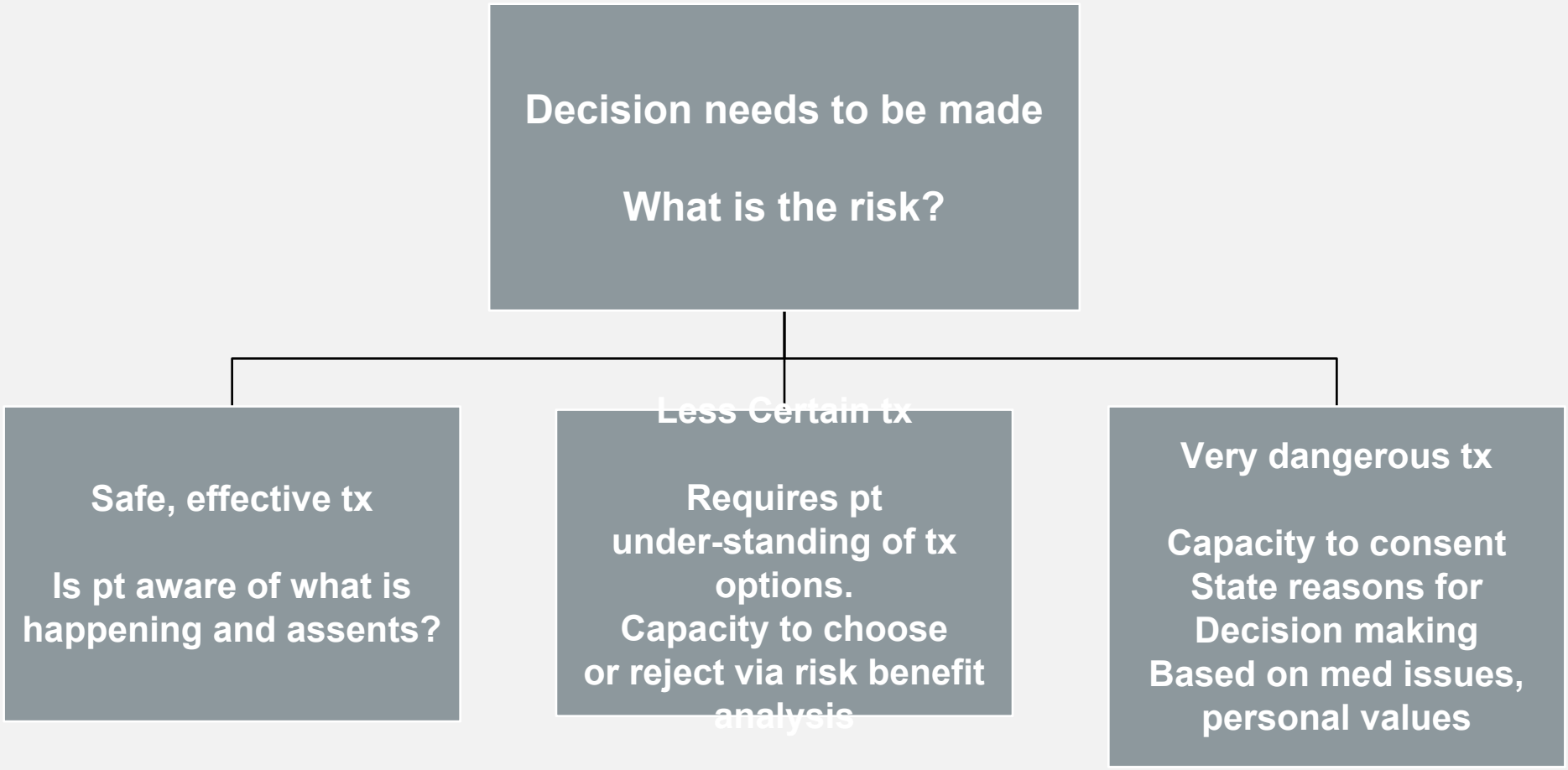
Which of the following is the most appropriate management?

A. Perform a SLUMS
B. Ask the patient's daughter to make a decision on his behalf
C. Discharge the patient home with home care services
D. Obtain a court order for the patient to be discharged to a rehabilitation facility
E. Refer the patient to a psychiatrist for a capacity assessment

DECISION MAKING CAPACITY

- **Clinical** determination of patient's ability to understand
- Capacity ≠ Competence
- Competence is a legal determination
- Lack of capacity should be proven, not presumed
- Affected by confusion, disorientation, psychosis, disease…
- **Capable patients can refuse ALL medical interventions**

THE SLIDING SCALE OF CAPACITY



Source: Drane J. JAMA 1984;252:925-927

ASSESSING CAPACITY

- Can the patient make and communicate a choice?
- Does the patient understand the medical situation?
  - Prognosis?
  - Nature of recommended care?
  - Options?
  - Risks and benefits of each option?
  - Outcomes of each option?
- Are the patient's decisions stable over time?
- Is this decision consistent with the patient's values and goals?
- Is the decision due to delusions or AMS?

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SURROGATE DECISION MAKERS

MKSAP 160

A 45-year-old man was hospitalized following a head-on motor vehicle crash. On day 4, he survived cardiac arrest but experienced anoxic brain injury. The care team concludes that he has a poor neurologic prognosis and is unlikely to regain consciousness or interact with his environment.

A family meeting is planned to discuss the decision to perform a tracheostomy and percutaneous endoscopic gastrostomy for enteral feeding. His wife reports that the patient has previously stated that he would not want to be kept alive if he could not interact with her or their children. The patient does not have an advance directive.

Which of the following should be the basis for the decision regarding this patient's management?

A. Patient's best interest
B. Patient's medical condition
C. Patient's previously expressed wishes
D. Risk management

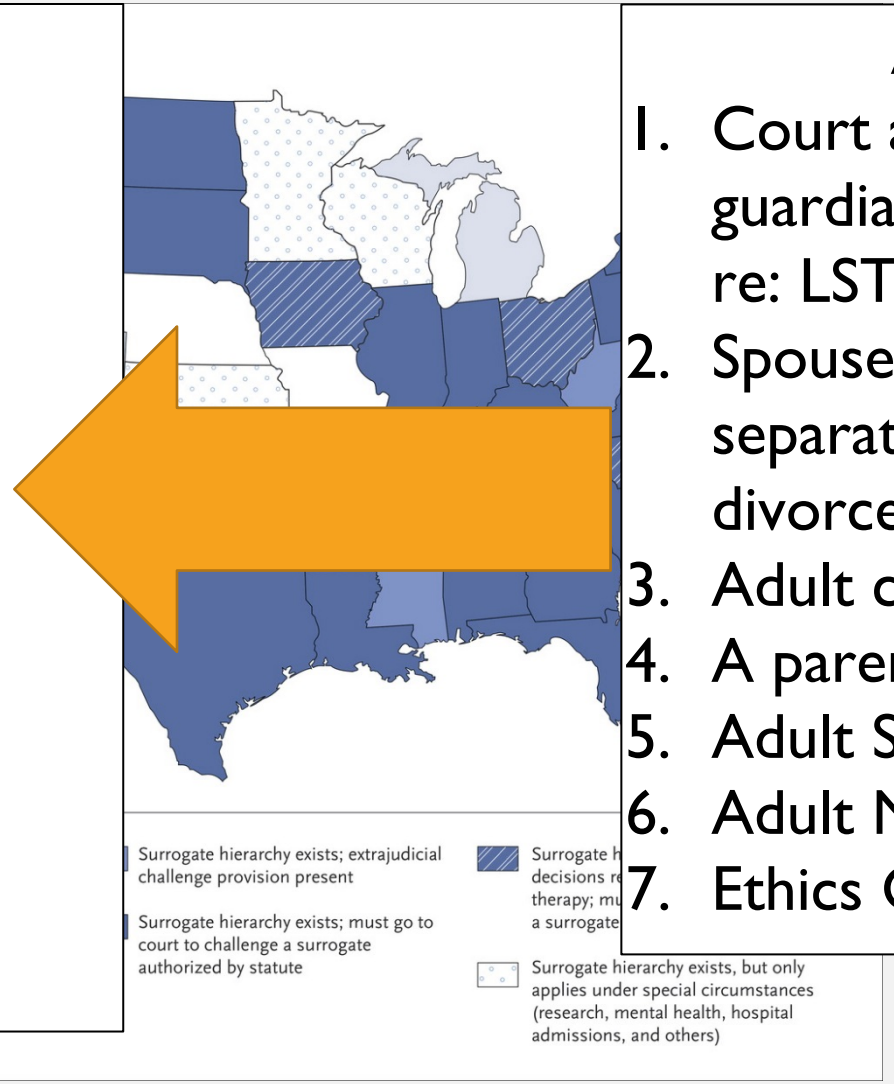
SURROGATE DECISION MAKERS

- Almost 40% adult inpatients (90% in ICU) lack decisional capacity
- Ideally designated by the patient before losing capacity
- 3 Broad Types:
  - Designated in durable POA for health care
  - Family member or the court (next slide)
  - Moral surrogate (usually a family member)
- Substituted judgment vs. Best interest standard
- May delegate while patient still has capacity (ex: cultural context)

SURROGATE HIERARCHY STATE-BY-STATE

VA (regardless of state)

1. Healthcare agent
2. Legal guardian or special guardian
3. NOK
   - Spouse
   - Adult child (>18)
   - Parent
   - Sibling
   - Grandparent or Grandchild
4. Close friend
5. Committee Review
   (Discuss with Chief of Staff)



Alabama

1. Court appointed guardian (if authorized re: LST)
2. Spouse (unless legally separated or a party to a divorce proceeding)
3. Adult child
4. A parent
5. Adult Sibling
6. Adult NOK
7. Ethics Committee

DeMartino ES et al. N Engl J Med 2017;376:1478-1482.

RESOLVING CONFLICT

- Surrogate decisions SHOULD NOT conflict with previous directive or other family members
- Physician responsibility is the patient
- Involve third-party arbitrator (ethics consult)
- Once established what patient would want, physician obligated to comply

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CARE OF DISPUTED EFFICACY

MKSAP 27

An 81-year-old woman was admitted to the ICU 8 days ago for multisystem organ failure associated with a severe episode of multilobar pneumonia. She has required mechanical ventilation since admission. Efforts to wean the patient from mechanical ventilation have not succeeded, and the patient remains somnolent and unresponsive to verbal stimuli. Medical history is significant for dementia, diabetes mellitus, COPD, chronic kidney disease, and heart failure.

The care team concludes and shares with the patient's family that she will not have a meaningful recovery; however, the patient's children request continued ICU-level care. The patient does not have an advance directive, and her wishes are unknown. After a family meeting with the care team to discuss the patient's prognosis, the children continue to request all treatment.

A. Consult with the hospital ethics committee

B. Discontinue ICU care in 48 hours if there is no improvement

C. Transfer the patient to another institution

D. Continue current level of care

CARE OF DISPUTED EFFICACY

- Patients can refuse any/all therapies (principle of autonomy)
- Not a right to all therapies/interventions (nonmaleficence)
- Physicians are not obligated to provide inappropriate care
  - Ex: Viral vs. bacterial pharyngitis
  - Ex: Surgical candidacy
- If physician and patient (or family) conflict, consult ethics for guidance

AMA *CODE OF MEDICAL ETHICS*
2000-2001 (2.035)

"Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care…not on the concept of 'futility,' which cannot be meaningfully defined."

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WITHHOLDING, WITHDRAWING, P.A.I.D. & EUTHANASIA

WITHHOLDING VS. WITHDRAWING LIFE-SUSTAINING TREATMENTS

- Carrying out a patient's request to withhold/withdraw is legal and ethical
- *Generally*, no ethical distinction between withholding and withdrawing
- Underlying disease remains the cause of death
- Intent is avoidance of an intervention that does not meet a person's goals of care
- "Right to refuse" ≠ "Right to die"
- Instead, patient has "right to be left alone"

PHYSICIAN AID IN DYING & EUTHANASIA

- Medical profession historically against (nonmaleficence)
- Challenged on basis of autonomy, beneficence, or compassion
  - "ending suffering"
  - "respecting autonomy"
  - "allowing death with dignity"
- AMA and ACP maintain stance against PAID & euthanasia
- AAHPM takes position of "studied neutrality"
  - Concerns re: physician-patient relationship, integrity of medicine

PHYSICIAN AID IN DYING & EUTHANASIA

- 1997 Supreme Court of the United States ruled on *Vacco v. Quill* and *Washington v. Glucksburg*
  - No right to physician-assisted death "guaranteed by US Constitution"
- Oregon re-approved referendum from 1994 allowing PAID
- California, Colorado, D.C., Hawaii, Montana, Maine (starting 1/1/2020), New Jersey, Oregon, Vermont, and Washington
- Euthanasia is illegal in all 50 states

VACCO V. QUILL

U.S. SUPREME COURT, 1997

"…when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication...[In *Cruzan*] our assumption of a right to refuse treatment was grounded not…on the proposition that patients have a…right to hasten death, but on well established, traditional rights to bodily integrity and freedom from unwanted touching."

END OF LIFE OPTIONS

	Withholding LST	Withdrawing LST	Palliative Sedation & Analgesia	Physician Aid in Dying	Euthanasia
Cause of death	Underlying disease	Underlying disease	Underlying disease, although may hasten death	Intervention prescribed by physician and used by patient	Intervention used by physician
Intent/Goal of intervention	Avoid burdensome intervention	Remove burdensome intervention	Relieve symptoms	Termination of patient life	Termination of patient life
Legal?	Yes*	Yes*	Yes	No*	No

*Several states limit surrogate's ability regarding LST. PAID legal in CA, CO, DC, HI, MT, ME, NJ, OR, VT, WA.

Source: Swetz, K. *J Palliat Care* 2018;34(2):75-77

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