

Student Medical Ethics Study guide 2011-12

Because every encounter between a doctor and a patient has a moral dimension, competency in ethics is essential to being a good doctor.

"Everyday ethics in internal medicine resident clinic: an opportunity to teach"

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PROFESSIONAL RELATIONSHIPS/ MEDICAL EDUCATION –Clinicalforum2Ethics

C-1 An Approach to Ethical Dilemmas in Patient Care

Clinical Ethics refers to the doctor- patient encounter

The law reflects the ethical consensus in society. The law sets a minimum standard of conduct. The law usually grants physicians discretion in clinical situations, requiring the physician to go beyond the law to make a final decision. (The law is the ethical minimum.)

Personal moral values create a disposition to do right actions.

More guidance is needed to make decisions in clinical ethics because (1) a physician's moral values may differ from those of other health care workers, (2) sometimes a physician's values may not address important issues in clinical ethics, (3) a physician's role specific obligations go beyond obligations as good citizens and (4) a physician's moral values may also differ from the religious & cultural back grounds of other stakeholders to the clinical dilemma

Text suggests an approach to resolving ethical dilemmas including:

Medical facts, concerns, values & preferences of the clinicians,

Concerns, values & preferences of the patients,

Ethical issues & ethical guidelines at stake,

Practical considerations which need to be addressed

Legal constraints

Sometimes physicians need seek outside legal and ethics (ethics committees) assistance to resolve ethical dilemmas.

C-2 Overview of Ethical Guidelines

When resolving ethical dilemmas physicians should refer to general ethical guidelines (principles) including:

Autonomy- A mentally competent, informed adult has the right to make his own medical decisions with the caveat: unless these decisions harm others, impose unfair claims on resources or violate another person's autonomy.

Nonmaleficence – Do no harm which includes physicians should not provide ineffective care. (See also C-4)

Beneficence- requires physicians to provide a net benefit to patients (See also C-4)

Justice- Fairness to all concerned- In health care this term is often defined as distributive justice and applied to fairly allocating finite healthcare resources.

Sometimes these principles conflict: A patient refuses the most beneficial care recommended by the physician. Which principle primes -autonomy or beneficence? At bedside should a physician engage in bedside rationing (distributive justice) or always be an advocate for his patient (beneficence)? Fairly allocating resources may conflict with best interest of an individual patient.

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Sometimes multiple principles are combined in one case: When patient does not have decision making capacity the physician is guided by the patient's best interest.

Guidelines always need to be interpreted in the context of specific facts. Physicians need to apply these guidelines with discretion & judgment to each particular case. The ability to make prudent decisions in these cases is 'discernment'.

Ethical theories:

Consequential theory weighs right & wrong by consequences.

Utilitarian theory weighs the overall benefits of all interested parties against the overall harm..

Casualty looks at how closely a particular case resembles an earlier precedent case, and how or whether the same principles apply to the present facts

Ethics of Caring- teaches responding to needs of individuals is more important than applying abstract principles.

Virtue Ethics- emphasizes the physician's character.

C-4 Promoting the Patient's Best Interest

Physicians have a fiduciary duty to act for the well being of patients as patients define their own well being.

Do no harm- physicians must not provide ineffective care, should not act maliciously, should act with due diligence, should not intervene to make situation worse, and if burdens & benefits are balanced should not intervene

Physicians have special fiduciary (holds something in trust for another) relationship with patients– special responsibilities to act for the well being of patient. Patients are vulnerable, they lack expertise, and they rely on their physician.

Disagreements occur over best interest

Quality of life-Physician goal is to increase survival. Patient goal is to avoid physical and mental decline.

Factors to consider – Symptoms of illness and side effects of treatment, patient's level of function, patient's subjective experiences, patient's independence, patient's privacy and dignity
Medical paternalism- Physician overrides a patient's choice.

Physician goal is to help patient cope with chronic condition & live an active life- patient wants relief of pain

The primary consideration should be analysis of benefits & risks and not costs

The ethical guideline of respect for patient autonomy and the legal doctrine of informed consent give patient the negative right to refuse unwanted treatments not the positive right to (demand) receive specific care

Physicians can satisfy ethical principles of beneficence (promote best interests of patient) & autonomy (patient's right to decide)

1-Understand the patient's perspective

2-Address misunderstandings and concerns

3-Try to persuade the patient

4-Negotiate a mutually acceptable plan of care

5-But ultimately let the patient decide

C-23 Overview Doctor patient Relationship

Models of physician- patient relationship

Paternalism- Physicians make the treatment decisions based on what they believe to be in the patient's best interest without input from the patient

Informed Choice- Physicians provide patients with the relevant medical information but withhold their opinions

Shared decision making-Physicians inform patients of treatment risks and benefits and both mutually agree on a plan of care

Patient centered approach-Physicians ascertain & incorporate patient's expectations, feelings & illness beliefs in treatment plan

Entrepreneurial physicians- make financial deals with medical device manufacturers to use their devices. This practice may raise a financial conflict of interest. Physician may be incentivized to drop unprofitable & increase profitable services- health care as a commodity for profit?

C-24 Refusal to Care for patients

Physicians' Ethical obligations-

Patient relationship: Patient's best interest primes physician's self interest

Physicians should not refuse care on basis of ethnic back ground, race gender, or religious belief-

Physicians should not refuse patients whom they think risky, difficult or when inconvenient

Physicians should tolerate patients whose behavior they consider immoral but

Physicians are not obligated to carry out what they consider to be immoral actions

Law: There is no general legal duty to provide care- doctor- patient relationship is a contract – freely entered and ended as long as patient is not abandoned- limited by hospital contracts, emergency care & on call contracts

Physicians are not obligated to care for patients when serious personal risks override ethical obligations to provide care

Physicians must balance risks and benefits and should provide care when appropriate precautions have been taken to reduce risks. Hospitals/clinics have responsibility to provide safe working environment- including protective equipment, masks, gowns, gloves

Conscientious objection:

Physicians should not be asked to forsake moral beliefs as condition of practice

Physicians should not withhold information about medically appropriate accepted options even if they disagree

There is a collective obligation to assure patients receive necessary care

Disruptive & uncooperative, angry & violent patients strain the physician – patient relationship.

Physicians should attempt to improve these difficult relationships:

Acknowledge problem, try to understand patient's perspective.

Try to understand physician's own responses.

Try to negotiate mutually acceptable grounds for continued care

Termination: Physician and patient may agree to transfer patient to another physician.

Physician may unilaterally terminate patients as a last resort; for example when patient is disruptive / violent- but they may not abandon patients- must give patients notice and time to

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find new physicians.

Under The Federal Emergency Medical Treatment Active Labor Act aka EMTALA, a physician in an emergency department must screen all patients and treat & stabilize all patients who suffer from an emergent medical condition

C-35 Impaired Colleagues

Physicians have an ethical obligation to be competent to refrain from harming patients.

Reasons to intervene with incompetent /impaired colleagues:

(1) To prevent harm to patients; (2) To carry out professional self regulation; (3) To help impaired colleague

Physicians are reluctant to intervene because of (1) uncertainty whether patients are at risk; (2) reluctance to criticize colleagues; (3) fear or retaliation against 'whistle blowers'

LA has adopted a law that requires physicians to report incompetent & impaired physicians who endanger patients to the board of medical examiners. LA offers wellness programs to rehabilitate impaired physicians, which protect physicians' confidentiality. Federal law requires hospitals & state licensing boards to report disciplinary actions taken against physicians that reduce their clinical privileges to the National Practitioners' Data Bank.

Physicians should deal with impaired colleagues by first protecting patients from harm. In addition they should determine whether there is sufficient suspicion of impairment to warrant further investigation to talk with colleague directly and/ or report the problem to responsible officials.

C-36 Ethical Dilemmas Student and House staff Face

Trainees' self interest in learning and long term goal of benefitting future patients may conflict with their patients' best interests. While patients may consent to be inconvenienced they may not be subjected to any serious risk of harm.

Students must be introduced as or introduce themselves truthfully as students. Patient trust cannot be built upon misrepresentations. Protecting patients from unnecessary worry and the argument that patients in a teaching hospital have given implied consent to be treated by students are untenable reasons to withhold this information. In addition to introducing themselves honestly, students must ask patients' permission to participate in their care. Attending physicians should tell patients about the participation of students in their care, and trainees should carry out procedures only under adequate supervision.

Learning on an unconscious patient violates patients' rights of privacy and autonomy. Learning on a dead patient violates the corpse's dignity. Dead people must be treated with respect. Trainees are ultimately accountable for taking too much responsibility with patients and placing patients at increased risk. Ethically, trainees need to know their own limitations and should not exceed them.

Lying or equivocating is unacceptable practice. When a student does not know the answer he should admit the lapse in memory or preparation and make amends by learning the answer. In clinical medicine there are sometimes disagreements or differences in clinical judgment among physicians. When a trainee is confronted with unethical behavior or substandard care by other physicians he should discuss the situation with trusted colleagues and senior physicians. Trainee does not need to inform the patient if he has informed a responsible senior physician. Writing an angry note in the patient' chart or accusing the attending physician of being unethical will only inflame the situation and is unprofessional conduct.

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Generally, trainees can and should protect their own interests and minimize risks to themselves. If, however, the harm to the patient is serious then students' first obligation is to their patients. even at some risk to their careers.