Bioethics Curriculum
Postgraduate Residency Programme
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PREFACE

Postgraduate teaching of bioethics in developing countries is very uncommon. To find any structured curricula for residency training programmes is even rare. The opportunity presented a challenge to develop a bioethics curriculum for residency training programmes, which was contextual and sensitive to the needs of developing countries.

During the teaching course in my masters programme at the Joint Center of Bioethics, University of Toronto, I took the challenge of developing bioethics curriculum for surgical residency programme. The idea of having such a narrow focus was to develop a relevant curriculum to my specialty. Having understanding and insight into relevant ethical issues in my field was considered an advantage. It also presented an opportunity to discuss, deliberate and pilot the curriculum within my specialty.

Many existing bioethics resources, mostly for undergraduate programmes were reviewed and have been cited in the relevant sections. A list of topics was generated and the content was prepared which was contextual. The discourse is relevant to our issues and the cases are chosen from our own surgical settings. The objective is to generate an engaging and stimulating discussion around the cases.

The curriculum was presented for critique and evaluation to the Directors of the Teaching Course, Dr. Martin Mckneally and Dr. Alex Levin both Consultant Surgeons at Toronto General Hospital & Sick Kids Hospital Toronto respectively. I am extremely grateful to them for their support, review and valuable critique. All their valuable suggestions have been incorporated. I am also obliged to Dr. Peter Singer, Sun Life Chair and Director, Joint Center of Bioethics, University of Toronto for his untiring encouragement and mentoring during this and many other exercises.

The curriculum has been initiated as a pilot in the surgical residency programme at Aga Khan University. The residents and colleague faculty are providing valuable feedback and evaluation. It is a dynamic document and I hope to refine it by incorporating valuable suggestions and rectifying deficiencies as it matures.

Dr. Asad Jamil Raja
January 2003
BACKGROUND

Undergraduate bioethics teaching is reasonably well developed now in most countries of the developed world. In developing countries it is still very erratic and in infancy. Aga Khan University (AKU) in Karachi, Pakistan has a welldeveloped ethics curricula for undergraduates which is spread over five years. Another university has recently started ethics teaching informally. There is still no ethics teaching in any of the other medical schools of the country. The common perception is that ethics education is best done through role modelling - the traditional concept. An international survey of medical ethics curricula in Asia by Miyasaka et al\(^1\) concludes that medical ethics education is a widespread feature of medical curricula throughout the study area. However the kinds of programmes, especially with regards to integration into clinical teaching, were greatly diverse. Many regional centers in India and Africa have variably developed curricula on teaching medical ethics (personal communications Jens Mielke\(^2\) Zimbabwe, Joesph Ochieng Uganda, G. D. Ravindaran India and Nandini K. Kumar India), which formally teach medical ethics however, literature search did not reveal any significant article or curricula on available resource sites. Peng\(^3\) and Li\(^4\) report from China that the medical ethics has been taught in China for the last 50 years. Reading the article it seems that until the 80’s it was traditional teaching of moral values and virtues and in subsequent years they have very well developed ethics curricula with faculty drawn from moral philosophy and medicine to teach bioethics. The curricula are quite detailed and comprehensive but one gets an impression that it is less patient centered. The teaching instructions and tools are well developed with elaborate system of faculty and student evaluation. As reported by Zu\(^5\) they also have programmes for faculty development in the field of bioethics.

The literature on ethics education in the postgraduate medical education is even sparser. There is hardly any significant literature available from any of the developing countries. Asai et al\(^6\) report a survey of 16 teaching hospitals from Japan where postgraduate residency is offered. The results suggest that there is no formal medical ethics education and residents desire a more comprehensive and interdisciplinary education in medical ethics and recommends that educators in Japan should aim to develop education programs to meet these desires. Similarly, Li\(^4\) from China state that the undergraduate ethics education continues into postgraduate medical education however, it is difficult to figure how objectives and teaching is different. Nandi\(^7\) from the department of surgery, University of Hong Kong, Queen Mary Medical Center reports the need and importance of ethics education with recommendations that these should be incorporated into the residency programmes. Downing et al\(^8\) have published an excellent National Survey on Ethics Education in General Surgery Residency Programs across United States. The survey revealed that despite the requirement of Accreditation Council for Graduate Medical Education there is no formal teaching or curricula in any general surgery residency programs. Majority of the programme directors were in favor of standardised ethics curricula and Interestingly over 50% did not want inclusion of ethics questions in the American Board of Surgery In-Service Training Examination (ABSITE) and Qualifying Examination in General Surgery. The
postgraduate bioethics education in Canada is relatively well developed. The University of Toronto has a well-developed Postgraduate Bioethics Programme\textsuperscript{9} however it is more of generic nature rather than a focus on surgery residency programme. McKneally\textsuperscript{10} however has developed one and the only comprehensive bioethics curriculum for surgery residents in the published contemporary discourse.

Aga Khan University has no postgraduate bioethics curriculum. The teaching of bioethics is mostly informal. There are few very generic sessions in the core seminars. The other learning avenue for residents is Ethics Grand Round, which is a quarterly event. It is not surprising that surgery department too has no formal bioethics teaching curriculum. Similarly there is no postgraduate bioethics curriculum nationally at any other institute in the country and there is none available in the region from any of the resources explored.

Bioethics as an academic discipline is relatively a recent development in the industrialised world. The formal teaching and development of ethics curricula in undergraduate medical education was the primary objective. Most universities in the developed countries have incorporated ethics teaching in undergraduate and postgraduate programmes but very few universities around the world have actually well developed formal ethics curricula in the field. Therefore it is not surprising that there is negligent published discourse on bioethics teaching from the developing world. This vacuum represents an ideal opportunity, for the door is open to innovation in the field of bioethics education, scholarship and activity that is responsive to the distinctive conditions prevailing in these countries. It may not be necessary to carry over all the models from developed world. Underdevelopment in this field sets a distinctive bioethics teaching agenda; it can begin with everyday concerns such as the patient’s consent and self-determination of the individual patients and research subjects; humane and effective treatment of the dying; futility; disclosure and truth telling; setting priorities and how to make just and accountable choices within the resource constraints. It should recognize the diversity of purpose and methodology of ethics teaching in developing countries, as it would be more of cultural change and a reform movement than merely an academic discipline in the school of medicine.

In the words of Pellegrino\textsuperscript{11}, “the physician today is an employee whose loyalties are divided between organisation and patient, and whose self interests are pitted against the patient to curb costs to make profits. Individual patients see physicians as interchangeable, of no special importance as individuals. Physicians are urged to practice social, rather than individual patient ethics. Their professional worth is measured in productivity. They are not held to moral standards higher than those of the general society in which they live.” This may be a typical reflection of a practice model in USA but unfortunately co modification of medicine is rampant in developing countries too. Obviously the writing is clear on the wall and there could be no better place to inculcate the cherished values of our profession amongst the physicians of tomorrow than the residency training programmes.

**Curriculum Development for Surgical Residents:**

Aga Khan University has approved residency programmes in 16 disciplines of Medicine. There are currently 184 residents in all the programmes. Traditionally since the introduction of bioethics education it has remained the domain of Postgraduate Medical Education (PGME)
department. The PGME conducts generic seminars for first and second year residents. The session is of one hour on every Tuesday, which is repeated on Thursday. This helps split hundred odd junior residents and provides opportunity for all to attend. The format is of didactic nature and there is an allotted time of 20 minutes for question answer session. The reason for it being of didactic nature is the size of the group. In the pool of generic lecture bioethics gets two lecture sessions on principles and issues in bioethics. The basic nature of the sessions reflects the recruitment of residents at AKU as almost all are graduates from institutes where there is no formal bioethics teaching. This is followed by half a day workshop on a Saturday and it discusses vignettes with ethical issues developed by the education department. It is obviously not at all a very comprehensive and satisfactory model of bioethics teaching, but this is how it stands as of today.

Most programs within the department of surgery are pyramidal systems. The initial two years for all residents is a core training period. During these two years they attend core seminars of one hour on every Thursday morning between 8-9 am. The topics discussed are very generic related to the principles and practice of surgery. The format of these seminars is of small group teaching. It is a very interactive format and is basically conducted by the residents themselves. The residents know the topic well in advance and prepare the topic, look at literature and discuss the topic amongst them. The faculty supervision is of a passive facilitator, which helps them remain focused and finish all the important areas of the topic in order to achieve the objectives. Very occasionally if the topic generates lot of discussion and the resident feel that more discussion would be helpful than it spills over to the next week. None of the seminars is related to bioethics.

The goal is to develop a bioethics curriculum in surgery for core period of training. The idea is to develop and test a comprehensive, relevant and practical model curriculum, which could then be incorporated by other specialties into their training programmes with relevant modifications. This curriculum development would be cognizant of the poor human resources in the field and how best to train other faculty by adopting them for a period as observers followed by instructorship. This will help them develop and set up their own programmes.

**Guiding Principles:**

- Ethics contributes to high quality patient care and professional behaviour;
- Knowledge of ethics enables medical trainees to become better practitioners of medicine;
- Ethics can be taught, learned, and evaluated along with the general corpus of medical knowledge.

**Goal:**

To train and develop professionals who recognise the moral foundation of professionalism in the vulnerability of sick person, in the necessity of trusting the physician and relying on his or her character, in the physician’s invitation to trust, and in the sick person’s moral claim on the physician’s competence and on the use of that competence in the patient’s best interests rather than the physicians own interest.
Curriculum:

A curriculum is designed which would cover all the major issues in bioethics relevant to the practice of surgery. While preparing the curriculum it is assumed that residents would have minimal prior knowledge. Details provided start with very basics and gradually progress to complex issues. An attempt has been made to include and discuss religious and socio-cultural issues and how to handle them. Besides the provided details, a reading list is also attached at the end of each topic. Twelve topics have been selected for teaching. These may not be comprehensive but essential for a surgical resident training as these issues are very relevant to the practice of surgery. Each session would be delivered over two-hour session:

1. Physician – Patient Relationship;
2. Informed Consent;
3. Confidentiality;
4. Truth Telling / Disclosure;
5. Interdisciplinary Team Issues;
6. Do Not Resuscitate/ Futility;
7. End of Life Issues;
8. Surrogate decision making;
9. Surgical Competence;
10. Conflict of Interest;
11. Resource Allocation;
12. Research Ethics.

Teaching Tools/Modalities for the session:

The teaching format and modalities would be:

- A two-hour session would be held every last Saturday of the month;
- The group would be of around 15 junior residents from the core years of residency;
- The objectives, ethics message and case/s for discussion would be provided with list of reading and reference material;
- One hour would be spent by residents about the learning objectives and the ethical message.
- Second hour would be spent discussing the case/s provided;
- Two faculty members; one would be a trained/experienced bioethicist and the other would be a trainee faculty. They would supervise and facilitate the session;
- The faculty would guide the discussion making sure that the learning objectives and the take home message is clear;
- Case discussion will follow on the case workup and evaluation described by Jonsen et al\textsuperscript{12} the Paradigm four boxes on Medical Indications, Patient Preferences, Quality of Life, Contextual features. The residents would be expected to have filled in the all the points about the case and this would provide a framework for discussion.
**Evaluations:**

There would be bilateral evaluation of bioethics curriculum and its teaching. The residents would evaluate the curriculum and the teaching; the faculty would evaluate the residents for cognitive knowledge and behavioural change. The course would also be recommended for evaluation by the Postgraduate Medical Education Department.

**Residents Evaluation:**

**Summative:**
A pre and post-session test to see knowledge gain would be conducted by administering a questionnaire. The score would give an idea of the knowledge gain.
Every three months the residents have an MCQ test on the topics covered on the core curriculum seminars. Five MCQ’s on each topic covered in bioethics would be included.

**Formative:**
This would be used to assess behavioural and attitude change. The methodology would be to inform and sensitise the faculty and senior residents to observe the ethical conduct of junior residents during their clinics, wards and in operating room sessions. The case/s discussed would be circulated amongst the surgical faculty and asked to observe whether the objectives are being achieved and if there is a behavioural change in the rotating residents. The focus should not be on knowledge of ethics but the actual virtues. The disadvantage is its subjective nature, but these descriptive observations become validated when a resident is consistently marked adversely and concerns are raised about the ethical conduct by different faculty and senior residents. End of rotation resident evaluation form would include observations to this effect.

**Counselling and Feedback:**
The usual channels of counselling and feedback would be provided to all residents at the end of rotations, as normally is the practice. If there is no observed change in behaviour than it would adversely affect the chances of promotions or selection in the pyramidal system.

**OSCE:**
Ethics OSCE\(^{13}\) may seem a very attractive tool for evaluating behaviour; however it has a low internal consistency and reliability\(^{14}\). To increase this shortcoming one would have to have large number of stations and this is not logistically a feasible exercise. Its use also as a teaching modality would be taxing on our limited resources. Moreover, having standardised patients is difficult in our environment. It may have future use in evaluating ethics curricula of different medical schools.

**Teacher evaluation:**

**Individual Evaluation:**
Evaluation of the teaching and the topics would be done regularly at the end of session by a standard developed questionnaire. This would have formative and summative components to it.
In our culture, the students are very respectful and do not criticise things at all. The value and validity of this evaluation is therefore difficult to judge.

**Group Evaluation:**
We would also use the same form to be filled in by the groups. The class would be divided in three small groups and asked them to do a group evaluation. We have found this a useful method as in a group as they are more candid and open in their critique because their identity is concealed.

**Focus Group Informal Discussions:**
We consider the informal focus group also a good tool for evaluation. Once you involve them in an informal discussion about the teaching and their views and suggestions to improve the exercise. They are very forth coming and give good constructive criticism. This is usually done every month by the Residency Program Director of Surgery and Coordinator of General Surgery Residency Programme when they have informal meetings with the junior and senior groups of residents. They specifically discuss each teaching modality of residents and formulate a report, which is sent to the Course Directors.

**Peer Evaluation:**
Peers and faculty would be involved to attend the sessions and their critique would be used in the process of mentoring faculty and improving the course content. All opportunities would be provided to develop the faculty in areas of their interest.

**Course Evaluation:**

The Postgraduate Medical Education (PGME) department reviews all approved postgraduate programmes every two years. As a similar exercise but on lesser scale, PGME could also be asked to review this course. The report and critique accompanied by suggestions would help us improve our course.

**References:**


PHYSICIAN – PATIENT RELATIONSHIP

Objectives:

To understand:

- The term and importance of “Fiduciary Relationship”;
- How and why it is important to develop a trust with the patient;
- The moral claims of the patient from the physician;
- The role played by physicians personal beliefs in this relationship;
- How physician patient communication could be hindered;
- How to resolve patient physician disagreement;
- In what circumstances can the physician override patient preferences;
- Whether the confidentiality in the relationship is absolute;
- The role of the family in this relationship.

Ethics Message:

The word ‘Fiduciary” is derived form Latin and means ‘confidence’ or ‘trust’. This bond between the patient and physician is vital for the management of patients. The patients trust the doctors with their most precious valuable “their life,” in turn the doctor has to honour and respect that trust and relationship. In order for physician to make accurate diagnosis the patient divulges all his secret information. It is a responsibility of the doctor to respect the trust and maintain the veracity, privacy, confidentiality and fidelity of the relationship.

The medical profession is very much a paternalistic model in developing countries. General prevailing consensus is that many patients in our societies are illiterate and do not have the capacity to make informed choices. This power relationship in which the physician plays a dominant role has to shift. The patient has to be respected as a key player and we should practice the deliberative model of Emanuel. Whereby the physician facilitates the decision making process for the patient by helping him make reasoned choices on the given facts and personal beliefs and values. This is also called a shared decision making process.

Residents should develop an honest and straightforward relationship by introducing themselves as a surgeon in training and their role and relations in the team. Many good residents develop a
special relationship and bonds of trust with the patient as they spend most of the time with their patient’s and provide them compassionate care.

There would be instances when the physician may be faced with requests to services, which are against the physicians’ beliefs e.g. contraception or abortion. The physician does not have to comply with those requests but treat the patient with respect and an autonomous individual. Wherever possible, the patient should be provided with resources about how to obtain the desired services.

The physician-patient free exchange of communication may be hindered if in anyway the patient feels embarrassed, overawed or at times intimidated by the position and authority of the doctor. There could be no worse situation than this as the physician will be unable to obtain the knowledge from the patient to make appropriate decisions. It is the duty of the physician to provide a comfortable and friendly environment, should listen with interest and respond to the patient’s history, explain and reassure during examinations and ask explicitly if their were any other concerns. The patient should always receive full attention of the doctor.

Sometimes patients disagree with physician recommendation. We usually call them “non compliant” this is typical of medical paternalistic medical profession in which the physician knows best. Physicians have the duty to explain and make the patient understand all the pros and cons of different management options, having done that the patient makes a decision on his beliefs and values. This decision should be respected by the physician. The non-compliance can be improved in developing countries especially when physicians there usually feel that it is due to ignorance and illiteracy by a shared decision-making process. Despite all this the competent patients have the right to refuse medical intervention. Dilemma arises when they continue to remain under your care as a patient. This may happen in variety of situations in emergency or elective setting, in clinic or as an inpatient and the physician may not have any choice but to respect the wishes of the patient and continue to treat them in the given circumstances.

Physicians will encounter a patient whose needs and demands exceed and strain the therapeutic relationship. The physician has to sit down and have an honest discussion with the patient. This usually resolves the problem. There may be occasions when no agreeable compromise can be reached between the physician and the patient. Yet the physician should not abandon the patient. At any stage when the physician patient relation is severed the physician is obliged to provide the patient with resources to locate a substitute who can provide for the on going medical care.

Physicians may have professional relations with multiple family members and it is important that confidentiality of each member be honoured. The duty of confidentiality is however not absolute and it is the duty of physician to draw a balance between the duty to protect the patient’s confidence against the physician responsibility to public at large e.g. a spread of an epidemic or a case of child abuse.

Current day physician is faced with health administrations policies that put enormous stress on the physician-patient relationship. This trust relationship should always be preserved. A physician should be a patient advocate, not for every service but only those that are needed, necessary and may benefit the patient, those for which good outcome data exists. Quality of care
should remain a priority however; it does not mean all available care. It refers to care which is rational, diagnostically sound, technically correct and cost effective.
Case:

A 38-year-old gentleman, who is a businessman by profession, is referred by a General Practitioner and he has been diagnosed to be having a very early and low rectal cancer, which requires an abdomino-perineal resection and this would be curative resection. He has a strong family history and would require screening of siblings. A detailed disclosure and discussion follows in the presence of his wife and he is told that the surgery will entail him having a permanent colostomy. He accepts everything but for a colostomy. He says he would rather die than having a colostomy. He is told everything about the effects of delaying surgery as it is curative at this stage. He is also warned of the consequences of obstruction at some stage for which he would still require a colostomy and yet would not be cured. He is offered a visit to stoma association, which he refuses. He also refuses screening colonoscopies for his siblings and says that his diagnosis should not be disclosed to other family members. Eventually, it was decided that they would think about the option and come next week. Next week his wife calls to say that he has refused treatment and has already started some alternative treatments.

- How should the surgeon proceed in such a situation?
- How can he improve compliance?
- What is his duty to the patient and to his siblings?
- Is breach of confidentiality acceptable?

Two years later, the patient returns to the clinic with sub acute obstruction now agreeing to the surgery.

- Should the surgeon refuse to take him under his care?

Bibliography and Reading material:

- Emanuel EJ, Emanuel LL Four models of Physician- patient relationship JAMA 1992;267(16):2221-2226
INFORMED CONSENT

Objectives:

To understand:

- What is an informed consent;
- The essential elements of informed consent;
- The adequacy of informed consent;
- The process of testing an individual's capacity to consent;
- The common situations when patients' ability to make decisions about surgery or anesthesia are questionable;
- If a consent is different in an emergency situation;
- The element of possible coercion in the consent process and how to eliminate or reduce it;
- How to disclose risks about surgery and anesthesia.

Ethics Message:

Informed consent is a process by which a fully informed patient can participate in making healthcare choices. This is an ethical and legal requirement as a respect for autonomy of the individual. The goal is that the patient should be an informed participant of every healthcare decision pertaining to himself. The essential elements of informed consent are:

- The nature of the decision and procedure;
- Reasonable alternatives to the proposed intervention;
- The relevant risks/benefits and uncertainties related to each alternative;
- The assessment of patient understanding;
- The acceptance of intervention by the patient.

Patients often are powerless and vulnerable especially in emergent situations. It is easy for them to be coerced into any situation. It is the responsibility of the physician to make the patient understand and participate in the decision rather than just signing a piece of paper.

Capacity is the ability to understand information relevant to the decision and the consequences of agreeing or refusing to any intervention. Most patients can be clearly judged to be competent to give consent. Unconscious and comatose patient’s, mentally retarded or patients under the influence of drugs need surrogate decision making. There are some who may have neurological or psychiatric disorders in which a mental capacity assessment is mandatory. Capacity assessment may be carried out by asking simple questions about their diagnosis and their
understanding of proposed intervention. Not just simple repetition but actual analysis of risks. Doubtful cases should be evaluated by the Psychiatrists. Beware of the patients who have fluctuating capacity; their consent should be obtained in their lucid phase. Etchell et al have described simple few minute Aids to Capacity Assessment (ACE). These are simple questions about the diagnosis, management and risk/benefit understanding.

The patient has the right to know (complete disclosure is the only way to make reasoned choices), the right to initiate or forgo any treatment be it life saving. It highlights the importance of capacity and voluntariness in the decision making process. In case of diminished capacity or in emergency situations the role of physician takes centre stage s/he should ensure appropriate surrogate decision making process. The issue here would be the cultural differences and the role of family in decision-making process. Who is the family and how much is their role in decision-making process? This is a tough issue in developing countries and the physician should ensure that all decisions are made in the best interest of the patient according to the patient’s beliefs and values. The topic would be discussed in detail in surrogate decision-making process.

Consent in emergency is different but may not be that elaborate as in elective operations. However, all efforts should be made to communicate options including alternatives, risks and benefits. However one has to be cautious of a patient who is in distress or under the influence of analgesia. Rationale decision-making may be impaired and the physician may have to assume the role of guardian until the patient’s family arrives.

How much information is considered reasonable to participate in informed decisionmaking or what reasonable person in the patient’s particular circumstances would want to know or be told? The best approach is to at least provide information that meets both; your professional obligation to provide the best care; and upholding the respect for a person, with the right to a voice in health care decisions. Risks should be realistically explained according to their incidences by drawing analogies for purpose of understanding.

**Case:**

A 26-year-old gentleman with a Masters Degree in Business Administration and Computer Sciences is admitted to the hospital with diagnosis of Gullian Barre Syndrome. He was gradually developing ascending paralysis and it had started to affect his chest muscles. He was unable to cough and expectorate properly and his ability to adequately ventilate himself was diminishing. The treating physician has had long discussions with the patient about the disease and its prognosis. He was advised to agree to intubation and elective ventilation if and when he crashes from respiratory arrest. The patient refuses to undergo elective ventilation. He is adamant that he would rather die than be a cabbage, paralysed and ventilated for a possible indefinite period. The parents want the physician to proceed with the treatment plan and should not listen to their son. They said they had enough resources to buy a ventilator and employ a nurse to look after him at home if the situation arises. The wife was quiet and would not say anything, as she was possibly still shocked at the sudden and grave nature of events. The physician refused to follow the instruction of the parents and kept on having consultations with the patient, but the patient continued to refuse the consent. The
physician feared that the patient’s capacity to make decision was reducing as the time passed as he was gradually becoming hypoxic and hypercarbic. On the other hand, the patient remained positive that he did not want ventilation. The parents threatened to sue the physician and the hospital if anything happened to their son. At the 11th hour the parents call the physician that the patient has agreed and the physician confirms this with the patient. He nods while he is gasping for breath at the respiratory rate of 45/minute and PO2 of 56 and PCo2 of 50. Physician is concerned about his capacity to make a decision.

- What should the physician do?
- Is the patient under informed about the outcome and the options the patient may have even after the intubation?
- Does repeated consultation amount to coercion and paternalism?
- Informed refusal of life saving procedure is a patient’s right and not parent’s choice. So what is the role of family in decision-making process?
- Has the patient got the capacity to consent?

**Bibliography and Reading material:**


- Ethics in Medicine, University of Washington School of Medicine. Informed Consent. [Http://eduserv.hscer.washington.edu/bioethics/tools/princpl.html](http://eduserv.hscer.washington.edu/bioethics/tools/princpl.html)


CONFIDENTIALITY

Objectives:

To understand:
- The duty of confidentiality;
- What this duty requires of a physician;
- What kind of disclosures are inappropriate;
- When a confidentiality could be breached and the concept and application of limited confidentiality;
- The limitations of providing information to the family members or any other interested parties.

Ethics Message:

The duty of confidentiality is the basic tenets of physician-patient fiduciary relationship. The confidence and privacy is one of the strengths and encouragements for the patient to be as honest as possible during the clinic visit or admission. This duty requires of the physician to keep confidential the information physicians receive about personal lives, health status and other information that the physician receive in their professional role. The patient entrusts the physician with not only his body but all his personal life and information which is very sensitive for the patient. The physician should never exploit their position and never use that information to the detriment of the patient. The physician should not divulge this information to any interested party. It is also the duty of the physician to ensure that all recorded information about the patient remains confidential. Computerised patient records and sensitive laboratory data are posing new and unique challenges to the obligation of confidentiality.

The other practice which is common and without any ill intent is discussing cases by health care providers in public places like hospital cafeterias, corridors and elevators; this should be discouraged. Any traceable information photocopied or recorded about any patient should be destroyed once the purpose is over. Never identify the patients in any case conferences or general discussions. All patient information on radiological films and other investigations should be masked in case conferences.

Culturally in developing countries, because of the large family systems the information about the patient becomes common knowledge. As number of family members approach the physician in hospital corridors inquiring about their relative, it is difficult culturally not to say anything to them. In such situations only give broad information as the patient is fine, stable, unstable or critical etc. It is sometimes seen that everybody else knows everything about the patient except
for the patient himself. This practice has to be discouraged and confidential information should be a well-guarded secret.

Maintenance of confidentiality is however not an absolute obligation. If concealing confidential information would be more dangerous than revealing it, the physician is justified to breach it. A case of child abuse must be reported before it is too late. A psychopath who wishes to kill some body should be reported. Reportable communicable/infectious diseases should be reported to public health authorities. Most countries reporting is mandatory in HIV, AIDS, Hepatitis A, B and C and many other communicable diseases.

In a case reported in 1906, a physician watches his patient getting wedded, whom he knows has syphilis. This was like the AIDS of yesteryears and there was no treatment. One whisper in the bride’s ear would have saved the life of young 19 year old. The physician’s error was based on a misconception that the obligation to confidentiality was absolute. This is not true. Today the partners and spouses have to be informed of such risks.

Confidential information about an incompetent colleague should also be communicated to the appropriate authorities. This is important for the protection of patients and maintaining public trust in the standards of the profession.

**Cases:**

A 36-year-old gentleman has tested positive for HIV. He asks that you do not inform his wife of the results as he claims that he is not ready to tell her yet.

- Confidentiality vs. harm to others
- Confidentiality vs. legal duty
- How best to resolve the issue?

A 65-year-old gentleman comes with severe acute pancreatitis and is admitted in High Dependency Unit (HDU). Within 24 hours, his condition deteriorates and anticipating ventilatory support he is shifted to ICU where he gets intubated within six hours. He has a doctor son and a graduate of the same university hospital. The physician understanding the concerns of the doctor children provides them with all necessary details about their father’s progress. They are very familiar with the working of different systems in the hospital. The son was noticed by the treating physician on one of the floors checking on computer terminal all the laboratory and radiological investigations including live pharmacy. It was apparent that he had access to all confidential information about his dad.

- How does a physician approach the family next time and what should be his response?

- The other issue is of technology making life easier for physicians by providing access to information about the patient from every nook and corner of the hospital. All kinds of patient information are now available on desktops in physician offices, which include all investigations, treatments and online discharge summaries. It is fine if the
information is relevant to a physician but what about the information which he may not have any business with? Similarly it is not physicians all health care providers nurses, technicians and other paramedical staff in different areas of the hospital have equal and full access. There is a code and password but everybody knows them as they have to access information about the patients under their care. How do you, and can you make information confidential these days?

Bibliography and Reading material:


- Confidentiality. Ethics in Medicine, University of Washington School of Medicine. Http://eduserv.hscer.washington.edu/bioethics/tools/princpl.html


TRUTH TELLING / DISCLOSURE

Objectives:

To understand
- What is meant by truth telling and disclosure;
- The standard and the method of disclosure of information;
- The situations when the patient does not want to know the truth or the family opposes telling the truth;
- That disclosing does not undermine the trust in the physician and the medical system;
- That disclosure only enhances the faith and reduces the chances of litigation;
- The ethical duty to disclose information about medical mistakes to their patients;
- Your duty if someone else makes a mistake.

Ethics Message:

Communications between physician and patients should be truthful; that is statements should be in accord with facts. If the facts are uncertain that uncertainty should be acknowledged. Deception, by stating what is untrue or by omitting what is true, should be avoided. Certain ethical problems do arise about truthfulness. Does the patient really want to know the truth? What if the knowledge causes harm? Deception might help by providing hope? In recent years the medicine has moved away from the paternalistic ambiguous position to a strong assertion of the rights of the patient to the truth. The arguments are based on:

- There is a strong moral duty to tell the truth that is not easily overridden by speculation about possible harm;
- That patient has a need to know the truth if s/he is to make rational decision about actions and plans for life;
- Concealment of truth is likely to undermine the patient–physician relationship. In case of serious illness, it is particularly important that this relationship be strong;
- Tolerance of concealment by the profession may undermine the trust the public should have in the profession;
- The physician’s or family’s assertion that truthful disclosure would be harmful is not a widely held view. It is the physician’s own uneasiness at being “bearer of bad news” or the family’s over sympathetic urge to protect the relative;
Empirical evidence strongly suggests that majority of patient’s want to know the complete truth. However there is also evidence that cultural issues and other beliefs in different societies influence the physician patient interaction about disclosure;

The truth may be “brutal” but the telling of it should not be. It should be a measured and sensitive disclosure with full comprehension of patient’s emotional resilience and intellectual comprehension;

Disclosure of the information should be complete. The risk/benefits and alternate options should all be clearly spelled out for the patient to make reasoned choices.

Errors are unavoidable in the practice of medicine. Sometimes these result from medicines inherent uncertainty and sometimes due to human oversight. There is a culture of not telling the truth in developing countries. There is an erroneous perception amongst the public because of combination of ignorance, illiteracy and too much faith in the infallibility of medical profession. In such societies people forget that to ‘err’ is only human and if errors are not communicated, does not mean they do not occur. Physicians perceive that telling the truth would be harmful to their reputation and loss of faith in their ability and judgment. It will require lot of physician patient education before the culture of truth telling becomes a common practice.

Cases:

A 21- year- old unmarried labourer was travelling unrestrained in a mini van they meet a head on collision with an on coming vehicle. The gentleman is trapped for 45 minutes before he is removed from the wreckage. He has sustained multiple injuries including concussion. On arrival to ER he is conscious and in shock. According to ATLS protocol he is resuscitated and he starts to stabilise. His main problem seems a severe crush injury to both legs. His cervical spine lateral film has been ruled out normal. He has no other bony injury but lot of soft tissue lacerations and bruises. He is bitterly complaining of pain in his legs. He denies any neck pain. The hard cervical collar is removed and as he is stabilising with resuscitation a narcotic analgesic is given and wheeled to operating room. He under goes a GA and has a Lt. above and a Rt. below knee amputation. Twenty four hours later he is taken back to theatre and a re-look and further debridement of his leg wound is done under GA. He is now shifted to High Dependency Unit, recovering well but requiring infusion analgesia. On the fourth day of the accident while being given a sponge bath by the nurses, as they turn him around he complains of severe neck pain and weakness of his upper limbs, his lower limbs were already amputated. The resident is called and he finds the patient quadriplegic with a sensory level of C5-C6. An urgent neurosurgical consult is initiated, he is started on mega doses of methylprednisolone and an MRI is done which shows an unstable dislocation of C5-C6. He is taken to OR and instability is fixed. Later it is revealed that the initial plain lateral cervical spine X-ray done in ER was reported the next day of having suspicious step over C5-C6 and the report recommended further views if clinically indicated. No member of the team had read that report. Later, one of the nurse admitted that the day before the patient became quadriplegic the mother was doing an olive oil massage on his head and he complained of tingling in his arms. She could not understand the significance of these symptoms and stopped the mother from massage. He was now on heavy doses of steroids and quadriplegic with both lower limbs amputated. On the 8th day he was noticed to be distended without
appreciation of pain as he was quadriplegic. He had abdominal distension and loss of liver dullness. A diagnosis of steroid and stress induced perforation was made which was confirmed by pneumoperitonium on plain abdominal films. He underwent a laparotomy, which revealed a 36-48 hour old duodenal perforation. Perforation was closed and belly washed out. The repair leaked within 48 hours and he developed a high output duodenal fistula. Internal diversions could not be created, as the state of tissues was very friable. After this the course was just downhill one complication after the other ensued. He had multiple OR visits and after staying for two and a half months in ICU he died.

- This case was unfortunately an encyclopedia of disasters. How and what would you tell the family?
- Unfortunately a time came when the care was considered futile but the patient and the family wanted to go all the way. Full of guilt the physicians had to go all the way with out having any conviction that he will ever survive. How should one handle such a situation?
- The case raises lot of other ethical issues of duty, interdisciplinary team issues and futility these should be discussed if time permits.

Reference and Reading material:

- Mistakes. Ethics in Medicine, University of Washington School of Medicine. Http://eduserv.hscer.washington.edu/bioethics/tools/princpl.html
INTERDISCIPLINARY TEAM ISSUES

Objectives:

To understand:

- How team dynamics work;
- The ethical obligations of members of the interdisciplinary team in patient care;
- The role of team leader and is he really a “Captain of the Ship”;
- When you have to follow the instructions of a team leader even if you disagree;
- The meaning of “respectful exchange” of views;
- To learn to handle interdisciplinary team disagreements.

Ethics Message:

With the increasing complexity of medical problems, patient management nowadays routinely involves multidisciplinary care. Very often there are situations where providing the best and comprehensive care is not possible by one physician. Therefore, there are situations whereby one physician assumes the role of main treating person. He interfaces with different kinds of health care professionals, all with diverse and important knowledge, technical skills and perspectives. Such organization and hierarchy usually has two tiers, one at the consultant level and the other amongst the interns, residents and fellows. It is important therefore that all service providers must balance responsibilities, values, knowledge, skills, and even goals of the patient care, against their role as a team member in shared decision making. Every effort should be made to work towards the best interest of the patient and all decisions should be made with unanimity and consensus.

Poor communication is a major factor in the interdisciplinary issues. Each team does their own rounds and it is frequently seen that communications are only on case sheets with illegible handwritings. These orders or instructions may never be read unless a physician is particularly looking for them. All this could have detrimental consequences and effect on the patient’s outcome. The teams should communicate better and evolve methods of evolving a consensus. It requires a cultural change from egos to ethos, on the part of physicians to achieve this objective. The juniors would only emulate whatever examples are set to them.

Interdisciplinary problems are rampant in all specialties but it is never so pronounced as in surgery especially in the operating room environment, which quite often requires interdisciplinary cooperation and compromise to avoid conflict. Disagreements may even exist within one team responsible for care of the patient. An intern, resident or a fellow have the right to suggest options and may also disagree with decision plan but they have to follow the attending
physician orders. This does not reflect an authority of the physician but his training years of experience, expertise and much greater responsibility as well. An attending physician may be morally and legally liable for the actions of interns and residents. Therefore the junior team members conversely have a duty and obligations to their attending and the patient, not to act recklessly or without the knowledge or approval of supervisors. Disagreements in management should always lead to respectful exchange of views and is part of the learning process of the juniors. Similar disagreements at a higher tier leads to a more complete inter-professional discussion of the patients care, resulting in renewed consensus and may require compromises from each individual.

Disagreements are common and expected because of the different knowledge, experience, values and perspectives of various team members; the idea is to channel them in the best interest of the patient.

**Cases:**

A 52-yearold gentleman present with acute abdomen and is diagnosed to be having enteric perforation. He has significant co-morbidities and suffers from COPD, hypertension and ischemic heart disease. The gentleman is very sick and is being resuscitated. The fellow in surgery speaks to the patient and the family and explains the gravity of the situation and the necessity of the surgery as the only hope of saving his life. They are told that he would have a stormy postoperative course and there is a high chance of him having a peri-operative MI or require prolonged ventilation and that he may never come off the ventilator. On the other hand, if surgery is not done the peritonitis will surely kill him. The patient consents for surgery understanding all the risks. The anaesthesia team is informed and their Chief resident on call comes and suggests that this gentleman would not survive the anaesthesia and surgery. He was a very high-risk patient and he wanted a respirology and cardiology consult before he could take any decisions. The Fellow in surgery is not happy as the patient already has a 6-8 hour old perforation and florid peritonitis. He feels that any further delay would further reduce the chances of this patient’s survival. The Chief resident in anaesthesia understands but insists that the patient should be assessed by the experts and some basic optimisation needs to be done before he could take any decisions.

- How do you resolve the issue;
- Is the consent of the patient to undertake the risks enough for physicians to take any risks;
- If an impasse has reached who is the final decision maker;
- Do you think senior people should be involved and how do you think they should resolve the issue;
- Is the surgeon right in saying that he is ‘Captain of the Ship’ and he has the primary responsibility of the patient;
- Suppose if the physicians come and say that he is a very high risk patient and there are very high chances of him dying if he has anaesthesia and surgery. What would you do?
Bibliography and Reading material:


DO NOT RESUSCITATE /FUTILITY

Objectives:

To understand:

- The meaning of medical futility;
- When CPR is futile;
- The obligation of putting a DNR order on the request of patient even when CPR is not considered futile;
- What to do in a situation where family does not want DNR order;
- The ethical obligations of a physician when an intervention is clearly futile;
- Who decides the particular treatment is futile;
- How to solve the issue when family wish to continue the care and the physician thinks that it is clearly futile;
- The difference between futile intervention and experimental intervention.

Ethics Message:

Physicians commonly use term ‘futile’ while referring to certain cases or interventions. It is important to understand and appreciate the meaning of this term. As it has very important bearing on future decision making in complex life and death scenarios. ‘Medical futility’ is a term referred to interventions, which are unlikely to produce any significant benefit for the patient. A quantitative futility is where likelihood of intervention in helping the patient is exceedingly poor and a qualitative futility is where a quality of benefit an intervention will produce is exceedingly poor. Both these terms refer to the prospects of benefiting the patient.

The use of H2 Blockers in preventing stress ulceration is qualitative futility. It will certainly reduce the acid output but it is not clear evidence whether it reduces stress ulceration. A CPR on a terminally ill cancer patient is a quantitative futility. Referring a patient with advanced metastatic gastric cancer for chemotherapy is both qualitative and quantitative futility.

CPR is considered futile when it offers no clinical benefit. CPR has been evaluated for clinical benefit in wide variety of clinical situations. Knowledge of the probability of success with CPR could be used to determine its futility. The CPR might also seem to lack benefit when the patient’s quality of life is so poor that no meaningful survival is expected even if CPR was successful at restoring circulatory stability. However, quality of life has to be individually judged
and is a difficult decision. There is obviously no disagreement that CPR is considered futile in patients with persistent vegetative states, as few would accept that quality of life.

Once CPR is considered futile it means that the physician is under no obligation to provide it. DNR orders can be put once the case is considered a ‘medical futility’. However, respect of the individual demands of a physician to discuss the issue with patient if compos mentis or the family before such orders are written. If the family disagrees it is advisable to involve the ethical committee, social workers and have frequent consults to convince them about the futility of such care. If the conflict is still not resolved than the opinions are divided. Although the physician is under no obligation to provide the CPR but he is generally expected to comply with the wishes of the patient and the family.

DNR orders can also be put if the compos mentis patient wishes to have DNR or if an unconscious patient has left advanced directives. In the absence of any such document from the patient, the law accepts the hierarchy of family relationships and surrogate decisions are acceptable. In our culture however the decisions are made by the family and less by the patient. It is ethically acceptable as long as the patient is part of the decision making process.

The slow codes which are practiced in some countries and institutions are not ethically justified. These codes violate the right of the patient as they involve deception and break the trust relationship with the patient.

**Case:**

A 52-year-old gentleman had an excision of massive Rt. Sided retroperitoneal liposarcoma two years ago. He has now developed a recurrence at the same site and is producing severe excruciating pain in his Rt. Leg. The tumour is deemed non-resectable and there is no role of chemo-radiation. He is otherwise mentally alert and physically active except during the episodes of pain when he is really down. He knows the diagnosis and understands that there is no cure for him except for palliation, which means symptomatic relief of symptoms. He has been referred to pain clinic for pain control. A month later his symptoms are difficult to control with local therapies and non-narcotic analgesics. He has been started on MST and this has given him lot of nausea and poor appetite. He has started to feel weak and although understanding that he has a non-curable condition feels he is not at the end of the road yet. He and his wife wish to have him admitted for nutritional support and palliative support. We do not have hospices in our country where most people are usually admitted for terminal care to general hospitals. However, this patient wants to be admitted for supportive care and not terminal care.

The discussion here would be on:

- Is this a case of futile medical care?
- Should nutrition and hydration be held in terminal care?
- How should the physician respond to the request of the patient?
• If the family still wishes active support to prolong his life, how do you handle this situation?
• Would you do a CPR on this patient if he arrests?
• Can you write DNR orders for this patient if the family does not agree?

**Bibliography and Reading material:**

• Futility. Ethics in Medicine, University of Washington School of Medicine. [Http://eduserv.hscer.washington.edu/bioethics/tools/princpl.html](Http://eduserv.hscer.washington.edu/bioethics/tools/princpl.html)

• Do Not Resucitate – DNR. Ethics in Medicine, University of Washington School of Medicine. [Http://eduserv.hscer.washington.edu/bioethics/tools/princpl.html](Http://eduserv.hscer.washington.edu/bioethics/tools/princpl.html)


END OF LIFE ISSUES

Objectives:

To understand:

- The meaning of death with dignity;
- Your ethical duty of providing a dignified death to your patient;
- Who is considered terminal;
- The meaning of palliative care for the dying;
- Dealing with your own feelings in the care of the dying;
- The importance of protecting the vulnerable;
- The difference between letting someone die and killing – foregoing life sustaining treatment vs. euthanasia and assisted suicide.

Ethics Message:

Discussion and debate about euthanasia usually takes an individualistic discourse. However, all individual decisions need to undergo some form of moral scrutiny. The generally held view is that withholding and withdrawal of life support treatment are not perfectly analogous to euthanasia. A health professional is obligated to honour an autonomous refusal for a life prolonging technology or therapy, but s/he is not obligated to honour an autonomous request for aid in dying. Sanctity of life is paramount in our culture because of strong religious belief that giving and taking of life is a divine act. Therefore it excludes the freedom of choice in the self-infliction of death and certainly in the involvement of others in carrying out that choice. Internationally at least, no new consensus has emerged in societies opposing the right of the state to regulate the involvement of others in exercising power over individuals ending their lives. In most countries therefore suicide is not a crime while assisted suicide is considered a felony. This is because of major concerns about the abuse of vulnerable persons, who might be coerced or induced to request aid in dying or conditioned even innocently to perceive an expectation that they should ask for such an aid. There is no certainty that abuses can be prevented by anything less than a complete prohibition.

On the other hand there is no controversy on the physician’s responsibility to provide palliative care, which is made available to ease the pain and suffering in the terminal stages of an illness even though the effect of treatment may significantly shorten the life. When one considers the principle of justice it is the duty to treat those who need treatment and also only fair to offer protection to the vulnerable. The objective here is to reduce and minimise the suffering of the patient and not to kill them, in the process if they gradually die then at least they would have not died with pain, suffering and in an undignified manner. Going by the ethical principles the physician has to be beneficent and expected to do no harm to the patient. To be beneficent one
has to do ones best to alleviate the pain and suffering of the patients by providing proper and adequate palliative care. The harm principle expects physicians not to kill the patient by e.g. giving potassium chloride. One has to clearly distinguish the difference between palliative care and ending somebody’s life that is not in any discomfort or distress but suffers from a non-treatable illness and wishes to die. There is no argument that the patient should ever be allowed to suffer if you cannot cure which you cannot always; you certainly can care for these patients and make them comfortable so that they die with peace and dignity. On the other hand if someone who has AIDS and feels depressed, abandoned and socially isolated requests for assisted suicide, such patients should be offered counselling and psychotherapy and any other treatments to improve their condition rather than putting them to death. Physicians should not only preserve life, they should also strongly promote patients well being, including the relief of suffering. End of life care does not mean withholding and withdrawing life support treatment and waiting for the patient to die. It expects of the physician to have a proactive role by providing pain relief titrated to the needs of the patient so that they don’t suffer and die with dignity. The potential of contemporary medicine to provide palliation and pain relief to those who are dying is tremendous. Health care professionals have a moral duty to provide adequate palliative care and pain relief, even if such care shortens the patient’s life. However, one must also admit that these are very simplistic views and may have strong religious angle in our beliefs. It is a very complicated issue and the debate mostly revolves around the definition of ‘suffering’ and in our society and culture they are too narrowly focused on physical suffering.

Cases:

A 56-year-old gentleman from a poor background and former office clerk who suffers from diabetes and hypertension comes to your clinic and requests for euthanasia. He states that he use to work in a small remote town as an office clerk. He has five children the eldest being 18 year old. Because of uncontrolled diabetes and hypertension, he had already lost vision in one eye four years ago. The meagre income he had was barely enough to run the house. It was impossible for him to afford medical treatment as the drugs were very expensive and they had to be taken daily including monitoring of blood sugars and blood pressures. Despite doctors warning he turned towards alternative medicines, as they were very cheap. Over a year ago he was working in his office when he suddenly felt a curtain coming down in front of his unaffected eye. He could not see anything. In his small town he had no specialist help available. He had no money to travel to a larger town to have his treatment. He again took some alternative medicines which had no effect and he was rendered permanently blind. He lost his job and the family was in dire straits. His 18 and 16- year- old sons had to leave their studies to look for a job. All they could find was some odd jobs with meagre pays, as they had no skills. The wife started stitching people’s clothes in her home and because of the poor locality she could never earn enough. The man sat the whole day hearing the plight of the family, their agony and the suffering they were going through. Over and above they all felt guilty for inability to pay for their father’s chronic diseases. The children still had hope that their father’s vision would come back if he was taken to a specialist in the city. He became conscious of the fact that he was becoming a liability both physically as well as financially. He approaches the doctor to give him some medicine, which would slowly kill him. He wants an end to his suffering.
• Should the doctor respect the wishes of the patient?
• Is it an individual right of the patient to demand such a treatment?
• Is the doctor duty bound to respect the autonomy of the patient and is it an absolute right?
• Would the doctor be liable if he complies with the patient’s wishes?

**Bibliography and Reading material:**


• End of life Issues. Ethics in Medicine, University of Washington School of Medicine. [Http://eduserv.hscer.washington.edu/bioethics/tools/princpl.html](http://eduserv.hscer.washington.edu/bioethics/tools/princpl.html)

• Annas GJ. The promised end constitutional aspects of physician-assisted suicide. NEJM 1996;335:683-87


SURROGATE DECISION MAKING

Objectives:

To understand:

- What is meant by surrogate decision making;
- The importance and necessity of surrogate decision making;
- The physicians’ role in surrogate decision making.

Ethics Message:

Surrogate decision making in health care mean making decisions about a patient who is incapable of doing so. This denotes the respect and protection of the person even when s/he has lost the capacity to make informed decisions. The surrogate decision maker should be an individual who closely knows the individual very well. The decision makers in the usual order of priority include a court appointed guardian, spouse, children, parents, brother, sister, any other relative or a concerned friend. A public official can be a substitute decision maker when no substitute is available. The surrogate decisions must promote patients welfare. This is determined in the following ways:

- If the patient has been able to express preferences in the past than the surrogate must use knowledge of these preferences in making the decision this is called ‘surrogate judgment’;
- If the patients own preferences are unknown or unclear, the proxy must consider the “best interest” of the patient, using some more objective, socially shared values, such as relief of suffering, preservation and restoration of function, extent and quality of life sustained. The answers should not be how this patient should be treated but how this patient would want to be treated;
- Close relatives are usually considered the surrogate decision makers as they supposedly know the patient very well and his beliefs and values. But if they are not sure how this patient would have wished to be treated than decisions are made in the best interest of the patient.

The role of the health professional is to facilitate the process of surrogate decision making by providing information that will enable the substitute to make informed choice on the patient’s behalf. Health care professionals should guide the substitute to make decision on the patient’s preferences. If the physician ever feels that the decisions are being made not in the interest of the patient, then he should take counsel of colleagues, ethical committee and lawyers.
According to Lazar et al. empirical evidence suggests that surrogate decision makers cannot accurately predict patient’s preferences for life sustaining treatments. They encourage and advocate advance care planning.

In some life threatening emergency situations patients are unable to express preferences or give consent because of shock or unconsciousness. Physicians should undertake life saving treatment without the express consent of the patient. This practice is legally justified as ‘implied consent’. It is done under the assumption that if patient was able to consent he would have consented to this life saving procedure.

**Cases:**

A couple has brought to you their 15- year- old mentally retarded daughter and requests you to perform hysterectomy on her. They give two reasons for their request. Firstly they fear that there is a risk of an unwanted pregnancy and the other that during her periods she is unable to look after herself. Both parents work and it is difficult for them to manage her during menstrual period.

- Should you perform the operation? What are the ethical issues here?

A 62-year-old gentleman who is an ex-smoker is being consented for esophagectomy for carcinoma esophagus. The surgeon informs him that there is a likely hood that he may require post-operative ventilation. There is also a small chance that this may become a prolonged affair and sometimes it becomes difficult to wean off from ventilation. He very candidly says “Oh! Doctor I would not like to be in that situation, I would rather die.” The doctor states that it is my duty to warn you and the patient consents. Unfortunately, the patient exactly comes to that very situation where he has nosocomial respiratory infections, is ventilated, paralysed and has developed multiple other problems. Six weeks have passed with no improvement and the family wishes to go all the way. According to them this is what the patient would have wanted. The surgeon is aware of his remarks in the clinic.

- How should this conflict be resolved?

**Bibliography and Reading material:**

**MEDICAL COMPETENCE**

**Objectives:**

To understand:

- That competence is a moral foundation of patient doctor relationship;
- The broad meaning of competence;
- The meaning of medical competence;
- The obligation to maintain medical competence;
- The moral responsibility if you see an incompetent surgeon;
- The ethical issue of treating or operating as a resident when one is not competent.

**Ethics Message:**

Competence of a physician is the moral foundation of fiduciary relationship between the physician and the patient. This becomes magnified and very important by the invasiveness of most surgical interventions and vulnerability of anaesthetised patient. Competence is possession of knowledge, skills and experience to perform the task reliably and produce appropriate outcome. It is an absolute variable one is either competent or incompetent to take the task at hand independently. One must appreciate the difference in the meaning of competence and experience.

Medical Competence is specific to tasks. One may be competent to perform certain operations in a specialty and some not. You may be competent to perform a cholecystectomy but not competent to perform a pancreatic resection. Similarly the competence could be specialty related competency e.g. general surgery vs. orthopaedic surgery. Therefore if you are a general surgeon you cannot and should not operate on an orthopaedic patient except in exceptional circumstances when one is the only surgeon available. This should be communicated to the patient and he should not remain under any false pretence. You must always do what you are credentialed to do and during any procedure you feel that you are not competent to handle a task, it is your moral duty to call for help, instead of risking the life of the patient. During a procedure if you enter into any other specialty domain e.g. working in the pelvis you may need the help of gynaecologist or urologist, unless the task is minor and you feel competent to handle it, you should seek help.

Surgeons have a moral obligation to attain and maintain competence. If one lacks a particular skill than one should always refer to a colleague who have the required skills. If due to any reason competence is impaired than you should not perform surgery. Surgical competence also requires not just skills to operate and finish a task successfully but it also requires the knowledge
and expertise to adequately work up the case and be able to manage the patient postoperatively. This expertise should be commensurate with the task at hand. It is the total commitment to the surgical mission, including appropriate follow up, is a fundamental component of fidelity to the trust that patients place in the surgeon.

In cases where deficiencies in competence are noted these must be notified to relevant authorities. This is a moral obligation to protect patients. Hospitals have the duty to protect the patients from incompetent physicians and have procedure for credentialing and privileges. This process should be regularly reviewed to ensure that competence is maintained as a condition to renewal.

Residents who are not competent to do any procedure should not do one independently. There is nothing wrong with operating in the presence of an experience surgeon under his supervision. The art of surgery has to be taught to the future generations of surgeons. This should be done by competent surgeons and teachers under their supervision and they should be a graded responsibility according to their assessments and level of comfort.

**Cases:**

A young surgeon who is fully qualified and has successfully completed an accredited training program has started his independent practice in a town attached to a secondary care hospital. He is trained from a well known centre and feels very confident about performing major surgical procedures. He comes across a 60-year-old patient in his practice who has obstructive jaundice due to periampullary tumor which is resectable. The gentleman is otherwise well and fit for surgery. He has done pancreaticoduodenectomy under supervision but has never done one independently.

- Should he perform the operation? What are the ethical issues involved here.
- Will your answer be different if he was working independently in his own institution or a tertiary care centre?
- Should competence or expertise be the standard of surgical care?

A 55-year-old surgeon is still practicing open cholecystectomy when the standard of practice for symptomatic gall stones is laparoscopic cholecystectomy unless contraindicated for any other reason.

- What are the ethical issues involved here?
- How would you resolve this ethical issue?
Bibliography and Reading material:


CONFLICT OF INTEREST

Objectives:

To understand:

- What is conflict of interest;
- How does it effect the fiduciary relationship with the patient;
- How it effects or influences the professional judgment;
- How to recognise the subtle coercion by interested parties;
- How to recognise the seductive interference of secondary gains;
- That you don’t get free lunches anywhere.

Ethics Message:

Conflict of Interest is defined by Thompson, “is a set of conditions in which professional judgment concerning a primary interest tends to be unduly influenced by a secondary interest.” The interest of the physician at all times should be with the patient. This is a fiduciary relationship, which at all times demand of its trust to safeguard the interest of the patient. Monetary gains are secondary interests and should not influence your professional judgment e.g. recommending an unnecessary operation is a clear conflict of interest. In clinical research the primary interest should be the well being of patient and the secondary interest is the completion of research. In no circumstances should one put patients at risk for the interest of research. As a treating patient coercing a patient into research in the name of better clinical care is a clear conflict of interest. Especially being a physician and a researcher at the same time does induce some conflict of interest but again primary interest should never be allowed to be influenced by secondary interests. As Thompson states it is not the presence of conflict of interest which is per se considered wrong but it is actually the actions which will determine the conflict of interest.

The subtle coercion by interested parties is when pharmaceutical and biotechnology industry influence you with providing gifts, sponsored travel, weekend trip to a resort in the name of CME etc are all ways to influence your judgment in using their product, prosthesis or drugs. There is a clear conflict of interest but your subsequent actions will determine whether your judgments are influenced. There should as far as possible not be any conflict of interest but any element of secondary gains should not be allowed to effect your professional judgment. Lastly there are no free lunches anywhere. There are always some strings attached and empirical research has shown that such practices do influence prescribing habits of physicians.
There are number of other clinical indicators of checking the motives of the patients e.g. if more than 10-15% normal appendices are being removed by an experienced surgeon than the motives of such a practice have to be questioned for any other motives. If a Cesarean Section rate is persistently above 15-20% than the practice of the surgeon should be checked for other motives.

**Cases:**

A reconstructive surgeon a very keen operator and has special interest in free flap transfers. He is regularly doing these free flaps the results of these have never been audited. Failure of one of his free flap leads to a complaint by the family to the hospital administration for negligence and requesting an inquiry. An independent reconstructive surgeon reviews the case and finds out that there was no indication for doing a free flap. As there were number of other options available to rotate a pedicle flap.

- Is the activity of the surgeon here in the best interest of the patient, for monetary interests, for interest of his experience or for increasing his series?
- Has he violated the fiduciary physician patient relationship?
- Does this incidence warrant an audit of free flap reconstruction?
- What should be done about his privileges?

A pharmaceutical company is launching a new anti arthritic drug. A one-day CME programme on Arthritis and its management has been arranged. They have booked a hotel for 50 leading general practitioners of the city and are inviting them with their spouses for a four-day paid trip to a five star hotel on this hill resort. After the CME programme they would spend one hour filling in a questionnaire based survey of the General Practitioner on their experience of management of arthritis and the choices of drugs. The other three days they would be free to have a holiday with their spouses before they are flown back.

- How many ethical issues can you pick up here?

Residents may be approached by pharmaceutical representatives and provided some free books or stethoscope or pizzas publicising their products.

- How do you feel about it?

**Bibliography and Reading material:**

• Lemmens T, Singer PA. Bioethics for clinicians 2: Conflict of Interest in Research, Education and Patient care Can Med Assoc J 2000;135-145


RESOURCES ALLOCATION

Objectives:

To understand:

- The ethical issues of macro, meso and micro allocation of resources;
- The ethical criteria for rationing decisions;
- The ethical criteria for making the triage decision.

Ethics Message:

There is nobody more cognizant than a health care worker in a developing country about the problems and limitations of working in a resource poor environment. In the miniscule pool of national resources, health care receives the least priority in developing countries due to variety of reason. As a macro resource allocation concerns the people should place democratic and transparent dispensations with oversight from judiciary, legislature and public watchdog bodies to have some fair and equitable distribution of scarce national resources. In resource poor environments, ideally all persons should have access to “decent minimum” of health care necessary to sustain life, prevent illness, and relieve distress & disability. Education and economic conditions should be the priority in such macro allocations as both are interlinked with better health indicators at all levels.

Meso resource allocation at institutional level should also be equitable, fair and transparent. A process should be in place for setting priorities in a chronically starved environment. The distribution should be according to the need and benefit assessment of different specialties who should be represented and involved in the decision making process. The process should be overseen by the management board and be available for public scrutiny.

Micro level resource allocation issues present at the patient physician level, in clinics, bedside and operating rooms. Need and benefit are used by caregivers to determine priorities and this level of allocation is less amenable to scrutiny. Morally the physician is duty bound to explain to the patient why s/he is deferred, delayed or denied access to treatment.

Rationing can be defined as distribution of resources by a manner of allocation as it happens in market. This is done by some criteria and priorities. This is an ethically troublesome issue for physicians. In one sense, no physician renders a “full measure” to any one patient, since physicians have many patients all of whom must be served. Thus physicians have traditionally rationed time and effort. Still, the idea of a plan for rationing medical resources is troubling for physicians. The easiest form of rationing for individual physicians and the least problematical ethically involves fore going medical activities that are useless or unnecessary. Costly scarce resources should not be expended wastefully on patients who will not benefit. This is an ethical obligation of physicians. However, when a particular form of intervention is likely to be useless
or unnecessary requires acute clinical judgment and is often impossible to make it in acute
settings. Whenever possible, judgments should be based on medical indications and patient
preferences rather than on quality of life issues. Similarly factors such as age, gender, race,
national or ethnic origin, mental status, financial resources should not influence such decisions. It
is also very difficult for the physician in an acute environment to be certain whether they are
dealing with someone who was terminally ill or whether they were just dealing with someone
who was critically ill but had a significant chance of recovering completely. These issues are
even more difficult for the on call trainees.

Triage criteria are used when many patients simultaneously need attention and medical and
health care resources are limited. Common sense approach is to attend and serve the persons
whose condition requires immediate attention. Others who are stable and do not require
immediate attention should wait. On the other hand in a multiple casualty and disaster situation it
implies that most seriously injured with less chance of survival may be relegated to the end of
the line and left untreated, even at the risk of death, as their care could absorb so much time and
attention that the work of rescue and saving many others would be compromised. This rule is
justified only because of clear necessity of greater public welfare and on the principle of utility in
a situation of crises.

Mckneally et al states that overall goal of clinicians is to provide optimal care within the resource
constraint environment. The following strategies, which they recommend, should become second
nature of clinicians in developing countries. They suggest to:

- Choose interventions which are known to be beneficial;
- Minimise the use of marginally beneficial tests;
- Minimise the use of marginally beneficial interventions;
- Seek least costly tests or treatments that will accomplish the diagnostic or therapeutic
goal;
- Treat patients in order of appearance unless there are other morally relevant consideration
of this approach;
- Support rather than apposing reasonable efforts to conserve health care resources;
- Avoid manipulation of the rules of the health care system to give unfair advantage to
your own patients;
- Resolve conflicting claims for scarce resources justly, on the basis of morally relevant
criteria;
- Employ fair and publicly defensible procedures for resolution of conflicting or competing
claims;
- Seek resolution of unacceptable shortage at the level of hospital management or through
political action at the level of government;
- Inform patients of the impact of cost constraints in a humanistic way, as matter of respect
for persons without criticizing any parties;
- Develop guidelines how to balance between personal choice and systemic cost control.

As Miles describes “that at present, an adversarial system seems to prevail between those who
provide and receive health care and those responsible for health policy and funding”, this conflict
has to end in any system but especially so in resource poor environments. The new ethics will need to look back at the values that ground the medical endeavour in its particular view of the importance of quality and quantity of life for each member of society, and they will need to work from a moral imperative that insists that the best care is provided in the inevitable resource constraints. All this is undoubtedly very true in systems, which are fair, and where everyone has equal access to health care and there is equitable distribution within those resource constraints. However in developing countries where two tier systems exist, where majority have no access to decent health care and the rich have limitless opportunities, such argument does not augur well. This is unfortunately against the principle of justice and fairness and may be ethically difficult to accept for physicians working in such inequitable environments.

**Cases:**

A 68-yearold gentleman has been brought in from a small town. He is a known diabetic and hypertensive was well controlled on treatment and leading a normal life. Two days ago he was admitted to a local small hospital with 12 hours history of severe acute abdominal pain and vomiting. A diagnosis of acute pancreatitis was made and he was admitted and resuscitated. Despite aggressive resuscitation his condition deteriorated as he had not produced any urine since admission and was increasingly breathless. He was referred to a tertiary care centre and on admission here he was found to be very ill looking. He was very breathless with respiratory rate of 40/min and pulse of 120/min. He had a tender distended belly. He had a Po2 of 62, blood sugars of 320mg%. He had no urine in his bag. A decision is made for elective ventilation, an insertion of Swanz Ganz catheter with invasive monitoring, hemodialysis at some stage depending on his potassium and Swan parameters and a CAT scan abdomen depending on his creatinine. It is presumed that he may require pancreatic necrosectomy if there was infected pancreatic necrosis. One resident on team asks the chief resident if the decision was waste of scarce resources as his chances of survival are minimal.

- How do you decide about rationing of resources in such a situation?
- What issues would you consider for arriving at a conclusion?

While these discussion are going on in Emergency Room another young lady of 32 years of age with two kids who was admitted couple of days ago with fulminant pulmonary Koch’s is gradually going into respiratory failure and the physicians have asked for this only bed on ICU. They have been told that this has been booked for a patient from ER. There is nobody in ICU who could be transferred. The medical chief resident has been on the phone to other hospitals and is unable to find a bed. He contacts the surgery chief resident and tells the story of his patient and asks if his patient really requires ventilation.

- What would you say in such a situation?
- How would you ethically justify what ever decision you take?
Bibliography and Reading material:


RESEARCH ETHICS

Objectives:

To understand:

- What constitutes research;
- The main ethical issues of human subject research;
- The principles governing the human subjects of research;
- The requirements of ethics of clinical research;
- The essentials of informed consent in research.

Ethics Message:

Medical research can be broadly defined as an application of scientific methods to test a hypothesis in the field of medicine. The overarching objective of clinical research is to develop generalisable knowledge to improve health and or increase understanding of human biology and subjects who participate are the means to securing such knowledge. By placing some people at risk of harm for the good of others, clinical research has the potential of exploitation of human subjects. Ethical requirements for clinical research aim to minimise the possibility of exploitation by ensuring that research subjects are not abused and are treated fairly and with respect while they contribute to the social good.

All the principles of bioethics apply to research ethics. The informed consent is derived from the principle of autonomy and means respecting this right of the person to make informed decisions. The principles of beneficence and non-malificence transpire into well-calculated risk/benefit analysis. The patients however educated may not understand the scientific complexities of research and are unable to make a reasonable risk benefit assessment. This highlights the role of the competent and independent ethical review boards to look at these assessments carefully as true protectors of the research subjects. Lastly the principle of justice expects of researchers to do fair selection of research subjects. To make sure that burdens and benefits of research are equally shared and nobody is used as a means to an end.

The ethical requirements of research expect that it should be valuable to the individual or the society. It also means that the evaluation of new treatment, intervention or theory will improve health well being or increase in knowledge. In clinical trials there has to be a true state of clinical equipoise, which means that the expert medical opinion remains divided on the choice of best treatment option. Similarly the study should provide scientifically valid results. An unscientific study is ipso facto unethical. The science which is expected to produce invalid results or
assumptions should not be allowed to put the research subjects at risk for no avail. Even if there is value and validity there has to be justification when there are scarce resources and the research subjects should never be exploited to get valid and valuable scientific answers. Selection of subjects should be fair that stigmatised, marginalised and vulnerable individuals are not enrolled are not targeted for risky research and the rich and socially powerful not favoured for potentially beneficial research or excluded from the risk. All efforts should be made to minimise the risk and enhance the potential benefits; risks to the subjects should be proportionate to the benefit to the subjects and to the society. Informed consent is not the only but essential requirement of research. It should contain information for subjects about the purpose of research, its procedures, potential risks, benefits and alternatives so that the individual understands the information and can make a voluntary decision whether to enrol or continue to participate. Respect of the subjects also requires allowing withdrawal from research any time without any ill effects. It should protect confidentiality. The subjects of research should be informed of newly discovered risks or benefits and the results of clinical research. It should always maintain the welfare of research subjects as its priority.

Investigators inherently have multiple, legitimate interests – interests to conduct high quality research, complete the research expeditiously, protect research subjects, obtain funding and advance their careers. These diverse interests can generate conflicts that may unwittingly distort the judgment of even well intentioned researcher regarding the design, conduct and analysis of research. Therefore all research requires a prior approval of the complete research protocol including informed consent by an independent and competent ethical review board. The board should have the scientific and ethical expertise to review such research and it should be independent of the researcher or institutional influence.

**Case:**

**Transplantation of Embryonic Dopamine Neurons for Severe Parkinson’s Disease**

*N Engl J Med, March 8, 2001; Volume 344(10):710-719*

**Double Blind Randomised Placebo Controlled Trial**

**Background**

Transplantation of human embryonic dopamine neurons into the brains of patients with Parkinson’s disease has proved beneficial in open clinical trials. The value of open-ended clinical trials is limited due to inherent biases in such kind of studies. Parkinsonism is a very debilitating disease and requires lot of life long medications with adverse side effects. This new method is an invasive procedure and has considerable risks. For it to become a standard of care there is a need to scientifically test whether this intervention is better than no surgery. To remove the bias of placebo effect of surgery the control group would be randomized to sham surgery in the trial.

**Objectives**

To determine whether transplanted embryonic dopamine neurons survived, the symptoms and signs of Parkinson’s disease improved and whether age had any effect on the outcome of transplantation.
Methods
Double Blind Randomised Placebo Control Trial;
Inclusion Criteria;
Patients with Parkinson’s disease for more than seven years;
Should have two of the three main signs;
Improvement on Levadopa of at least 33%;
Positive PET scan for Parkinson’s disease;
Exclusion Criteria;
Mini Mental State Examination Score of < 24;
Hallucination and delusion during Levadopa therapy;
History of Epilepsy;
Previous brain surgery;
Severe depression;
Cerebro-vascular disease;
MRI evidence or any other neurological disorder;
Medical contraindication to surgery.

Randomisation
40 patient randomly assigned in groups of 10 to undergo sham surgery or transplantation with adjustments to balance the groups according to age, sex and duration of disease

Procedure
In OR the patient was randomized to sham surgery or transplantation – GA / LA to forehead
4 Twist drill holes were made on the forehead and through the frontal bone along the planned axis of the track.
In transplant group the cells were implanted with the guide cannula which was introduced sterotactically.
In sham surgery the whole procedure was the same up to dura, except that the dura was not penetrated.

Results
Human embryonic dopamine-neuron transplants survive in patients with severe Parkinson’s disease. There was some benefit in younger but not in an older patients

CONSIDER

Social and Scientific Value
Evaluation of a treatment, intervention, or theory that will improve health and well-being or increase knowledge
Scarce resources and non-exploitation

Scientific Validity
Use of accepted scientific principles and methods, including statistical techniques, to produce reliable and valid data
Clinical equipoise should exist which is defined as ‘Uncertainty about whether the experimental intervention is better than the status quo’
Scarce resources and non-exploitation

**Fair selection of subjects**
Selection of subjects so that vulnerable individuals are not targeted for risky research and the rich and socially powerful not favoured for potentially beneficially research Justice

**Risk benefit Analysis**
Minimization of risks; enhancement of potential benefits; risks to the subjects are proportionate to the benefits to the subjects and society
Nonmaleficence, beneficence, and non–exploitation

**Informed consent**
Provision of information to subjects about purpose of the research its procedures, potential risks, benefits and alternatives must understand and makes a voluntary decision either to enrol or to continue to participate.
Respect of Autonomy

**Bibliography and Reading material:**


