Ethical/Legal Issues in Medicine
An Introduction to Clinical Ethics
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Required Reading:
1. Syllabus – Professionalism pp. 26-32, Ethical/Legal Issues in Medicine, Introduction to Clinical Ethics
2. Syllabus – Articles pp. 72-73, Facing our Morality, the Virtue of a Common Life

Goals:
At the end of this session, the student will be able to:

1. Understand the meanings of the following terms and concepts:
   a. Competence and Incompetence
   b. Rationality and Irrationality
   c. Valid (informed) Consent and Refusal
   d. Paternalism: Justified and Unjustified

2. Understand that medical ethics is largely the application of everyday morality to medical practice situations.
3. Identify the moral aspects of medical practice and what features of a medical situation are morally relevant.
4. Understand and apply the necessary facts to reach a moral decision.
5. Communicate medical information effectively to patients and families and ascertain whether they understand that information.
6. Determine whether a patient is competent to consent or refuse treatment.
8. Understand and utilize patient's values in helping them to make decisions about their care.
9. Understand when it is morally justified to withhold information from a patient or to otherwise deceive a patient.
10. Decide when it is morally justified to breach patient confidentiality.

   a. Describe the difference between a values conflict and an ethical dilemma.
   b. Understand the need to respect a patient’s legal rights even when they are sick.
   c. Understand that ethics and the law are not always the same and that there may be penalties for doing something which you think is ethical, but may be illegal.

Analytic Methods to Resolve Ethical Dilemmas

I. Morality: Dr. Bernard Gert's Analysis

1. What moral rules are being violated?
2. What harms are being (a) avoided, (b) prevented, (c) caused?
3. What are the relevant desires of the people toward whom the rule is being violated?
4. What are the relevant rational beliefs of the people toward whom the rule is being violated?
5. Does one have a relationship with the person(s) toward whom the rule is being violated such that one has a duty to violate moral rules with regard to the person(s)?
6. What benefits are being promoted?
7. Is an unjustified or weakly justified violation of a moral rule being prevented?
8. Is an unjustified or weakly justified violation of a moral rule being punished?
9. Are there any alternative actions that would be preferable?
10. Is the violation being done intentionally or only knowingly?
11. Is the situation an emergency that no person is likely to plan to be in?

II. Clinical Ethics: Dr. Bernard Lo's Analysis

A. Gather Information
   1. What is the medical situation?
   2. If the patient is competent, what are her preferences?
   3. If the patient lacks decision-making capacity, have advance directives been provided?
   4. If the patient lacks decision-making capacity, who should act as surrogate?
   5. What are the views of the health care team?
   6. What pragmatic issues complicate the case?

B. Clarify the Ethical Issues
   1. What are the pertinent ethical issues?
   2. Articulate the ethical guidelines participants are using.
   3. What are the reasons for and against alternative plans of care?

C. Resolve Dilemmas
   1. Meet with the health care team and the patient or surrogate.
   2. List the alternatives for care.
   3. Negotiate a mutually acceptable decision.

Case 1: Child Abuse Reporting and the Physician-Patient Relationship

Dr. Staples has been treating the Jones family for years. He went to college with Mr. Jones, has followed the development of the family, and has occasionally socialized with them. One day Mrs. Jones brings in their 15-year-old son for evaluation. She says that he was hurt rough-housing with some of his friends, but Dr. Staples notes considerable reluctance on her part to discuss the precise details of his injuries and the boy himself is non-communicative. Dr. Staples has heard through his friends at the local country club (where both he and Mr. Jones are members) that Mr. Jones recently lost his job, had been taking it very badly and was drinking heavily.

On examining the boy, his contusions and abrasions are not consistent with the limited facts supplied by the mother. In fact, they are quite suspicious for child abuse. Dr. Staples questions the mother and boy about the possibility of abuse, but his insinuations are vigorously denied.
The next day Dr. Staples receives a telephone call from an angry Mr. Jones who states that his wife informed him of Dr. Staples' questions and tells him that if he reports or makes any suggestion of abuse to anyone that he will sue him for libel and, through their mutual friend, have an article put in the local paper attacking him. Dr. Staples is aware that there is a strict reporting requirement under state law whereby he is required to report suspected abuse to the state. When he discusses the matter with his Chief of Service, he is specifically directed not to report the matter because of the adverse publicity that will inevitably arise.

**Suggested Questions**

1. What are the elements and nature of the physician-patient relationship?
2. How is the physician-patient relationship begun and ended?
3. How do legal duties impact on the relationship?
4. What would you do in this case?

**Case 2: Cultural Issues in Medical Care**

A 78-year-old man was admitted for evaluation of rectal bleeding. The patient was the father of a local professional man who brought his father to the United States from Russia a week earlier for medical treatment. The patient spoke only Russian and his son acted as his interpreter.

Workup revealed carcinoma of the sigmoid colon metastatic to the liver. When the staff and resident gastroenterologist explained to the patient's son that they wanted to discuss the diagnosis and proposed treatment with the patient, the son insisted that his father not be told the diagnosis or prognosis. The son explained that it was the usual custom in Russia not to tell patients when they had cancer, especially when they likely would die as a result. The physicians were uncertain whether their duty was to respect the patient's cultural beliefs or to tell the truth.

**Suggested Questions**

1. Should the patient be told his diagnosis and prognosis?
2. Are there reasonable alternatives?
3. How should we settle conflicts between cultural practices and what physicians may regard as "right" medical practices?

**Case 3: Physician Assisted Suicide**

Ella Washington, age 60, visits Dr. Jones, her internist for the past twenty years, with complaints of nausea, stomach pain and weight loss. Dr. Jones' workup reveals pancreatic cancer, with metastases to the liver.

Dr. Jones and Ms. Washington talk extensively about the diagnosis, her poor prognosis and the lack of curative therapies. In response to her direct question, Dr. Jones says that she probably has less than six months to live. He refers her to an oncologist for further advice, and schedules another appointment with him a few weeks later to go over the situation.
Ms. Washington returns in a few weeks, accompanied by her husband and son. She has consulted
the oncologist and seems to have a clear understanding of her condition. Her family appears
supportive as they talk about palliative therapies and home hospice care.

Before leaving, Ms. Washington tells Dr. Jones that she wants to "die with dignity", and needs to
be able to take her own life in the least painful way possible, when the time comes. She says that
she has spoken to her family at length and that they support her decision to control her own dying
process. She claims that fear of a painful, lingering death will prevent her from enjoying her
remaining time. She tells Dr. Jones that she has received information from the Hemlock Society
on methods of suicide and has purchased a copy of Final Exit by the Society's executive director.
She asks Dr. Jones to prescribe barbiturates.

Dr. Jones initially refuses Ms. Washington's request, and asks her to return to see him in a few
weeks after she consults with a psychiatrist for verification that there is no significant depression.
She complies, and returns to Dr. Jones with the same prescription request. "This is my decision,"
she says firmly. "We've known each other a long time. I trust you; but if you don't help me, I'll
find someone who will, or do it myself. Please don't make this harder on me and my family."

She explains that the security of having enough barbiturates to commit suicide, when and if the
time comes, would allow her to live fully and enjoy the present. Dr. Jones is convinced that Ms.
Washington is not despondent and is thinking rationally. They agree to meet regularly, and she
promises to consult with him before taking her life. Dr. Jones then writes the prescription for
barbiturates.

The next four months are intense for Ms. Washington, and while she fatigues easily and has some
pain, this is a fulfilling period. She spends time with her husband and son, and renews and
reinforces old friendships. She endures intermittent physical and emotional hardships, but seems
to bounce back from periods of sadness and anger.

But then she becomes weaker, and the nausea and stomach pain grow more constant and intense.
Despite extensive efforts to minimize her discomfort, she feels that the immediate future holds
what she fears most: increased pain, dependence and disability. As agreed, she meets with Dr.
Jones to inform him that she would soon commit suicide. Two days later, Ms. Washington's
husband calls to say that she died at home, after saying goodbye to her family and closest friends.

Suggested Questions

1. Is this a case of physician-assisted suicide? How does it differ from euthanasia?
2. What is the definition of physician-assisted suicide?
3. What are the moral arguments favoring and opposing physician-assisted suicide?
4. What is the current legal status of physician-assisted suicide?

Case 4: Medical Futility

Sandra Jones is an 83-year-old woman with Alzheimer's type dementia, severe osteoarthritis and
Type II Diabetes Mellitus who has been a resident of the Greenview Nursing Home for five
years. For many years she lived with her daughter and son-in-law but, as her mobility decreased,
caring for her became exceedingly difficult. Four years ago, Mrs. Jones' children reluctantly admitted her to the nursing home.

One year after admission, Mrs. Jones developed end stage renal disease, and dialysis was initiated. At the time, despite mild dementia, her daughter and physician observed that she had a reasonably good quality of life, enjoyed a variety of activities, and tolerated the dialysis well. Unfortunately, in the last three years her cognitive ability has declined markedly. Now, Mrs. Jones only occasionally recognizes her daughter and is entirely dependent for her activities of daily living. She is mostly mute, except when she cries out in pain or fear, and shows signs of pleasure only when being spoon-fed or when listening to the accordion player who visits the home every month. Throughout this time, her daughter has visited frequently and has always appeared to have her mother's best interest in mind.

Recently, each trip to dialysis has become a difficult ordeal. Mrs. Jones resists moving to the transport gurney and fights the introduction of the arteriovenous catheters. A medical workup reveals no new underlying illnesses to account for this change in behavior, and her physician ascribes her response to progressive dementia. The nursing home director, Dr. Andrews, begins to wonder whether dialysis is more of a burden than a benefit for Mrs. Jones. Furthermore, she wonders if dialysis is a waste of resources for someone with such a poor "quality of life". Without dialysis, the patient would surely die in several weeks. Dr. Andrews discusses the situation with Mrs. Jones' daughter, who requests that her mother continue to receive dialysis. She argues that "Mom was always a fighter who loved life" and that she deserves to have "everything" done for her. Besides, she observes, Medicare pays for the treatments so the nursing home need not worry about the resources.

Suggested Questions
1. What is the definition of medical futility? How is it measured?
2. Do physicians alone have the right to determine futility? What if the family disagrees?
3. How have the courts treated the concept of medical futility?

Case 5: Conflicts of Religion in Medicine

Dr. Andrews has been treating a 15-year-old pregnant female for ulcerative colitis. His patient is 7 months pregnant, and Dr. Andrews is told by the patient and by her obstetrician that she is having an uneventful first pregnancy. The patient's ulcerative colitis suddenly worsens markedly, and she requires a transfusion because of continued rectal bleeding. Both the patient and her mother are members of a religious sect which prohibits blood transfusions. Both the patient and her mother advise Dr. Andrews that they agree with the tenets of their religion, and refuse to consent to the transfusion. Dr. Andrews knows through his own knowledge and through an obstetrical consult that the unborn child will be put at considerable risk if the mother does not receive a transfusion.

Because of the fact that a large number of people who are members of this religious sect live in the community, the hospital refuses to become actively involved in the conflict, and simply leaves the interested individuals to their own devices to resolve the dispute.
The father of the unborn child, to whom the patient is not married, tells Dr. Andrews that irrespectively of the beliefs of the fetus, he wants his child to have the security which only a transfusion can provide. He demands that Dr. Andrews go ahead with the transfusion.

**Suggested Questions**

1. How does society resolve conflicts of religion and medicine?
2. Does the fact that there is a fetus at risk affect this consideration? What if the patient were a 2-year-old child?
3. How do the courts treat such cases?

**Case 6: Sexual Misconduct**

Dr. Gates is a 38-year-old single cardiologist with a busy practice. He meets Sue Carson through a referral from her primary care physician and begins treating her.

He is immediately attracted to her emotionally and physically and, during her second appointment, asks her for a date.

The relationship progresses and, over time, an intimate physical relationship ensues. During this time, Dr. Gates is still seeing Sue occasionally for the condition for which she was referred to him.

The social, sexual relationship is entirely mutual and consensual and continues to this day. When Sue's former (and very jealous) boyfriend hears of the relationship, he files a complaint with the state medical licensing board stating that Dr. Gates has violated state law by having a social and (especially a sexual) relationship with a current patient.

**Suggested Questions**

1. Define sexual harassment and sexual misconduct.
2. How would you classify this case?
3. Does it make any difference that the relationship was entirely consensual?
4. Does it make any difference that Sue refuses to participate in the complaint process?
5. Would it make any difference if Dr. Gates and Sue subsequently were married?
6. Would it make any difference if the social/sexual relationship did not begin until after the doctor/patient relationship ended?
7. Would it make any difference if the genders of the parties were reversed, namely, if the physician was female and the patient was male?

**Case 7: Sexual Misconduct**

Dr. Woods is a very effusive individual. He always has his arms around the shoulders of his patients and the people with whom he works. He regularly pinches (facial) cheeks, squeezes the back of the neck, and other actions which, he thinks, are friendly.
When it comes to females, he is not above the occasional pat on the behind or comment on someone's figure or attractiveness. ("Sweetie" and "Honey" are in common usage.) However, he has never made any explicit sexual overture to a female, never propositioned a female, and never placed his hands where they clearly shouldn't be.

Nurse Johnson takes extreme exception to this behavior and reports him to the EEOC for sexual harassment.

**Suggested Questions**

1. Define sexual harassment and sexual misconduct.
2. How would you classify this case?
3. Does it make any difference that all individuals, male and female, are treated essentially the same by Dr. Woods?
4. Does it make any difference that he has never made any explicitly sexual overtures towards any female?
5. Does it make any difference if all the other females with whom he routinely comes in contact have accepted this as his (somewhat eccentric) behavior and do not object to his conduct?

**Case 8: Ethics and Legality of treating family members**

Dr. Moe is a well established primary care physician in a small town setting. He and his wife, Curly, are very active in community affairs. Their son, Larry, is away at college.

Curly has developed shingles and has been treated with Acyclovir by her PMD who has just left for a week in Aspen. However, she has developed severe post-herpetic neuralgia.

Dr. Moe decides to prescribe Percocet to make her more comfortable.

Larry returns home for the weekend and complains of a severe sore throat. Dr. Moe does a Quick-Strep test and prescribes amoxicillin for him.

It is a violation of law in the state in which they live for a physician to prescribe (controlled) medications for himself/herself or for a member of his immediate family.

**Suggested Questions**

1. What are the medicolegal issues in this 'case'?
2. What are the ethical issues raised in this 'case'?
3. Should the pharmacist contact the state?
4. Are there alternatives for each transaction?