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978-0-521-13064-6 - Clinical Ethics in Anesthesiology: A Case-Based Textbook

Edited by Gail A. Van Norman

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Co-editors

Stephen Jackson

Stanley H. Rosenbaum

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This book is dedicated to Melvin F. Van Norman (1920–2006), a pilot and flight instructor, who said that a good teacher listens to the question that is asked, hears the questions that didn't get asked, and answers the questions that should have been asked.

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Foreword

The medical profession has had, virtually since its inception, codes of behavior and rules of conduct encompassing the physician's obligations to patients, colleagues and society. Classic versions of the Hippocratic Oath include exhortations to "do good," "avoid harm," and "remain free of intentional injustice," three of the classic principles that are cited as the core of the moral practice of medicine even to this day. Modern medical practitioners have significant power, social importance and financial impact that affect nearly everyone's lives. Medical practice crosses national boundaries, cultural enclaves and systems of spiritual beliefs. A fundamental challenge to the modern physician is achieving balance among patient values and needs, societal costs, and professional standards and codes. Given the vast range of medical need, cultural beliefs and available resources, this challenge to practitioners of all medical specialties globally is daunting.

Anesthesiologists and Bioethics

While the moral foundation of medical practice has been long recognized, the *study* of bioethics is relatively new in the history of medicine, having solidified in the late 1970s. Ethical issues are common to all medical specialties, but the specialty of anesthesiology has been at the forefront of bioethics, being among the first historically to raise critical moral questions. In 1957, Pope Pius XII was invited to address the International Congress of Anesthesiologists about such fundamental issues as whether the use of artificial respiratory equipment was required in even hopeless cases, whether the physician was under obligation to remove such therapy if such withdrawal will result in imminent patient death, and whether permanently comatose patients can be considered dead even before circulation has ceased. John J. Bonica, first chair of Anesthesiology at the University of Washington in Seattle was an early advocate for labor analgesia, at a time when religious institutions considered pain relief for laboring women morally controversial. He was later honored by Pope

John Paul II "for contribution to the improvement of the welfare of people worldwide." Henry Knowles Beecher MD, first chair of the Massachusetts General Hospital, famously exposed breaches of the Nuremberg Code in human research being conducted in the United States, leading to the establishment of human subjects review boards. He later chaired the Ad Hoc Committee of the Harvard Medical School that offered a definition of brain death, paving the way for withdrawal/withholding of life-sustaining care at end-of-life, and facilitating developments that made vital organ transplantation possible.

The clinical practice of anesthesiology includes many of the thorniest problems in medical ethics. Anesthesiologists practice in operating rooms involving care that has profound impact on patients' lives at a time when their ability to participate in decision-making may be severely limited. Many anesthesiologists practice in intensive care units, where end-of-life decision-making occurs, including withdrawal and withholding of life-sustaining therapies, resuscitation and do-not-resuscitate orders, and initiation of vital organ transplantation. Anesthesiologists are involved in obstetrical care, where the interests of mothers and fetuses may not always be aligned. They are experts in the treatment of acute, chronic, oncologic and palliative pain. They are researchers, authors and editors of medical journals. They are on the front lines in caring for the casualties of war and natural and man-made disasters. It is no surprise therefore that anesthesiologists have posed some of the most troubling ethical questions confronting modern medicine.

Ethical Theory

The classical style of medical practice until well into the 20th century was paternalistic. Doctors did what they considered best for patients, and patients usually complied. Such paternalism was derived from 'virtue-based' ethics, in which the physician was assumed to be a virtuous person with inherent qualities of competence,

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sincerity, and altruism, and who would naturally know what was correct for the patient.

In parallel with the rise of individualism, and political activism surrounding human rights, the discipline of bioethics has increasingly emphasized respect for the definition, integrity and autonomy of persons. This has been expressed in bioethics as an emphasis on appropriate consent free from moral, economic, politic, scientific, or social pressures. Medicine is too often practiced as a predominantly technical pursuit, however, and the education of physicians in the art of communication with patients has lagged behind the demands of society. Physicians are accustomed to explaining medical conditions to their patients, but the quality of their conversations concerning the patient's functional status, values or fears is often poor or even non-existent.

Medical practice that minimizes the core of human interactions could be seen as a breach to patient dignity. As patients, we would certainly not like to be treated by physicians who are lacking concern for the humane components of medicine. A respectful and proper way of practicing medicine therefore should lead us not only to concentrate on the *hows* of performing our tasks, but also on the *whys* that govern our care to unique individuals.

In this regard, growing attention has been paid to the ethical dimensions of medical care, and how we can improve the fulfillment of our duties to patients. The publication and wide acceptance of *Principles of Biomedical Ethics* by James F. Childress and Tom Beauchamp more than thirty years ago was certainly a cornerstone event for what became an authentic discipline. They described cardinal ethical principles (*Autonomy, Beneficence, Nonmaleficence* and *Justice*) that are now routinely discussed and debated among medical professionals.

Although there is general acceptance of these principles as being foundational to ethical medical care, the exact *prioritization* of these principles is not as clear or accepted. Ask virtually any physician in the United States about the order of importance of these ethical principles, and the answer will be "Autonomy first, then Beneficence, Nonmaleficence and Justice." However, if we consider French-speaking textbooks, these principles are usually presented in a different order: Beneficence, Nonmaleficence, then Autonomy and Justice. Among certain Pacific Island cultures, where community values receive more emphasis than

individual needs, *autonomy* might not be recognized as an ethical principle at all.

What could be the cause of these differences? In the case of the French physician, has there been difficulty or lag in shifting from a purely paternalistic logic to a contract-based logic? Or a cultural-based reluctance to consider autonomy the dominant relevant principle? Are Pacific Islanders "backward" in placing autonomy low and communitarianism high on the list of important principles? Accordingly, an excessive attention to the principle of respect for autonomy has the potential to prevent us from striving for humanism, philosophy, and spirituality—and thereby promoting a true *therapeutic alliance* between the physician and the patient.

The aims and limits of beneficence are well known. Though intended to protect the vulnerable, and ensure justice, a "beneficence" that is disrespectful of autonomy is unfair, representing a throwback to the paternalism of the past. However, there is a growing realization that over-attention to autonomy which is not imbued with beneficence is also unfair. We, as health care professionals, have an obligation to respect the common good, with a fair balance between empowerment of patients and the concepts of beneficence and nonmaleficence.

In an opinion on education in medical ethics, the French National Ethics Advisory Committee (available at <http://www.ccne-ethique.fr>), indicated four legitimate reasons for a "disquiet" in the field of bioethics, linked to:

- a depersonalizing effect of specialization, that might limit true chances of personal relationships between the patient and his/her physician,
- a relative eclipse of the clinical side of medicine because of the increasing technology of medicine,
- an emerging form of "excessive legalism" with judicialisation of the relationships, a symptom of poor quality of communication, as "respect for patients is no longer dependent on the individual virtues of the doctor; it is commanded by the need to observe the law",
- and finally, side effects of apportioning health care, with a need for an ethical reflection linked to the attention for collective accountability of health care expenses.

Ethical concerns, though not limited to these questions, should be seen as an opportunity to share, in

harmony, a common understanding of medicine among physicians and their patients. Among the values that are at the core of bioethics, promoting dignity, with its tensions between means and ends is of special interest.

The Concept of Dignity and Medical Ethics

Dignity is a concept not restricted to the medical field. It encompasses good manners and morals. For a politician, it might mean putting national above personal interests, although it cannot be restricted to a battle between “my” autonomy and the collective interests of a group. Human dignity is a complex concept that many believe is the very core of bioethics. It is present in numerous international texts such as the Universal Declaration on the Human Genome and Human Rights (1997), or the Oviedo convention, but can be found as early as in the opening of the Preamble of the 1948 Universal Declaration of Human Rights of the United Nations (“*Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world*”), as well as in its first Article (“*All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.*”).

Dignity however is difficult to define. Like the cardinal principles of bioethics, it is rooted in practical grounds (preventing abuses) but it is also aiming for a clear respect for principles and values. Dignity is somewhat ambiguous, as it can be understood to be:

- a *quality* (dignitas) attached to a rank or an official position (dignitaries);
- a *general principle* protecting the sovereignty of humans. Dignity here, seen as humanity (i.e. what behavior I expect from my fellow human), would be taken as the concept of equal dignity of all humans;
- an *individual claim* defined by the person itself, that can be used to request new “rights.” In this regard we will each have a personal or cultural idea of what dignity is. Special requests have for example been claimed by persons requesting a right to “die with dignity”, because they believe that their dignity is now lost and that consequently they have the “right” to obtain euthanasia.

Dignity, furthermore, is a characteristic that *cannot* be suppressed. Even if we consider the horror of

Nazi concentration camps, the prisoners held there--although they were inhumanely treated--did not lose their human dignity.

One of the difficulties (and beauty) of the concept of dignity, is that it possesses all of these various meanings. Taken as a general principle, it infers that it is a collective or community characteristic to be protected against external aggressions. But it also represents an individual claim--a means to promote the individual's conception of liberty.

Thus, in human interactions, and in medical practice, there is tension between the good (or dignity) of the group versus the good (or dignity) of a single individual. In this respect, if we consider the four cardinal bioethics principles, would the concept of dignity be more aligned with the *autonomy* of the individual, or the *justice* of the group? If justice is defined as *the promotion of dignity* (with the goal of first promoting equity and equality of chances, and then fighting against discriminations), we find a harmonious agreement that is valid with the different theories of justice, whether the theory be procedural (libertarian), utilitarianism (“classic” economic reasoning), egalitarianism of primary goods (as expressed by John Rawls), egalitarianism of “capabilities” (as expressed by Amartya Sen), or even elitism of merit.

Promotion of human dignity plays out differently in different cultural settings. Comparing Western and Eastern philosophy, the classic: “I think, therefore I am”, could be transposed for Eastern philosophers to: “*You are, therefore I am*”. An understanding of these differences can be very useful in light of a trans-cultural approach to medical care. To enhance understanding between physicians and patients, we must discuss and promote the idea, not only of simple information and communication, but of true and mature dialogue about our differences. And dialogue is not enough. It is merely a means, a tool towards the goal of ensuring relationships and bonds between us.

Dignity is a “human common denominator” in the promotion of peace and harmony. It encompasses the usual means of communication of culture (through Art, Science, or Prayer), but avoids the accusation that could have been made against culture of not furthering integration (“...*culture does not unite. It identifies, therefore it divides as much as it assembles. The word is ambiguous*” says Alain Lamassoure, member of the European parliament).

In the philosophic understanding of bioethical principles in the practice of medicine, issues are

Foreword

probably more complex even than imagined. Although progress could mistakenly be seen as ever increasing control over life, *authentic* control is knowing where to stop and think about what *ought* to be done, and not just what *can* be done. The beauty of a mature, ethical practice of medicine is that it unites humans while respecting cultural specificities of individuals, by taking reference in our common humanity and through the promotion of dignity.

This textbook attempts to explore many of the issues that confront the modern anesthesiologist, even when those issues cause great uneasiness. They include the variability of autonomy (in vulnerable persons), and respect for autonomy (via consent) in medical practice, along with ideals of communitarianism (in Native American culture). End of life issues include not only concepts of death (e.g. brain death) and turning off bioprosthetic devices, such as pacers and ICDs, but the idea that physicians play a role in understanding and promoting humane legislation to protect dignity at end-of-life. Cultural differences are examined in the management of pain in addicted patients. Critical research issues are discussed, including new and more global concepts concerning

the “rights” and interests of animals in research and our obligations to them, as well as the problem of unethical publication practices. Issues of considerable discomfort are scrutinized, such as physician participation in torture, disaster and military triage, and lethal injections of prisoners.

All are presented from the perspective of anesthesia practice in all of its breadth, and by a wide range of experts from Canada, Europe and the United States. Some questions have clear answers that are already incorporated widely into practice. For other questions, the answers are not as evident. For still others, anesthesiologists may not have widely adopted correct moral behaviors, even when there is global consensus about what such behaviors should be. For all, the exploration of moral questions occurring in anesthesia practice involves consideration and balance of the ethical principles of medicine—respect for patient autonomy, beneficence, nonmaleficence and justice—in the promotion of human dignity, for our patients as well as for ourselves.

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Preface

Anesthesiologists have broad representation in private and academic clinical practices, clinical and laboratory research settings, intensive care units, palliative care facilities, pain treatment centers, journal review boards, and expert panels charged with legislative initiatives and practice guidelines, to name a few. Ethical questions abound in all walks of anesthesia practice; this is abundantly clear to the editors of this book, all of whom have been members and/or chairs of the American Society of Anesthesiologists' Committee on Ethics since its inception in the early 1990s*. The committee receives a steady flow of communications from anesthesiologists seeking answers to questions, wanting someone to vent their frustrations to, and/or asking for reassurance that they "did the right thing." It is moving testimony to the importance ethical principles hold for most members of the specialty.

But while the importance of physician understanding of ethical principles in the practice of medicine is almost universally recognized, few resources exist specific to anesthesia practice or the issues facing anesthesiologists in other settings. This textbook respectfully follows the footsteps of such books as Draper and Scott (*Ethics in Anaesthesia and Intensive Care*, Butterworth-Heinemann 2003), and Scott, Vickers and Draper (*Ethical Issues in Anaesthesia*, Butterworth-Heinemann, 1994).

While the ethical issues facing anesthesiologists are a numerous and varied as anesthesia practice itself, some general themes emerge. We considered issues roughly (and admittedly artificially) divided into 6 categories. In Section 1 (Informed consent and refusal), common issues such as Do-not-resuscitate orders, and the Jehovah's Witness patient are covered as are more controversial issues, such as anesthesiology involvement in female circumcision. Maternal-fetal issues

are explored in the context of "Ulysses directives" and maternal demand for cesarean section delivery. Consent issues in non-Westernized cultures where autonomy may not be the dominant principle are reviewed. In Section 2 (End-of-life issues), withholding and withdrawing treatments includes considerations of discontinuing cardiac assist devices, organ transplantation issues such as donation-after-cardiac death (DCD) and the legislative efforts of anesthesiology experts, and euthanasia. Section 3 (Pain management) includes different considerations in management of addicted patients in the UK and US settings. In Section 4 (Ethical issues in research and publication), controversial topics concerning the treatment of animals and animal rights are included, as are the relatively new debates around quality improvement initiatives as research, and the pivotal roles of authors, editors and reviewers in publishing medical information. Dealing with the addicted or disabled provider, sleep deprivation, industry gifts to physicians, disclosure of errors to patients, and physician conscientious objection are covered in Section 5. Section 6 concerns anesthesiologists in their roles and duties within the state: expert testimony, response to disasters, ethical issues in the military, torture, and physician involvement in lethal injection of prisoners.

Physicians are educated in their art by study and contemplation, but also, if not primarily, by involvement in and discussion of cases and their management. Highly abstract analyses of ethical issues is not always well understood or received because physicians deal in real-life situations, and seek both practical understanding and advice. For the most part, we have tried to imitate and emphasize the case-based nature of medical education throughout the book. Chapters begin with a case example. By reading the case and subsequent discussion, the authors have attempted to discuss the major issues and principles involved in each case. Where possible, they have proposed some example resolutions, and a list of important points close each chapter. While it is not possible to anticipate the entire

* This contents of this book are not a product of the American Society of Anesthesiologists and does not, except where noted by references in the text, represent official policies, guidelines, or statements of the American Society of Anesthesiologists.

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scope of complexity of ethical issues that might present in any one case, it is our goal that the discussion fosters thoughtful reflection and aids the physician in future case management.

Because even among Western countries, the perspectives on ethical controversies in medicine are not always in agreement, we have purposefully sought authors from different nationalities, educational backgrounds, and practice experiences to provide international breadth to the book. Whenever possible, resources are cited regarding management in both US and European settings.

The chapter discussions are not meant to provide an exhaustive list of references for each and every issue—to do so would add unnecessarily to the volume of the book, and distract from the main purpose, which is both philosophical and practical discussion. Where needed, we have supplied in the References at the end of each chapter any key resources. Other important, but non-cited readings are included in a “Further reading list” to aid readers in expanding their knowledge of specific topics. In both of these lists, those readings felt to be especially helpful, historic, or even controversial are highlighted with an asterisk.

I would like to personally acknowledge all of the wonderful people who contributed so substantially to the creation of this book. Stephen Jackson and Susan

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