

MEDICAL ETHICS AND MEDIATION

Prof. Ellen Waldman
Thomas Jefferson School of Law

Major Principals of Medical Ethics

A. Autonomy - Respect the Values and Goals of the Patient.

B. Beneficence/Non-Maleficence - Take Actions that Benefit the Patient/Do No Harm

C. Justice - Allocate Resources in a Fair and Just Manner.

Note that often these principles seem to come into conflict.

CASE #1

Mrs. D., 77 years old, is brought to the emergency department by a neighbor. Her left foot is gangrenous. She has lived alone for the last 12 years and is known by neighbors and by her doctor to be intelligent and fiercely independent. Her mental abilities are intact, but she is becoming quite forgetful and is sometimes confused. On her last two visits to her doctor, she consistently called him by the name of her former physician, who is now dead. On being told that the best medical option for her problem is amputation, she adamantly refuses, although she insists she is aware of the consequences and accepts them. She calmly tells her doctor (whom she again calls by the wrong name) that she wants to be buried whole. Should judicial authorization be sought to treat her?¹

Specific Topics to be Addressed When Considering an Ethically Troublesome Case

1. Medical Indications
2. Patient Preferences
3. Quality of Life
4. Contextual Features

Questions to Ask to Explore Relevant Topics (Chart)

¹This case and subsequent cases and analysis are drawn from Clinical Ethics, Jonsen, Siegler and Winslade, (4th Ed. 1998)

CASE #2

D.C., age 25, was severely burned in a propane gas explosion. Rushed to the Burn Treatment of the local hospital, he was found to have severe burns over 65 percent of his body; his face and hands suffered third degree burns and his eyes were severely damaged. Full burn therapy was instituted. After an initial period during which his survival was in doubt, he stabilized and underwent amputation of several fingers and removal of his right eye. During much of his 232 day hospitalization at Big City Institute of Rehabilitation and Research and his subsequent six months' stay at the University Hospital, he repeatedly insisted that treatment be discontinued and that he be allowed to die. Despite this demand, wound care was continued, skin grafts performed and nutritional and fluid support provided. He was discharged totally blind, with minimal use of his hands, badly scarred, and dependent on others to assist in personal functions. Ultimately, D.C. married, went to law school, and became a frequent speaker at national conferences on patient rights and physician paternalism. Was the initial decision made to disregard D.C.'s desire to terminate treatment ethical?

Patient Preferences - What to do When the Patient is not Capable of Making a Medical Decision?

1. Surrogate Decision Making Must follow one of two standards

A. Substituted Judgment - If the patient has been able to express preferences in the past and has done so, the surrogate must use knowledge of these preferences, or at least of the known values of the individual, in making the decision.

B. Best Interests - If the patient's own preferences are unknown or are unclear, the proxy must consider the "best interests" of the patient. This requires that the surrogate's decision promote the welfare of the individual; welfare is defined as those choices about relief of suffering, preservation or restoration of function, extent and quality of life, sustained that reasonable persons in similar circumstances would be likely to choose.

CASE #3

A newborn infant is noted to have the stigma of Down's Syndrome which is confirmed by chromosome studies. He also suffers from duodenal atresia, for which immediate surgery is indicated. His parents refuse permission, saying that the baby was better dead than living the life of a retarded person. Medical staff feel the infant has a promising prognosis if the surgery is performed.

CASE #4

Amy was diagnosed with acute myelogenous leukemia (AML) at age 8. She received a course of chemotherapy, resulting in a remission after six months. Three months later she relapsed. An allogeneic bone marrow transplantation was performed with her 17 year old sister as a compatible donor. Again, after several months, Amy's cancer returned. Her parents requested more chemotherapy, which her oncologist advised would be extremely unlikely to succeed. Despite a course of experimental chemotherapy, Amy's disease progressed. After 2 months, Amy, who had been a cheerful patient, became very discouraged and depressed. Her parents, devoutly religious and believing in the likelihood of a miracle, are insisting on chemotherapy, over Amy's objections. Medical staff are unhappy at the prospect of Amy's continued suffering given the likelihood that further treatment will be futile.

Mediation - A process in which a third party or parties assists disputants in reaching an agreement that meets their own needs and interests.

In bioethics, the mediated agreement must also accord with accepted bioethical norms.

Stages of the Mediation Process

1. Introduction - Explain process and your role in it;
2. Story-telling - Allowing parties uninterrupted time
3. The Exchange - Begin with relatively innocuous issue; Move toward exchange of information about issues directly in dispute
4. Generating Options - Creative Brainstorming; No judgment on options expressed

5. Selecting Options - Rank articulated options based on criteria mentioned by parties
 6. Agreement Writing - Write up oral agreement in language parties understand.
-

Copyright 2003 Ellen Waldman. Teachers are free to copy these materials for educational use in their courses only, provided that appropriate acknowledgment of the author is made. For permission to use these materials for any other purpose, contact the author.