

GROUP 2

GROUP LEADERS;

1. Inegbedion omone 17/mhs02/045
2. Animashaun Faith Adedoyin 17/mhs02/023

GROUP MEMBERS;

3. Akpiroroh Efe 17/mhs02/022
4. Awodoyin Omolabake Kwathar 17/mhs02/026
5. Awulu Mary Inikpi 17/mhs02/027
6. Ayinde Waliat Odunayo 17/mhs02/028
7. Bakare Bosola Opemipo 17/mhs02/029
8. Bamisaye Mary Odunayo 17/mhs02/030
9. Bernard Ehi Faith 17/mhs02/031
10. Chukuigwe Emmanuella 17/mhs02/032
11. Dabor Anirejuoritse 17/mhs02/033
12. **DIAYI SUSAN MERCY** **17/MHS02/034**
13. Dorsu Ulioritsesan 17/mhs02/035
14. Ekpubeni Joyce Eloria 17/mhs02/038
15. Eyo Edidiong Joseph 17/mhs02/040
16. Felix Aremo Oluwatominsin 17/mhs02/041
17. Ifajeunnu Oluwatoyin Ngozi 17/mhs02/042
18. Ilori Blessing Yetunde 17/mhs02/044
19. James Boluwatife 17/mhs02/046
20. Jimoh Zeenat Idowu 17/mhs02/047
21. Lucky Favour Chiamaka 17/mhs02/051

22. Ndie Ogochukwu

17/mhs02/055

23. Nwoke Precious Okechukwu

17/mhs02/056

PREFERENCE OF PATIENT

Patient preference is essential to the analysis of an ethical problem in clinical medicine. By preference of patient we mean "the choices that persons make when they are faced with decision about health and medical treatment". And these choices reflect the patient's own experience, beliefs and values as informed by the physician's recommendation. The following subtopics will be discussed;

- 1) Principle of respect for autonomy
- 2) Legal, clinical, psychological significance of patient preference
- 3) Informed consent
- 4) Decisional capacity
- 5) Truth in medical communication
- 6) Cultural and religious belief
- 7) Refusal of treatment
- 8) Advance planning
- 9) Surrogate decision
- 10) The challenging patient and
- 11) Alternative medicine

PRINCIPLE OF RESPECT FOR AUTONOMY

The guiding ethical principle of Patient Preferences is the respect for autonomy. Respect for autonomy is one aspect of a larger principle, namely, respect for persons, which is a fundamental principle of all morality. Respect for persons affirms that each and every person has moral value and dignity in his or her own right. In clinical ethics, respect for the autonomy of the patient signifies that physician's judgments about how to benefit their patients should never ignore or override the preferences of those patients. Patients have the right to freely accept or reject physician's recommendations. . As a moral principle, respect for autonomy is a "two-way street": the autonomy of physicians to act only on their best judgment about how best to benefit a patient medically, must also be respected. Therefore, respect for patient autonomy does not imply that patients have the right to demand inappropriate treatment, or that a physician must accede to any and every request of a patient if it conflicts with the physician's best judgment. In clinical ethics, respect for patient preferences takes place within a therapeutic relationship, that is, when some health problem prompts a patient to seek help from a physician and a physician responds with diagnosis, advice, and a proposed treatment. In this relationship, physicians possess a de facto power: they have knowledge and skills that the patient needs. Also, patients are often so ill that they cannot clearly formulate or express preferences: they simply want and need help. Therefore, the therapeutic relationship can be distorted by what has been called "physician paternalism": a physician assumes that his or her medical judgment alone should determine the course of care. Modern

medical ethics repudiates this sort of paternalism. Instead, both the physician and the patient must form an alliance in which medical recommendations and patient preferences together guide the course of care.

LEGAL, CLINICAL, PSYCHOLOGICAL SIGNIFICANCE OF PATIENT PREFERENCE

In Clinical care attending to patient preferences is essential to good. Patients who collaborate with their physicians to reach a shared health care design have greater trust in the doctor-patient relationship, cooperate fully to implement the shared decision and express greater satisfaction with their health care. Research has shown that patients with chronic diseases such as: hypertension, non-insulin dependent diabetes mellitus, peptic ulcer, rheumatoid arthritis enjoy better health outcomes when they ask questions, opinions and make preferences to be known.

In Legal all states now have laws requiring informed consent for medical treatment, except in certain emergency situations. The legal requirement of explicit consent for specific treatment protects the legal rights of patients to control what is done to their own bodies. Examples

- a. recognizes that all persons have a fundamental right to control their own body and the right to be protected from unwanted intrusions by Self-Determination American law
- b. Every human being of adult years and of sound mind has a right to determine what shall be done with his body.
- c. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, prohibit the performance of life-saving surgery or other medical treatment by Anglo-American law.

In Psychological aspect there is a Control Respect for patient preferences which is a psychologically significant because the ability to express preferences and have others respect them is crucial to a sense of personal worth. The patient, already threatened by disease, may have a vital need for some sense of control. When patients are overtly or covertly uncooperative, the effectiveness of therapy is threatened. Furthermore, patient preferences are important, because their expression may lead to the discovery of other factors, such as fears, fantasies, or unusual beliefs, that the physician should consider in dealing with the patient.

We ask six questions that comprise the issues that must be raised in identifying and assessing an ethical problem regarding patient preferences.

- (1) Has the patient been informed of benefits and risks, understood this information, and given consent?
- (2) Is the patient mentally capable and legally competent, and is there evidence of incapacity?
- (3) If mentally capable, what preferences about treatment is the patient stating?
- (4) If incapacitated, has the patient expressed prior preferences?
- (5) Who is the appropriate surrogate to make decisions for the incapacitated patient?
- (6) Is the patient unwilling or unable to cooperate with medical treatment? If so, why?

INFORMED CONSENT

Informed consent is the usual way in which patient preferences are expressed. It is the practical application of respect for the patient's autonomy. Informed consent consists of an encounter characterized by mutual participation, good communication, mutual respect, and shared decision making. Example is a

patient with pneumococcal meningitis, is told that he needs immediate antibiotic therapy. After he is informed of the nature of his disease, the benefits and burdens of treatment, and the possible consequences of non-treatment, he expresses his preference by consenting to the antibiotic therapy. A therapeutic alliance that is clinically, ethically, and emotionally satisfactory is formed and reinforced when the patient recovers. Now this case exemplifies what might be called routine consent. The physician expresses clinical judgment by making recommendations to the patient regarding an appropriate course of care. The patient makes known his preference by consulting the physician for diagnosis and treatment and by accepting the physician's recommendations.

Case I is also an example of routine consent, but it occurs in a chronic disease setting. Ms. Cope's doctor was assiduous in informing and educating her patient. Ms. Cope accepted the treatment regimen, and her compliance with it shows her preferences. She is now considering whether she will accept the benefits and risk of the insulin pump. Patients with chronic diseases, which often have variable courses far into the future, must consider a wider range of consequences.

Standards for what information is reasonable for patients to know to make rational decisions.

1. The former standards accords greater discretion to the physicians
2. The latter is more patient-centered
3. The third standard, sometimes called a subjective standard is patient-specific.

scope of disclosure are as followed

1. The patient's current medical status, including the likely course if no treatment is provided.
2. The intervention that might improve prognosis, including a description and the risks and benefits of those uncertainties associated with the intervention.
3. A professional opinion about alternatives open to the patient and;
4. A recommendation that is based on the physician best clinical judgment.

Stringency

Information can be curtailed in emergencies. when treatment is elective, much more information should be provided. Finally detailed and thorough information should accompany any invitation to participate in research, particularly if the research maneuver is not directed to the patient's therapy

.Comprehension

The comprehension of the patient is fully as important as the provision of the information. The physician has an ethical obligation to make reasonable efforts to ensure comprehension. explanation should be given clearly and simply questions should be asked to assess under understanding written instructions or printed materials should be provided.

Documentation

The consent is documented in a signed “consent form” that is entered in the patient’s record. health care institutions require signed documentation before a medical or surgical procedure is initiated. The document typically names the procedure and merely states that the risks and benefits have been explained to the patient.

Difficulties with informed consent

1. Patient may believe that decisions are the physician’s prerogative physicians may not appreciate the rationale for the patient’s participation.
2. Informed consent is not merely pushing information at a patient .
3. It is limited by the inability of many physicians to listen carefully to their patient’s words and the emotions underlying them.
4. The time limits for patient’s visits imposed by some management care plans and clinics, and reimbursement policies that compensate for procedure but not for education discouraging good communication.

DECISIONAL CAPACITY

In medical situations, this is the ability to understand medical information and its possible implications and to consider one’s own value in relation to the physician’s recommendations about treatment options. The patient may lack or possess the ability to make decisions about their health. Those who lack these abilities may need a surrogate decision make.

However, there are some cases whereby the patient will fall between theses situation and their decisional capacity may be altered and so often unclear whether they can make reasonable decision for their own welfare. In determining decisional capacity;

The first step is to engage the patient in a conversation, observing the patient’s behavior and to talk with the third parties. Although it is often difficult to distinguish the signs of the mental illness in some cases (For example, paranoid patients appear normal until certain situation trigger a delusional belief system) Experienced clinicians are often able to assess decisional capacity through simple conversations noting inconsistencies, confusion and incoherence.

Psychiatric diagnosis often rule out the possibility of the patient has the ability to make particular choices. Tests for cognitive functioning, psychiatric disorders that may affect decisional capacity can be used by the clinician when there are doubts about the patients decisional capacity.

MacArthur Competence Assessment Tool is commonly used assessment tool.

A single test cannot be used to determine the inability of the patients’ decisional capacity because some conditions can be reversed or managed through psychiatry intervention while others may be impossible to remedy. In some cases, evidence for decisional incapacity is more complex, especially when a mental disorder is present, a consultant should be invited for a more expert recommended. When the clinical evidence is enough to show that the patient is decisional incapable, an appropriate surrogate decision maker assumes authority. In evaluating decisional capacity in relation to the need for intervention: the sliding scale criterion

“it has been suggested that the stringency of criteria for capacity should vary with the seriousness of the disease and urgency for treatment”.

this simply means that the patients' capacity is determined due to the urgency of treatment and seriousness of the disease. for example for a procedure with low risk and high benefit a low standard of capacity to consent is need while for a high risk procedure and little benefit a greater standard of capacity is needed. Although this sliding scale of stringency test has been criticized, it has been helpful to clinicians in determining whether the refusal can be simply accepted or further steps should be taken to investigate and take action to counter by legal means. delirium, confusion, and waxing and waning capacity. Decisional capacity can also be affected by delirium which is the characterized by confusion, inability to concentrate, anxiety and sometimes hallucination. Also in the sun downer syndrome where a patients mental capacity waxes and wanes i.e. person may appear velar and oriented then later be assessed as confused.

competent refusal of treatment by person with capacity to choose are Patient who are well informed and have decisional capacity sometimes refuse recommended treatment. If this treatment is elective, the consequences might not be serious although if the treatment is necessary to save life or prevent serous consequence physicians may be confronted with an ethical dilemma.

The ethical principle of respect supported generally by the American law, requires that the refusal of care by a competent adult should be respected. And there is refusal due to religious beliefs and cultural diversity in which the Patients with different religious beliefs usually affect their decisions about care but this does not make them incapable of decision but instead the clinicians will be faced with making decisions that seems reasonable to them and ethical judgment that seems obligatory, with the patients' preference for a different course of action.

TRUTH IN MEDICAL COMMUNICATION

Communications between physicians and the patient should be truthful, this means it should be in accord with facts and not deceit. Deception which is by stating what is not true should be avoided. However in the communication between patient and physicians certain ethical issues about truthfulness may emerge and certain questions like;

1. Does the patient really want to know the truth?
2. What if the truth once known, causes harm?
3. Might not deception help by supporting hope?
4. More recently, with the presence of informed consent, truthfulness has been commended as the ethical course of action.

Importance;

- a. Effective physician-patient communication has been shown to positively influence health outcomes
- b. Increased patient satisfaction

- c. Led to greater patient understanding of health problems and treatments available
- d. Contributing to better adherence to treatment plans
- e. Providing support and reassurance to the patient

Placebo Treatment

This is a clinical intervention intended by the physician to benefit the patient, not by any known physiological mechanism of the intervention, but because of certain psychological or psychological effects due to the positive expectations, beliefs, hopes of the patient.

Placebo treatment raises a problem of truth telling, because it seems inevitably to involve deception. The physician knows the intervention does not have objective properties necessary for efficacy and the patient is kept ignorant of this fact. Placebo agents are now commonly used in controlled clinical trials of therapy for non- life threatening conditions. However no deception is involved, because research subjects must be informed that they will be randomized and may receive either an active drug or any ethicists that clinical use of placebos is unethical. There are some conditions in which a placebo can produce results even when people know that they are taking a placebo. Studies show that placebos have effect on conditions which may include;

Depression

Pain

Sleep disorders

Irritable bowel syndrome

Menopause

Clinical significance;

Understanding how placebo responses from is vital for clinical practice as it can play a crucial role in determining the therapeutic outcome of the patient. Although placebo effects frequently occur in clinical practice, they often go under recognized . Translating the knowledge of the placebo effect to benefit the patient requires a thorough evaluation of the clinical effectiveness of the intended effect.

Therefore, attempts to generate beneficial placebo responses should only be done under strict professional, legal, and ethical norms after obtaining appropriate informed consent.

Completeness of disclosure

Disclosure of options for treatment of a patient's condition should be complete. That is containing all information that a thoughtful person would need to make a good decision in their own behalf. It should include options that the physician may believe are less desirable but which are still medically reasonable.

In so doing, physicians may make it clear why they consider these other options less desirable. The disclosure might include;

The proper medical care to improve the patient's condition and also the prognosis.

The patient's medical record, underlying conditions and may be allergies to certain type of medication.

Professional opinions about alternatives open to the patient and probably the patient's family.

Making the treatment decisions that are in the best interest of the patient.

CULTURAL AND RELIGIOUS BELIEF

Certain religious groups hold beliefs about health, sickness, and medical care. Sometimes such beliefs will influence the patient's preferences about care in ways that providers might consider imprudent or dangerous. Similarly, persons from cultural traditions differing from the prevailing culture may view the medical practices of the prevailing culture as strange and even repugnant. In both cases, providers will be faced with the problem of reconciling a clinical judgment that seems reasonable to them and even an ethical judgment that seems obligatory, with a patient's preference for a different course of action.

For example, Some clinicians who encounter unfamiliar beliefs may consider these beliefs "crazy" and even assume that anyone who holds them must suffer from impaired capacity. This response is wholly unjustified: it reveals bias and ignorance. The mere fact of adherence to an unusual belief is not, in and of itself, evidence of incapacity. In the absence of clinical signs of incapacity, such persons should be from a particular religious or cultural tradition should foster "cultural capacity." They should provide opportunities for providers to educate themselves about cultural beliefs. Cultural mediators, such as clergy or educated persons who can explain the beliefs and communicate with those who hold them, should be available. Competent translators should also be available for language problems. It should be noted, however, that the fact that a person speaks the same language or comes from the same country or religion as the patient does not guarantee competence as a translator or intermediary. Also, cultural stereotypes should be avoided; there are individuals from particular cultures who depart, in their values, preferences, and lifestyle, from the predominant mode of their cultures. Also a treatment course that is acceptable to the patient and provider alike should be negotiated. It is first necessary to discover the common goals that are sought by the patient and the physician, and then to settle on mutually acceptable strategies to attain those goals. The appropriate ethical response to a genuine conflict is dependent on the circumstances of the case.

REFUSAL OF TREATMENT

Patient has a right to information about themselves. They have the right to refuse information or to ask the physician not to inform them.

Case 1

Mr. A.J. is scheduled for surgery for spinal stenosis. The neurosurgeon begins to discuss the risk and benefit of the surgery. The patient told the doctor he did not want to hear anything more. He agreed to the

surgery while knowing the risk, and he has confidence in the doctor. The surgeon is concerned that he has not completed an adequate disclosure.

Recommendation

In case 1, Mr. A.J.'s refusal of information should be respected. There is no obligation to press the matter, although the surgeon may repeat the offer of information when in due time. It should be charted by the surgeon that the patient has refused information. It is desirable to seek the patient's permission to discuss the detail of the procedure with an involved family member.

Disclosure of Medical Error

Medical errors are what obligation does the physician and the hospital have to disclose errors to patients. Some errors are due to negligence, but the majorities are due to accident, misinformation, or organizational malfunction. Some causes harm while others do not. When errors occur what obligations do physicians have to discuss them?

Comment

Any inclined to hide medical mistakes must be discouraged. Secrecy is unethical and maybe counterproductive. Mistakes should be reported for risk management and quality insurance purposes. Charges should be waived and appropriate compensation provided. Malpractice actions are certainly possible, particularly if the errors are the result of negligence, but threat of legal claims is reduced in a climate of confidence and honesty. Errors that are truly harmless, without any adverse effects for the patient. It is obligatory to disclose harmless error; it is advisable to do so to sustain the climate of honesty in the relationship between the patient and physician

ADVANCE PLANNING

Advance planning encourages individuals to inform their physicians about the persons they must trust and their behalf and how they would wish to be treated at a future time when they might be unable to participate in decisions about their care. The most important features of advance planning are the discussion with one's family and a conference with one's doctor and the physician should and always document the conversation in the patient's record where it can be accessible in time of crises. In some of these conversations wishes of the patient should be stated legally and accepted documents generally called "advance directives" and there are several forms such as

1. The durable (or medical) power of attorney for health care.
2. The legal instruments entitled "directive to physicians in the statutes enacted by various states"
3. The less formal "living will" Other forms are called POLST (physician's order to lift sustaining treatment). The idea of advanced directives has become both familiar and accepted in ethics and law. Medicare regulations require hospitals to provide patient with information about their rights under state or to accept refuse. They also ask for admission whether they have advance directive and if they have advance directives they must submit copies for their record and if they don't have they will be asked to prepare the document. Physicians should learn how to encourage their patient to prepare advance directives that are valid in their locale. Although the legality has been formalized by the legislation and upheld by court. Some physicians might still neglect these methods some empirical studies has been

documented that physicians are reluctant to discuss end- life issues with patients. Systematic attempt to improve communication information between patients and physicians met with little success .

THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

The most important element of advance planning is the authorization by the patient of the person whom will make decisions on his or her behalf . This statute authorizes individuals to appoint another person to act as agents to make all health care decisions after they have become incapacitated the person may name a relative or friend made in the writing . This gives a legal priority to the designated agent over all the parties including next of kin it also avoids bureaucratic burdens .

DOCUMENTATIONS OF ADVANCE PLANNING:

The appointment of a designated decision maker may be accompanied by a document that states in more or less explicit terms. Such is called an advanced directives or directive to physicians and this directives can sign up and give to physician typically worded in this fashion

- injury disease or illnesses certified to be terminal condition by two physicians

! Living wills : an advanced directives may be communicated by a person to a physician family and friends in a less formal than the statutory document . Some groups suggest this living wills for their adherents the Roman Catholics and conservative Jews have forms that reflect their own doctrines on forgoing life support . A form called five wishes is a document that allows people to state their wishes about who will be the one to state wishes for them, the kind of medical service they want , how comfortable they want to be ,how to be treated and what they wish their loved ones to know finally advance directives should be placed in patients hospital chart physician caring for patient should always discuss with the patient.

CASE 1. Mr. Care, with MS is now hospitalized because of aspiration pneumonia. He is alternatively obtunded and severely. He had given his physician a copy of the directives to physician 4 years earlier. Now, in reviewing the directive, the physician notices the words (common in this document). “The patient death must be imminent, that is death should be expected whether or not treatment is provided “should the physician consider that if intubation is medically indicated, it should be withheld in accord with the patients prior preferences?

In this case, the physician may withhold intubation on the basis of the patients advance directive. The words “whether or not treatment is provided” are a clumsy attempt to define the imminence of death. In this case, those words should not obstruct the fulfillment of Mr. Care’s preferences, which seem quite clear.

SURROGATE DECISION

A surrogate can be defined as person that speaks on behalf of other person when crucial clinical decisions have to be made and the patient is known to be very sick and unable to communicate his or her desires about care. Traditionally, next of kin have been considered the natural surrogates, and clinicians have turned to family members for their permission to treat the patient. This practice has been tacitly accepted in Anglo-American law, but was rarely expressed in statutes.

So, the question is; ‘Who Is the Appropriate Surrogate to Make Decisions for the Incapacitated Patient?’

In recent years, efforts have been made to clarify the determination of surrogates for medical decision making. Statutes authorize persons to appoint their own surrogates, or holders of durable powers of

attorney. These appointed surrogates supersede any other party, including immediate family members. These statutes avoid the need to seek judicial recourse, except in cases of conflict or doubt about legitimate decision-makers. Statutes of this sort are helpful in avoiding conflicting claims to authority. On the other hand, they may automatically appoint some party who is inappropriate. Finally, all states have provisions for the judicial appointment of guardians or conservators for those declared incompetent by a judge.

The Standards for Surrogate Decisions

The decisions of surrogates are guided by two definite standards. The first is called "substituted judgment": when the patient's preferences are known, the surrogate must use knowledge of these preferences in making medical decisions. The second is called "the best interest standard": when the patient's preferences are not known, the surrogate's judgment must promote the best interests of the patient.

(a) Substituted Judgment. "Substituted judgment" is when a surrogate relies on known preferences of the patient to reach a conclusion about medical treatment. This is used in two situations: (1) where the patient has previously expressed her preferences explicitly, and (2) where the surrogate can reasonably infer the patient's preferences from past statements or actions.

The first situation is very direct and occurs when the patient has previously expressed preferences concerning the course of action they would desire in the present circumstance either in writing or merely informing another person of the preferences orally. The surrogate should follow the patient's preferences as closely as possible and not making medical decisions for the patient, but give effect to decisions the patient would have made for herself.

When the patient has not specifically stated what she would want, a surrogate should base his decision on familiarity with the patient's values and beliefs must be careful to avoid the common pitfall of applying their own values and beliefs into the decision-making process. Obviously, only individuals with a close association to the patient are suitable as surrogates when this sort of judgment is called for.

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

Implied Consent

In life-threatening emergencies, patients may be unable to express their preferences or give their consent because they are unconscious or in shock and no surrogate may be available during that point in time. In such situations, it has become customary for physicians to presume that the patient would give consent if able to do so, because the alternative would be death or severe disability. This is sometimes called implied

consent. The patient is not, of course, giving consent; the physician is presuming that the patient would consent, if they could in order to save his or her life. It is a reasonable presumption that a person would, if they could, accept help in a critical situation. Implied consent also provides the physician with a legal defense against a subsequent charge of battery, although it may not defend against charges of negligence if the emergency treatment falls below acceptable standards of care; for example, a physician incorrectly performs a Heimlich maneuver, thereby breaking ribs and puncturing a lung.

Decisions for Patients Who Lack Surrogates

A patient who has lost decisional capacity may have no person who can be identified as a surrogate. The term "unbefriended or unrepresented patient" is sometimes used. In such cases, it's best that the physician acts as the surrogate and proceeds with decision making.

Statutory Authority to Treat

In all jurisdictions, statutes exist that authorize psychiatrists to restrain mentally ill persons who are dangerous to themselves or others for psychiatric treatment against their will.

These statutes pertain to persons who are suffering from mental disease, and the treatment authorized is treatment only for mental disease. In some situations, both mental disease and medical problems may be present. These situations of dual diagnoses deserve special consideration.

The consulting psychiatrist will examine the patient and, having made a diagnosis of paranoid schizophrenia, may authorize involuntary commitment for treatment of this mental disorder. The emergency department resident does not have this authority. The term medical hold is sometimes used to describe this procedure but it is misleading for two reasons: physicians, other than psychiatrists, cannot "hold" patients, and only psychiatric treatments may be administered.

THE CHALLENGING PATIENT

On occasion, persons who are under care in a health care facility may cause serious disruption and even endanger other patients. At the same time, they may desire to continue in treatment. Physicians who encounter such challenging patients may be concerned that discharging them because of the danger posed to others or the disruptions caused may induce serious harm, even death, for the patient.

Case

Mr. R.A., an intravenous drug addict, is admitted for the third time in 3 years with a diagnosis of infective endocarditis. Three years ago, he required mitral valve replacement for *Pseudomonas* endocarditis, and 1 year ago, he required replacement of the prosthetic valve after he developed *Staphylococcus aureus* endocarditis. He now is admitted again with *S. aureus* endocarditis of the prosthetic valve.

After 1 week of antibiotic therapy, he continues to have positive blood culture results. One cardiac surgeon refuses to operate, saying that the patient is a recidivist and that correcting his drug addiction is futile. Another surgeon agrees to operate on him. Mr. R.A. consents to open heart surgery to replace again

the infected prosthetic mitral valve. Postoperatively, for 10 days he is cooperative with his management and antibiotic treatment. While on this treatment, he becomes afebrile and blood culture data are negative. Plans are in place for his discharge, with venous access for antibiotics. He then begins to behave erratically. He leaves his room and stays away for hours, often missing his medications. On several occasions, a urine screening test demonstrates the presence of opiates and quinine, revealing that he is using illicit narcotics even while being treated for infective endocarditis. Two repeat blood culture tests now grow *S. aureus*. On two separate occasions, he verbally abuses two nurses who reprimand him for being away from his room. Several patients on the unit complain that he threatened them. Nurses suspect that he is also dealing drugs within the hospital. This information becomes known to the patient's physician; despite the fact that the patient's infective endocarditis has not been treated optimally, the physician asks him to leave the hospital immediately.

Comment

Considerations leading to an ethical justification of this decision are as follows:

(a) The patient's use of intravenous street drugs at the same time that his physicians were attempting to eradicate his infective endocarditis indicated that the likelihood of medical success in this case, both short-term and long-term, was not great. Physicians are not obliged to treat people who persist in actions that run counter to the goals of treatment.

(b) The patient wanted to be treated and, at the same time, continued his abusive behavior. The physicians are obliged to determine that the patient has the mental capacity to make such choices and that he was not suffering from a metabolic encephalopathy (see Determining Decisional Capacity).

Recommendation

Clinicians should recognize that this patient's primary medical problem is not endocarditis, serious though that condition is. As the first surgeon noted, it is drug addiction. The focus of his treatment should shift to treatment for that problem. The management of addiction requires long-term outpatient care and support. Nevertheless, he is at risk of dying in the short term from another episode of infective endocarditis. In our opinion, he should be discharged with an indwelling venous line and with home nursing service to administer antibiotics. If he proves intractable, then it can be argued that efforts to manage his endocarditis by surgical means will not be effective and the patient may be discharged.

Signing Out Against Medical Advice Mr. R.A. might simply walk out of the hospital, leaving even before physicians judge his treatment adequate. When patients choose to discharge themselves in this manner, most hospitals request them to sign a statement confirming that they are leaving against medical advice (AMA). The document merely provides legal evidence that the patient's departure was voluntary, and that the patient was warned by the physician about the risks of leaving.

Conscientious Objection

The preferences of patients have significant moral authority and must be considered in every treatment decision. The ethical obligations of physicians are defined not only by the wishes of their patients but also by the goals of medicine. Physicians have no obligation to perform actions beyond or contradictory to the goals of medicine, even when requested to do so by patients. Patients have no right to demand that physicians provide medical care that is contraindicated, such as unnecessary surgery or medically inappropriate drug regimens. Finally, physicians may refuse to accede to a patient's wishes when they believe that doing so will make them complicit in something they believe is immoral. Traditionally, medical ethics has required physicians to abstain from moral judgments about their patients in regard to medical care. However, despite this professional neutrality, physicians and nurses have their own personal moral values. Traditionally, laws permitting abortion and laws permitting physician-assisted dying contain explicit exemptions for conscientious objection. For example, a pharmacist refuses to fill a valid prescription for a "morning after pill." Physicians and nurses may refuse to cooperate in actions they judge immoral on grounds of conscience. It is important, in forming one's conscience, to separate the moral values to which one is committed from personal distaste or prejudice. For example, a physician refuses to undertake the care of a Jehovah's Witness with a hemorrhagic diathesis on moral grounds, although, in fact, the physician does not want to take the risk that the patient may die from blood loss. The

traditional ethics of conscientious objection require the objector to make clear his or her position in a public way and to accept the consequences of objection, such as legal liability for violation of a law. Withdrawing from the Case and Abandonment of the Patient At times, such as the case of Ms. Cope (see Failure to Cooperate with Medical Recommendations), the physician may serve the patient best by deciding to dissolve the physician–patient relationship. The physician's principal goal is to help patients in the care of their health. If this proves impossible, the physician may best demonstrate ethical responsibility by withdrawing from the case. Physicians who terminate a relationship with a patient sometimes wonder whether they can be charged with abandonment. Abandonment, in the legal sense, means that a physician, without giving timely notice, ceases to provide care for a patient who is still in need of medical attention or when the physician is dilatory and careless). A charge of abandonment can usually be countered by showing that the patient did receive warning in sufficient time to arrange for medical care. A physician may withdraw from the care of a patient without legal risk. The decision to do so should meet ethical as well as legal standards. Physicians inherit an ethical tradition that requires them to undertake difficult tasks and even risks for the care of persons in need of medical attention. Inconvenience, provocation, or dislike are not sufficient reasons to exempt a physician from that duty. That obligation is, of course, limited by several conditions—if the patient absorbs excessive time and energy, drawing the physician away from other patients; if the patient is acting in ways to frustrate the attainable medical goals; or if the patient is endangering others by overt action—the ethical obligation to continue to care would be diminished. These conditions appear to be verified in the case of Mr. R.A. Finally, a physician may decline to provide nonbeneficial treatments or treatments contrary to conscience, as noted in The Disruptive Patient.

ALTERNATIVE MEDICINE

Many persons seek care from providers who are not trained in conventional scientific medicine. These providers apply physical, psychological & herbal remedies that are commonly recognized as scientifically or proven effective by clinical trials. The most common of these providers are neuropaths, homeopaths, chiropractors and acupuncturists. Methods include spiritual healing, physical manipulation, special diets, imaging relaxation techniques, massage & vitamin therapy. These methods are described as “alternative” or “ complementary ” medicine.

CASE: A 64-years old man has been under the care of a family physician for increasingly severe osteoarthritis. On one visit , he complains of dizzy spells. A workup reveals no specific cause for his dizziness, In discussing his arthritis , he tells his doctor that he gets some relief from mushroom tea. The physician has seen reports of illness caused by “Kombucha tea” which, although called “mushroom tea”, is actually a colony of bacteria and yeast fermented in sweetened tea. The physician questions the patient, and the patient reluctantly admits that he has been seeing a “natural healer” who sold him the concoction.

COMMENT: The large number of people who visit alternative practitioners (estimated to be about one of every three adult American, making some 425 million visits yearly—more than are made to regular primary care practitioners) commonly do so in conjunction with care from regular practitioner, using unconventional therapies as adjuncts rather

than replacement of conventional therapy. The majority of these patients do not inform their regular physician about their use of alternative treatment. Preferences for alternative treatment are often motivated because they are less arduous and less costly than conventional treatments, or because patients are frustrated with the failure of conventional treatment to assure problems such as chronic back pain, headache, insomnia, anxiety and depression. Most conventional practitioners know little about alternative medicine, and many commonly disdain it and disparage its claims.

RECOMMENDATION: a) A conventional physician should encourage their patients to reveal their use of alternative medicine.

b) Conventional physicians should try to attain a better understanding of the healing system which patients have frequent recourse and to appreciate their beneficial features.

c) When patients are using alternative therapies for serious conditions to the neglect of demonstrated efficacious therapies, or when they are using therapies that have toxic effects, physician should carefully explain the consequences of such a course.

d) The physician should ask the patient's permission to contact the alternative provider, explain the situation and negotiate a program that will be acceptable to the patients and comfortable to the ethics of the providers.

e) Hospitals should develop policies that acknowledge the prevalence of alternative therapies and establish guidelines for acceptable collaboration between regular physician and providers of alternative treatments.