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Bioethics and Medical Practice
(Analysis of a Clinic Case)

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Abstract: The author presents a case of a 61-year old American woman who gets into cardiac intensive care with a mild heart attack. She refuses to be resuscitated during, before or after the surgery, while the surgeon insists on her permission for resuscitation, because he is not willing to do surgery "with his hands tied". The author analyses in detail the patient's and surgeon's conflicting interests taking into account the historical and cultural context of how their understand their rights and duties, as well as the changing ethical values of medical profession (to do good vs. to respect patient's autonomy). The author's recommendations on how to resolve this ethical dilemma are in line with today's western bioethical thinking: 1) to make sure the patient has all the information to make an autonomous choice; 2) let her decide; 3) in case she decides to remain DNAR find another surgeon who could handle the operation on these conditions.

Case description

S. is a 61-year old patient in the CICU, and she has had a mild heart attack. The doctors have performed a cardiac catheterization and have determined that she has blockage in many vessels to her heart and she requires CABG. S. has diabetes and end stage renal disease (she has been on dialysis

for about 1 year). Other than these problems, the doctors think that she is a good candidate for open heart surgery.

S. is an informed and stubborn woman. About 6 months ago, she told her physician that she wanted to be DNAR if anything happens and she must be admitted to the hospital. Therefore upon admission to the CICU her code status has been made DNAR. The problem is that the surgeon is insisting that if he takes her to surgery, the DNAR must be temporarily reversed. He says that he is not willing to do surgery "with his hands tied." In other words, if something happens during the surgery, he wants to be able to resuscitate S. Following surgery, if she wants to be DNAR again, he is willing to honor her wishes.

S. does not agree. She says that she wants surgery, but does not want to be resuscitated if something happens before surgery, during surgery, or after surgery. She insists that it is her right to refuse resuscitation.

The surgeon has had many long discussions with S., explaining his point of view, and listening to hers. But they cannot come to an agreement. The surgeon calls for an ethics consult.

Ethical analysis

This case presents a good example of how the conflicting interests of a patient's autonomy and a doctor's intention to promote the patient's beneficence could clash in the modern medical setting. S. is a DNAR patient who needs to undergo a serious open-heart operation, and the doctor wants to resort to all medical tools available in order to accomplish his duties as a health care professional. However, S. doesn't want to withdraw DNAR for the time of the surgery, and the doctor's insisting requests do not help. Her clear and competent decision is to be operated without resuscitation.

Health care professionals are the ones empowered with social trust and responsibilities to advance people's well-being. Society entitled this stratum of professionals with the duty to promote health and delay death, and they started their 'battle' against diseases. Historically, western doctors were very aggressive in the fight against death. They've been fighting literally till 'the last drop of blood'. Take, for instance, work of Benjamin Rush, one the US Founding Fathers, who promulgated the idea that "the physician is a soldier in the war

against disease" (the same idea may be confirmed by the presence of much of 'combative' vocabulary in English medical slang). With time, though, the role and social perception of health care providers changed and now, in the 21st century, people in the West don't always want to see an almighty figure of the doctor, whose only goal is to 'defeat the disease by all means'. Sometimes people want to sacrifice their well-being and best health interest for the sake of some other valuable things, like psychological and physical comfort, pain relief, and, quite often, respect for their autonomous choice (made due to various reasons) not to be treated (or not to be treated in a certain way). This brings many medical workers into the state of complete perplexity and loss of professional orientation.

In line with the common professional thinking, S.'s doctor feels that it is his basic responsibility to apply all medical means he knows (including DNR), if he agrees to perform such a complicated open-heart surgery. Indeed, why do he and other members of the medical team have to spend time (3-6 hours) and effort, and know all along the way that they can't resort to all the effective measures they were trained and feel obliged to use? This "tying of hands" may be psychologically unsettling for the medical team, and even discourage them from achieving their best medical results. In medicine, as in all other professional fields, we can't do without a certain amount of trust and respect towards professional knowledge and experience – otherwise, we risk starting to teach cooks what to put in a pot, technicians how to repair a car, etc. Although in every field there always should be a provider-client dialogue, it feels that attitude described above may undermine the ideas of professionalism and separation of duties in society.

On the other hand, at the end of the 20th century, it was seen how patients' preferences, opinions, doubts and wishes started to receive more and more acknowledgment and consideration by society and western health care providers, especially in situations of serious medical interventions and end-of-life decisions. Even though patients' choices may not be seen as best from doctors' perspective, people now can opt in out many vital medical procedures, including cardiopulmonary resuscitation. In its essence, DNR (DNAR) sometimes

violates the basic health care principles of beneficence and 'battle-by-all-means' rule that some 50 years ago was decisive in medical practice. Now S. may refuse resuscitation on the grounds that she doesn't want pain, discomfort, esthetic side of the procedure, or, for instance, she is not satisfied with the low rate of CPR success (only about 15-20% of patients survive to discharge after CPR (*Cotter et al.* 2009: 200)).

Sitting on the fence between the doctor's professional opinion and S.'s autonomous choice, I can't say objectively which one of these should be overridden by the other. I think, though, that the modern attitude to human rights and special attention and value of individual self-determination in the western culture require that the final decision in this case rests on the shoulders of the patient, provided that she can make a well-informed autonomous choice[1]. In fact, in modern bioethical paradigm, a decision to proceed with CABG surgery and make S. full-code against her wishes might be seen as an example of 'hard paternalism', defined as the attitude that involves 'interventions intended to prevent or mitigate harm to or to benefit a person, despite the fact that the person's risky choices are informed, voluntary, and autonomous" (*Beauchamp and Childress* 2009: 210). According to T. Beauchamp and J. Childress, even hard paternalism could be sometimes justified, but most often when paternalistic actions 'prevent major harms or provide major benefits while only trivially disrespecting autonomy' (*Beauchamp and Childress* 2009: 214). In our case, however, the decision to refuse resuscitation appears to be more than of 'trivial' meaning for the patient, so it needs to be given overriding value.

Therefore, I believe that in our case the proper way of making decision is to 1) make sure the patient has all the information to make an autonomous choice; 2) let her decide; 3) in case she decides to remain DNAR find another surgeon who could handle the operation on these conditions.

First, we need to make sure that the person understands all the limitations of DNAR during the surgery. If the surgeon has already had multiple discussions with S., a team of other medical workers could be called, so that the patient may have a 'fresh', more objective look at the real state of things. It seems reasonable, for example, to give S. approximate figures on how her

chances to survive the operation are with and without DNAR, and other relevant information.

If the patient persists, her personal choice should be given priority. At the same time the doctor has a right to justifiably refuse to provide a certain type of intervention, if his professional standpoint tells him so. This right is similar to the right for 'conscientious objection' of health care providers (for example, to assist in abortion), with the exception that in our case the doctor's refusal to treat the patient is made on professional rather than personal moral grounds. I think that in such a situation the medical team should find another surgeon who agrees to do the operation on S. Although, apparently, the patient's wishes here take precedence over medical necessity, we have to seek to respect at most the rights of the doctor as a medical expert and as a human.

The dilemma of professional beneficence vs. respect for autonomy remains one of the central bioethical problems. Although resolved differently at different times, today's western ethical thinking (especially in the USA) often puts autonomous choice before health interests. Alternatively, it is thought that 'beneficence could be construed to incorporate the patient's autonomous choices in the sense that the patient's preferences help to determine what counts as a medical benefit' (*Beauchamp and Childress* 2009: 207). In line with this theory, S.'s opinion should be given an important role in the health care team's decision about what her 'medical benefit' is.

Litarature

Beauchamp, T.L. and Childress, J.F. (2009), *Principles of biomedical ethics*, 6th ed., Oxford University Press, Inc.

Cotter, P.E., Simon, M., Quinn, C. and O'keeffe, S.T. (2009), "Changing attitudes to cardiopulmonary resuscitation in older people: a 15-year follow-up study", *Age and Ageing*, Vol. 38 No. 2, pp. 200–205.

Notes

1. On the other hand, several dozen of years ago the opposite decision – following the doctor's recommendations – would have been, probably, considered appropriate, in line with the medical and ethical thinking of that time.