Clinical ethics
Trinity Baptist Church
March 12, 2017

Today we want to explore some of the ethical issues that come up in the everyday practice of medicine. A number of these have to do with what we do but perhaps more important is how we do it. Here we get more into the style of medicine. For this I believe we have no better model that Jesus himself of whom we read "he went about doing good and healing" (Acts 10:38). And after telling of the loving care given a suffering man by a good Samaritan told his hearers to "go and do likewise" (Luke 10:37).

Matt: **Jesus, the model physician ~10 min**

Informed Consent or Shared Decision Making

With increased emphasis on autonomy it was recognized that the patients themselves should have more input into their own care. It became the standard to require informed consent. Soon this became a complicated several page legal document that needed to be signed establishing that the patient had been informed fully as to the nature of the procedure, its potential benefits, side effects and what other alternatives would be available. In our geriatric rounds Tuesday we were talking about one form that was 14 pages long. After reading this document the patient was then frequently presented with the choice of whether to have the procedure often without any recommendation from the physician. This was often intimidating if not totally confusing. Furthermore it became evident that truly informed consent was a myth. Not every possibility could be addressed either in terms of alternatives to the treatment or potential adverse outcomes. Typically death was listed as one potential outcome and if the patient wasn't totally put off up to that point that finished it. I recall discussing a procedure with a patient who said they wanted to know everything about the procedure in question. In a gentle but loving way I suggested they go to medical school, do a residency and do the same surgical training that their surgeon had done. For the most part patients signed the document in the same way that most of us click the box on our computers that says we have read and accept the terms of any software agreement. But the concept of informed consent had some redeeming value in that it made an effort to involve the patient but in my view it went too far.

A great improvement on informed consent occurred when we began to talk about "shared decision making." Here is emphasized a coming together of medical expertise with patient values. The patient needs to be helped to think through their values and express them to begin the discussion. Simplistically values tend to fall into three categories: I want everything done to prolong my life, I want reasonable things done to allow me to function, or I just want to be made comfortable and die peacefully. Then the physician should make recommendations that are consistent with the patient's values. Practioneers should do their best to limit their recommendations to those consistent with the patient's values. Then a decision is mutually made. For example a 90 year old has a severely leaking heart valve that could be fixed. The discussion between the patient and physician should start with a brief discussion of the problem e.g. you know this heart valve problem is getting serious and you are getting more short of breath limiting many of your activities. We could talk about surgery to replace the valve but first let me ask you what are your goals of care at this time? Do you want everything done possible to prolong your life, do you want as little as you can just to help you keep as active as you can without talking about major surgery, or do you feel you are getting near enough to the end that you just want to be comfortable. Now the patient must think through their values and once they have expressed them the doctor can make a wiser recommendation. Shared decision making requires a mutual respect between the doctor and patient. The doctor respecting the values of the patient and the patient the expertise of the doctor.

It should go without saying but to make any decision a patient must be capable of making it. To quote my friend Robert Orr: "To have capacity a person must understand the necessity of a decision, must be

aware of the treatment options, must understand the likely outcomes with the various options, and must be able to rationally manipulate the information to make a decision. Ideally they should be able to repeat back their understanding of the situation." Capacity will vary with the importance of the decision. Deciding about open heart surgery requires a higher level of capacity than what to have for dinner. Capacity is a subjective term and is different from competence, a legal state determined by a judge.

Truth telling

Fundamental to any clinical relationship must be a mutual trust in the truthfulness of all those involved. I expect my patients to tell me the truth and when they understate or overstate their symptoms it will undermine the quality of the care I give them. Similarly, if I am not truthful in the way I represent the potential benefit or side effects of what I am recommending it is unfair to my patient.

One area where this is of particular concern is in making prognoses. I recall once a neurosurgeon telling my patient that I he did the procedure it had a 70% success rate. He failed to go further and explain that success meant living through the surgery. He failed to say that only 10% would be expected to get back to a normal life at home. Most of the survivors would be significantly disabled and unable to live outside a nursing home. Did he tell the truth? I do not think so.

Another area is in predicting when death will come. Here I acknowledge that this is not an exact science, no one knows for sure and so perhaps truth telling is not the issue. Nevertheless doctors are terrible at predicting the length of time patients have to live. Several studies have shown that the average prediction is 3-5 times longer than what actually happens. I understand some of this, the doctor wants to be optimistic and offer hope feeling that may promote quality of life. In my observation it may do just the opposite. We will discuss next week the agenda that a dying person should have to finish life well. When they think they have more time they fail to pursue it and then all of a sudden death comes on them unprepared. On the other hand when the prognosis is underestimated, the patient fulfills the agenda, is ready to die and then comes back and has fun telling the doctor how wrong she was.

Matt's experience with truth telling/prognosis ~ 5 min

Confidentiality

I quote Hippocrates: "Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret." This is another way in which we can show respect for the dignity of our patients. Out of respect for patients we should not divulge information to others without their permission. In the same context we should not use our privilege to seek information that is not necessary to their care.

There are times when we must respect cultural values in interpreting confidentiality. For example elderly people from India will often defer all medical decisions to their oldest son. They may not want to be told the diagnosis or the prognosis. Elderly Muslims will often want decisions to be made by the consensus of their children. In these cases the entire family will expect to be fully informed and the dying parent may not be expected to give permission.

At times this can be carried to far. When we know our patients well I feel it is in their best interest to share some information without assuring their permission. For example when I get a call from the daughter of my 95 year old patient who I know well, I do not check to see if I have a signed consent. There are other ethical issues that confidentiality raises where certain facts may endanger other people and they deserve to be warned of their danger, e.g. the HIV positive husband who refuses to tell his wife.

Right of Conscience

Emerging as a key issue in Bioethics is the threat to right of conscience. Several years ago when Michael Bloomberg became Mayor of New York, one of his first executive orders was that all NY city owned hospitals require their OB residents to be trained in abortion. One of the key objectives of the Obama administration was to disallow a right of conscience. Pharmacists were forced to fill prescriptions for morning after pills even when they felt they were immoral. One stand which Hilary Clinton took in her presidential bid was that no medical person should be allowed to let their conscience prevent access to care that a patient wanted. It does not look like the Trump administration will pursue that agenda. I was giving a talk in Guilford last year and in the Q and A time one women made a very passionate plea for assisted suicide. When I said I would not do that she responded, "Why not, you aren't really doing anything but signing your name." A good response would have been, "If I were a gun salesman and someone came in telling me they wanted a gun to kill themselves." Would I be in the right to refuse to sell it to them? The Christian Medical and Dental Association surveyed their members hip and found that a significant percent of their 16,000 members would leave medicine rather than do something they felt was morally wrong.

Professionalism

Many with careers in medicine, whether doctors, nurses, physical therapists, pharmacists etc. are professionals. That is they profess to offer something they are uniquely trained to do. Medicine in the broad sense is not a job, it is a vocation, which means a calling. For believers, I believe it can be a call from God to serve him in medicine. I do not imply that it is necessarily a life-long call but while we are doing it we should feel that call. For decades this necessitated a whole life commitment. They would view their relationship to their patients as covenantal not contractual. They would be available 24/7. Attending at the hospital, spending the day in the office and then doing house calls--medicine was their life. They had long term relationships with many patients and the "family medicine doctor" truly became part of the family. Yet it led to fatigue, burn out and frequently a sloppiness in medicine. The extent of medical knowledge was far too great for one person to master. Of critical importance there was little room for women to serve in medicine while raising a family.

Medicine in the last 30 years is rapidly receding from that sense of professionalism. The days of the doctor being available to his patients 24/7 are gone. Rarely does a patient have one doctor he looks to for all of his care. There is a specialist managing almost every organ system. The long term relationships between doctors, patients and their families are less frequent.

But before we get too nostalgic and wish for the "good old days" we should give equal time to the advantages of the new system. Now these professionals work fewer hours and are able to respond to God's calling in other areas of their lives. Fathers can be more present with their children and it opens up the opportunity for women in medicine to be mothers. The doctor is no longer a "lone ranger" but is integrated into a team. There is much more input to the needs of the acutely ill. Decisions are made when the doctor is rested and fresh, not after working 20 hours. Help comes from an electronic medical record that give access to a volume of information that would overwhelm one individual.

We must recognize the pros and cons of this new way of doing things and strive to maintain many of the values previously professed. We must see our patients not as projects or as problems but as people of dignity with needs worthy of our full attention. When possible we should develop long term relationships and be faithful to our patients. We should assure that we have a competent team who will be able to care well for our patients in our absence and carefully communicate with them. We must maintain our competence to offer the best care we can. Perhaps most importantly we should love them with the love of Christ working through us.

Matt's experience ~ 5 min

Spiritual care in practice

Even in the context of a secular practice there is much that can be done to minister spiritually to our patients.

Spiritual history-We should know what spiritual resources all of our patients have to draw on. Do they have a faith tradition? Do they regularly practice their faith? Do they have a faith community? Who do they turn to for spiritual help?

Prayer-Many people will casually say, "Please pray for me." It is always appropriate to respond to that by asking, "May I pray for you now?" At other times we are free to spontaneously tell people that you pray for your patients and ask if they would like you to pray for them right then.

Share the Gospel-At times you may feel led to ask if the patient would be willing to have you share from your own experience. There may be opportunity to share the gospel but recognize that patients will often do anything thinking they are pleasing their doctor and this can lead to difficulty. I like Paul's strategy:

> Continue steadfastly in prayer, being watchful in it with thanksgiving. At the same time, pray also for us, that God may open to us a door for the word, to declare the mystery of Christ, on account of which I am in prison— that I may make it clear, which is how I ought to speak. Conduct yourselves wisely toward outsiders, making the best use of the time. Let your speech always be gracious, seasoned with salt, so that you may know how you ought to answer each person.
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> Col. 4:2-6

Paul would say pray for your patients, enlist other to pray for you, be wise, always speak graciously, be uplifting and encouraging,. Occasionally say something that may turn attention to God. When they tell you something good has happened respond with "I thank God for that." etc. Then be available to answer any questions they may have.

It is wise to work with some of the area clergy so that if the opportunity for a longer conversation comes up you can refer the patient to a pastor in their local community.

Care for the poor

When so much of medicine is done by large corporations and individual doctor has little control over how much time he can follow Jesus in caring for those with limited resources. Fortunately there are many public and private clinics where we can work full time as we serve the poor. There are also many volunteer opportunities that give free or substantially reduced rates for care.

Brita to share about Cornell Scott ~ 5 min

Alternative medicine

Traditional allopathic physicians whether Medical Doctor (MD's) of Doctors of Osteopathy (DO's) seek to practice evidenced based medicine. They rely on high quality research to inform how they practice. For all of medicines failures I do give them credit for expending incredible time, money and energy on research. They are joined by a wide variety of other medical practitioners who serve as an alternative to traditional medicine. These include such providers as chiropractors, homeopaths, naturopaths, etc. They tend to have distinctive theories of disease and treatment. Many of these practioneers are well educated, sincere and loving to their patients. I believe they often do patients a lot of good. However it is unfortunate that often they do not take the time to study the impact of the treatments they recommend. They may go more by anecdotal stories. Over time some of their techniques have been demonstrated to be effective. Acupuncture and chiropractic are two cases which have been proven to be effective in certain conditions.

Supplements are widely used especially in the Christian community. They are often touted for their health benefits. Some have been looked at more rigorously and have been shown to benefit only a limited number of people, most have been shown to cause no harm. Should they be used? That is an individual choice. Even though they may not be recommended because they do not help many that does not mean they do not help some. At times I quote the experience of Fred and Ned. These were two friends who walked in the woods each day. When they got to the edge of the woods Fred would put on these big red sun glasses. Finally one day Ned got up the gumption to ask why he wore those crazy things. Fred answered, "Because they keep the elephants from jumping out of the trees on me." Ned responded, "Come on when did that ever happen?" Fred retorted "See how good they work."

Some supplements can be dangerous. For example taking supplements of Beta Carotene can increase the risk of lung cancer. On the other hand carrots that contain a lot of beta Carotene can be very beneficial. I am not sure we know the explanation but I am attracted to the theory that when the Lord created carrots he included other essential nutrients that allow the body to effectively use the beta carotene but when we take it my itself we may not be able to utilize it and it may build to toxic levels.

Vitamins are essential to health and we must get them to maintain good health. My preference is to get them from food by eating a well-balanced diet including dairy, whole grains, fruits and veggies. But when we are unable to get these, especially as we get older, taking a daily vitamin supplement may be wise. The one exception is likely vitamin D where most of us over 40-50 would benefit from some supplement.

In summary I would say that I am opposed to alternative medicine when it offers unproven treatments for conditions that are easily treated by other means (whether allopathic or not), when claims are made that cannot be substantiated, and when something is recommended that does not seem safe, or has overtones of the occult. I am not opposed to it in most other contexts.