Principles of Bioethics

The place of principles in bioethics

In the realm of health care it is difficult to hold rules or principles that are absolute. This is due to the many variables that exist in the context of clinical cases as well as the fact that in health care there are several principles that seem to be applicable in many situations. Even though they are not considered absolute, these rules and principles serve as powerful action guides in clinical medicine. Over the years, these moral principles have won a general acceptance as applicable in the moral analysis of ethical issues in medicine.

How do principles "apply" to a certain case?

Principles in current usage in health care ethics seem to be of self-evident value. For example, the notion that the physician "ought not to harm" any patient appears to be convincing to rational persons. Or, the idea that the physician should develop a care plan designed to provide the most "benefit" to the patient in terms of other competing alternatives, seems self-evident. Further, before implementing the medical care plan, it is now commonly accepted that the patient must indicate a willingness to accept the proposed treatment, if the patient is cognitively capable of doing so. Finally, medical benefits should be dispensed fairly, so that people with similar needs and in similar circumstances will be treated with fairness.

One might argue that we are required to take all of the above principles into account when they are applicable to the clinical case under consideration. Yet, when two or more principles apply, we may find that they are in conflict. For example, consider a patient diagnosed with an acutely infected appendix. Our medical goal should be to provide the greatest benefit to the patient, an indication for immediate surgery. On the other hand, surgery and general anesthesia carry some small degree of risk to an otherwise healthy patient, and we are under an obligation "not to harm" the patient. Our rational calculus holds that the patient is in far greater danger from harm from a ruptured appendix if we do not act, than from the surgical procedure and anesthesia if we proceed quickly to surgery.

In other words, we have a "prima facie" duty to both benefit the patient and to "avoid harming" the patient. However, in the actual situation, we must balance the demands of these principles by determining which carries more weight in the particular case. Moral philosopher W.D. Ross claims that prima facie duties are always binding unless they are in conflict with stronger or more stringent duties. A moral person's actual duty is determined by weighing and balancing all competing prima facie duties in any particular case.

What are the major principles of medical ethics?

The commonly accepted principles of health care ethics include:
1. Respect for Autonomy
Any notion of moral decision making assumes that rational agents are involved in making informed and voluntary decisions. In health care decisions, our respect for the autonomy of the patient would, in common parlance, mean that the patient has the capacity to act intentionally, with understanding, and without controlling influences that would mitigate against a free and voluntary act. This principle is the basis for the practice of “informed consent” in the physician/patient transaction regarding health care.

2. The Principle of Nonmaleficence
The principle of nonmaleficence requires of us that we not intentionally create a needless harm or injury to the patient, either through acts of commission or omission. In common language, we consider it negligence if one imposes a careless or unreasonable risk of harm upon another. Providing a proper standard of care that avoids or minimizes the risk of harm is supported not only by our commonly held moral convictions, but by the laws of society as well. In a professional model of care one may be morally and legally blameworthy if one fails to meet the standards of due care. The legal criteria for determining negligence are as follows:
   1. the professional must have a duty to the affected party
   2. the professional must breach that duty
   3. the affected party must experience a harm; and
   4. the harm must be caused by the breach of duty.
This principle affirms the need for medical competence. It is clear that medical mistakes occur, however, this principle articulates a fundamental commitment on the part of health care professionals to protect their patients from harm.

3. The Principle of Beneficence
The ordinary meaning of this principle is the duty of health care providers to be of a benefit to the patient, as well as to take positive steps to prevent and to remove harm from the patient. These duties are viewed as self-evident and are widely accepted as the proper goals of medicine. These goals are applied both to individual patients, and to the good of society as a whole. For example, the good health of a particular patient is an appropriate goal of medicine, and the prevention of disease through research and the employment of vaccines is the same goal expanded to the population at large.

It is sometimes held that nonmaleficence is a constant duty, that is, one ought never to harm another individual. Whereas, beneficence is a limited duty. A physician has a duty to seek the benefit of any or all of her patients, however, the physician may also choose whom to admit into his or her practice, and does not have a strict duty to benefit patients not acknowledged in the panel. This duty becomes complex if two patients appeal for treatment at the same moment. Some criteria of urgency of need might be used, or some principle of first come first served, to decide who should be helped at the moment.
4. The Principle of Justice

Justice in health care is usually defined as a form of fairness, or as Aristotle once said, "giving to each that which is his due." This implies the fair distribution of goods in society and requires that we look at the role of entitlement. The question of distributive justice also seems to hinge on the fact that some goods and services are in short supply, there is not enough to go around, thus some fair means of allocating scarce resources must be determined.

It is generally held that persons who are equals should qualify for equal treatment. This is borne out in the application of Medicare, which is available to all persons over the age of 65 years. This category of persons is equal with respect to this one factor, their age, but the criteria chosen says nothing about need or other noteworthy factors about the persons in this category. In fact, our society uses a variety of factors as a criteria for distributive justice, including the following:

1. to each person an equal share
2. to each person according to need
3. to each person according to effort
4. to each person according to contribution
5. to each person according to merit
6. to each person according to free-market exchanges

John Rawls and others claim that many of the inequalities we experience are a result of a "natural lottery" or a "social lottery" for which the affected individual is not to blame, therefore, society ought to help even the playing field by providing resources to help overcome the disadvantaged situation. One of the most controversial issues in modern health care is the question pertaining to "who has the right to health care?" Or, stated another way, perhaps as a society we want to be beneficent and fair and provide some decent minimum level of health care for all citizens, regardless of ability to pay.

INTRODUCTION: Case Analysis in Clinical Ethics

Clinical ethics is a practical discipline that provides a structured approach to assist physicians in identifying, analyzing and resolving ethical issues in clinical medicine. The practice of good clinical medicine requires some working knowledge about ethical issues such as informed consent, truth-telling, confidentiality, end-of-life care, pain relief, and patient rights. Medicine, even at its most technical and scientific, is an encounter between human beings, and the physician's work of diagnosing disease, offering advice, and providing treatment is embedded in a moral context. Usually, moral values such as mutual respect, honesty, trustworthiness, compassion, and a commitment to pursue shared goals, make a clinical encounter between physician and patient morally unproblematic. Occasionally, physicians and patients may disagree about values or face choices that challenge their values. It is then that ethical problems arise. Clinical ethics is both about the ethical features that are present in every clinical encounter and about the ethical problems that occasionally arise in those encounters. Clinical ethics relies upon the conviction that, even when perplexity is great and
emotions run high, physicians and nurses, patients and families can work constructively to identify, analyze and resolve many of the ethical problems that arise in clinical medicine.

We suggest that every clinical case, when seen as an ethical problem, should be analyzed by means of four topics. These four topics are

1. Medical Indications;
2. Patient Preferences;
3. Quality of Life,
4. Contextual Features,
that is, the social, economic, legal, and administrative context in which the case occurs. Every case can be viewed in terms of these four topics; no case can be adequately discussed without reference to them. Although the facts of each case differ, these four topics are always relevant. The topics organize the varying facts of the particular case and, at the same time, the topics call attention to the moral principles appropriate to the case. It is our intent to show readers how the topics provide a systematic way to identify, analyze and resolve the ethical problems arising in clinical medicine.

Clinicians will recall the method of case presentation that they learned at the beginning of their professional training. They were taught to "present" a patient by stating in order the patient's history, including the chief complaint, the history of the present illness, past medical history, family and social history, followed by physical findings and laboratory data. These are the topics that an experienced clinician uses to reach a diagnosis and to formulate a case management plan. While the particular details under each of these topics differ from patient to patient; the topics themselves are constant and always relevant to the task of arriving at a case management plan. Sometimes one topic, for example, the patient's family history or the physical examination, may be particularly important or, conversely, may not be relevant to the problem at hand. Still, clinicians are expected to review all topics in every case. Our four topics -- (1) Medical Indications, (2) Patient Preferences, (3) Quality of Life, and (4) Contextual Features--are the ethical equivalents of these familiar clinical topics.

These topics help clinicians understand where the moral principles meet the circumstances of the clinical case. The general headings of the topics describe the major features that define the ethics of clinical medicine; each of these features takes on specific, concrete form from the circumstances of the particular case. In a given case, a patient comes to a physician, complaining of feeling ill. Medical Indications include a clinical picture of polydipsia and polyuria, nausea, fatigue and some mental confusion, with laboratory studies showing hyperglycemia, acidosis and elevated plasma ketone concentrations. A diagnosis of diabetic ketoacidosis is made. Fluids and insulin are indicated in specific doses and volumes. These particulars are the occasion for implementing the moral principle of beneficence, that is, the duty of performing actions that benefit the patient. However, in the same case, the patient may be confused and, after hearing the physician's recommendations, rejects further medical attention: these circumstances, noted under Patient Preferences, raise questions about the principle of autonomy, that is, the duty to respect the patient's wishes.. As the case is described, circumstances accumulate under all four of the topics and affect the meaning and relevance of the moral principles. It is advisable to review the entire four topics in order to see how the principles and the circumstances together define the
ethical problem in the case and suggest a resolution. It is rare that an ethical problem involves only one ethical principle. Every actual ethical problem is a complex collection of many circumstances. Good ethical judgment consists in appreciating how several ethical principles should be evaluated in the actual situation under consideration. We hope our method helps practitioners to do just that.

We illustrate our method by a brief summary of a case familiar to many who have studied medical ethics, namely, the case of Donald "Dax" Cowart, the burn patient who related his experience in the videotape Please Let Me Die and the documentary, Dax's Case. [1]

In 1973, "Dax" Cowart, age 25, was severely burned in a propane gas explosion. Rushed to the Burn Treatment Unit of Parkland Hospital in Dallas, 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 Parkland, his few weeks at Texas Institute of Rehabilitation and Research at Houston, and his subsequent six month's stay at University of Texas Medical Branch in Galveston, 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.

Discussion of a case like this can begin by raising any number of questions. Did Dax have the moral or the legal right to refuse care? Was Dax competent to make a decision? Were the physicians paternalistic? What was Dax's prognosis? All these questions, and many others, are relevant and can give rise to vigorous debate. However, we suggest that an ethical analysis should begin by an orderly review of the four topics. We recommend that the same order be followed in all cases: (1) Medical Indications, (2) Patient Preferences, (3) Quality of Life, (4) Contextual Features. This procedure will lay out the ethically relevant facts of the case (or show where further information is needed) before debate begins. It should be noted that this order of review does not constitute an order of ethical priority. The determination of relative importance of these topics will be explained in the four chapters.

Medical Indications. This topic comprises the usual content of a clinical discussion: the diagnosis and treatment of the patient's pathological condition. "Indications" refers to the relation between the pathophysiology presented by the patient and the diagnostic and therapeutic interventions that are "indicated," that is, appropriate to evaluate and treat the problem. Although this is the usual material covered in the presentation of any patient's clinical problems, the ethical discussion will not only review the medical facts, but also attend to the purposes and goals of any indicated interventions. In Dax's case, the medical indications include the clinical facts necessary to diagnose the extent and seriousness of burns, to make a prognosis for survival or restoration of function, and the options for treatment, including the risks, benefits and probable outcomes of each treatment modality. For example, certain prognoses are associated with burns of given severity and extent. Various forms of treatment, such as fluid replacement, skin grafting and antibiotics are associated with certain probabilities of
outcome and risk. After initial emergency treatment, Dax's prognosis for survival was approximately 20%. After six months of intensive care, his prognosis for survival improved to almost 100%. If his request to stop wound care and grafting during that hospitalization had been respected, he would almost certainly have died. A clear view of the possible benefits of intervention is the first step in assessing the ethical aspects of a case.

**Patient Preferences.** In all medical treatment, the preferences of the patient, based on the patient's own values and personal assessment of benefits and burdens are ethically relevant. In every clinical case, the questions must be raised: "What are the patient's goals? What does the patient want?" The systematic review of this topic requires further questions. Has the patient been provided sufficient information? Does the patient comprehend? Does the patient understand the uncertainty inherent in any medical recommendation and the range of reasonable options that exist? Is the patient consenting voluntarily? Is the patient coerced? In some cases, an answer to these questions might be "We don't know because the patient is incapable of formulating a preference or expressing one." If the patient is mentally incapacitated at the time a decision must be made, we must ask "Who has the authority to decide on behalf of this patient? What are the ethical and legal limits of that authority? What is to be done if no one can be identified as surrogate?

In Dax's case, a question about his mental capacity arose in the early days of his refusal of care. Had the physical and emotional shock of the accident undermined his ability to decide for himself? Initially it was assumed that he lacked the capacity to make his own decisions, at least about refusing life-saving therapy. The doctors accepted the consent of Dax's mother in favor of treatment, over his refusal of treatment. Later, when Dax was hospitalized in Galveston, psychiatric consultation was requested which affirmed his capacity to make decisions. Once capacity was established, the ethical implications of his desire to refuse care became central. Should his preference be respected? If not, on what grounds? Did Dax appreciate sufficiently the prospects for his rehabilitation? Are physicians obliged to pursue therapies they believe have promise over the objections of a patient? Would they be cooperating in a suicide if they assented to Dax's wishes? Any case involving the ethics of patient preferences relies on clarification of these questions.

**Quality of Life.** Any injury or illness threatens persons with actual or potential reduced quality of life, manifested in the signs and symptoms of their disease. The object of all medical intervention is to restore, maintain or improve quality of life. Thus, in all medical situations, the topic of quality of life must be raised. Many questions surround this topic: What does this phrase, "quality of life" mean in general? How should it be understood in particular cases? How do persons other than the patient perceive the patient's quality of life and of what ethical relevance are their perceptions? Above all, what is the relevance of quality of life to ethical judgment? This topic, which is less well worked out in the literature of medical ethics than the two previous ones, is perilous because it opens the door for bias and prejudice. Still, it must be confronted in the analysis of clinical ethical problems.

In Dax's case, we note the quality of his life prior to the accident. He was a popular, athletic young man, just discharged from the Air Force, after serving as a fighter pilot in
Viet Nam. He worked in a real estate business with his father (who was also injured in the explosion and died on the way to the hospital). Before his accident, Dax's quality of life was excellent. During the course of medical care, he endured excruciating pain and profound depression. After the accident, even with the best of care, he was confronted with significant physical deficits, including notable disfigurement, blindness and limitation of activity. At some stage in his illness, Dax had the capacity to determine what quality of life he wished for himself. However, in the early weeks of his hospitalization, he was probably mentally incapacitated at the time critical decisions had to be made. When he was, others would have had to make certain "quality of life" decisions on his behalf. Was the prospect for return to a normal or even acceptable life so poor that no reasonable person would choose to live? Who should make such decisions? What values should guide them? The meaning and import of such considerations must be clarified in any clinical ethical analysis.

**Contextual Features.** Patients come to physicians because they have a problem that they hope the physician can help to correct. Physicians undertake the care of patients with the intent and the duty to make all reasonable efforts to help them. The topics of medical indications, patient preferences and quality of life bring out these essential features of the case. Yet every medical case is embedded in a larger context of persons, institutions, financial and social arrangements. Patient care is influenced, positively or negatively, by the possibilities and the constraints of that context. At the same time, the context itself is affected by the decisions made by or about the patient: these decisions have psychological, emotional, financial, legal, scientific, educational, religious impact on others. In every case, the relevance of the contextual features must be determined and assessed. These contextual features may be crucially important to the understanding and resolution of the case.

In Dax's case, several of these contextual features were significant. Dax's mother was opposed to termination of medical care for religious reasons. The legal implications of honoring Dax's demand were unclear at the time (they are clearer today). The costs of sixteen months of intensive burn therapy are not insignificant (although this was not emphasized in the various discussions of the case). The distress caused to medical and nursing personnel by Dax's refusal to cooperate with treatment might have influenced their attitudes toward him. These and other contextual factors must be made explicit and assessed for their relevance.

These four topics are relevant to any clinical case, whatever the actual circumstances. They serve as a useful organizing device for teaching and discussion. More important, however, is the way in which a review of these topics can help to move a discussion of an ethical problem toward a resolution. Any serious discussion of an ethical problem must go beyond merely talking about it in an orderly way: it must push through to a reasonable and practical resolution. Ethical problems, no less than medical problems, cannot be left hanging. Thus, after presenting a case, the task of seeking a resolution must begin.

The discussion of each topic raises, or presupposes, certain common ethical notions. These notions propose certain standards of behavior or attitudes that are morally appropriate to the topic. They can be called moral principles or rules: rules tend to be quite specific to particular topics, while principles are stated in broader, more general
terms. For example, one version of the principle of beneficence states, "There is an obligation to assist others in the furthering of their legitimate interests." The moral rule, "physicians have a duty to treat patients, even at risk to themselves," is a specific expression of that broad principle, suited to a particular sphere of professional activity, namely, medical care. The topic of medical indications, in addition to the clinical data that must be discussed, raises the further questions, "How much can we do to help this patient?" "What risks of adverse effects can be tolerated in the attempt to treat the patient?" Answers to these questions, arising so naturally in the discussion of medical indications, can be guided by familiar moral rules applied to medical ethics such as, "Be of benefit and do no harm" or "Risks should be balanced by benefits." Rules such as these reflect in a specific way the broad principle that the philosophers have named beneficence. Similarly, the topic of patient preferences contains rules that instruct clinicians to tell patients the truth, to respect their deliberate preferences, to honor their values, etc. Rules such as these fall under the general scope of the principles of autonomy and respect for persons.

Our method of analysis begins, not with the principles and rules, as do many other ethics treatises, but with the factual features of the case. We refer to relevant principles and rules as they arise in the discussion of the topics. In this way, abstract discussions of principles is avoided as is the tendency to think of only one principle, such as autonomy or beneficence, as the sole guide in the case. Moral rules and principles are best appreciated in the specific context of the actual circumstances of a case. For example, a key issue in Dax's case is the autonomy of the patient. However, the significance of autonomy in Dax's case is derived, not simply from the principle that requires we respect it, but from the confluence of considerations about preferences, medical indications for treatment, quality of life, decisional capacity, and the role of his mother, the doctors, the lawyers and the hospitals. Only when all these are seen and evaluated in relation to each other, will the meaning of the principle of autonomy be appreciated in this case.

Competence in clinical ethics depends not only on being able to use a sound method for analysis, but also on familiarity with the literature of medical ethics. Some readers will seek further elaboration of the issues dealt with so briefly in this introductory book. We direct these readers to a few sources where they will find, not only that elaboration, but references to the major literature. Thus, we place in brackets after our discussion of an issue references to The Encyclopedia of Bioethics (2), Principles of Biomedical Ethics (3), and Medical Ethics (4).

REFERENCES

Summary of Methodology

In a collaborative effort, 3 clinical ethicists (a philosopher - Jonsen, a physician - Siegler, and a lawyer - Winslade) have developed a method with which to work through difficult cases. The process can be thought of as the "ethics workup," similar to the "History and Physical" skills that all medical students come to use when learning how to "workup" a patient's primary complaints. While this method has deep philosophical roots, what clinicians who use this method like about it is the ease with which it fits into how they normally think about tough medical cases.

We will introduce this method briefly here, offer the decisionmaking tool (the "4 boxes"), and then discuss a sample case to illustrate the method. For a more in depth discussion of this method and for extensive examples of case analysis, students should refer to Jonsen, Siegler, Winslade's Clinical Ethics.

Jonsen, Siegler and Winslade have identified four "topics" that are basic and intrinsic to every clinical encounter. Focusing our discussion around these four topics gives us a way to organize the facts of the particular case at hand.

- **Medical Indications** - all clinical encounters include a review of diagnosis and treatment options
- **Patient Preferences** - all clinical encounters occur because a patient presents before the physician with a compliant. The patient's values are integral to the encounter.
- **Quality of Life** - the objective of all clinical encounters is to improve, or at least address, quality of life for the patient
- **Contextual Features** - all clinical encounters occur in a wider context beyond physician and patient, to include family, the law, hospital policy, insurance companies, and so forth.

These four topics are present in every case. In the interest of consistency, the order of the review of topics remains the same (again, much like the review of systems in a complete H&P), yet no topic bears more weight than the others. Each will be evaluated from the perspective of the facts of the case at hand.

Once the details of a case have been outlined according to the four topics (using the 4 boxes), there are a series of questions that the clinician should ask.

- What is at issue?
- Where is the conflict?
- What is this a case of? Does it sound like other cases you may have encountered? (e.g., Is it a case of "refusal of potentially life-sustaining treatment by a competent patient"?)
- What do we know about other cases like this one? Is there clear precedent? If so, we call this a paradigm case. A paradigm case is one in which the facts of the case are very clear cut and there has been much professional and/or public agreement about the resolution of the case.
• How is the present case similar to the paradigm case? How is it different? Is it similar (or different) in ethically significant ways?

• The resolution in any particular case will depend on the facts of that case. After analyzing a difficult case in this way, clinicians are usually able to think clearly about what is at issue and to identify the best course of action available to them. If a best course of action remains elusive, a formal ethics consultation can be helpful.

Paradigm

<table>
<thead>
<tr>
<th>Medical Indications: Consider each medical condition and its proposed treatment. Ask the following questions:</th>
<th>Patient Preferences: Address the following:</th>
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<tbody>
<tr>
<td>• Does it fulfill any of the goals of medicine?</td>
<td>• What does the patient want?</td>
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<td>• With what likelihood?</td>
<td>• Does the patient have the capacity to decide? If not, who will decide for the patient?</td>
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<td>• If not, is the proposed treatment futile?</td>
<td>• Do the patient's wishes reflect a process that is</td>
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<td>• informed?</td>
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<td>• understood?</td>
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<th>Quality of Life:</th>
<th>Contextual Features: Social, legal, economic, and institutional circumstances in the case that can:</th>
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<tr>
<td>• Describe the Patient's quality of life in the patient’s terms.</td>
<td>• influence the decision</td>
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<tr>
<td>• What is the patient's subjective acceptance of likely quality of life?</td>
<td>• be influenced by the decision</td>
</tr>
<tr>
<td>• What are the views of the care providers about the quality of life?</td>
<td>e.g., inability to pay for treatment;</td>
</tr>
<tr>
<td>• Is quality of life &quot;less than minimal?&quot; (i.e., qualitative futility)</td>
<td>inadequate social support</td>
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Sample Case Analysis

Case:
John, a 32-year-old lawyer, had worried for several years about developing Huntington's chorea, a neurological disorder that appears in a person's 30s or 40s, bringing rapid uncontrollable twitching and contractions and progressive, irreversible dementia. It leads to death in about 10 years.

John's mother died from this disease. Huntington's is autosomal dominant and afflicts 50% of an affected parent's offspring. John had indicated to many people that he would prefer to die rather than to live and die as his mother had. He was anxious, drank heavily, and had intermittent depression, for which he saw a psychiatrist. Nevertheless, he was a productive lawyer.

John first noticed facial twitching 3 months ago, and 2 neurologists independently confirmed a diagnosis of Huntington's. He explained his situation to his psychiatrist and requested help committing suicide. When the psychiatrist refused, John reassured him
that he did not plan to attempt suicide any time soon. But when he went home, he ingested all his antidepressant medicine after pinning a note to his shirt to explain his actions and to refuse any medical assistance that might be offered. His wife, who did not yet know about his diagnosis, found him unconscious and rushed him to the emergency room without removing the note.

What should the care team at the emergency room do?

Review of Topics:

Medical Indications

There are 2 diagnoses/prognoses that merit consideration. The underlying chronic disease of Huntington's has no available treatment and a bleak long term prognosis. However, there are effective treatments available for the acute diagnosis of drug overdose. How does the chronic diagnosis affect our response to the acute condition?

Patient Preferences

We know from the patient's suicide note that he is refusing all medical treatment. However, what do we know about these statements of preference? Were they informed? Was the patient competent to make that decision? The answers to these questions remain unclear, but we do know that the patient does not have decision making capacity for the present decision of whether to proceed with the gastric emptying. Is there a surrogate decisionmaker available?

Quality of Life

Life with Huntington's can be difficult with the onset of spasms and dementia. John was familiar with the quality of life associated with living with Huntington's as he watched his mother die of this disease. On the other hand, John does have a supportive family and continues to be able to work for the time being. How should the diminished quality of life that is anticipated in the future affect the current decision?

Contextual Features

Several factors in the context of this case are significant. While the patient has a legal right to refuse treatment, he is currently unconscious and his surrogate (his wife) is requesting treatment. There are also certain emergency room obligations to treat emergent conditions. How should the emergency staff weigh the various competing legal and regulatory duties?

Case Analysis:

This is a case of treatment refusal of potentially life-sustaining treatment when the competency of the patient to decide is questionable. Also at issue is the distinction between the acute and chronic conditions of the patient.

The precedent for cases such as this one is fairly clear. When the patient's preferences are unclear, and the acute condition is easily treatable, and the harm of not treating is very great, medical teams can feel comfortable about providing the treatment for the
immediate life-threatening condition, creating an opportunity to talk with the patient about his preferences regarding his chronic condition at a later time. Notice that the facts of this particular case determine if the precedent case is applicable. If the medical team was very familiar with this patient's expressed preference to refuse any medical treatment or if the available treatment for the acute condition was considerably less certain to be effective, the case could be decided differently. The clinicians would look for a different precedent or consider whether it made a significant difference to be very clear about the patient's beliefs and certain about his competency to decide to refuse.