

FOURTH EDITION

CLINICAL
ETHICS

Albert R. Jonson
Mark Siegler
William J. Winslade

R
724
.J66
1998

FOURTH EDITION

CLINICAL ETHICS

A Practical Approach to Ethical Decisions in Clinical Medicine

Albert R. Jonsen, Ph.D.

Professor of Ethics in Medicine
Chairman, Department of Medical History and Ethics
University of Washington School of Medicine
Seattle, Washington

Mark Siegler, M.D.

Lindy Bergman Professor of Medicine
Director, MacLean Center for Clinical Medical Ethics
University of Chicago
Chicago, Illinois

William J. Winslade, Ph.D., J.D.

James Wade Rockwell Professor of Philosophy of Medicine
Institute for the Medical Humanities
Director, Ethics Consultation Service
University of Texas Medical Branch at Galveston
Galveston, Texas

McGraw-Hill
Health Professions Division

New York · St. Louis · San Francisco · Auckland · Bogotá
Caracas · Lisbon · London · Madrid · Mexico City · Milan · Montreal
New Delhi · San Juan · Singapore · Sydney · Tokyo · Toronto

NOTICE

Medicine is an ever-changing science. As new research and clinical experience broaden our knowledge, changes in treatment and drug therapy are required. The authors and the publisher of this work have checked with sources believed to be reliable in their efforts to provide information that is complete and generally in accord with the standards accepted at the time of publication. However, in view of the possibility of human error or changes in medical sciences, neither the authors nor the publisher nor any other party who has been involved in the preparation or publication of this work warrants that the information contained herein is in every respect accurate or complete, and they are not responsible for any errors or omissions or for the results obtained from use of such information. Readers are encouraged to confirm the information contained herein with other sources. For example and in particular, readers are advised to check the product information sheet included in the package of each drug they plan to administer to be certain that the information contained in this book is accurate and that changes have not been made in the recommended dose or in the contraindications for administration. This recommendation is of particular importance in connection with new or infrequently used drugs.

McGraw-Hill



A Division of The McGraw-Hill Companies

**Clinical Ethics: A Practical Approach to Ethical Decisions
in Clinical Medicine, Fourth Edition**

Copyright © 1998, 1992, 1986, 1982 by The McGraw-Hill Companies, Inc.
All rights reserved. Printed in the United States of America. Except as permitted
under the Copyright Act of 1976, no part of this publication may be reproduced
or distributed in any form or by any means, or stored in a data base or
retrieval system, without the prior written permission of the publisher.

1 2 3 4 5 6 7 8 9 0 DOC DOC 9 9 8 7

ISBN 0-07-033120-0

This book was set in Garamond Book by V&M Graphics, Inc.
The editors were John Dolan and P. McCurdy;
the production supervisor was Heather Munro;
the designer was Robert Freese;
R.R. Donnelley and Sons was printer and binder.

This book is printed on acid-free paper.

Cataloging-in-Publication Data is on file for this title at the
Library of Congress.

Contents

Locator vii

INTRODUCTION 1

Case Analysis in Clinical Ethics 1
Four Cases 10
References 12

CHAPTER 1

Indications for Medical Intervention 13

The Goals and Benefits of Medicine 15
Decisions to Forgo Inefficacious
or Futile Interventions 22
Orders Not to Resuscitate 32
Care of the Dying Patient 40
Determination of Death 42
Summary 45

CHAPTER 2

Preferences of Patients 47

Informed Consent 53
Decisional Capacity 58
Unfamiliar Beliefs: Religious and
Cultural Diversity 63
Truthful Communication 65
Competent Refusal of Treatment 71
Advance Planning 81
Decision-Making for the Mentally
Incapacitated Patient 86
The Limits of Patient Preferences 94
Failure to Cooperate with Medical
Recommendation 96

Alternative Medicine	104
Summary	106
Quality of Life	107
Enhancing Quality of Life	123
Quality of Life Below Minimal	127
Legal Implications	135
Proportionate Care	138
Euthanasia and Assisted Suicide	141
Suicide	148
Summary	150

CHAPTER 4

Contextual Features	153
Role of Interested Parties	161
Confidentiality	166
The Economics of Care	171
Allocation of Scarce Resources	182
The Law	189
Research	192
Teaching Involving Patient Cooperation	198
Occupational Medicine	202
Public Health	203
Ethics Committees and Ethics Consultation	204
Summary	206

Locator

Abandonment	2.9.6
Active/passive	3.4
Advance directives	2.6–2.6.5
Advocacy of patient's interests	4.1.1
Allocation, <i>see</i> Scarce resources	
Alternative medicine	2.10
Anencephaly	1.2.4P, 4.4.4P, 4.5.1P
Assisted suicide	3.5.2
Autonomy	2.0.5 , 2.6.4, 3.5.3, 4.3.5.
Baby Doe Rules	1.4.2P, 2.7.8P, 3.0.10P, 4.5.1P
Beneficence	1.1 , 2.7.3.
Best interests	2.7.2, 3.0.3, 3.0.10P
Blood transfusion	2.5.1, 2.5.2P, 2.7.9P
Brain death, <i>see</i> Death, determination of	
Cardiopulmonary resuscitation, <i>see</i> Resuscitation orders	
Children	1.1P, 1.2.4P, 1.3.5P, 1.4.2P, 1.5.1P, 2.0.7P–2.0.8P, 2.5.2P, 3.0.9P–3.0.10P, 3.5.4P, 4.1.4P–4.1.5P, 4.4.4P
Christian Scientists	2.3, 2.5.2P, 2.7.9P
Clinical ethics introduction, Introduction	
Clinical judgment	1.1
Clinical trials, <i>see</i> Research	
Competence, <i>see</i> Decisional capacity	
Complementary medicine, <i>see</i> Alternative medicine	

Boldface numbers indicate major discussions of the topic.

In some cases, however, the ethical aspects become ethical problems. Even in the simple case mentioned above, ethical problems would appear if the patient stated that he did not believe in antibiotics, or if the urinary tract infection developed in the last days of a terminal illness, or if the infection was clearly associated with a sexually transmitted disease where sexual partners might be endangered, or if the patient could not pay for the care. Sometimes, these problems can be readily resolved; at other times, they become major obstacles in the management of the case. A clear understanding of the patient's medical status—namely, the nature of the disease, its prognosis, the available treatments and, above all, the goals of intervention—is crucial to the understanding of any ethical problem that might arise in the case.

In this chapter, we focus on the ways in which uncertainty or disagreement about the medical facts of the case can contribute to an ethical problem. The topic of medical indications is explained, the ethical principles relevant to medical intervention, namely, beneficence and nonmaleficence, are defined, and three ethical issues that depend heavily on the indications for medical intervention will be discussed: (1) medical futility; (2) the decision not to resuscitate a patient in the event of cardiorespiratory arrest; (3) the determination of death.

Every discussion of an ethical problem in clinical medicine must begin with a statement of the medical facts. This statement should follow the pattern familiar to medical students and physicians when they present a patient for clinical purposes: presenting complaint, history, results of physical examination, laboratory and other diagnostic studies, presumptive diagnosis and prognosis, and current or planned therapies. In the usual clinical presentation, this review of indications for medical intervention leads to the formulation of recommendations for further diagnostic studies, treatment regimens, and the education of the patient. When the clinical presentation includes an ethical problem, this review clarifies the medical aspects that are significant in the case.

Case. Mr. Cure, a 24-year-old white male, who is a graduate student, has been brought to the emergency room by a friend. Previously in good health, he is complaining of severe headache and a stiff neck. Physical examination shows a somnolent but arousable patient with a temperature of 39.5°C, pulse of 115 and

regular, BP of 105/50, and respiratory rate of 20/min. Examination of the chest reveals rales in the right base and neurological examination is normal except for nuchal rigidity and a positive Brudzinski's sign. Laboratory studies show a white count of 20,000 with a left shift; chest x-ray demonstrates a right lower lobe infiltrate. After obtaining the patient's consent, a spinal fluid examination reveals cloudy fluid with a white count of 2,000; a gram stain of the fluid shows many gram-positive diplococci. A diagnosis of pneumococcal pneumonia and pneumococcal meningitis is reached.

In this case, the medical indications are the physical and physiological findings that reveal a specific disease for which a specific therapy, namely, administration of antibiotics, is appropriate. There is no suggestion yet that this case poses any ethical problem. However, in Chapter 2, we shall encounter a major ethical problem with Mr. Cure: he will refuse therapy. That refusal will provoke dismay among the physicians and nurses caring for him and will be designated as an ethical problem. In any discussion of this ethical problem, even though the refusal of treatment will be the center of attention, the formal review of the case must begin with a clear exposition of the medical indications. In other words, the analysis should begin, not with the question, "Does a patient have the right to refuse treatment of a life-threatening condition?" but with answers to the question, "What are the medical indications for treatment?"

1.1

THE GOALS AND BENEFITS OF MEDICINE

Beneficence and Nonmaleficence. Medicine aims to prevent or cure disease, to treat patients' symptoms, and to improve or maintain their functional abilities. The two ethical principles that are particularly important guides in the attempt to achieve these aims are beneficence and nonmaleficence. The presence of medical indications raises the question, "How can a medical intervention help this patient?" This question reflects one of the central ethical maxims of medical practice, stated in the Hippocratic oath, "I will use treatment to help the sick according to my ability and judgment but never with a view to injury and wrongdoing." Another Hippocratic writing states, "As to diseases make a habit of two things: to help or at least to do no harm" (*Epitaphics* I, xi). These maxims reflect the ethical principles of "beneficence," the duty to assist persons in need, and its con-

Explore Litigation Insights

Docket Alarm provides insights to develop a more informed litigation strategy and the peace of mind of knowing you're on top of things.

Real-Time Litigation Alerts



Keep your litigation team up-to-date with **real-time alerts** and advanced team management tools built for the enterprise, all while greatly reducing PACER spend.

Our comprehensive service means we can handle Federal, State, and Administrative courts across the country.

Advanced Docket Research



With over 230 million records, Docket Alarm's cloud-native docket research platform finds what other services can't. Coverage includes Federal, State, plus PTAB, TTAB, ITC and NLRB decisions, all in one place.

Identify arguments that have been successful in the past with full text, pinpoint searching. Link to case law cited within any court document via Fastcase.

Analytics At Your Fingertips



Learn what happened the last time a particular judge, opposing counsel or company faced cases similar to yours.

Advanced out-of-the-box PTAB and TTAB analytics are always at your fingertips.

API

Docket Alarm offers a powerful API (application programming interface) to developers that want to integrate case filings into their apps.

LAW FIRMS

Build custom dashboards for your attorneys and clients with live data direct from the court.

Automate many repetitive legal tasks like conflict checks, document management, and marketing.

FINANCIAL INSTITUTIONS

Litigation and bankruptcy checks for companies and debtors.

E-DISCOVERY AND LEGAL VENDORS

Sync your system to PACER to automate legal marketing.