Health Ethics in South-East Asia

Teaching Health Ethics
Resource Materials from the WHO SEA Region

Volume 4
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MESSAGE FROM THE REGIONAL DIRECTOR

Ethics in health and health research is a major concern facing the South-East Asia Region. In the medical and health professions, ethics has transcended centuries of evolution from the time of Hippocrates. It is the pride of any health practitioner to honour and uphold the oath. The simple message conveyed by the oath can be summarized as “do no harm”.

Scientists, researchers and health policymakers around the world are engaged in exploring new and efficient ways to deal with new and emerging diseases and conditions, both communicable and noncommunicable. With rapid globalization and swift evolution of human behaviour and technology, ethical issues are increasingly becoming complex.

With increasing population and declining resources, health systems are coming under pressure because of increased demands for health care, especially in countries characterized by the double burden of disease. In some countries, health insurance schemes are being considered as a partial solution to the problem. In other countries, privatization in the health sector is growing rapidly. These developments, in turn, are challenging basic ethical considerations for fair distribution of health care in populations with very uneven income distribution.

The South-East Asia Advisory Committee on Health Research has emphasized the need to strengthen the knowledge base on ethics, in relation to medical and public health education and practices. It has also called for reinforcing the teaching of ethics in the curricula of medical and public health schools. It has stressed the importance of reviewing the existing situation in relation to ethical issues in education and practice, within the sociocultural context of the South-East Asia Region.

This CD Rom is based on studies that included a large number of physicians from teaching hospitals in different countries across the Region. These are real encounters with patients developed as learning scenarios for this Instructional CD ROM for Teaching of Health Ethics. The CD has been field-tested in seven teaching institutions in Bangladesh, India, Indonesia, Myanmar and Thailand.
This CD is designed as a flexible tool that can be used in many different ways in actual learning situations such as classrooms, interactive small groups and continuing education programmes in medical schools and teaching hospitals.

The open-ended format will inspire lively discussions on difficult ethical dilemmas. Many such dilemmas often do not have simple solutions. A frank discussion on these difficult issues should help develop skills in critical analysis and problem-solving.

I hope the CD will be used as a resource material and integrated with existing initiatives in the teaching of health ethics in the countries of the WHO South-East Asia Region.

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INTRODUCTION

Welcome to: Teaching Health Ethics: Resource Materials from the WHO South-East Asia Region.

These materials have been developed by the World Health Organization, South-East Asia Regional Office (SEARO), in consultation with a number of experts with background in a range of medical disciplines, anthropology and philosophy. The resource materials are primarily intended for the training in clinical health ethics of medical students and continued education of physicians in the WHO South-East Asia Region.

The overall purpose of the resource materials is to stimulate teaching and discussions of health ethics among physicians and students in the member countries of the Region by providing scenario-based education materials that originate from South and Southeast Asia.

The objectives of the resource materials are:

- to provide conceptual learning tools for health ethics;
- to sensitize physicians and medical students on ethical issues;
- to strengthen capacity to address ethical dilemmas in medical practice.

Guide to the Resource Materials

The core of this book is constituted by a wide range of situations where clinicians in teaching hospitals of the WHO SEA Region experienced ethical dilemmas. These have been extracted from in-depth interviews about ethical dilemmas faced in everyday clinical practice. Some of the scenarios have been divided into different parts, allowing for the unfolding of a problem. The scenarios are classified under three broad topics, which each addresses a number of specific issues. The learning scenarios can be accessed in two different modes: standard mode for reading through the materials, and presentation mode for LCD projection directly from the CD-ROM. All scenarios have a number of discussion points. These are easily recognized by the "Questions" icon following the text of a given scenario. The facilitator has full control over if and when to make use of the discussion points. Annex 3 provides a list of the learning scenarios.

For each specific health ethics topic, a number of teaching guidelines have been developed to help the facilitator organize learning sessions. Each
In the literature section, reference texts on health ethics topics along with legislative texts and codes of conduct from some of the countries of the WHO SEA Region have been suggested (Annex 4). Many texts are available in full-text versions on the CD-ROM and can easily be printed. The facilitator may add texts in the language of the country of teaching.

This publication was planned as one of the main outcomes of the South-East Asia Health Ethics Network (SEAHEN) project which was launched in 1997. Annex 1 provides brief background information about the project and full-text versions of the "WHO (SEARO) Health Ethics in South- and Southeast Asia" document series are available on the CR-ROM.

Annex 2 provides some useful hints that will help the user get the maximum benefit from the CD-ROM.

Flexible approach

The resource materials are not intended as a fixed set of modules. The facilitator may select any number and combination of learning scenarios to achieve an optimal combination for a particular target group and set of learning objectives. Examples of ethical dilemmas from the local setting can be added to the material. The teaching guidelines focus on certain interesting aspects that are illustrated in the learning scenarios. However, the resource materials may also inspire other discussions than those suggested in the teaching guidelines.

Learning scenarios can be presented directly from the CD-ROM, if computer and LCD-projector are available, or the PDF-files can be printed and handed out to students. Learning scenarios and guidelines can also be copied directly from this book.

It is hoped that these resource materials will serve to encourage and facilitate systematic as well as informal discussions on ethical issues among health staff and students alike.
TEACHING GUIDELINES

In this section, the teaching guidelines will help the facilitator select the learning scenarios that are suited to raise discussions about specific ethical issues. Specific guidelines are organized with reference to key issues under three different areas of health ethics.

Introduction to teaching guidelines
1. Use of the material in different teaching settings
2. The physician-patient relationship
   2.1 Patient autonomy
   2.2 Truth-telling in serious illness
   2.3 Informed consent
   2.4 Conflict and conflict-solving
3. Fairness and equity
   3.1 Choosing patients for treatment under resource constraints
   3.2 Considering the economic situation of patients and families
4. Specific health issues
   4.1 HIV/AIDS
   4.2 Mental illness
   4.3 End-of-life decisions
   4.4 Organ donation/transplant
   4.5 Medical termination of pregnancy
Introduction to Teaching Guidelines

The basic notion of these teaching guidelines is the notion of ethical dilemma. An ethical dilemma arises when different treatment options involve a conflict between ethical principles that the physician otherwise wishes to adhere to. Hence, an ethical dilemma is a dilemma between different ethical principles, which, under particular circumstances, are in conflict with each other. In this situation, the physician has to choose which value is more important.

An ethical dilemma of this nature cannot be resolved once and for all since every case involves different issues. Therefore, these guidelines are not intended to provide answers for any given situation. Rather, they are guidelines that should help the teacher/facilitator in pointing to such dilemmas and stimulate open discussion during teaching sessions and outside. Such discussions should help improve students' and physicians' ability to identify ethical dilemmas and to reflect on the values and principles that underlie their own and others' decision-making in clinical practice.

The scenarios included here are extracted directly from interviews held with physicians in teaching hospitals in the WHO South-East Asia Region. Some scenarios have been slightly modified to make them more suitable for teaching purposes. This method has been used to ensure maximum relevance for the teaching institutions of the SEA Region. It also provides a realistic and authentic understanding of the ethical dilemmas that face physicians in hospitals today.

The teaching materials have been organized according to a number of general areas and specific issues. Sometimes, a given scenario illustrates dilemmas involving numerous ethical principles at the same time, and the association between a given scenario and a particular ethical issue should be seen as indicative rather than exclusive. For a full overview of the scenarios, please see the learning scenario index (Annex 3). This way of organizing the resource materials should facilitate both class teaching and integrated teaching, where scenarios may be selected according to ethical dilemmas that emerge in the clinical setting. The facilitator may use the possibility of presenting the scenarios and related questions directly from the CD via a projector, or print the selected scenarios from the PDF-files for use with an overhead projector or as handouts to students. Teachers/facilitators are encouraged to try different types of learning processes in different situations, including role-plays.
Together, the scenarios presented here form a resource base for teaching health ethics in an urban hospital context. Scenarios should be selected according to the local learning needs. Factors to take into account when selecting cases include national legislation; institutional policies; religion; culture; available medical technologies and facilities; payment structures; and economical situation, among others. The selection of scenarios should preferably be done by a multidisciplinary group of faculty members.

While identifiers that link a particular scenario with a particular country have generally been removed for pedagogical and other reasons, some scenarios are specifically related to a particular (religious, legislative, etc.) context. It is hoped that physicians and students alike will reflect on all scenarios as potentially stemming from their own institution/country.
1. Use of the Material in Different Teaching Settings

The material on this CD constitutes a resource base, where scenarios can be selected and combined to serve a range of different teaching needs. It can be used in various teaching settings, and a few suggestions are outlined below for inspiration. Actual use of the resource materials should always be tailor-made according to local learning needs and available facilities and resources.

1.1. Teaching in the undergraduate medical school curriculum with no formal teaching in bioethics

Some medical schools have formal teaching in biomedical ethics, others do not. Even if there is no formal teaching programme, the material can be used to incorporate ethics training in the regular clinical teaching of medical school. One way to do this would be to expose students to the scenario material at appropriate times in the curriculum. Some of the learning scenarios take up issues related to specific diseases and could be used in conjunction with the regular teaching when these diseases are covered in the curriculum. Scenarios on general issues such as informed consent and patient autonomy could be covered when students are taught clinical examination.

1.2. Teaching in formal programmes in bioethics in the undergraduate medical school curriculum

If there is an established teaching programme, then one might consider using the material to complement existing teaching methods and materials, depending on the topics covered in the curriculum. Some teaching programmes have initial training in bioethics at the beginning of the medical school curriculum, where topics such as autonomy, informed consent and confidentiality are covered. Disease-specific topics are often covered in conjunction with clinical teaching, and issues such as equity could be covered in conjunction with teaching in public health. In such teaching programmes, it would probably be useful to have some lectures giving an overview of the topics to the students, and to provide some background readings. After such an introduction it would be useful for the students to work through some scenarios in groups, and then to present and discuss in a plenary session. Alternately, one could present some scenarios in a plenary session for general discussion.
1.3. Teaching in continuing education programmes

Such programmes could run for 3-5 days, or even longer. Given below is a sample programme for a 3-day workshop. If the workshop is extended to five days, one could introduce more sessions on special issues, as well as research ethics for the remaining two days. Following an introduction to key issues, selected scenarios can be used for group discussions. In the plenary sessions, it is important that the facilitator makes an attempt to show how the scenario material can help to structure the examination of similar scenarios in the future. The literature section on this CD-ROM provides some background materials for the participants in the workshops.

It is important to note that continuing education programmes also could be multi-disciplinary. Institutions that have organized clinical care in health teams would benefit from providing health ethics training to the entire team. Many of the scenarios provided deal with ethical dilemmas that are relevant to all members in such teams, including issues of information management, conflict management and equitable delivery of care.

Sample 3-day programme

**Day 1**
- 9:00 Introduction and welcome
- 9:30 Introduction to physician-patient relationship - autonomy and beneficence
- 10:00 Coffee and group work on autonomy
- 11:30 Plenary discussion
- 12:00 Lunch
- 13:30 Introduction to physician-patient relationship - informed consent/truth-telling
- 14:00 Tea and group work on informed consent
- 15:30 Plenary
- 16:00 Lecture: Approaches to bioethics
- 17:00 End of Day 1

**Day 2**
- 9:00 Lecture on cross-cultural bioethics
- 9:30 Introduction to confidentiality
10:00  Group work on confidentiality
11:30  Plenary discussion
12:00  Lunch
13:30  Introduction to professional conflicts
14:00  Group work on professional conflicts
15:30  Plenary
16:00  Lecture on research ethics, or another topic not covered through scenarios
17:00  End of Day 2

Day 3
9:00  Introduction to issues of justice and equity
9:30  Group work on equity
11:30  Plenary discussion
12:00  Lunch
13:30  Introduction to special topics to be selected based on interests of group
14:00  Group work on special topics
16:00  Evaluation of workshop
17:00  End of workshop
2. **The Physician-Patient Relationship**

Ethical dilemmas in the physician-patient relationship often involve the management of important information concerning the patient's diagnosis, prognosis and treatment options. There are underlying issues of patients' rights and physicians' obligations. Sometimes, the patient must rely upon the assistance of a third party, as in the case of a minor child and the parents, or a mentally ill person and the guardian. Sometimes, patients are not given information about their health status for other reasons, even if they are otherwise legally capable of autonomous decision-making.

One set of scenarios concerns patient autonomy, i.e., the patient's right to make certain kinds of decisions based on the information provided. Another set is about truth-telling in serious illness. Here, the role of the family is often important in determining the level of information to the patient. In the third set of scenarios this theme is further pursued under the heading of informed consent, i.e., information to the patient and prior approval from the patient of the treatment carried out. The issue here is on what basis decisions on sharing of information with the patient (or the patient's legal representative) are made. The final set of scenarios deals with conflicts and conflict-solving. Conflicts may involve physician, patient and relatives, but may also develop among physicians.

2.1 **Patient autonomy**

It has often been said that there has been a dramatic change of values from paternalism to autonomy in the physician-patient relationship. Traditionally, it was globally accepted that the physician knew best and should decide what should be done to patients, without informing them and without involving them in the decisions. Today, it is no longer valid that physicians make decisions without involving their patients and/or the patients' relatives. The principle of patient autonomy prescribes that he/she should be the one to ultimately decide what should be done in the clinical encounter. There are, however, limits to patient autonomy, and some of these are probably dependent on the specific cultural conditions in a country. The question to be discussed in this and the two subsequent sessions is how one should understand the principle of patient autonomy in the clinical setting, and in what circumstances can one legitimately override the patient's preferences.

A potential conflict between the principle of autonomy and other values often arises when a patient refuses a treatment the physician, or others, think
is beneficial for him/her. In this section the student will therefore be working with scenarios concerning the patient's right to refuse a treatment that is being offered. However, as will be discussed in connection with informed consent and truth-telling in serious illness, the family often plays a pivotal role. Sometimes, the patient is not informed and hence cannot exercise his/her autonomy, and sometimes the family and the patient simply do not agree in a particular situation.

**General learning objective**

Students are able to formulate the principles of autonomy and paternalism and can apply these principles to the discussion of actual clinical situations. They are able to formulate justifiable exceptions to the principle of autonomy.

**2.1.1 Life-saving treatment**

Sometimes a patient refuses a life-saving intervention in a critical situation. Under certain circumstances, the physician may decide to set aside the patient's decision. The scenario about the man who did not want his leg amputated but was operated to save his life illustrates this point. It also points to certain possible legal issues pertaining to the decision of the doctor to overrule the patient.

**Specific learning objective**

At the end of the session, students are able to clarify under what circumstances the physician should or should not respect the patient's right to autonomy in cases concerning life-saving interventions.

**2.1.2 Non-life-saving treatment**

Contrast the above situation with the scenario about the elderly woman who did not want surgery. Here, an elderly woman refuses to have a vulvectomy performed. The physician suspects malignancy and performs a biopsy, which confirms this condition. She considers the patient medically fit but does not inform the patient of the diagnosis. A case can be made that a more serious condition is likely to develop if the surgery is not performed at this stage. The physician and the relatives put considerable pressure on the patient, who finally accepts to undergo the operation. After discussion, students should
compare this situation with the scenario of the patient with a brain tumour. Here, the operation is not life-saving, but, in the physician's opinion, it may enhance the quality of life a little and increase the expected life span from six or nine months to 18 months. The patient is not a good surgical candidate, but the family can well afford the operation. The physician leaves the decision about the treatment to the family without informing the patient of his condition. During discussions, the students should describe on what basis a decision is made to set aside the patient's involvement in decision-making, given the nature of the disease and the intervention.

**Specific learning objective**

Students are able to understand the possible conflict between patient autonomy and the interests of the family in the two scenarios, including questions concerning inheritance.

**2.1.3 Patient autonomy versus family autonomy**

It has sometimes been argued, especially in Asian countries, that the family is the decision-making unit, and therefore the concept of patient autonomy should be replaced by a concept of family autonomy. While the family is certainly often very important in negotiations about health care, and while the patient is often depending on his/her social network for treatment and care, there are also some important difficulties if the concept of family autonomy is given more importance than the concern for the best interests of the patient, as is illustrated in the scenario about the pregnant woman with leprosy and her husband. The husband does not allow the physician to discuss the case with his colleagues and refuses to have his wife admitted to the hospital for treatment. The students should include in their discussions that the patient will depend on the support from the family after the consultation and/or treatment is completed.

**Specific learning objective**

Students understand and are able to describe the ethical dilemmas facing the physician in cases where there is an open conflict between the position of the family and the rights and interests of the patient.

**Learning scenarios**

The man who did not want his leg amputated

**Physician:** This was a 64-year-old man who had had a stroke which had affected his mental condition, though his awareness was good. He also suffered from diabetes mellitus and hypertension. One day gangrene was found on his leg with sepsis, high fever, and it was a progressive gangrene. I advised him and his family to have an amputation. The family agreed, but the patient did not. The family followed my reasoning, that is, I did not want the patient to die merely because of gangrene and diabetes. Then I suggested to the family that if the patient falls into a coma, I would have the right to undertake a professional intervention to save his life without having to obtain his approval. Once the patient went into coma, I asked the family to sign the informed consent for the amputation. The amputation was finally done.

When the patient became conscious, he was delighted because he felt that he had recovered. He was able to sit and became quite happy and felt that he still had his two legs. When he became completely conscious, and was about to descend from the bed and walk, he realized that he had been amputated. He was shocked. He flew into an extraordinary rage and threatened that he would prosecute me and his family. He was a former lawyer. He was aware of his rights and he had not permitted that his leg be amputated. The dilemma here was: first, we had to fulfil the principle of autonomy, and, second, we had to save a life. There were two aspects that quite contradicted each other. An extraordinary process of negotiation after the operation followed, and as the patient showed spiteful hatred against me, I had to delegate the care to others for the time being. When the negotiation was over, we finally came to terms. The patient survived and had the opportunity to witness a marriage in his family.

Consider this case. Is the doctor justified in awaiting the coma and then intervene with the family's consent?

The doctor states that the patient's mental condition had been affected due to the stroke. If that were not the case, would it make a difference?
Is it possible that the doctor sees the patient's mental capabilities as decreased because the patient opposes the amputation? If the patient's mental condition is affected so as to cause him to make irrational decisions, would the physician then need to await the coma before obtaining the family's consent?

Why do you think the patient may have wanted to oppose the life-saving amputation?

The elderly woman who did not want surgery

Physician: One patient was a doctor's mother who had a vulval dysplasia. There was a doubt of malignancy. So we did a biopsy that showed a carcinoma. This lady was not at all willing to undergo a second surgery. She said, "No, I just do not want to have the second surgery." She was over 70 years old. She said "I have no symptoms. There was a little growth, which you have already removed, so why should I have a second surgery?" She was medically fit so I wanted to convince her that the surgery would not harm her. But the patient was absolutely not willing. We all had a tough time – her husband, her daughter and myself. We continued putting pressure on her but it was a tough decision for her to accept that she needed a second surgery. At the same time we did not want to tell her that she had a cancer. I convinced her that she must get herself operated. If she had not agreed to the surgery, then she would have persisted with the disease and any day this could have become invasive. She would have landed up in more problems and with a more extensive surgery. Now it was only simple vulvectomy; later she would have required a radical vulvectomy.

Consider this case. Is the physician justified in putting pressure on the patient in this case until she finally accepts the surgical intervention? Why/why not?

Can the patient give informed consent to the operation when she is not informed of the diagnosis? Do you find the degree of involvement of the patient in the decision-making process ethically justifiable? Why/why not?

Under what circumstances should the physician accept the patient's right to refuse a treatment offered?
The patient with a brain tumour

**Physician:** There was a man aged 75 years who had a primary malignant tumour of the occipital lobe. The dilemma was whether to operate on him or just give him symptomatic treatment. Because I had explained to the family that even if we operated on him and then gave him chemotherapy and radiotherapy post-operatively, then most likely his life span would not extend beyond one- or one-and-a-half years, even after full treatment. On the other hand, if we left him without surgery and subjected him to supportive therapy, he might then survive for about 6-9 months. Now, really, I was quite confused whether to take a decision in favour of the surgery or to manage his condition conservatively, because he was not a very good surgical candidate. He was obese and hypertensive. I left the final decision to the family.

This physician leaves the decision concerning treatment to the family without giving a clear recommendation and without involving the patient. Discuss the ethical implications. Do you find this process agreeable? Why/why not?

The pregnant woman with leprosy and her husband

**Physician:** A 23-year-old pregnant lady comes with leprosy and erythema nodosum leprosum (ENL) reaction. This is a difficult problem to handle. The treatment of choice for this particular disease is thalidomide, which is a banned drug, which is not easy to get in this country. Only one pharmaceutical company is making it in the world. It is only given to male patients with ENL. This particular patient had a very severe form of erythema nodosum and my first choice would have been to treat her with thalidomide. This drug really controls this problem. But because she was pregnant, this drug cannot be used, or, for that matter, it is not supposed to be used for women of childbearing age. And this was her first child after six years of marriage. She was married when she was 16 and, because of her leprosy, she had not conceived. She was having problems with her in-laws. She had already got an ultrasound done and had found out that the child was a boy. So, the question of aborting the child did not arise at all. She developed this severe reaction during the pregnancy. The second drug which we have for ENL is corticosteroids. Again, this treatment is contraindicated in the first three months of pregnancy. And that made it more difficult because she was really in severe pain. So, we did give her corticosteroids because she was having
involvement of the nerve in a very severe form. She would probably have
developed motor deficit over the next couple of weeks, which would have
been a life-long stigma for her, so we did take the decision of giving her a
drug which may not be totally safe in pregnancy but because of the long-term
problems she might have faced if we had not given her corticosteroids, we did
take the conscious decision to give corticosteroids.

Identify the different important factors and concerns in this case. Who
should make the final decision on the treatment in a case like this?

**Physician:** This particular patient's husband was very emphatic and said 'no' to
his wife being seen by so many doctors. He didn't want many people to get
involved in this. Her husband was not very cooperative. When I said I wanted
to show this problem to my junior colleagues, he was very emphatic and said
he did not want a lot of people to come and see his wife. He also refused to
admit his wife. And managing this as an ambulatory case was very difficult
because sometimes they did not come back for follow-up. I did try to
convince the patient, or, more importantly, her husband. Women in our
environment do not have a major decision-making power. So, in this
particular case, I did try to emphasize to the husband that he should bring the
patient back to us so that we could look after both the mother and their child.
But he was more concerned about the child than the mother. The woman
was just a means to produce the progeny and, more so, they had apparently
got an ultrasound done and found out that it was male baby. I also believed
the elder brother of the husband did not have any issue. So the child
becomes a very important focus in this whole family. He was least bothered
about his wife; he was more concerned about the child because every time
he would ask 'Would it be alright for the child?' He was not bothered that his
wife was in severe agony.

Consider the husband's attitude in this case. How would you handle a
case like this?

Should the physician have attempted to manipulate the husband's
concern for the baby so as to facilitate the admission of his wife?
Why/why not?
2.2 Truth-telling in serious illness

In line with the change from paternalism to autonomy, there has been a general trend towards more openness in physician-patient communication. A few decades ago, in all countries, physicians usually did not inform patients about serious conditions such as cancer. Today, most would accept that there is a general obligation to be truthful to patients about their conditions, but there are important limitations to how much information it might be appropriate to convey to patients. For example, while many physician agree that a patient is entitled to know his/her own diagnosis, many also believe that a serious diagnosis such as certain types of cancer cannot be given to the patient without taking great care, or maybe not at all. Hence, the issue arises as to who should be informed of a serious diagnosis, how the information should be given, and what consequences this has for the subsequent treatment. In this section the student will be working with cases concerning giving of information about the diagnosis to patients and/or relatives in serious illness.

General learning objective

At the end of the session, students are able to identify conflicts of interest between the patient, the physician and the family in relation to diagnostic information, and to identify the values that guide the physician's management of the diagnostic information in serious illness in the learning scenarios provided in this section.

2.2.1 Truth-telling and hope

Serious illness can be tragic for the person(s) involved and it can be difficult for physicians to deal with, particularly when it comes as a surprise to the concerned people. In the scenario about the child with encephalitis, the parents are not informed of the prospect of a severely handicapped child if the boy survives. The physician has sympathy with the parents and fears that they may not be able to cope. In the scenario about the young woman who was not informed of advanced cancer, the physician does not want to make it clear to a 25-year-old mother of three children that she has cancer and is likely to die soon. On the contrary, the physician tempers the information with a little hope, even if he finds it hopeless. This may negatively affect the ability of the young mother to plan for her children in the event that she dies soon.

Specific learning objective
Students can assess whether the consideration for the concerned individuals who are not informed is justified. They should be able to take into account that lack of information may block the patients' planning of the future.

2.2.2 Truth-telling and compliance

In the scenario about the man who is not informed of a stomach cancer diagnosis, the physician considers the patient's ability to cope with the bad news. However, for this physician, the central issue is whether or not the patient can be expected to accept the treatment plan once the diagnosis is revealed. It may be considered ethically questionable to set aside the principle of informed consent to avoid compliance problems.

Specific learning objective

Students are able to identify and discuss the underlying principles of informed consent and patient autonomy, i.e. whether the patient has the right to know the diagnosis in order to be able to accept or reject the treatment plan. The only effective way for the doctor to find out may be to tell the diagnosis to the patient.

2.2.3 Truth-telling and rejection of treatment

In contrast, in the scenario about the child with leukaemia who was not treated, a father is informed of the high expenses of the treatment as well as the poor prognosis for his 8-year-old son. Based on this information from the physician, the father decides to leave his child untreated, as he recognizes that he will not live for long no matter what he does. Also, in the scenario about the child with hydrocephalus, the parents decide not to have their infant operated. However, this decision is based on the information that he is likely to survive an operation and grow up as a handicapped person.

Specific learning objective

Students identify similarities and differences between these two cases, then between all five cases under this key issue. In particular, they should be able to decide whether the way information is given by the physician is in the best interest of the patient and/or the family.

2.2.4 Truth-telling in case of wrong diagnosis
In the suspected appendicitis case with pelvic inflammatory disease, the patient was wrongly diagnosed with appendicitis, for which operation she had given informed consent. She did not, however, have appendicitis, but was diagnosed with and subsequently cured for pelvic inflammatory disease (PID) in connection with the operation. Afterwards, she is neither informed about PID nor about the fact that she did not have appendicitis. The physician states that the patient has the right to know the diagnosis. The students should discuss why they believe the physician conceals the truth in this case, whether they believe this is justified, and what may be the future health consequences for the patient.

**Specific learning objective**

Students can critically differentiate between relevant and irrelevant criteria for limiting the patient’s right to informed consent.


**Learning scenarios**

The child with encephalitis

**Physician:** This case was a boy aged two years whom I admitted. His previous growth was good. He had been able to walk and talk. His teeth grew well. However, all of a sudden he had an infection with symptoms of high body temperature followed by seizures. The seizures lasted rather long and he had to be treated at the hospital, where the child had very high body temperature and went into coma. In fact, there was a disorder in liquor spinalis. Thus, the working diagnosis by laboratory at that time was encephalitis. The patient’s parents were highly educated. At a meeting with us, the father asked whether his child would be able to recover or not. As a physician, of course we should make efforts, be optimistic and hope that the child would recover. However, he pursued us with the question of whether his child would be able to walk again as before. That’s where the dilemma lied, because the diagnosis was encephalitis. While this child could possibly be saved, statistically, in most cases a sequel would occur. It meant that there would be a mental and motoric disorder. That was my dilemma, whether I should let the father know the truth and inform that the child could be saved but they should be
prepared that he may not be able to walk any more. He could have paralysis
along with possible mental disorder and retardation.

Think about this case and identify the pros and cons of providing full
information concerning the prognosis of the child.

Given the direct question of the father, is the physician justified to hold
back the information?

**Physician:** I did not tell him the prognosis that I knew and believed.
However, I did not cover it up either. So, I said that the child might survive
with the treatment and care we provided. Nevertheless, because it involved
the nerves and the brain, there might be some resistant symptoms. We did
not say that the child would not be able to walk and see and might have a
mental disorder. At that time, I did not have the heart to inform them in
detail, although in my conscience, I felt that I should let the parents know
about it. Perhaps it was not the right time.

**Interviewer:** So, in providing the explanation which included the prognosis,
you decided to give only limited information.

**Physician:** That's right. I tried to infuse some optimism. However, in the
dilemma that I faced, I also felt some pessimism in the resistant symptoms,
even though the child might survive.

The physician provides technical information to the parents that they
may not fully understand, thereby infusing optimism without violating
his obligation to inform. In general, how do you see the physician's
obligation to ensure that the patient and/or relatives understand the
information given in connection with informed consent?

While the prognosis is surely a difficult message to give to the parents,
do you think that it helps the parents in any way that they are not
informed? Would it help them in any way if they were informed? Would
it help the physician in terms of the treatment plan? Would it help the
patient?

The young woman who was not informed of advanced cancer

**Physician:** Well, there is currently a patient with very advanced cancer which
is very difficult to manage and we hardly have anything to offer. But she does
not understand. So, it is very difficult to tell her the actual situation that we
are at the end of the tether and that surgical treatment is at best uncertain.
She has a neurofibrosarcoma in the perisacral region and surgery in this particular patient involves removal of the whole section. And that might leave her with some neurological problem.

**Interviewer:** Did you tell her that she is suffering from cancer?

**Physician:** Yes, she has been told that she has cancer but it was tempered with a little hope that surgery might cure her. But this was not absolutely true, and at best it was uncertain. We used the word tumour, but by implication it was made clear to her that she has some serious disease. I am thinking of surgery but chances are that I may not be able to carry out a curative resection because of her advanced disease. She is given preoperative radiotherapy but it will not help her much. So, she is a big problem for me.

In this case the physician finds it very difficult to convey a very bad prognosis to the patient. Discuss the ethical implications in telling and not telling the patient of the diagnosis in this case.

**Physician:** It is very difficult for me as a clinician to tell her that we cannot offer her anything. That leaves her in a state of desperate despair, which cannot be avoided. She is a young lady of 25 years with three children, who are very young, and every time I go to her she talks about her children. That is a very heart-rending situation for a clinician to face.

Do you think that the fact that this is a young mother with three children makes a difference for her need to know the prognosis?

Do you think that the tragic circumstances makes it more difficult for the physician to tell the prognosis, even if it might enable the mother to plan for the future of her children?

The man who is not informed of a stomach cancer diagnosis

**Physician:** I have a 35-year-old stomach cancer case but I did not tell him he had cancer. Although every patient should know about the nature of his disease and the possible prognosis, I did not explain that he had cancer due to the psychological stress it would cause him. He is young, has been admitted for two weeks, and his prognosis is very poor. He has the signs and symptoms of gastric outlet obstruction. We diagnosed the disease and are planning to operate on him.

**Interviewer:** Would you kindly tell me the mental state of the patient?
Physician: Yes, he is assumed to be depressed.

Is the physician justified in not informing the patient of the diagnosis if the primary motivation is to ensure the patient's acceptance of the treatment?

Physician: I have not told the diagnosis to the patient, but I have told his family. Although every patient should know about the nature of his disease and possible prognosis... but because of the psychological stress it might cause, and because he might not agree with our treatment, we did not tell. In the past, some people have refused our treatment after knowing that their disease was very serious.

Interviewer: So, you think that telling the diagnosis depends on how they would accept their condition?

Physician: Yes, it depends on how the patients accept the diagnosis, how much they understand and how much they accept the treatment. It depends on their general knowledge and educational status. The patient must know the actual situation about his disease; I should tell about his disease and its prognosis and probable outcome. Although the patient was suffering from cancer, we did not tell him about the disease, because we were afraid that his mental state would be weakened and also he would not follow the treatment plan if he knew about his disease. Yes, the patient has the right to know his diagnosis, but we did not tell it in this case, and thus the ethical issue arose.

Think about this case. Is the physician justified in sparing the patient for the psychological distress of knowing the diagnosis?

The child with leukaemia who was not treated

Physician: One patient was a boy of about eight years of age who presented with very severe haemorrhagic manifestations and the diagnosis was confirmed to be leukaemia. And not a very good prognosis either. The father was a driver. I told him that it was leukaemia, blood cancer, and probably even if he provided treatment, the child may not survive more than a few years. I also told him the cost involved. It all now depended on him. The father was very frank. He told me that in that case he would not get his boy treated and took him home.

In this case, do you agree with the physician's decision to inform the father of the prognosis and the treatment options and costs?
Physician: I think basically whether to treat or not to treat... you tell the facts to the parent. And, in spite of that, if the parent wants to treat the patient after you have described the prognosis and cost of the treatment, I think you have to provide the treatment.

Interviewer: You said that the father did not want to get his child treated because of the poor prognosis and because of financial problems. Do you see any problem in the clinical setting in this connection?

Physician: I think if you have got a very good clinical unit, which will treat and follow up these patients, and if the government can cover the cost, in that situation I would tell the father that "yes, these things are available here, and now we are going to treat this patient. Let's hope that he will get better, but let us see what will happen".

This doctor reflects on the significance of the health system's resources available for treating the child. He also informs the father of the child's disease. Do you think that the availability of free treatment should influence the information given to parents in such cases, and why/why not?

Compare this case with that of the child with encephalitis. Why do you think the physicians in these two cases took opposite positions on truth-telling?

The child with hydrocephalus

Physician: Recently, a parent came with a small child who was about three months old with a suspected enlarged head. And one possible diagnosis was hydrocephalus. The patient had a CT scan done and it showed a huge hydrocephalus. The parents asked me about the treatment plan. I knew that the condition was not good, and the child would not survive; even if it survived the parents would have difficulty in the follow-up. The prognosis for the child was very bad. I explained the disease pattern to the father. If the child underwent an operation, the prognosis was not good and the child would not have normal development. The child might have complications after the operation. I explained everything to the father. The father asked me "what would you do in this case if it was your child?" I told him frankly that "if it were my child, with my experience and what I have learned from medical science, probably I would not go for the operation."
Think about this case. Do you think the physician was justified in advising against treating the child, given that he considered the prognosis after potential surgery to be bad?

Physician: I could have told the father to go to the neurosurgeon and let the neurosurgeon decide everything concerning the child's condition and what can be done. And tell the father that I will not cure this patient because this is a surgical condition. So, the first option was not to tell anything to the father and ask him to go to the surgeon. That was the first option.

Interviewer: Was it a difficult case for you?

Physician: It was a difficult case in the sense that it was a medically untreatable condition. It was surgically correctable, but even with surgery, the prognosis and the future neurological sequel the child might have in the adolescent period would have been a burden to the family and the child may not have had a good follow-up.

Do you find that the physician in this case had sufficient information to inform the patient and/or relatives at the time?

How do you view the physician's decision not to involve a neurosurgeon before informing the parents in this case?

How do you view the physician's inclusion as a criterion for the decision that the patient will be a burden for the family if he survives after an operation? Is it a legitimate concern on the part of the physician?

The suspected appendicitis case with pelvic inflammatory disease

Physician: This case was a 30-year-old married woman who was admitted in our ward for pain in right iliac fossa (RIF). Although we asked her about any gynaecological problems, she could not precisely explain the cause. But the clinical signs and symptoms pointed towards acute appendicitis. So we decided to do appendectomy. We took her consent for appendectomy before the operation. We started the operation by giving "gridiron" incision, which is a routine incision for appendectomy. However, we found that the appendix was normal, but the tubes were inflamed (salpingitis). There was also pus in the pelvic cavity, i.e. salpingitis with pelvic abscess. We drained the pelvic abscess through the appendectomy incision and gave peritoneal toilet. We also did appendectomy. The postoperative outcome was good. The patient
was discharged from hospital after the stitches were removed after a 7-day postoperative period. But we did not tell the actual diagnosis, i.e. pelvic inflammatory disease, to the patient. We also did not tell that the case was of pelvic abscess. From the beginning we told the patient that the appendix was inflamed. But we did not tell her that the appendix was normal, and also did not tell her what we had done. The ethical issue had arisen because although the patient was cured and discharged from the hospital, she should have known the actual diagnosis.

Think about this case for a moment. Try to identify all ethical issues that are involved. Describe the values that you think are in conflict.

**Physician:** Although the appendix was normal, the original incision was "gridiron" incision which was standard for appendectomy. So, if the appendix was not removed and if the patient had gone to another hospital or if the records about her first operation were lost, by looking at the "gridiron" incision, the doctors would conclude that the patient had undergone appendectomy and thus the diagnosis could be wrong. So, although the appendix was normal, we still did the appendectomy.

The physician does not inform that the patient did not have appendicitis and that he had reason to carry out the appendectomy anyway. Do you think that the physician was justified in this decision? Or should he have explained the possible consequences had he not performed the appendectomy?

**Interviewer:** You told the patient that the case was of appendicitis at the very beginning, but you did not tell the patient that the actual diagnosis was pus in the pelvic cavity?

**Physician:** That is correct, I did not tell about that.

**Interviewer:** Do you think that the patient has the right to know the actual diagnosis?

**Physician:** Yes.

**Interviewer:** You did not tell the patient about the actual diagnosis; how do you feel about that?

**Physician:** I think I should have told the actual diagnosis. The patient lost the right to know the diagnosis.
The physician knows that he contradicts himself here. He states that it is the patient's right to know the diagnosis, yet he does not inform the patient. Why do you believe he did not inform the patient?

Pelvic inflammatory disease may be caused by a sexually transmitted disease such as Chlamydia. The physician does not discuss this aspect of the case. What ethical issues does this raise? Is the physician justified in not informing the patient of the actual diagnosis?

2.3 Informed consent

The principles that patients should be given information about their condition and should be involved in decision-making are joined in the principle of informed consent. The basic concept implies that patients are provided information that enables them to take an informed decision. In the context of widespread poverty and lack of education among big population groups, and with scarce resources available for health care, providing information on the medical status and best treatment from a purely medical perspective may not necessarily empower the patient to decide on a given treatment option. Exceptions to the principle of informed consent also occur with regard to persons with impaired or diminished autonomy, such as children or seriously incapacitated mentally ill persons, who are usually represented by a third party, such as parents or other close relatives, vis-à-vis the physician. However, it is sometimes argued that in some countries the family rather than the patient should be seen as the main counterpart to be informed by the physician.

General learning objective

Students are able to identify and critically assess the reasons for giving or not giving information to a patient concerning his/her health status, medical interventions and likely treatment outcome. They understand what consequences may follow from these decisions. Specifically, students should be able to determine whether it is justifiable to deny a person information because of his/her educational or socioeconomic level, or in order to ensure compliance.

2.3.1 Informed consent denied due to educational level

In this group of cases the physician decides not to give important information concerning diagnosis or prognosis to the patient and/or relatives for a number of reasons. The issue is, whether these reasons justify setting aside the patient's right to informed consent. In the scenario about the child with Non-Hodgkin's Lymphoma, the students should discuss the implications involved in denying
this right to poorly educated patients/relatives. The scenario also illustrates that it may be difficult for the physician to tell the patient that the optimal treatment option is not available.

**Specific learning objective**

Students are able to identify relevant criteria for limiting the patient's right to informed consent, and refuse irrelevant criteria pertaining to the patient's social status.

2.3.2 Informed consent denied to ensure compliance

In the scenario about the child with Down syndrome, leukaemia and chemotherapy, the mother is not informed of the poor prognosis of the child because it is believed that if told she would not pay for a very expensive treatment, which is jeopardizing the economic situation of the family. In the case of the patient who had a tubal ligation performed during a caesarean section without informed consent from either herself or her husband, the physician assumes that the husband would not consent to the operation and therefore does not ask him.

**Specific learning objective**

Students understand the basic principles of informed consent and can establish under what special circumstances it could be justified to set aside these principles for the sake of the treatment.

2.3.3 Informed consent for a procedure different than the one carried out

In the suspected appendicitis case with pelvic inflammatory disease, the patient was wrongly diagnosed with appendicitis, for which she had given informed consent for an operation. She did not, however, have appendicitis, but was diagnosed with and subsequently cured for pelvic inflammatory disease in connection with the operation. Afterwards, she is not informed about this unexpected result. However, the physician does not explicitly state the reason for this but states that the patient has the right to know the diagnosis. The students should discuss why they believe the physician does not inform the patient of the diagnosis and the treatment.

**Specific learning objective**

Students are able to identify relevant criteria for limiting the patient's right to informed consent, and refute irrelevant criteria.

Learning scenarios

The child with non-Hodgkin's lymphoma

**Physician:** A 5-year-old boy who came from a district 80 miles north of the city is presently admitted in our ward. He was quite ill when he came to the hospital. We investigated the case and it turned out to be a case of non-Hodgkin's lymphoma (NHL). When he got the diagnosis, we routinely referred him to the oncologist concerned. The oncologist advised a treatment regime and we gave the treatment to the boy in the ward. We sent the patient to the oncologist for follow-up and the treatment was changed. Here, what bothers me is that... we did what we could for the child. As for the parents, they came to this hospital as it is a big hospital and they had faith in us. They asked us about the condition of the child. We replied that the child was ill, but we would try our best, that is what we told them.

What procedures for obtaining informed consent would you consider in connection with the child's treatment?

Would you have any special concerns when discussing the diagnosis, the prognosis and the treatment with the parents?

**Physician:** But we did not tell anything to the patient's parents about the treatment being given. We have not explained. The reason that we did not inform them about the treatment was that they were peasants from the country and would not understand what we were saying.

How do you view the physician's decision not to inform the parents of the treatment?

**Physician:** I feel uncomfortable with the treatment given to the patient. What I had read and what I know is that for NHL, depending on the cell types, there are at least four types of treatment available. Frankly, those are trial drugs. The National Cancer Institute of Britain has also another regime. With that regime there are favourable five-year survival rates and mortality rates. Most of the latest regimes have 80-85% five-year survival rates. Nearly all of them have more than 70% five-year survival rates. In spite of that, for the
children with this disease in our country, we do not give those regimes. We do not give these standard drugs. We have to give the drugs that are available. By available drugs I mean what the oncologist supplies free. Mostly, injections of Oncovin, Dexamethasone, and Endoxan are available and are given. That's all.

Do you think that the physician's inability to offer the best drugs to the child influences his decision not to discuss treatment options with the family?

Which factor do you see as more important as a barrier to full informed consent - the educational status of the parents or the physician not being comfortable with the treatment he can offer?

Interviewer: What did you tell the parents?

Physician: That's what made me unhappy. Do we hold back the information? What I have heard is that in Western countries physicians explain to the patients beforehand, what treatment they are going to give, and what are the possible outcomes and untoward side-effects. Here, we do not do anything like that. The patients and their families have great expectations from us. Is it fair that we do not tell them anything? We do our best, but we also foresee the outcome of the treatment. We know that in most of such cases the patients are not going to be all right. I feel sorry for that.

Do you think that the parents in this case should have the option to say no to a treatment with known serious side-effects if it is expected not to be very helpful for their child?

The physician makes a judgment that the family members would not be able to understand the relevant information concerning the treatment even if he had attempted to tell them. How do you see the concept of informed consent for patients with limited or no education?

Down syndrome, leukaemia and chemotherapy

Physician: It is a girl with Down syndrome and leukaemia. I told the mother about leukaemia in layman's terms, but I think she did not understand the actual consequence of the disease. She is still hoping for the survival of the child, and she wants us to give chemotherapy. The girl has had this disease for a long time, and now she has secondaries. There is infiltration into the skin.
The condition has deteriorated and she is in the last stage of leukaemia. She came from the countryside and the father was left behind. If I explain to the mother that the child was at the last stage, it is our culture that they would go back home, so that the child would have a reunion with the rest of the family members.

**Interviewer:** What did you do in this case?

**Physician:** I gave chemotherapy and did some investigations. In spite of that, the condition of the child deteriorated. The mother understood the Down syndrome, and I told her that the child had leukaemia. However, she did not know the prognosis of leukaemia. I did not tell her that the patient was at the late stage and the prognosis was bad.

What is the physician's justification for not telling the mother about the prognosis of the child's disease and how do you view this?

**Physician:** If I told the mother the actual situation, she would go back to the village. She would not take the chemotherapy. In addition, she would not take the treatment for infections. The child would die soon with septicaemia. Otherwise, the mother would stay here and continue taking the treatment, hoping... In that case, the child would get treatment for leukaemia as well as the infection. As the girl has leukaemia, she would have to suffer a lot during her last days because of the invasive investigations. And it would cost the family a lot. Just one dose of chemotherapy is expensive. Some patients may have remission, but it is short. The cost of treatment will be so high that when they go back they will have no home to return to because they would have sold the house to get the money for the treatment.

**Interviewer:** What is your decision now? Are you going to tell or not?

**Physician:** I have not told yet.

**Interviewer:** What options do you have?

**Physician:** I have no options; I did not tell the mother about the prognosis. She is still here and the child is taking the treatment.

Think about this case and summarize the factors you consider to be involved in the physician's decision not to inform the mother.

How do you view the physician's statement that he has no options?
The case of tubal ligation

**Physician:** Well, I had to face a difficult case today in the hospital. I examined a patient who was in a very bad shape. It was a case of full-term pregnancy with eclampsia. She had a history of high blood pressure. She had delivered three children before and only one was alive. This time also her blood pressure was very high and I had to do a caesarean section.

What procedures for informed consent would you consider before the operation?

**Physician:** After performing the caesarean section, I had to perform a tubal ligation. And, I think, it was a case which might raise an ethical issue, because I was unable to seek the permission of the father of the child. The main reason why we did not take the consent of the father was that I was sure that he would not give his permission for tubal ligation.

How do you see the central ethical dilemma in this case?

Try to formulate the principle that the physician applies when she decides not to seek informed consent from the husband.

**Physician:** They would say that they had only one issue previously and they would like to have more children. That is ignorance, I would say. It is the most important factor here, the ignorance and illiteracy of the people.

**Interviewer:** Did you tell the patient after the operation?

**Physician:** No, I did not.

**Interviewer:** Do you think that the decision made was the right thing to do?

**Physician:** I am more than sure that I did the right thing.

The physician discards the family's wish to have more children as an expression of 'ignorance' and 'illiteracy'. Try to formulate the underlying principle and discuss its implications.

The physician took three important decisions: 1) to proceed with the tubal ligation without the prior knowledge of the patient; 2) to deliberately not seek informed consent from her husband before the
operation was carried out; and 3) to not inform the patient afterwards. Why do you believe the physician decided as she did?

Try to formulate the ethical implications of these decisions. Consider alternative choices and their possible consequences.

The suspected appendicitis case with pelvic inflammatory disease

Physician: This case was a 30-year-old married woman who was admitted in our ward for pain in right iliac fossa (RIF). Although we asked her about any gynaecological problems, she could not precisely explain the cause. But the clinical signs and symptoms pointed towards acute appendicitis. So we decided to do appendectomy. We took her consent for appendectomy before the operation. We started the operation by giving “gridiron” incision, which is a routine incision for appendectomy. However, we found that the appendix was normal, but the tubes were inflamed (salpingitis). There was also pus in the pelvic cavity, i.e. salpingitis with pelvic abscess. We drained the pelvic abscess through the appendectomy incision and gave peritoneal toilet. We also did appendectomy. The postoperative outcome was good. The patient was discharged from hospital after the stitches were removed seven days after the operation. But we did not tell the actual diagnosis, i.e. pelvic inflammatory disease, to the patient. We also did not tell that the case was of pelvic abscess. From the beginning we told the patient that the appendix was inflamed. But we did not tell her that the appendix was normal, and also did not tell her what we had done. The ethical issue had arisen because although the patient was cured and discharged from the hospital, she should have known the actual diagnosis.

Think about this case for a moment. Try to identify all ethical issues that are involved. Describe the values that you think are in conflict.

Physician: Although the appendix was normal, the original incision was “gridiron” incision which was standard for appendectomy. So, if the appendix was not removed and if the patient had gone to another hospital or if the records about her first operation were lost, by looking at the “gridiron” incision, the doctors would conclude that the patient had undergone appendectomy and thus the diagnosis could be wrong. So, although the appendix was normal, we still did the appendectomy.
The physician does not inform that the patient did not have appendicitis and that he had reason to carry out the appendectomy anyway. Do you think that the physician was justified in this decision? Or should he have explained the possible consequences had he not performed the appendectomy?

**Interviewer:** You told the patient that the case was of appendicitis at the very beginning, but you did not tell the patient that the actual diagnosis was pus in the pelvic cavity?

**Physician:** That is correct, I did not tell about that.

**Interviewer:** Do you think that the patient has the right to know the actual diagnosis?

**Physician:** Yes.

**Interviewer:** You did not tell the patient about the actual diagnosis; how do you feel about that?

**Physician:** I think I should have told the actual diagnosis. The patient lost the right to know the diagnosis.

The physician knows that he contradicts himself here. He states that it is the patient's right to know the diagnosis, yet he does not inform the patient. Why do you believe he did not inform the patient?

Pelvic inflammatory disease may be caused by a sexually transmitted disease such as Chlamydia. The physician does not discuss this aspect of the case. What ethical issues does this raise? Is the physician justified in not informing the patient of the actual diagnosis?

### 2.4 Conflict management

In this section, the student will work through a number of learning scenarios dealing with conflict and conflict-solving. The focus is not primarily on medico-legal issues, though some conflicts eventually become court cases. The issue here is how a physician deals with conflicts between a colleague and a patient in which the physician becomes a party, or conflicts between the physician him/herself and the patient. This type of conflict is an everyday occurrence in medical practice, and the nature of the conflicts differs considerably. Given below are given some examples which reflect a basic
dilemma for the concerned physician between safeguarding the interests of self or a colleague versus the best interests of the patient.

**General learning objective**

At the end of the session, students are able to identify the interests involved in a given learning scenario. They are able to assess the pros and cons of the management strategy adopted in handling a given conflict as presented in the scenarios. They can identify and understand the underlying ethical principles. They should generally be able to identify alternatives to the conflict-solving processes that are outlined in the learning scenarios.

2.4.1 **Conflict over referral of patient**

In the learning scenario about the infant who was not referred for proper treatment, the physician indicates that referral did not take place due to personal animosities among the concerned doctors. Furthermore, referral is firstly made to own private clinic indicating vested interests. Hospital referral is made too late, and the infant dies.

**Specific learning objective**

Students understand the factors involved and can decide whether the physician who came to know about this case had any responsibility to subsequently interfere, and, if so, how, and what would be the likely consequences.

2.4.2 **'Doctor-shopping'**

If patients, on their own initiative, go from one doctor to another with a given ailment, it is sometimes called 'doctor-shopping'. While doctor-shopping may be unpopular among physicians, it also places the physician in an ethical dilemma because it may not be realized from the outset that the patient has been seen by a colleague. In such cases, the physician has to decide whether to continue treatment or send the patient back to the previous physician. From the patient's perspective, he/she gets a second opinion of his/her disease that may sometimes be important, as in the case of 'doctor-shopping' that resulted in the discovery of a malignant tumour. Compare with the learning scenario about correcting a colleague's excessive medication of a patient and discuss the ethical aspects of excessive and/or insufficient medication.
Discussions should differentiate between a) conflicts among physician in the same department/hospital, and b) conflicts related to the public-private interface. Through role-plays, students should also learn to position themselves in the place of a patient who suspects that he/she has not received optimal treatment in a given situation.

**Specific learning objective**

Students can identify appropriate responses in a situation where a physician realizes that a patient has been seen by a colleague, especially in cases where there is a difference of opinion on the diagnosis or treatment.

### 2.4.3 Adverse events in medical treatment

The occurrence of adverse events and medical errors in medical practice is not always in itself an ethical issue, but the way such errors are subsequently managed may involve ethical issues. In the case of post-surgery complications involving fear of litigation, the physician sees it as his responsibility to take care of the follow-up. He also indicates that it is difficult for him to provide free treatment since in case the patient sues him this would indicate acceptance of guilt. The scenario is further complicated by the involvement of a substitute physician in the treatment. Contrast this with the learning scenario about the baby who had a lumbar puncture and died, and discuss whether this is merely an example of a case that went wrong, or whether there are ethical issues involved.

**Specific learning objective**

The objective for the students is to be able to identify the physician's and the patient's perspectives respectively and assess the ethical and legal implications of the conflicts. Students should be able to identify alternative management procedures and explain their implications for patients and physicians respectively.

### 2.4.4 Serious allegations against a colleague

Sometimes, a physician comes across an instance of a colleague's obviously unethical conduct, as in the learning scenario about covering for a physician who tried to extract money from the patient. Here, the students should discuss the course of action taken by the various people involved and consider the
importance of family ties in this kind of conflict – and, by implication, what would be the likely outcome if the patient had not had close relatives within the health care sector. Contrast this to the scenario about the psychiatric case involving allegations of sexual misconduct. Here, what at first may seem to be a case of ‘doctor-shopping’ turns out to involve serious allegations that a colleague may have sexually abused a female patient. The scenario is further complicated by the fact that it is a mentally ill patient. Students should compare the line of action in the two scenarios and discuss the similarities and differences.

**Specific learning objective**

Students, at the end of the session, are able to suggest what course of action the physician should take vis-à-vis a colleague in a case like this. Students also learn to consider the implications if allegations of sexual abuse of mentally ill patients are systematically ignored due to the possibility that the patient could have made up the allegations as a consequence of the illness.

**2.4.5 Allopathic and alternative medicine**

In most societies different systems of medicine and treatment exist; this is known as medical pluralism. Patients often shift form one system to another, or use several systems simultaneously. This issue is illustrated in the learning scenario about the man who preferred the traditional healer's treatment. Students should identify and discuss the ethical implications of different approaches to medical pluralism.

**Specific learning objective**

Students are able to suggest how physicians should deal with the co-existence of different systems of medicine.

There is little literature on this issue from the SEA Region. You may consult the WHO (SEARO) Health Ethics in South- and Southeast Asia document series, Volume 3, pp. 108-120, as well as the respective ethical guidelines of the concerned professional bodies.

**Learning scenarios**

The infant who was not referred for proper treatment
Physician: One of the neonatal cases came from a district hospital in the suburb of the city. The obstetrician and the paediatrician there did not have a good relationship. The baby was a forceps delivery, and it had birth injury resulting in haematoma of the head, which is a precipitating factor for neonatal jaundice. We should look for jaundice from day 1. There was a history of exchange transfusion in a previous child. The history of exchange transfusion was not taken. It was blood group "O". Thus, the birth injury, haematoma of the head, blood group "O" and history of exchange transfusion in the sibling, all suggested monitoring neonatal jaundice in the newborn baby. In spite of that, the obstetrician did not consult the paediatrician in the same hospital. She looked after the baby by herself. At last, the baby had intense yellow coloration (of the skin). In spite of that, she did not refer the baby to us. She sent the mother to consult a paediatrician who was practicing privately in that district. When the baby finally arrived here on day 5, he had impending kernicterus. However, in spite of our efforts to save the child with exchange transfusion, the condition deteriorated and the baby died after two hours of exchange transfusion.

Summarize the important factors in this case and list ethical issues involved.

Given the circumstances, do you find that this physician has an ethical obligation to take action to address the fatal lack of collaboration between the obstetrician and the paediatrician? Why/why not? What would you do in a similar situation?

The case of 'doctor-shopping' that resulted in discovery of a malignant tumour

Physician: Sometimes, patients who are being seen by another consultant, would like to come over and seek your opinion as well. I want to discourage 'doctor-shopping' by all means. But if the patient is in trouble, or in case they really push me hard, then I have to give in, but this is against the ethics. I am not very sure whether it is good or bad for the patient. Like yesterday, there was a 36-year-old lady who was seen by another doctor in the last eight months. But the patient was not feeling better. She had pain in her back and the doctor had tried all kinds of pain killers. She came over to me and said she really wanted to see me because she was not getting any better. Initially, I said no, but she insisted, and I relented. I told the other physician that I was going to see her. It turned out that her X-ray showed a secondary deposit in the L-3 vertebra, which was a cancer, just perhaps missed being detected.
The diagnosis has still to be confirmed. Looking at the chances of having a secondary, if it has arrived in the bone, we also have to look for a primary. And in case from a primary site there is a secondary deposit in the bone, then the prognosis is not very good.

Describe the ethical dilemma in this case. Discuss how you think physicians should deal with the phenomenon of 'doctor-shopping' in the context of a busy hospital department.

**Physician:** So, in a way, it might do some good. But not in all cases, because most people simply go from one doctor to another. There are a number of people who press you very hard to see them. Of course, I would like to see the patients on the same day but we have other commitments. If you are the senior person in the department, people like to consult you.

I do not think that we should try to encroach upon other doctors' patients. This is as per the rules. The way I tried to resolve this problem was to go to the consultant concerned and tell him that this was a patient who had been coaxing me to see her. Did he have anything against my seeing her? I think an open dialogue with the concerned physician is better to resolve this problem.

Patients should have a choice whom to see, where to see and when to change the doctor. At the same time, the doctor also has a responsibility. In case the patient is not feeling better with the treatment offered, one should definitely go to another person and seek a second opinion. I very frequently do so. Even with one of my juniors I seek a second opinion.

Look at the wording used in the first two paragraphs and compare with the third paragraph. Why do you think that the physician uses words like 'press you very hard', 'encroach' and 'coaxing' at first, and then talk about 'patients should have a choice' and 'second opinion' later? Identify the ethical values underlying the use of these words in this context.

What, according to you, should a patient do if he or she feels that the treatment is not helpful and the physician does not - for whatever reason - make a renewed effort to address the problem?

Correcting a colleague's excessive medication of a patient

**Physician:** Sometimes you see patients who have been seen by other doctors. And they come with the prescriptions. Sometimes a prescription which has
been given to the patient contains many drugs, which may not be needed. A mother came with her child who had been prescribed a lot of unnecessary drugs. Now, the question arises: Should I tell the mother that "Don't give the medicines, it will harm your child", because if you tell that, then your personal relationship with your colleague might be strained. But you know that so many drugs are not good for the child and therefore should not be used. It is a difficult situation. I told the mother that "probably these medicines were prescribed when your physician saw the child for the first time. But I don't think these medicines should be taken any more. So you can stop all these medicines and give only these drugs."

Discuss the problem of excessive, unnecessary and potentially harmful overprescription of drugs. Identify factors that may contribute to this problem. List all the ethical issues involved and discuss how the individual physician should deal with the problem.

Is the physician correct in protecting his colleague in this way? Discuss the conflict of professional ethics versus the obligation to serve the patient's interests in cases like this.

The case of post-surgery complications involving fear of litigation

Physician: This was a case of usual spontaneous partus involving a substitute physician. However, a complication occurred in the process and the episiotomy wound did not recover. It was suspected that there was a cyst. It had not recovered in two months and the patient began to complain. We were involved in it and were probably responsible for that. There were some problems to be dealt with, but we also wanted to make sure that this patient would not sue us for the intervention done.

Think about this case. What would you do in this situation?

Do you think that there is a basis for the physician's fear of litigation? Why/why not?

If a mistake has been committed that justifies that the patient sues the physician in this case, how should the physician deal with it?
Physician: Secondly, the patient had to bear the expenses for the subsequent operation. How should we deal with it? As for me personally, probably I would not impose any fee because I saw it as my responsibility. However, there were some other fees that the patient should pay anyway. It was a dilemma to me.

If a mistake has been committed, covering the patient's expenses may be seen as admitting responsibility which could later be used in connection with a lawsuit. However, if a mistake has been committed it would be reasonable to cover the patient's expenses. Not doing so may be seen as a legitimate reason for her to sue the physician. How would you deal with the financial aspects of this case?

Physician: Third, another problem to me is that we should agree with the substitute physician. I did not want to blame him and we should not blame each other as well. The problem should be resolved in a satisfactory way because perhaps I would still need him as a substitute physician in the future, and it should not make him resign from his duty as substitute physician.

When I am off duty, I ask another physician to replace me. However, the patient in this case considered that it was my responsibility, because when she was admitted for the first time it was I who treated her. Because I was unable to perform my duty, she accepted the substitute physician. However, she had hoped that it would be me who would manage her.

Consider the fact that the treatment was carried out by a substitute physician. Who do you see as being responsible for the patient's previous and current treatment in this case? Why?

Discuss the conflict between the protection of a colleague and the best interests of the patient in this case. Consider the senior physician's future dependence on the concerned substituting doctor.

The baby who had a lumbar puncture and died

Physician: A 7-week-old male baby was admitted to our ward with fever and fits for one day. No generalized convulsions were seen, but the mother mentioned upward rolling of the eye balls. On examination the general condition was found to be OK and the baby could suck well. There were no fits at the time of examination and the cardiovascular system was normal. But
I was afraid of meningitis and septicaemia, so I informed my first assistant and she agreed that a lumbar puncture should be done. In this case I performed fundoscopy, but papilodema was not seen, and anterior fontanel was normal, not tense and not bulging. I obtained the consent of the mother for a lumbar puncture, which I performed. Immediately after the lumbar puncture, the general condition of the baby was good. The respiration and cardiovascular examination were normal. But after 30 minutes the mother complained that the baby had fever and fits. On examination the baby showed respiratory depression. At that time, the professor of the paediatric department came for the ward round and saw the case. Cardiopulmonary resuscitation was tried but the patient died after five minutes, probably due to cerebral coning.

Think about this case. How do you evaluate the decision-making process?

Physician: For this small baby, when the anterior fontanel is open we can pass through it with a hollow needle and suck so as to reduce the pressure inside. I was thinking to do that. However, my superiors did not give permission. If I had done that, it might have been better, I hope. Actually, I have never seen anyone do that. I did not ask my professor if I could do this procedure. I cannot discuss the procedure with my professor, but I can discuss with the first assistant, but at this point in time the condition of the baby was not stable so she did not agree with me to do this procedure.

As a junior doctor, if I have a problem, I inform my senior, who may inform his or her senior, up to the level of consultant or even the professor, if necessary. If it is very urgent, and if the professor is present at the site, I may directly inform the professor. In this case, the professor had a ward round, and she suspected coning and directed us to do resuscitation. Then she went on to see other cases. Besides me the first assistant was there and I asked her whether I should do that procedure on the baby. She said she had never done that before. She was also afraid of this procedure.

Discuss the decision-making process in this emergency situation. Consider other possible lines of action and discuss their ethical implications and possible consequences.

Discuss the conflict between personal ethical concerns and the decision-making power of the junior physician at different stages of patient management in this case.
The man who preferred the traditional healer’s treatment

**Physician:** This patient lived here in the city but had an accident in another part of the country. He had a knee injury. A physician accompanied him when he was referred for treatment here. He had no problem in terms of expenses, because he was covered by an insurance company. It had been explained to him that there was no problem and we would provide the facilities for the surgical intervention. However, he refused to be treated by us. I advised the patient and his family that if no intervention was performed, the configuration of the patient’s knee would change, and this would result in disturbance of his movement. There would also be some pain if the patient took a long walk. There would be post-trauma arthritis. A deformity would occur which would cause the patient to walk unsteadily. He remained adamant even though he was advised about all these things. He asked to be sent to a place to be treated by a famous traditional healer. His family agreed with him. I was unable to change their minds, so I left it to them to decide. It turned out that the healer to whom this patient went had a lot of patients – more than the hospital or physicians.

In all societies different types of medicine and treatment co-exist, including traditional healing. Discuss how the physician should deal with patients’ use of treatment other than that of biomedicine.

Does it make a difference that this is not a life-threatening condition? why/why not?

Covering for a physician who tried to extract money from the patient

**Physician:** I was assigned to do a job abroad. At that time my brother-in-law complained that when urinating he had pain. He went to a hospital and was managed by an urologist who said that laser treatment should be performed because it might be due to prostate. So far only USG had been performed. The doctor was threatening to such an extent that my sister started crying. The threat was made like this: “If a laser is not performed, you will have to read the holy verses," that is, he would die. This physician proceeded to perform intravenous pyelography. Then the patient was instructed to undergo a laser treatment that same evening by paying an advance of approximately 750 USD. And if it was to be paid by credit card it would be 1,500 USD. My brother-in-law was bewildered and contacted my husband who was engaged in the health field. He told him to delay it for one day until he would reach
there. But the physician got angry and said, If this was not conducted, he would not care any more. It was not until realizing who my brother-in-law was that the physician was alerted. He asked what he should do to apologize for what he had done. Finally, the hospital director and one of his staff apologized to my husband. My brother-in-law decided to go to another private hospital where ultrasonography and other specific laboratory examinations showed that it was an inflammation.

**Interviewer:** What did you do toward the concerned physician?

**Physician:** I just remained silent because the matter had been clarified, and it was not my business, was it? It just happened that I also worked at that hospital, and I knew that the concerned urologist did not do such things to poor patients. Perhaps my brother-in-law was considered to be able to pay. I later asked the nurse why other patients were not treated the way he treated my brother-in-law. The nurse replied, “He wanted only money.”

Discuss the conflict between the best interests of the patient and solidarity with a fraudulent physician in this case. Discuss professional obligations in cases like this.

The psychiatric case involving allegations of sexual misconduct

**Physician:** This particular patient is an unmarried woman of 28 years of age, brought by her brother and father. She is suffering from depressive illness with some dissociative symptoms. This illness has been there for about two years now. This patient was being treated by a consultant in the department. But the family had certain grievances against the consultant. They wished to consult me and continue treatment with me. Our department guideline suggests that if a patient is being treated by one consultant, another consultant should not accept the patient unless a discussion has taken place or a clear referral has been made. In this case neither of the two was done. But the details the patient and their relatives gave me persuaded me to take up the patient even without going through a clear referral or a discussion with the consultant. The details were so persuasive that I decided to accept the patient for further treatment. In fact, I got a new card made which, administratively, is something which is very debatable. The patient felt that there were some advances made by the consultant, which made her very uncomfortable. The relatives felt that the behaviour of the consultant was neither professional nor acceptable.

I cannot believe the patient and her relatives fully when they say that sexual advances were made. Although I should not casually ignore these
things because it shows the profession in a bad light and can be damaging to the profession as well as to the department. So, it did create a problem for me. I resolved it by taking the patient up for treatment because she needed help and she was not willing to go back to the other consultant. But I did not do anything concerning the allegations because I was not quite sure if these were true.

Summarize the ethical obligations of the physician towards the patient, towards his colleague and towards the Department in this case. What would you do in this situation?

At this stage the doctor is not sure whether the allegations are trustworthy or not. What would you do if in the course of the treatment you became convinced that the patient had been sexually molested by your colleague? Outline the possible consequences of your decision for all concerned persons.
3. Fairness and Equity

Physicians often face resource constraints when treating patients. The learning scenarios provided here involve resource constraints of various kinds.

Not all patients that could potentially benefit from treatment can be treated because of lack of resources. One then has to decide which patients should get priority, and the issue is on what basis those decisions are made. In one set of cases students will consider deliberations of physicians when they have to decide what patients to choose for treatment within the system. In the other set of cases students will discuss deliberations of physicians about what information to disclose when they know that this will create financial pressures on the family.

3.1 Allocation of scarce resources

In this section the student will work through a series of learning scenarios that involve the need to prioritize. As a result of scarce resources, the health facility cannot provide treatment to all patients who need treatment, and the physicians/staff will have to decide who they should treat when they cannot treat everybody. The issue is how, or on what basis, the physician should make these types of decisions. One obvious principle is that one should choose the patient who can benefit the most from treatment. In most of the learning scenarios in this section, this is a factor in decision-making. However, the learning scenarios illustrate that there are several other values and principles that physicians have to consider when they make these types of decisions.

**General learning objective**

The aim of this section is to enable the student to identify ethical principles and values involved in allocation of scarce resources. Through discussions, students are enabled to decide whether they agree or disagree with the relevance of the implied values for the decisions in question.

3.1.1 Giving preference to the patient with the most serious condition

It has often been suggested that there is a special obligation to treat patients who are the sickest, irrespective of their chance to benefit from the treatment. The learning scenario about the paraplegic versus the quadriplegic patient illustrates a situation, where a different principle is adopted.
Specific learning objective
At the end of the session, students understand the ethical implications of adopting seriousness of illness versus perceived maximum benefit from treatment as principles guiding prioritization of the use of scarce resources.

3.1.2 Treating patients to whom one has special relationships
Some have argued that the usual principles of justice are impersonal, and that this does not place enough emphasis on the importance of personal relationships in moral decision-making. The learning scenario about the patient who did not want to go home can be used to discuss this issue. Here, a patient has earlier been given preferential treatment by a physician, who has subsequently retired. This places the physician, who has taken over the treatment of the patient, in a dilemma. The learning scenario about the boy where the physicians start to raise money for treatment provides a contrasting example (the ‘precious boy’). Here, cultural values concerning son preference influence fund-raising activities at the hospital in the favour of a boy.

Specific learning objective
Students understand and can discuss the trade-off between a fair distribution of health care services and special efforts to give care under particular circumstances.

3.1.3 Giving lower priority to patients who have caused their own illness
Some have argued that those who are responsible for their own illness should have lower priority. This might include illnesses caused by smoking or other habits that are injurious to health, or it may include suicide as in the learning scenario about the suicide patient in need of dialysis. Students should discuss whether the patient's perceived agency in developing a given illness is a relevant factor in prioritizing scarce resources, and they should identify ethical issues involved in this type of policy. Agency in this respect can refer to specific acts (such as a suicide attempt, driving when under influence of alcohol, etc.) and lifestyle (such as excessive smoking, drinking, unhealthy diet, etc.).

Specific learning objective
Students are able to discern the ethical implications of health care given to all irrespective of the cause of the health problem versus giving lower priority to patients who can be perceived to have caused their own illness.
3.1.4 Differentiating between life-saving treatment vs. treatment that improves quality of life

Some have suggested that life-saving treatments should always have priority, whereas others have argued that it is legitimate to make trade-offs between saving life and quality of life. The learning scenario about the patient who did not want to go home should be used to illustrate this point. Contrast this with the scenario of the cancer patient who needs a bed. Here, surgical treatment of a child patient is delayed because a hospital bed cannot be made available to the patient during necessary medical treatment prior to the surgical intervention. In addition to the contrast between life-saving treatment versus treatment that improves quality of life in these two cases, the facilitator should also encourage students to discuss values attached to the age and social networks of these two patients.

Specific learning objective

Students identify ethical dilemmas involved in the trade-off between saving life and quality of life in prioritizing patients for treatment. They are able to identify ethical problems concerning preferential treatment given to less severe cases in a context of overall serious resource constraints.

3.1.5 Giving some priority to teaching needs of hospital

A public hospital also has the responsibility to train future health professionals. These training needs sometimes conflict with patient care. One may, for example, want to treat a particular patient because it fits with the training schedule, or one may not be able to provide optimal treatment because of these types of concerns. The learning scenario about a conflict between clinical care and a seminar illustrates this point.

Specific learning objective

Students can identify and discuss ethical issues pertaining to possible conflicts between the needs of individual patients and the need for a teaching hospital to perform its teaching duties.

The above issues are analyzed in the WHO (SEARO) Health Ethics in South- and Southeast Asia document series, Volume 2 and Volume 3, pp. 66-75 and 93-108.
Learning scenarios

The paraplegic versus the quadriplegic patient

**Physician:** Because of the constraints of the number of beds in the ward, we have to make certain decisions which bother us ethically. If we have two patients and we have one bed, we tend to look at that person where we can have a better result. Suppose we have one patient with quadriplegia and another with paraplegia. From the patient's point of view, quadriplegia is a more serious condition because the hands and legs would be paralysed. And paraplegia is comparatively less grave from the point of view of the patient. We look at it from another angle: The number of hours or the amount of labour we spend on the paraplegic, we will be getting better results, whereas it will be more labour and less results in the case of the quadriplegic. So, we have to make a choice: who would be a better person to be admitted for one available bed. Naturally, as per this logic, we decide that those who can get more benefit should be preferred. So we admit a paraplegic rather than a quadriplegic. Though from the patient's point of view, we are making a mistake because the quadriplegic needs more attention. This is one of the problems, which I think would be bothering a number of doctors. We cannot decide ethically what is right and what is wrong.

Formulate the two selection principles that the physician uses here.

**Physician:** This occurred recently, when we admitted a paraplegic patient. We had one patient of C-6-7 quadriplegia and another of L-1 paraplegia. We admitted the L-1 paraplegic.

**Interviewer:** How old was this patient and what was his prognosis?

**Physician:** The quadriplegic patient was a 38-year-old male. He had quadriplegia for the last three months. And the prognosis was uncertain because we do not know what is going to be the outcome. So far he has not shown any recovery, whereas the L-1 paraplegic is a 28-year-old boy who has minimal power in the hip muscles. The upper extremities and the trunk are fine. Four months back he developed paraplegia. The prognosis is that since he has shown some improvement in the hip muscle, he might improve a little, but at the same time, even if he does not improve, we think he will be able to walk. That makes a tremendous difference. The quadriplegic patient will have to use a wheelchair. The last three months, he has not shown much recovery. So we are not very sure if he is going to recover further or not. Recovery as
such is not the only factor which makes you decide whether to admit or not. Besides the prognosis, the quadriplegic, despite an intervention, would remain dependant to a large extent. The paraplegic, with a smaller intervention, becomes independent to a greater extent. That is how we weigh the prognosis.

Do you agree with the physician that one should choose the paraplegic patient, and why/why not?

**Interviewer:** You said that there is a shortage of beds. But in both these cases, the intervention that you are planning would consist primarily of physiotherapy. So, do you think they have other options, such as coming to the OPD or do you have some intervention which can be done only in the ward?

**Physician:** For both the patients the intervention can be done in the OPD as well. Both patients had certain other problems like bedsores which I thought would be better managed in the ward. And since they do not live in the city, they have no other place to stay. Both the patients would be eligible to be admitted. I think it would be better if they are admitted in the ward because the amount of money they need to spend on transportation and the number of people they would require to go from home to the hospital would be much more.

**Interviewer:** Are you happy with the decision you have taken and would you repeat this if you faced a similar situation again?

**Physician:** Frankly, I am not very happy. But, in view of the circumstances, I think I will do the same. I wish I did not have to. I would like to have more patients admitted but we have to make a decision one way or another. I do not think anywhere in the world there are beds for all patients. We have to make a choice which one would benefit more.

The doctor does notquestion that maximum benefit for the patient should guide prioritization of scarce resources. Discuss what role seriousness of illness should play for decision-making, if any, and how to weigh the two against each other.

The patient who did not want to go home

**Physician:** There is sometimes an ethical dilemma with patients who do not want to go home. There is a lady in the ward who is about 52 years old. She has a condition called exfoliative dermatitis or erythroderma. Many severe skin diseases that involve large parts of the skin manifest themselves in this way.
This patient was being looked after by the previous head of the department and he retired. The patient was coming and going in the OPD. Recently she sought my advice. Last week I admitted her in the ward and we started with the treatment. Now, she has improved about 30-40% while tests are being done, but she wants to stay in the ward until she is completely well. That may take a few months or even longer. She does not want to go home. She says that it will be difficult to come back to the hospital in the OPD, even if her residence is not extremely far from the hospital. There is an implication that her family members may not bring her to the hospital, if she is discharged. But we are weighing the need for beds for numerous other patients against one particular patient’s desire to stay on. Often, we get patients who have suffered severe burns and who need immediate treatment.

I have decided that I will let her stay until her test results are available and I have spoken to her son and told him what I plan to do. This is the reason why I did not discharge her already even if her condition did not require continued admission.

Explain the ethical dilemma that this doctor faces.

Does is matter that the patient was previously seen by the Head of Department, who had then retired? Discuss the implications, if preferential treatment was previously given to this patient.

The physician decides to postpone her discharge even if other patients may be in greater need of the bed. Discuss why you think he took that decision and whether it can be ethically justifiable.

The condition of other patients in need of this bed is not mentioned. Discuss the above issue if another patient is blocked from receiving life-saving treatment versus treatment that improves the quality of life.

The ‘precious boy’

Physician: There is a 12-year-old boy who has had four operations at various places in his part of the country. He came to us about a year ago. We admitted him. He was very sick. His father could not afford to pay for his medicines. I had the option to try and manage him with whatever my hospital could provide, which, to my mind, would not be enough. We took a
conscious decision that this boy's life was precious. Why? He was the only brother to his six sisters. He was 12 years old and was the youngest of the siblings. We felt that he had a very fair chance of recovery, if we could organize money for him. Now, in this particular case we were able to raise enough finances. Obviously he was lucky. He got well. You can say this is not a dilemma. Where is the dilemma? But to me, there is a dilemma. I cannot do this for every patient. And, I am sure, 30-40% of the patients who come to us definitely require financial assistance. How much can you do and for whom do you do it?

In this situation the physician decides to give a patient special treatment. Summarize the motives that you think are important for the physician's decision.

Do you agree with the physician that personal circumstances should play a large role in such cases? What would you do in this case?

Do you think it would have made a difference if the patient had been a 12-year-old girl with six elder brothers?

The suicide patient in need of dialysis

**Physician:** I have in the intensive care unit a patient who has been diagnosed with diabetes, hypertension and kidney failure. This patient has consumed poison. She is being ventilated; in addition, her kidney is in a bad shape and she is not passing any urine. I have been asked to provide treatment for the renal disease. My problem is: whether we should give any form of treatment for her renal disease because she is already a known case of terminal renal disease, and now she has taken poison and is dying. Whether we should offer her dialysis and try to save her life, that is a real ethical issue.

Identify the issues involved in the ethical dilemma that this physician faces.

**Physician:** I have two options. I can either say that her prognosis is very bad and there is no point trying to save her because, with the money and facilities available, if we expend so much on this one patient, others are bound to suffer. On the other hand, I can try with lots of equipment and expenditure to purify her blood and give a chance to live. I may not succeed but I can try. So, I have two options. So, this is an ethical question.
The physician states that treatment resources can only be spent once, so if spent on this patient they cannot be spent on others. But he also weighs the treatment of this one patient against the treatment of many other patients who may need less expensive care. How do you view his reasoning?

**Physician:** I have decided just to conservatively manage this patient in the sense that we do not actively do anything for this patient.

**Interviewer:** Could you kindly tell me why you took this decision over other options?

**Physician:** Well, this patient is already diagnosed with a severe kidney disease. She would not have lived anyway for more than a few months or a year. In this country, there are no facilities for a patient like this for a dialysis and for a transplant. She does not have that kind of financial capability. Her situation would remain the same even without her taking the poison. I really don't know what led to the poisoning, but I think she took this step because she is depressed with so much suffering. Now her kidney disease has become worse because of the poison. Now she is about to die. I was asked to attend to her kidney disease. We may spend a few thousands on her or even more, but I will save a patient who may live another six months in very bad health. She will be even worse off. So I thought it would be best that we let her die.

Do you agree with the physician's decision not to treat the patient? Why/why not?

The physician now justifies his decision with her low quality of life leading to her suicide attempt and the even lower quality of life expected after the treatment. How do you view this reasoning compared to the earlier weighing of treatment of this patient against treatment of other patients?

**Interviewer:** Provided that you had all the sophisticated instruments and equipment and the necessary funds as in some other countries, would you have taken the same decision?

**Physician:** No, I would certainly not. I would certainly make all efforts to help the patient live. And, of course, most importantly, I also would need enough time to devote to one patient. Because she is only one patient. I have 170 patients more in my care. So, if I had the time and if it was sure that she had all the money then my decision would have been different.
Interviewer: Do you think these kinds of dilemmas are typical and common in our set-up?

Physician: Yes, they are very common. Since I am involved in the treatment of renal diseases, I often see these dilemmas. I have to take such a decision at least 3-4 times daily.

Given that optimal treatment was available, the physician would not have accepted the patient's wish to die. Do you agree with this reasoning? Why/why not?

Think of this case. Would the patient be likely to attempt suicide if optimal treatment options had been available? How do you view the relationship between resource scarcity, poverty and suicide in a case like this?

The cancer patient who needs a bed

Physician: Well, it happened today itself. We had a child who had an abdominal mass and all the investigations pointed towards cancer, but we did not have the histology yet. But the child was not fit for surgery. The child had a lot of other problems like fever and chest infection. So obviously he could not be operated in this condition. But, ideally, he would have required admission and should have been treated for the chest infection while in hospital and operated upon at the first available opportunity. But we could not do that because we did not have enough beds. The non-availability of beds is probably the biggest problem at the moment. But apart from that I feel we could have admitted this child and treated the chest infection which would have made the process much faster. But his non-admission would delay things. The treatment which should have been started within a week from now may be delayed to two weeks. So, there is a delay in the starting of the treatment, and we all know that delaying the treatment in cancer will worsen the situation.

Think about this situation. Is there any other information that you may want to have before making a decision about admission?

Physician: This was a 3-year-old boy with an abdominal mass but on the MRI scan a cancer was indicated. The final diagnosis will only be done when we take a biopsy from this mass. I mean, either you do an operation or a laparotomy and see. If the mass is removable we remove it. If it is not removable, we will take a formal biopsy, and maybe we will give chemotherapy according to the biopsy and when the mass becomes smaller and resectable, we will remove that mass.
Think about this situation. Are there other alternatives for the physician than delaying admission?

**Physician:** Suppose we had admitted this child. Then the entire operating list for the next week would have been disturbed because we plan our admission schedule according to our operation plan. And if you block your bed with a child who is not fit for a surgical procedure, then obviously someone else who is fit is denied admission. Therefore, as far as the hospital is concerned, although the bed occupancy is there, the time lost because of a case not being available for operation is also very costly. And we have to keep these logistics in mind that the operating time, which is also very valuable, must be used optimally.

Before you proceed, please answer the following questions:

- What exactly is the reason that the physician gives for denying this boy a bed?
- Do you agree with this reason, or should the physician admit the boy?
- Who should make decisions like these?

**Interviewer:** Did you have an occasion to discuss your decision with your colleagues?

**Physician:** Well, in the OPD it is usually not possible. There is usually a mad rush and the amount of time we can give to each patient is not much. So, one really tries to avoid too many discussions in the out-patient setting.

**Interviewer:** Who is the central person involved in this ethical dilemma according to you?

**Physician:** The consultant in charge of out-patients. He or she is the senior-most person in the OPD and all decisions pertaining to out-patients would ultimately rest on the consultant there.

**Interviewer:** Think about this situation. Do you agree with the physician that it is not possible to discuss a case like this with other colleagues?

The conflict between clinical care and a seminar

**Physician:** In the ward setting we have shortage of doctors. We had patients and there was another very important programme coming up. We are three
doctors and all are required in another activity. So we have to deal with the rest of the activities on a low-priority basis. Suppose WHO asked us to conduct a seminar. Conducting a seminar at the expense of patient care in the hospital is a big dilemma, which bothers us. If we are engaged in a seminar, we are supposed to work very hard, morning to evening with full attention because we have to arrange so many things. We have to stay away from OPD. The inpatients would need attention which we will not be able to give. We had one instance where a patient had a fracture of the femur. A massive pressure sore went into the facial plains, it went into the muscle and involved a bone. The bone got fractured and came out of the skin. The patient was a young boy of 18 years and he was in such a bad shape. He required dressing 4-5 times a day. In case he had gas gangrene he might not survive. It was a life-threatening condition. Of course, we were doing all the necessary things for him but we were not able to pay sufficient attention to this patient because of the impending seminar. At the same time we could not neglect him completely. As soon as his medical condition stabilized and his infection came under control, which was some 3-4 weeks before the seminar, we told him that we did not have the means then because we were engaged in another activity. "In case you can get dressings at home by another doctor, you would be better off. The danger phase is over, and you can now go home," we told him. But had the seminar not been there, we would not have told him to go.

Here the seminar goals conflict with the goals of clinical management. How should one deal with these conflicts?

3.2 Considering the economic situation of patients and families

The cases in this section deal with the issue of what to do when patients cannot pay for beneficial treatments. This issue is relevant in all health care systems, as there will always be some potentially beneficial treatment that is not available within a publicly financed system, or that is not covered by a patient's health insurance. This issue is much more pressing in resource-poor settings, where the range of potentially beneficial treatments that is not accessible for financial reasons is much larger.

General learning objective

The general aim of this section is to explore the ethical principles involved when the financial limitations of the patient (and the patient's family) determine the provision of an existing beneficial treatment. At the end of the
session, students have developed an understanding of the ethical implications of poverty in the patient population.

3.2.1 The right to pursue an existing treatment at own cost

Once a treatment is started, patients may see it as their right to pursue it at their own cost even if the physician is not satisfied with the progress. The scenario about the boy with sclerosis and encephalitis on Interferon treatment illustrates this point. Noticing the potential socioeconomic consequences of the expensive treatment for the family, the physician nearly regrets having informed them of the available treatment option. One possible implication of the physician's position is that poorer patients have less right to information about available treatment compared to patients with more financial resources.

Specific learning objective

Students are able to decide to what extent it is justifiable for a physician to contest the informed choices made by the family if he/she is concerned about the long-term social and economical consequences of these choices.

3.2.2 The futility of treatment

The scenario about a terminal cancer patient provides an example where, according to the doctor, the patient would die no matter what is done for him. At the most, life could be extended by a few months, but even then the treatment itself could hasten death. The treatment would be very expensive for the patient and his family. The doctor discusses how he deals with the case, and the student should analyze the doctor's reasoning. The scenario with a patient with a brain tumour should be contrasted with this one. In this case the family, in the judgment of the physician, can obviously afford the treatment. The students should also explore the conflict of interest between this patient and the relatives who stand to inherit more if less is used for the treatment (patient autonomy versus family autonomy).

Specific learning objective

Students are able to identify ethical principles and dilemmas involved in the learning scenarios, including issues of beneficence, non-maleficence and patient autonomy.
3.2.3 Potentially life-saving, but expensive treatments for children

The learning scenario about the ‘precious boy’ where physicians raise money for treatment is an example of cultural values concerning son preference influencing fund-raising activities at the hospital. Students should discuss whether they agree to the action taken to save this boy. They should also be able to understand the underlying equity- and gender problems given that this financial help would probably not have been offered to a girl in a similar situation. This point is illustrated by the scenario about a child who needs expensive chemotherapy where parents decide that a life-saving treatment of their daughter is too expensive for them and treatment is stopped. Another scenario, the case of the child with retinoblastoma, also illustrates the dilemma of not being able to afford life-saving treatments for children. In this case, however, it is not necessarily the parents who do not wish to have the treatment, but the doctor who considers whether to disclose the possibility of an expensive treatment. The students should discuss how much doctors should push or support parents when the treatment of their children has profound financial consequences for them.

Specific learning objective

Student are able to identify ethical principles related to the issue whether children are valued less than adults, and whether girls are valued less than boys by physicians and/or parents. They can identify similarities and differences in ethical reasoning between these three scenarios.

3.2.4 Practical decision-making

The scenario about the child with Wilm’s tumour and expired drugs illustrates how physicians may have to compromise when deciding what drugs to use. The case also points to local consequences of inequity at the global level, illustrated in this case by the use of expired drugs. The students should identify external constraints for treatment and discuss how physicians can provide treatment in an ethically justifiable manner.

Specific learning objective

Students are able to identify and discuss issues of informed consent, beneficence and non-maleficence under constraints of overall inequity.

Learning scenarios

The boy with sclerosis and encephalitis in Interferon treatment

Physician: Today, we had a 7-year-old boy in our unit with a diagnosis of sub-acute sclerosis and encephalitis. This is supposed to be a long-term sequela of measles. There is no known treatment for this disease, but there are some reports that one very expensive drug called Interferon can help. Now, this is a middle class family. They are farmers. Last time they had come, they were explained that the prognosis was quite bad and the child was not going to live for long. But there was one alternative that might help the child, though the child was not going to be completely normal. This is the only child in the family. They wanted to save the child at any cost. They took the first course of Interferon, which is very expensive, one vial costs around 200 USD. They took the first course and went home. They found that the child was showing some improvement. When we re-assessed the child we could not find any significant improvement apart from a slight improvement in the frequency of convulsions. They have now come back for the second course. They have sold some of their land and are willing to sell some more of their property to pay for the child's treatment. We tried to explain to them that we were not sure how much we would be able to help the child, and yet they are insisting that they would like to give full treatment to the child even if they had to sell more of their property. There is a tremendous psychological pressure on the parents all the time, because they see the child just lying on the bed and they can't do anything. The child's condition keeps deteriorating in front of them because it is a chronic disease. He is not going to survive. Since he is a boy, they are taking more care. Probably, if this patient was a girl, they might have said no to treatment. This will definitely affect the family, especially if there is another sibling who is normal. The care of that baby will be neglected. But they will only realize later when they have lost the child.

Think about this case. The parents have presumably understood the prognosis and made a conscious decision to spend their resources on an expensive treatment. Is the physician justified in her reluctance to continue the treatment in a case like this?

Would it make a difference if the family was rich? Why/why not?
Is the concern for a possible future sibling relevant in this case?

Some physicians choose not to inform their patients of expensive treatment options if they believe they cannot afford them. How do you view this issue?

The terminal cancer patient

Physician: I have been seeing a patient for the last 10 days. This patient has carcinoma. Six months ago when he was operated outside, the impression given by the surgeon to the patient was that there was some kind of a blockage in the intestine and that it had been corrected. Five months later, he came up with a lump in the abdomen and after that he developed jaundice. He has now come to us with a huge lump with jaundice. There are different options available but none of them is very safe and none of them is going to help on a long-term basis. I am sure he is going to die. He has a confirmed cancer. It is not curable, and it is not treatable. So, should you palliate his symptoms and to what extent. In this case, his relatives are very keen that he is not told what is happening to him. I can't give him any hope and I feel very bad telling him that I can't do anything. I have already told the relatives. But if he asks me directly, "Am I going to live? Am I going to die? Do I have a cancer?", then I will tell him the truth. But if he doesn't, then I will probably end up telling only his relatives.

There have been occasions when after the patient has spent about 40 to 50,000 or 100,000 and goes back home, the relatives ask you the question: "have we achieved anything after we have spent so much money, and should we continue to spend not knowing when it will end?" I often tell myself that I cannot play God. Here you come across situations where a poor man has 40,000 in his bank, he's got a house and if he dies he's going to leave behind three children and a wife who doesn't earn. So is it worth that his family spends all of that on him and then be out on the street after he dies?

Do you agree with the doctor's position here that he will not give the patient himself the choice of treatment?

Does it make a difference that the treatment is very expensive?
The patient with a brain tumour

**Physician:** There was a 75-year-old man who had a malignant tumour of the occipital lobe. The dilemma was whether to operate on him or just give him symptomatic treatment. Because I had explained to the family that even if we operated on him and then gave him chemotherapy and radiotherapy post-operatively, most likely his life span would not extend beyond one or one-and-a-half years. On the other hand, if we left him without surgery and subjected him to supportive therapy, he may survive for about 6-9 months. I was quite confused whether to take decision in favour of surgery or to manage him conservatively. So, I gave the prognosis to the family and left the final decision to them whether they would like to go in for surgery, because he was not a very good surgical candidate. He was obese and hypertensive but with no history of heart disease. Well, for me, the issue was whether to leave the patient who would obviously benefit from surgery. Supposing he tolerated the anaesthesia and came out of the surgery, probably the quality of life or whatever time he remained alive would be slightly better than what it would be if he were not operated upon. The dilemma for me was whether to leave him like that or to go ahead and operate on him. In case of this particular patient there were no financial constraints because he came from a well-to-do family. They could possibly afford any treatment that we were willing to offer. I left the final decision to the family.

Consider this case and summarize the reasons for and against an operation. Discuss the ethical implications of the physician not being able to give the relatives a definite recommendation concerning the treatment.

Contrast this case with the case of the terminal cancer patient, and discuss the importance of the family's financial capacity for the overall management of the two cases.

The 'precious boy'

**Physician:** There is a 12-year-old boy who has had four operations at various places in his part of the country. He came to us about a year ago. We admitted him. He was very sick. His father could not afford to pay for his medicines. I had the option to try and manage him with whatever my hospital could provide, which, to my mind, would not be enough. We took a conscious decision that this boy's life was precious. Why? He was the only
brother to his six sisters. He was 12 years old and was the youngest of the siblings. We felt that he had a very fair chance of recovery, if we could organize money for him. Now, in this particular case we were able to raise enough finances. Obviously he was lucky. He got well. You can say this is not a dilemma. Where is the dilemma? But to me, there is a dilemma. I cannot do this for every patient. And, I am sure, 30-40% of the patients who come to us definitely require financial assistance. How much can you do and for whom do you do it?

In this situation the physician decides to give a patient special treatment. Summarize the motives that you think are important for the physician's decision.

Do you agree with the physician that personal circumstances should play a large role in such cases? What would you do in this case?

Do you think it would have made a difference if the patient had been a 12-year-old girl with six elder brothers?

The child who needed expensive chemotherapy

**Physician:** We had operated on a 10-year-old girl for a tumour after which we put her on chemotherapy. The child showed some response to chemotherapy but after some time the tumour started growing again. We had to change the treatment to a more advanced form of chemotherapy, which was also several times more expensive than the chemotherapy which we were giving earlier. The parents did not have the means to give that therapy and they just dropped out of the treatment. They came back to us after some time and by then the tumour had grown very large. At that moment of time, we knew that we would not succeed in treating this child. That was a big dilemma. You know that there is something which is treatable, or at least something which can be controlled, and yet you cannot do it.

**Interviewer:** Do you know what happened afterwards? Did this girl finally improve, or did she die?

**Physician:** No, we ultimately explained the prognosis to the parents and we told them there is very little that we could do now. The parents then decided to try out other systems of medicine. We have not really heard from them what happened after that. Going by my experience, I doubt if this child could have survived.
In this case, the parents of the child decided that the therapy was too expensive for them. Discuss to what extent the doctor should try to convince the parents to try to pay for the treatment.

In this case, the doctor lost the patient for necessary treatment. Can you think of other ways to continue the treatment that could have been pursued?

The child with retinoblastoma

Physician: This is about a 2½-year-old male child who had been operated on at a peripheral eye centre. The eye had been removed. The child now came to us after four months with what appeared to be re-occurrence of a retinoblastoma. We knew the prognosis was not very good. If he needed chemotherapy the expenses were prohibitive. Secondly, it was expensive for the parents to stay in the city during the treatment period. What concerned me was if I was able to arrange chemotherapy for them and made them stay here, what would be the final outcome? The parents would have spent so much money but the final outcome could be life prolonged just by a few months. Was it really worth that effort and money? As a physician I had to tell them what medicine could offer. I told the family that this was possibly a recurrence of the old disease. Although surgery could be done, it would only offer very limited hope. Therefore, under the circumstances, we would recommend surgery and hope for the best. I briefly told the father about what chemotherapy is without going into detail and that it is also an expensive treatment. Initially, I had certain reservations about exenteration, but some colleagues thought we should go ahead and do it. I was not favourably disposed to doing an exenteration which is fairly extensive destructive surgery. But I gave in to that suggestion and said, okay, this is the one thing that we can offer to the child at no great cost to us and to the family. So, although I was initially not favourably inclined to doing an exenteration, I took the advice of others and went ahead with it.

Compare this case with the case of the child who needed expensive chemotherapy. What differences and similarities can you identify? What values are important for decision-making in the two cases?

Do you agree with the way the physician informs the parents of the option of chemotherapy in this case? Why/why not?
The child with Wilm's tumour and expired drugs

**Physician:** One of my cases was of Wilm's tumour. A three-year-old boy came from a town in the delta region. He reached here with late stage of Wilm's tumour. After doing the surgery, we transferred the patient for further treatment. His parents were not rich and could not buy expensive chemotherapeutic drugs. The patient's condition was not good. After giving three doses of chemotherapeutic drugs, the patient's condition did not improve as expected. But the parents wanted to have the treatment continued. I would have liked to explain to the parents that the child's condition was not improving, and it was difficult for them to buy those expensive drugs. I was not sure whether I should tell them not to buy the drugs. According to my experience with this disease, some patients would die even though they are given the full course of chemotherapy. But, in rare cases, they also recover. In this case, ascites had developed and he had dyspnoea. We had to do the tapping of the abdomen in order to reduce ascites once a week. I explained to the parents that the condition was not good. I could not ask them not to continue the drugs.

In this case, the physician considers whether to apply the right to refuse treatment on the patient's behalf, even if the parents are willing to pay for the treatment. Analyze his reasoning and discuss whether the physician or the parents should take the decision in this case.

**Interviewer:** Don't you have faith in the drugs?

**Physician:** Faith? Ah... most of the chemotherapeutic drugs are expired drugs. If they were not expired, they would cost much more.

**Interviewer:** Then, what about other drugs? Are there any alternatives for them, like importing from a neighbouring country, or using cheaper ones?

**Physician:** Yes, they can buy cheaper chemotherapeutic drugs from a neighbouring country. Normally, the drugs come from Germany and Australia.

**Interviewer:** You mean the drugs that come from Germany and Australia have good potency based on quality control. You are not sure about the potency of the drugs from this or neighbouring countries?

**Physician:** Yes.

**Interviewer:** But most of the cancer patients use these drugs, or if they got the drugs from Germany or Australia, they are all expired. Is that right?
Physician: Yes, about two thirds of all patients use expired drugs or drugs with questionable potency. And I have only seen one person cured with these drugs. Usually, they are not effective. But I continue to treat my patients with the available drugs. In this particular case, where the condition of the child is so bad, I don't know whether I should tell the parents to buy good quality drugs, which they may not be able to afford. Some of my colleagues have told me that they would like to tell the parents that the boy shouldn't receive more treatment since his condition was so bad.

Lack of potency in the medicines previously sold to the parents of the patient in this case may be a reason for the lack of improvement. Discuss the ethical implications of the use of expired drugs in this case.

Analyze possible consequences for all involved in this case.

Consider the role of drug availability and affordability as a factor creating ethical dilemmas for doctors when treating poor patients. What would you do in this situation?
4. Specific Health Issues

A number of health issues are associated with certain specific ethical problems, either because of particular characteristics of a disease (such as HIV/AIDS and mental illness), or because of certain specific challenges involved in certain types of treatment. Given below are a number of specific health issues. It is the aim of this section to introduce the student to some of the ethical dilemmas that are commonly encountered in this connection.

4.1 HIV/AIDS

In this section, students will be working through a number of cases that deal with ethical issues pertaining to testing, counselling and managing people with HIV infection and AIDS. AIDS is now treatable with antiretroviral (ARV) combination therapy, and intensive efforts have been undertaken to increase coverage world-wide. Still, many HIV-infected persons in the world have no access to ARV treatment, and in many resource-poor communities the disease is seen as 100% fatal. In addition to the physical deterioration of the body, patients suffer under stigma and social exclusion because of undue fear of attracting the infection, fear of death, or moral condemnation of the infected. In this environment there may be little incentive for a person to undergo an HIV test. A caring environment in the health services towards AIDS victims is necessary to help curbing the HIV epidemic.

**General learning objective**

Students are, at the end of the session, able to understand the balance of the best interests of the person with HIV-infection and the risk of infection in the community and in the country. They also understand the negative role of stigma at both individual and community levels and can relate this to ethical issues of confidentiality, patient rights and non-maleficence.

4.1.1 Rights of the patient vis-à-vis concerns for public good in connection with HIV testing

With an asymptomatic latency period of many years in HIV infection, it can be argued that testing a few patients with AIDS symptoms produces a false sense of security. Ideally, measures should be in place to protect health care
staff from the risk of infection based on the assumption that any patient may potentially be infected. This implies that there may be little or no justification for testing patients without their consent. Furthermore, a secretive testing procedure can be counterproductive because it establishes a difficult platform for subsequent counselling. The case of a HIV-positive man and his HIV-negative wife illustrates this point. Here, a man is tested HIV-positive without his knowing. Subsequently, only the wife is informed, and she tests HIV-negative. After deliberation, but contrary to the wife's wish, the wife's brother in whose house the couple lives is also informed. After having been cured for his immediate health problem, but uninformed of his infection, the husband remains admitted in hospital, as his brother-in-law does not allow him to return home. Student should critically assess information management as described by the physician in this case. They should consider the potential large-scale effects on controlling the epidemic related to: 1) confidentiality of information; and 2) systematic involvement of the patient in decisions concerning HIV testing and subsequent counselling.

Specific learning objective

Students understand the ethical dilemmas involved in HIV testing, including informed consent, confidentiality and non-maleficence.

4.1.2 Rights of the patient vis-à-vis concerns for third party in counselling

Confidentiality of information may conflict with the need to protect a third party from contracting a life-threatening infection such as HIV. In the scenario about a HIV-positive injecting drug user, the physician is clear in his mind that he will do everything possible to ensure that the patient himself informs his wife. Compare this with the scenario of the 20-year-old widow with HIV and her new husband. Here, the physician is asked specific advice concerning the marriage of a known HIV-positive widow to her brother-in-law, following the AIDS-related death of her husband. The physician suggests that the marriage is carried out. Note that the HIV status of the brother-in-law is unknown.

Specific learning objective

Students are able to understand the dilemma of respecting the patient's right to confidentiality and the possible infection of a third party, and analyze the basis for the decisions made in the two learning scenarios of this section.
4.1.3 Management of HIV-infected patients

The HIV epidemic constitutes a major challenge for the health care systems in most countries in South and South-east Asia. The following learning scenarios illustrate that persons with HIV may be left untreated even if their acute health problems are treatable. In the learning scenario of the pregnant HIV-positive woman who was not welcome in the hospital, the physician indicates that the woman is made to understand that she should not come back for her delivery. In the learning scenario of the pneumonia patient with HIV who was denied treatment, the patient is not admitted when his HIV status is known. Students should compare these two cases and identify the underlying ethical issues involved.

Specific learning objective

At the end of the session, students can formulate why discrimination against HIV-positive patients is likely to aggravate the epidemic. They are able to take into consideration that effective counselling and necessary support to the patients cannot be provided in a hostile environment.

4.1.4 HIV and vulnerability

The story of the deaf-mute woman in labour brings out several ethical issues. Many doctors make decisions on behalf of the patient. In a small hospital where universal precautions may not be possible, the staff may want to know the HIV status of those undergoing surgery. Discuss if this is a safe and ethically sound strategy. Being a deaf-mute person it might have been impossible to get informed consent from the wife, but when the husband turned out to be negative, the doctor was in a dilemma.

Specific learning objective

Students are, at the end of the session, able to formulate strategies to respect informed consent in cases like this. They are able to formulate their own views and how they would deal with a situation of this nature.

Legislation of relevance to HIV-control differs across countries. The facilitator should be conversant with existing laws and regulations of relevance to this issue in the concerned country. If required, these should be distributed among students as part of the training.
Learning scenarios
The case of a HIV-positive man and his HIV-negative wife

A 50-year-old man was admitted to a hospital with multiple non-specific symptoms for investigation. His HIV test turned out to be positive. Without informing the man of the test or its outcome, the doctor discussed the situation with the patient's wife and encouraged her to undergo an HIV test. She turned out to be negative. Though the wife was quite upset about the situation, she showed that she was a bold woman. She asked the doctor several questions on the disease transmission, treatment and curability. Later, she came to the doctor and made just one request. The husband and wife were living with the wife's brother, "Please don't tell my brother that my husband is HIV-positive. We are labourers without any land and need my brother's help for shelter and survival. If he finds out about this he may ask us to leave the house."

Why do you think the HIV test was done on this patient?

The test was carried out without his knowledge and consent. Describe the ethical problems involved in this action.

Consider the fact that no counselling can be done without informing the patient of the diagnosis. Do you think that not obtaining informed consent is a barrier for counselling? Discuss the ethical implications.

Can you think of any situations where HIV testing is justifiable without the consent of the patient? Explain why, and identify ethical problems.

Do you think that the doctor in this case was justified in adopting this testing procedure and managing the information in this way?

What would you do next in this case?

The doctor never discussed the diagnosis with the husband. But when the wife's brother came and enquired about his brother-in-law's condition he was
told that the patient was HIV-positive. After that, it was very difficult to discharge the patient:

**Physician:** From the medical point of view it is perfectly all right to give him a discharge certificate, because the patient has been cured for his lung infection and he has not got any other superadded infections. The only problem is, he is HIV-positive, he hasn't got a home, he has to go back to his wife's brother's house, who is willing to take him in if he is not HIV-positive, but who will refuse him shelter very strongly because he is HIV-positive. So that's a very big problem.

**Interviewer:** What were the options, when you took the decision?

**Physician:** Well, I had two options: One was to tell the wife's brother, the other one was not to tell him anything. I think those were the only two options. In any other disease, the problem wouldn't be so great, but people are very health conscious these days, especially with AIDS. They may not be afraid of any other disease but they are really afraid of AIDS and no one, I can understand, wants an AIDS patient in his house. That's one thing. The other thing is the status of the patient. If he had a house of his own, this problem would not have arisen.

Do you agree with the decision to inform the wife's brother? Why/why not?

The physician justifies his decision with reference to the widespread fear of aids in the public. From a scientific perspective, what is the risk of non-sexual HIV transmission within a household?

Do you think that the actions of the physician in this case served to increase or decrease public fear of HIV? Discuss the ethical implications both in connection with this specific case and in view of the HIV epidemic.

The HIV-positive injecting drug user

The following is from an interview with a doctor looking after HIV-positive patients.

**Physician:** Another dilemma arose in connection with an injecting drug user in his early 30s, married for about 2-2½ yrs. He is HIV-positive and is undergoing treatment. He has not till now informed his wife that he is HIV-positive. We discussed this with him so that he would understand the implications of being HIV-positive I would not disclose the test result to his wife without his consent. However, I will use all my resources, gentle
persuasion and convincing argument to make him understand why it is important that his wife must know. So, step one would be informing him about what it means, assessing his knowledge about being HIV-positive, how does it spread, and how it can affect others. Also, what precautions he needed to take.

The point that this particular patient illustrates is that as he came for treatment, during the process of investigations or treatment if we come across certain phenomenon, we cannot disclose to others without his knowledge and permission. Information is to be treated as confidential. This is an ethical question. At the same time, my dilemma is, if I do not disclose the real situation, I know, he may infect his wife.

Summarize the ethical dilemma in this case. Do you agree with the physician's position? Why/why not?

Interviewer: In this particular case, what are the options left to you if he does not agree to inform his wife?

Physician: I will go slowly. I will not be aggressive because it may not solve his problem, and further, his wife may already have been infected. What is more important for me is not to lose him in the treatment process so that he is retained in the treatment. First, I will focus on his giving up drug abuse. Second, he has partners with whom he should stop sharing needles. And also ensure that he takes precautions with regard to safer sex. So this is most important for me. And, in this process, if he says, look, do not tell my wife yet, I will wait. But it will constantly bother me that his wife has not been informed. I will definitely suggest to him to use condom and I will check with his wife subsequently whether he is adhering to this.

The physician chooses counselling as the best strategy to solve the problem. In your opinion, does it make a difference with the adoption of this strategy when the patient is an injecting drug user? Explain.

Having adopted this strategy, what do you think the physician should do if the wife asks him directly about her husband’s health problem? What if she asks directly whether he is HIV-positive?

Physician: If the spouse comes to know, she can come and say, “Doctor, you knew this. But you have not told us.” Meanwhile, if a child is born, it can be disastrous for the child. There are several aspects to this.
Consider the fact that the wife is not HIV-positive and may be at high risk of being infected. Would the wife be justified in suing the doctor in this case? Would it make a difference if the physician knew that she was pregnant?

Consider the potential implications if the wife is informed and the patient is abandoned by his wife and lost to subsequent medical follow-up.

Is there in your country any legislation of relevance for this case?

The 20-year-old widow with HIV and her new husband

**Physician:** This was a young woman of 22 years who had lost her husband to AIDS. After three years, her in-laws brought the woman to us as the mother-in-law wanted to get her married to her second son. The woman was HIV-positive. The parents were pushing their son towards a bad fate. They probably wanted a better life for her. We told them to go ahead without informing them of her HIV status. Eventually, we lost the patient and they their second son. In such cases one needs to work with the family, and maybe if we had discussed her status openly with the family their decision might have been different.

Consider this case and discuss the ethical implications, taking into consideration the best interest of the patient and the position of the family and her new husband.

The pregnant woman who was not welcome in the hospital

**Physician:** A pregnant woman of 23 years with HIV infection came to us and we said that we needed to sort it out with the head of the department. We told the patient to come back the same week. She did not come back. She was also a young woman who had been married recently and her husband had a touring job. The husband then left her and went away. So she is on her own now. She said that she wanted to have the baby but we didn't want to encourage her because of the risks involved for her and the baby.

**Interviewer:** How was HIV detected in her?

**Physician:** Actually, the husband presented with the problem and because he was found to be HIV-positive, the routine testing was done on the wife as well and she was also found to be positive. The husband's family is now aware of
all this and she is being ostracised by her own family as well. She was told that she should bring somebody along with her and come back this week for discussion. She hasn't reported yet.

Think about this case for a moment. Given the circumstances, is the physician justified in requesting the woman to come back accompanied by a relative? Consider the ethical issues involved in this decision-making.

**Physician:** We have not really seen full-blown AIDS in pregnant women, but only HIV infection. And we still do not have a policy in this hospital for HIV-positive patients. We have never admitted any HIV-positive patient for delivery through our department. And this, in fact, is a big dilemma because if the patient comes and tells us honestly that she has HIV infection, then we are not too encouraging. We tell her, "OK, come back" as we have to sort it out with the medical superintendent where we would conduct such a case and whether they would give us all the protective equipment we need. And usually the patient perceives that this is not a very supportive environment and they don't come back. What do these patients do when they don't come back to us?

The absence of a hospital policy on HIV/AIDS in this case results in discrimination against pregnant women with HIV, sending them to deliver under presumably less controlled circumstances. Discuss the ethical issues involved at the institutional level, including the hospital's responsibility to deal with this health problem. Consider the ethical issues pertaining to the individual pregnant HIV-positive woman.

The pneumonia patient with HIV who was denied treatment

A 45-year-old truck driver with cough, fever and chest pain was diagnosed as a case of pneumonia. Since it was considered to be relatively rare, a screening for HIV was done and he was found to be positive. When the results showed this patient to be HIV-positive, the assistant doctors and managers wanted him to be discharged immediately. This created a very unpleasant situation for the patient. The hospital staff became very vocal about the patient's immediate discharge. The poor patient was kept in the corridor all the time. The patient was discharged and was told to seek treatment elsewhere.

Should informed consent have been obtained in this case before testing for HIV? Consider the ethical implications of first taking a test without consent and subsequently denying treatment.
Would this patient, in your opinion, be justified in suing the hospital? Why/why not?

Would it have been possible to treat for pneumonia without any risk for the concerned hospital staff?

Identify different options available to treat this patient, and at the same time manage the fear of the hospital staff.

As a junior doctor, would you openly have gone against the decision to deny this patient treatment?

The deaf-mute woman in labour

A deaf-mute second gravid woman came to the hospital in labour. She had severe foetal distress and was admitted for emergency caesarean section. A pre-operative HIV test was done without the consent of the woman or her husband. The rapid HIV test turned out to be positive. The baby died in the early neonatal period. A confirmation HIV test on the woman turned out to be positive too. The husband, who was a rickshaw driver, was requested to undergo a blood test without being told the exact nature of the test. His HIV test turned out to be negative. Their 3-year-old daughter also was HIV-negative. The physician is worried that the woman's husband may throw her out if he finds out that she is HIV-positive.

Why do you think a pre-operative HIV test was done on the woman?

How do you view the fact that consent was not obtained from her and/or her husband? Consider the communication difficulties in this case. How should informed consent be obtained in such cases?

How do you view the fact that the husband was ‘tricked’ into giving blood for an HIV test?

You learn that the woman has no known relatives and that the two met in a nearby town and were forced to marry when they were found in a compromising situation. Does this information change how you would manage the situation?

4.2 Mental Illness

Under this topic, students will look at some of the ethical issues that often arise in connection with the treatment of mentally ill patients. The
management of mentally ill patients involves complex ethical issues. Here, the aim is to introduce the student to some of these. A cross-cutting issue in connection with mental illness concerns the extent to which the patient can be considered capable of autonomous decision-making. Also, the issue of making treatment available for the mentally ill in resource-poor environments remains an important focus for the discussion of ethics.

The facilitator using the scenarios provided in this section should involve psychiatric expertise and should consider national legislation and institutional policies of relevance for the issues raised.

**General learning objective**

The students are, at the end of the session, sensitized to the special ethical obligations for physicians dealing with mentally ill patients. They are also able to formulate for what reasons and under what circumstances respecting the patient's expressed wishes can be secondary to other concerns.

### 4.2.1 Treatment against the patient's wish

In this section, the issue is on what basis a treatment is carried out against the will of a patient. In the scenario about the man who was admitted against his will at his family's request, the psychiatrist in-charge states that the family forced him to admit the patient even if there was no psychiatric diagnosis to justify the decision. Students should identify the ethical values implied in the decision and discuss possible consequences. Compare with the scenario of the doctor who was admitted against his will. Here, the issue is complicated by the fact that the patient is a medical doctor who strongly refutes a psychiatric diagnosis. Medical treatment is attempted without his knowledge before he is lured to visit the psychiatric hospital under the impression that he is to discuss the treatment of his wife.

**Specific learning objective**

Students are able to formulate reasons why the admission procedures in these scenarios are ethically justifiable or unjustifiable, given the diagnoses and the description of the two cases. They are able to formulate general principles that are in accordance with their own reasoning.

### 4.2.2 Mental illness and stigma

The fear associated with loss of control over one's own actions contributes to the widespread stigma and social exclusion of patients with mental illness. At the same time, patients often depend on the support of their close relatives.
The issue is, how physicians should inform relatives of the disease in cases where this is believed to have serious negative consequences for the patient. In the scenario of the wife with acute psychosis, the physician is requested not to inform her husband of her illness as he may then want to divorce her. Compare with the scenario of the absconding girl who became involved in commercial sex work. Here, the patient is a child, and the crucial issue is not so much the diagnosis itself as the management of confidential information. The physician has informed the patient's mother but not her father that the patient during absconding has been involved in commercial sex activities. Once students have settled their opinions about the first two situations, the scenario with the family who refused to take back a mental patient after end of admission can be introduced. Here, the rejection of the patient by his relatives is obvious. After having discussed this case, students should review the issues pertaining to the first two cases in this section again and it should be noted whether any students have changed opinion, and why.

**Specific learning objective**

Students are able to identify the ethical issues involved in the above scenarios and consider the best interests of the patient.

**4.2.3 Legal-administrative barriers to treatment**

Legislation concerning mental illness differs among countries. In addition, there may be policies at the institutional level that determine case management in particular circumstances. Sometimes, physicians may be placed in a situation, where the circumstances under which the patient is brought to the hospital form a barrier to necessary treatment. The scenario of the woman brought by the police illustrates this point.

**Specific learning objective**

Students are able to formulate the ethical implications of not being able to give necessary treatment in a case like this.

**4.2.4 Protection of vulnerable patients**

Mentally ill patients may in different ways be more vulnerable than others. In the scenario of the psychotic kidney donor, the story of a girl with psychosis who had been identified as a potential kidney donor brings out ethical issues
related to compromised autonomy and the inability to give valid informed consent. Students should discuss the roles of the family members and treating physicians in the decision-making process and the conflict of interests in the kidney donor case. Mentally ill patients are also particularly vulnerable to violent and sexual abuse. Such abuse may in itself cause or aggravate mental illness. In the psychiatric case involving allegations of sexual misconduct, a colleague has allegedly made sexual advances to the patient. Here, students should discuss the underlying conflicting values and should consider the significance of the fact that the victim is a mentally ill female patient and the alleged offender is a physician who is a colleague.

Specific learning objective

Students are sensitised to the special ethical obligations of the physician dealing with vulnerable and mentally impaired patients.

Legislation of relevance to psychiatric treatment and mental illness differs across countries. The facilitator should be conversant with existing legislation and regulations of relevance to this issue in the concerned country. If necessary, these should be distributed among students as part of the training.

See literature section, entry on "Special topics": Pandya, S. K. (1997).

Learning scenarios

The man who was admitted against his will at his family's request

Physician: It happened when I was on emergency duty last Monday that a 30-year-old male patient was brought. I had already seen him more than three times before. The patient had no overt psychotic features when I saw him. However, his relatives forced me to admit the patient in the hospital against his will because the patient was very hostile to the family members, he spent a lot of money, he was aggressive at times, and he damaged the family possessions. When I saw the patient, he talked and acted very normally. He answered my questions as a normal individual. However, his personality seemed to be a little odd - somewhat antisocial behaviour, like a sociopath. This kind of behaviour is very common in psychiatric patients who are drug addicts or have alcohol-dependence syndrome.

Consider the sentence "his relatives forced me to admit the patient in the hospital" and discuss its ethical implications.
Physician: When I saw the patient, there were no overt psychotic features. Nevertheless, I decided to put the patient in the hospital as a crisis intervention between the patient and the family.

Interviewer: What did the family ask?

Physician: They asked for forced admission in our hospital.

Interviewer: How did the patient respond?

Physician: The patient refused to be admitted. However, I ordered his admission but we cannot do anything for that patient in the hospital. The patient settled in the ward. He had no psychotic features, and we did not give him any medicine or treatment. Another option would have been to discharge the patient, have regular follow-ups, listen to the patient's problems, and discuss means of problem-solving. Then, we would have had the family section for both the patient and the family. But because of lack of time and because the family was neglecting his condition it was not possible.

But now the patient is behaving very well in the ward. He is polite and obeys all orders. Sometimes he even helps us to distribute medicines to other patients. I have a feeling of guilt because I put the person in the hospital against his will and without a strong justification.

How do you view the diagnosis 'sociopath' in this context?

How do you view admission against the patient's will as a means to solve a family crisis?

In your country, would this admission procedure be legally acceptable for a case like this?

The doctor who was admitted against his will

Physician: This was a doctor who was suffering from a mood disorder. His wife, who had two children, came and saw me in the OPD. She complained that her husband was spending money, wandering about and had sexual relationship with other women. There was an unacceptable behaviour and sometimes he had aggressive outbursts. She believed that her husband was not in a normal condition. She said that her husband, being a doctor, would
never accept that he had a psychiatric problem. Earlier, she had come to our ex-professor at his private clinic without the patient. She had received some medication for him from that medical doctor, but her husband never took the prescribed medicine, even though she tried to hide the medicine in the meals he took.

Think about this case. Do you think it was justified to attempt to give medicine in this secretive way in this case?

Consider the fact that the patient had not been medically examined and the possibility that the wife might want to avenge her husband’s extramarital affairs. Discuss various options and identify their ethical implications.

Physician: When she came to me she said that her husband could not be managed at home and that he needed admission. First I had to see the patient. She had to bring the patient to me at the OPD. After having talked with the patient, and depending on his condition, I might admit him. She said that he would never come and see the psychiatrist in that environment, because he said he had no illness. But I said to his wife, "With any kind of action you must take the patient to me to see and interview him."

She then discussed with her brother-in-law and they told her husband that she was in a state of depression, and that he should discuss her treatment with the doctor in that hospital. Then the patient - that doctor - he drove in his car to the OPD and saw me and discussed about his wife. He said that he would consent to do anything on his wife, including ECT (Electro-Convulsive Therapy).

After talking about fifteen minutes with him I found that he was suffering from a little bit of mood disorder and hypomania. But I never said directly to him that he was suffering from a mental illness. I told him to see his wife in the hospital ward. This was not actually true. I told him to discuss about his wife with the ward staff and Medical Officer concerned. I sent him to the ward along with the ward attendant and his brother. In the ward, he was physically and chemically restrained by the staff.

Discuss the indication for admission of this patient against his will. Do you find this procedure ethically justifiable in this case? Why/why not?
The case of the wife with acute psychosis

Physician: A 23-year-old female patient has been admitted in the ward for four weeks. The diagnosis is acute psychosis and the prognosis is good. We are hoping that she will recover in two weeks' time and after 3-4 months of medication she should not require further management. She has been married for about one year and was brought by her parents. The parents have asked us not to let her illness be known to her husband. When her husband came to the ward and met the patient he requested information about her illness from the doctors. This posed an ethical dilemma for us because we have the patient's best interests in mind and we hope that she will have recovered in a few weeks' time. We complied with the request not to inform the husband, although we felt that his involvement in her treatment and subsequent care during follow-up could be better for the patient. If the medicines are discontinued, the chances of relapse are very high.

Describe the ethical dilemma in this case and consider the possible consequences of different decision options.

Do you agree with the decision not to inform the husband in this case?

Physician: We told the parents and the patient that taking the husband's help would actually be better for her treatment and welfare. Accordingly, they have requested us to take him in confidence in their presence. But they still do not accept that the husband should be fully informed about the patient's condition. We are afraid that the husband may decide to leave her but we also feel that hiding information from close family members may be incorrect and unethical. But one of my colleagues feels that our primary responsibility is toward the patient and those who brought her for treatment.

The physicians in this case put some pressure on the parents and the patient to obtain their consent to inform the husband. Do you agree with this procedure? Why/why not?

Suppose the husband is informed and subsequently decides to divorce his wife. Would the decision to inform him then have been wrong? How should it be decided whom to inform in such cases?

Does the husband have a right to know about his wife's disease?
Does the wife have a right to decide who should be informed?

Would you have a different opinion on this case if the husband was ill and he and his parents did not want to inform his wife?

Would it make a difference to your opinion if you discovered that the wife had a similar episode prior to her marriage? Why/why not?

**Physician:** Another option was to tell the husband that we will refuse to discuss anything with him because the patient and her parents were not giving us the consent. This we could have easily done. There could be another option also. We could take legal advice and request the husband to file an application to give him information, but we usually prefer not to involve ourselves in too many legal tangles because we are neither competent to handle that nor are we aware of such rules and regulations. The hospital policy is not clear on this issue and we don't have enough time to go deep into such matters.

Consider two options in this case: 1) the doctors accept the request not to inform the husband according to the principle of confidentiality of patient information, implying a possibility that he seeks information through legal process, and 2) they inform the husband of his wife's condition. Describe the ethical implications of these two options and discuss which option you consider to be best.

The absconding girl

**Physician:** One day there was a 16-year-old girl who came to my clinic. She presented with sleep disturbance, laughing and crying alone, desirous of wandering, not eating well and not sleeping well. So, I treated this patient for stress reaction. I gave her anti-psychotic and anti-depressants. During the first week, her mental state became more settled. But then she developed more mental symptoms and she said that she had lost her honour and virtue as a human being. I asked her what she meant by this. She told me that one day she quarrelled with her mother and ran away from home. She went to her boyfriend who was a heroin addict. He sent her to a brothel where she was made to work as a sex worker. Her clients paid well but she was not allowed to keep the money. After one month, after an argument with the brothel owner, she managed to get back home with the help of a girlfriend. This girlfriend told her mother that she had been living with her for one month. But the girl was mentally disturbed and was brought to me.
The girl had studied only up to fifth standard in school. She had two sisters who were better educated. They were joining the university. She had very little education and faced many problems in her family. She had to work hard in her home.

Now, I am not sure if I should tell her father about this event. Her father is a company manager. If he came to know these events he would be ashamed and might become aggressive. But if he is not informed, it might happen again. I told her mother what happened and she was disappointed, alarmed and fearful. The girl had given me the permission to tell her mother. But I think I will not tell the father.

Reflect on this case. Do you agree with the physician to inform the mother and not the father about the events during the girl's absconding period? Consider possible scenarios for the patient with different decisions made.

As a doctor, what would you do if the father asked you directly whether you knew what happened to the girl during that period?

Is it important for your decision that the girl is only 16 years old?

The family who refused to take back a mental patient after end of admission

Physician: It is a case of schizophrenia. The male patient is now settled with treatment. However, his family does not want the patient to be discharged from hospital. They said that the patient was very aggressive before coming to the hospital. But, in the hospital the patient was settled, and the patient's condition was quite suitable for living with the relatives in the community. Psychiatric patients account for one per cent of the general population. We can accommodate only 1,200 patients in our hospital. So, the majority of the patients are in the community. The patient's family would not take the patient home, and this is my problem.

In this case, the follow-up treatment of the patient is likely to depend on the cooperation of the family. What is the physician's dilemma and what are the options in a case like this? Do you see this as a problem for the physician or as an internal family problem?
The psychotic woman brought by the police

**Physician:** This patient I saw in the Casualty. She was an unknown lady brought by the police with suspected mental illness. She was found wandering about near the airport. She was about 35 years of age and unidentified. She did not even give her name and address fully. She was referred from the airport police station for examination and for treatment. I, along with a junior resident, examined her later in the evening and we found her clearly to be suffering from a psychotic illness. She also had bodily injuries, which needed some attention. Our main dilemma was: because she was not accompanied by any family member we were not expected to admit her in the hospital because of the rules. She was registered as a medico-legal case in the Casualty.

In this case, there is no person present to give consent for treatment. Discuss how you think physicians should deal with cases like this.

Why do you think the hospital regulations do not permit admission of this patient? What are the ethical implications of this policy?

The psychotic kidney donor

**Physician:** This was a 22-year-old woman who had been under treatment for psychosis from age 18. She lost her father when she was young and her two older sisters had been married off. The family was under the care of her mother's brother, who was always kind and benevolent to them.

Now, the uncle needs kidney transplantation and this girl has been identified as a possible donor. The nephrology department referred her to the psychiatrists. The girl has been on medication intermittently and the psychiatrist was of the opinion that she lacked insight to offer informed consent. Her condition could improve in about three months with proper treatment when she could be re-evaluated to assess her ability to offer consent.

The mother, on the other hand, feels that as the girl's mother she has the right to make the decision. Her brother's life is in danger. If anything were to happen to him, her own family will suffer. The girl, by donating the kidney, would not be in danger and would have helped saving her uncle's life. She says that "this decision should be left to the family and the doctors should not interfere with that".
Who has the right to give informed consent in a case like this?

Are the doctors justified in refusing to accept a mentally ill patient as kidney donor? Why/why not?

It became obvious in the course of the discussion with the mother that they would go elsewhere to carry out the transplant surgery. Does that absolve the doctor of responsibility in this case?

Consider the fact that the two other sisters were not considered as possible donors.

Discuss ethical versus legal aspects of this case.

The psychiatric case involving allegations of sexual misconduct

Physician: This particular patient is an unmarried woman of 28 years of age, brought by her brother and father. She is suffering from depressive illness with some dissociative symptoms. This illness has been there for about two years now. This patient was being treated by a consultant in the department. But the family had certain grievances against the consultant. They wished to consult me and continue treatment with me. Our department guideline suggests that if a patient is being treated by one consultant, another consultant should not accept the patient unless a discussion has taken place or a clear referral has been made. In this case neither of the two was done. But the details the patient and their relatives gave me persuaded me to take up the patient even without going through a clear referral or a discussion with the consultant. The details were so persuasive that I decided to accept the patient for further treatment. In fact, I got a new card made which, administratively, is something which is very debatable. The patient felt that there were some advances made by the consultant, which made her very uncomfortable. The relatives felt that the behaviour of the consultant was neither professional nor acceptable.

I cannot believe the patient and her relatives fully when they say that sexual advances were made. Although I should not casually ignore these things because it shows the profession in a bad light and can be damaging to the profession as well as to the department. So, it did create a problem for me. I resolved it by taking the patient up for treatment because she needed help and she was not willing to go back to the other consultant. But I did not
do anything concerning the allegations because I was not quite sure if these were true.

Summarize the ethical obligations of the physician towards the patient, towards his colleague and towards the Department in this case. What would you do in this situation?

At this stage the doctor is not sure whether the allegations are trustworthy or not. What would you do if in the course of the treatment you became convinced that the patient had been sexually molested by your colleague? Outline the possible consequences of your decision for all concerned persons.

4.3 End-of-life decisions

In this section, students will explore issues pertaining to end-of-life decisions. Decisions such as when and how to stop attempts to resuscitate terminally ill patients, and when to switch off machines that enable basic bodily functions to continue in brain-dead or deeply comatose patients, are universally difficult. In resource-poor contexts other patients may benefit more from the equipment, and the long-term treatment costs may threaten the economy of the patient's family.

The facilitator using the scenarios provided in this section should involve relevant expertise and should consider national legislation and institutional policies of relevance for the issues raised, particularly concerning the status of brain death in the country.

General learning objective

Students will be able to identify the ethical issues involved in end-of-life decisions. In particular, students will understand the conflict between a physician's duty to save lives and other values, such as using the resources to improve the health of others. The students will also be able to reflect on who should make these decisions, and how.

4.3.1 Switching off a ventilator

The basic bodily functions may be kept running for a very long time in a ventilator, even if there is no hope that the patient will ever be able to regain
consciousness. The issue is, when and how the decision to switch off the ventilator should be made. Often, the relatives find it very difficult to consent to this decision, as illustrated in the scenario with the brain-dead patient and the family's dilemma. Contrast this to the scenario of the terminal patient who did not die. Here, a husband of a deeply comatose patient refused to switch off the ventilator. The wife subsequently recovered. Students should discuss these cases and consider the different perspectives of physicians, relatives, and other patients in need.

**Specific learning objective**

Students can describe dilemmas of informed consent and allocation of scarce resources in the context of switching off a ventilator and they are able to discuss appropriate decision-making processes.

**4.3.2 Use of aggressive treatment in terminal illness**

The balance between 'doing harm' and 'doing good' in terminal illness can be difficult. This dilemma is often aggravated by the strong emotions of relatives involved, particularly in cases where the patient may not be capable of autonomous decision-making. The scenario with the terminal cancer patient illustrates the shift from curative to palliative treatment and the issues involved in decision-making. Compare with the scenario of the child with end-stage kidney disease, who is left to die without treatment. The students should identify the criteria that actually influenced decision-making in these cases and deduct the underlying ethical principles. Secondly, they should decide on the criteria that should guide such decision-making and attempt to rank ethical principles where they are in conflict. If there is no consensus among the students, the different positions should be clarified in terms of which ethical principle is given more importance.

**Specific learning objective**

Students are able to discern factors influencing decision-making in treatment of terminal illness and they are able to analyze the involved ethical principles and rank the values given to ethical principles that conflict in a given case.

Legislation concerning the status of brain death and end-of-life treatment differs across countries. The facilitator should be conversant with existing rules and regulations of relevance to this issue in the concerned country. If necessary, these should be distributed among students as part of the training.
Learning scenarios
The brain-dead patient and the family's dilemma

Physician: There is a patient in the ward who is on ventilator. He is around 40-45 years. He suffered major injuries and is now brain dead. The family members have been explained everything. They are in a dazed state and don't know what to do. Probably, their heart does not allow them to let their loved one go and take the responsibility of switching off the ventilator.

Interviewer: So what do your colleagues have to say on that?

Physician: We cannot do anything. We may discuss it among ourselves but it is pointless. Switching off the ventilator is euthanasia which is not permitted. It also depends upon the family. If they are well educated and reconciled to the idea, then some of them do decide that, OK, you can switch off the support system. But it can go on for days or weeks. In the past, whenever this situation came up, it has gone on like this. Ultimately, when the patient's heart failed, Nature took the final decision.

Can a group of physicians take a decision to switch off the ventilator in this case if it is needed by another patient?

Should the group be assisted by a person with legal expertise?

Discuss legal versus ethical issues in this case.

The terminal patient who did not die

Physician: We had a patient with chronic obstructive airway disease who developed pneumothorax and she was put on a ventilator. She was in her early sixties and able to communicate. We managed her on the ventilator, but it was very difficult to wean her away from the ventilator. Ultimately we discussed with the patient's relatives that she may not make it. If the relatives agreed, we could switch off the ventilator. The husband of the patient said: "You see, she is going to die if you switch off the ventilator. But I will not be able to excuse myself if I let you remove the life support. For my whole life I will feel guilt. So please, continue the ventilator till she improves or dies." To my surprise she recovered very well and I have subsequently discharged her.
This case is a good example of a conflict between limited resources and the nature of the disease itself. We can say that we cannot waste our resources by pulling on with a patient for a long time. This was a collective decision. All involved staff thought that it was wise to switch off the ventilator, but, retrospectively, I can see that it would have been a wrong decision.

Do you think that the physicians were justified in their decision to wean off the patient from the ventilator at the time they made it, in light of the scarce resources available?

Under what circumstances (if any) do you find it ethically justifiable to wean off a patient from the ventilator, expecting the patient to subsequently die, if the patient is not brain-dead?

The terminal cancer patient

Physician: I have been seeing a patient for the last 10 days. This patient has carcinoma. Six months ago when he was operated outside, the impression given by the surgeon to the patient was that there was some kind of a blockage in the intestine and that it had been corrected. Five months later, he came up with a lump in the abdomen and after that he developed jaundice. He has now come to us with a huge lump with jaundice. There are different options available but none of them is very safe and none of them is going to help on a long-term basis. I am sure he is going to die. He has a confirmed cancer. It is not curable, and it is not treatable. So, should you palliate his symptoms and to what extent. In this case, his relatives are very keen that he is not told what is happening to him. I can’t give him any hope and I feel very bad telling him that I can’t do anything. I have already told the relatives. But if he asks me directly, “Am I going to live? Am I going to die? Do I have a cancer?”, then I will tell him the truth. But if he doesn’t, then I will probably end up telling only his relatives.

There have been occasions when after the patient has spent about 40 to 50,000 or 100,000 and goes back home, the relatives ask you the question: “have we achieved anything after we have spent so much money, and should we continue to spend not knowing when it will end?” I often tell myself that I cannot play God. Here you come across situations where a poor man has 40,000 in his bank, he’s got a house and if he dies he’s going to leave behind three children and a wife who doesn’t earn. So is it worth that his family spends all of that on him and then be out on the street after he dies?
Do you agree with the doctor's position here that he will not give the patient himself the choice of treatment?

Does it make a difference that the treatment is very expensive?

The child with end-stage kidney disease

**Physician:** The other day we had a child who had an end-stage kidney disease. The child had very severe hypertension and was in pulmonary oedema. He was not passing urine. The parents were urging us to do something. We did peritoneal dialysis and exchange transfusion and gave aggressive drug therapy to bring down the blood pressure. It did come down but the child did not start passing urine. Then we knew that nothing more could be done and the child had to die.

We told the parents that nothing more could be done but they said, do whatever is possible. They were ready to spend any amount of money as they had sold some of the property for this purpose. And, finally, when the parents refused to accept the reality, I took a decision along with the residents and senior residents that if the child would develop more infections we would not make any changes in the drug intake. We would allow the child to die. About 7-8 days later the child died. I am not sure whether we are empowered to take such a decision. But we do take such decisions almost everyday.

Here, the decision of the physicians went against the will of the parents. Discuss the ethical implications.

Do you find the decision to stop treatment in such cases ethically justifiable?

### 4.4 Organ donation and transplantation

In this section, students will work with certain ethical issues related to organ donation/harvesting and transplantation. Decisions on whom to offer this expensive treatment in a resource-poor environment, where it may be difficult for some patients and families to follow subsequent necessary lifelong follow-up treatment, have to be made in a context of chronic shortage of organs. This section may be explored in connection with Section 4.3 on end-of-life decisions and Section 3.1 on allocation of scarce resources.
Appropriate information about the country's legislation concerning organ donation and transplantation should be provided in connection with the training session.

**General learning objective**
Students are sensitized to the ethical issues involved in organ harvesting and transplant treatment.

**4.4.1 Offering organ transplantation**
An organ transplant operation is very expensive, both in terms of the immediate costs in connection with the operation and in terms of its life-long follow-up treatment, and some doctors may consider it futile in certain cases to offer this type of treatment. This dilemma is illustrated in the scenario of the baby with biliary atresia who needed a liver.

**Specific learning objective**
Students are able to formulate ethical dilemmas and values in connection with the inequitable distribution of organ transplantation as a treatment of choice.

**4.4.2 Donation of an organ**
In some countries organ donation is allowed from live donors (in contrast to brain-dead patients) if there are close familial ties between the donor and the recipient. This is meant to ensure that the organ is donated out of compassion for the recipient, the underlying assumption being that a family member would not be pressurized to donate an organ. This issue is complicated by the existence of illegal trade with organs at national and international levels.

The scenario of the woman who was forced to donate her kidney illustrates that it may be very difficult for the physician to evaluate the relationship between a donor and a recipient, and even if this can be established, there may be indications of coercion. Compare this with the scenario of the psychotic kidney donor, where the family ties are not in question but the donor is not able to give informed consent due to her illness.

**Specific learning objective**
Student can identify ethical dilemmas concerning informed consent, patient autonomy and non-maleficence and discuss relevant principles, which may guide the decision-making process. They can describe ethical obligations
towards the donor in terms of possible post-operative complications. They are sensitized to the harmful effects of illegal trade with organs.

Legislation of relevance to organ donation and transplantation differs across countries. The facilitator should be conversant with existing rules and regulations of relevance to this issue in the concerned country. If necessary, these should be distributed among students as part of the training.

See literature section, entry on "Special topics": Phadke KD, Anandh U. (2002) and Ivanovski et al. (1997).

Learning scenarios
The baby with biliary atresia who needed a liver

**Physician:** We had a 7-month-old boy with biliary atresia. He had been operated elsewhere. The operation had not been successful and the child had developed liver failure. The only option available was a liver transplant. However, the parents were poor and could not afford the operation and post-operative treatment with immunosuppressants. I told the parents that they would not be able to afford it. Knowing that this treatment is available, we were in a dilemma whether to go ahead with preparations for this treatment or tell the parents, "look this is the end of the road for your child."

The physician in this case assesses the family's economic situation and informs accordingly. What are the ethical implications of this approach?

What would have been the deciding factors if the family had had sufficient resources?

**Physician:** The prognosis of the disease itself is very poor, but following liver transplantation, at least in Western centres, it is very good. We have not yet done liver transplantation in children, but having had some training in the procedure, I am quite confident I can do it. But the reasons for not offering it to the parents were economic and various technical problems associated with liver transplantation. As things stand at the moment in this country, donors have to be taken either from brain dead individuals or living relatives, mostly parents. Now, the problem was that both the parents were earning members of the family. Particularly in a low socioeconomic group, if one of the earning members has to go out of job for more than one or two months, then the family has a difficult time trying to make ends meet. I thought I would be doing the family a favour by not offering this kind of treatment.
The physician feels confident that he could do liver transplant surgery. Discuss confidence versus competence in this case.

Consider the child's prognosis with and without treatment. Do you agree that the physician is doing the family a favour by not informing them of the existing treatment options?

In this case the patient is a baby. In your opinion, would it make a difference if the patient had been seven years old? Or if he had been 17 years?

The woman who was forced to offer her kidney

**Physician:** This was a case of a woman of 22 years of age who came to donate a kidney for our patient who was supposedly her brother. She was a good match, but I strongly suspected that she was not related and was either being coerced or being paid to donate the kidney. We have a policy against doing transplants from unrelated donors. We make it very clear that we will consider a transplant only if the donor is related to the recipient and is not doing it for gain. I asked her several times but she said that she was his sister. I still had my suspicions, so I sent her to a psychiatrist for assessment. She was of subnormal intelligence and did not understand the procedure.

Think this case through and try to identify all ethical issues involved. Try to weigh them against each other and decide what you would do in this case.

**Physician:** We could have refused to do the operation here, but they would have gone to some other centre and had it done anyway. So, we carried out the operation. Much later, we learned that she was a paid, distantly related person who was possibly forced by her family. We are trying to avoid that this becomes a commercialized process of buying and selling goods in the market.

Do you agree with the decision to carry out the operation in this case? Why/why not?

Does it make a difference for your opinion that the suspicion of coercion was subsequently confirmed?

**Physician:** We have pioneered the process of renal transplantation in the country and we have found that our results are comparable to the advanced centres in the West. A very important cornerstone of our policy is that we do not accept unrelated donors. Many hospitals in our country allow unrelated
Specific Health Issues

donations. The demand for transplants is far greater than available donors can meet. We do not have a government-approved cadaver organ harvesting policy. So the patients have to rely on willing relatives or buy it in the market. It would cost the recipient a big sum of money and then there is the cost of life-long immuno-suppression. Some people can afford this and they create a demand for kidneys from unrelated willing donors. The donors desperately need the money and the doctors tell them they can manage with one kidney. Innocent people, underprivileged, unrelated or distantly related, are coerced or even tricked into giving a kidney. Sometimes they don't even know it. They may not be given any money or less than what was promised. This is not new; we have had quite a few reports already. The implications are very serious as have been seen in many developing countries.

We had another case where the donor was clearly a first cousin of the patient and was apparently willing. We had some vague feeling about her and sent her for psychiatric assessment. They found that she had subnormal intelligence and had no clue about the issue, the procedure and what it meant for her. We refused. The patient and his family, and even the donors' parents were upset with us.

Consider the context outlined by the physician. Describe the ethical dilemmas in this situation. Under these conditions, how do you view patient's rights and donor's rights, respectively?

Does the donor become a patient in the process?

Compare the case where an operation was carried out with the one where it was refused. How was it possible to arrive at two different decisions in these two cases? Discuss the ethical values involved in the different decisions?

The psychotic kidney donor

Physician: This was a 22-year-old woman who had been under treatment for psychosis from age 18. She lost her father when she was young and her two older sisters had been married off. The family was under the care of her mother's brother, who was always kind and benevolent to them.

Now, the uncle needs kidney transplantation and this girl has been identified as a possible donor. The nephrology department referred her to the psychiatrists. The girl has been on medication intermittently and the psychiatrist was of the opinion that she lacked insight to offer informed
consent. Her condition could improve in about three months with proper treatment when she could be re-evaluated to assess her ability to offer consent.

The mother, on the other hand, feels that as the girl's mother she has the right to make the decision. Her brother's life is in danger. If anything were to happen to him, her own family will suffer. The girl, by donating the kidney, would not be in danger and would have helped saving her uncle's life. She says that "this decision should be left to the family and the doctors should not interfere with that"

Who has the right to give informed consent in a case like this?

Are the doctors justified in refusing to accept a mentally ill patient as kidney donor? Why/why not?

It became obvious in the course of the discussion with the mother that they would go elsewhere to carry out the transplant surgery. Does that absolve the doctor of responsibility in this case?

Consider the fact that the two other sisters were not considered as possible donors.

Discuss ethical versus legal aspects of this case.

4.5 Medical termination of pregnancy

Under this topic, a number of learning scenarios have been collected on ethical issues pertaining to medical termination of pregnancy (MTP). National legislation differs widely and in important ways on this issue. The ethical dilemmas that appear in this section would be evaluated differently in different legislative contexts. This section should be used in connection with detailed information on the relevant legislation in the concerned country.

It is important to note that the guidelines below may not take all legal matters into considerations. It remains the responsibility of the user of this material to ensure that students are advised according to the existing legislation of the country concerned. In some countries, MTP is offered according to certain criteria, such as the pregnancy endangering the life of the
mother, or the foetus having severe malformations or genetic diseases, and in other countries it may not be legal under any circumstances. Accordingly, not all scenarios are relevant in all countries. Prior to using any given learning scenario, the facilitator should determine the relevance of the scenario in the context of national legislation in the concerned country. For advanced discussions, the scenarios can also be used to compare ethical issues under different legislative frameworks.

It has often been argued that women should have the right over their own body, including pregnancy. Particularly in resource-poor contexts involving gender inequity, lack of basic education and high birth rates, it may not be the choice of the woman to become pregnant. At the same time, all religions consider life as sacred, and some see termination of pregnancy as violating the basic tenets of their religion.

**General learning objective**

Students are able to discern the ethical principles that are applied when physicians agree or reject to perform MTP in a given legislative context. Students are able to identify and understand ethical dilemmas involved in MTP.

**4.5.1 Pregnancy endangering the life of the woman**

The scenarios of this section are relevant in contexts where MTP is legal when a pregnancy involves a significant risk to the life of the pregnant woman. In the scenario where a request for medically terminated pregnancy is not being met, the physician denies the woman's request to have an abortion. The woman has delivered by caesarean section three months earlier. Students should consider the importance the risk to the mother is given in this case versus other ethical values. Contrast this with the scenario of a medically terminated pregnancy to prevent unauthorized abortion procedure. In this case, the legal and religious framework is similar, but the conclusion drawn is the opposite. Compare with the scenario of the diabetic mother who refused a medically advised abortion procedure and consider what factors are important and what options the physician has. Discussions on the latter scenario should involve the issue of patient autonomy. The facilitator should explore whether male and female students view this question differently and discuss the related issue of whether they believe that the sex of the treating physician is a factor in clinical decision-making about MTP.
Specific learning objective

Students are able to analyze what factors influence decision-making in MTP due to risk to the pregnant woman’s life, including gender issues.

4.5.2 Prenatal diagnosis

Prenatal diagnostic techniques have made it possible to detect serious disease in the foetus. In some countries this is a legally valid reason to perform MTP within a certain gestation period. This raises the question whether diagnostic testing should also not be performed after that point in time, as discussed by the physician in the scenario about prenatal diagnostics and medical termination of pregnancy. If serious disease or malformations are then identified, there may be a medical indication for MTP, but it will no longer be legal. Compare this with the scenario of an illegal abortion of an anencephalic foetus. In this case, it is not legally acceptable to carry out the intervention. The facilitator should ensure that the scenario is not used to justify that a physician takes the law in his/her own hands.

Specific learning objective

Students can analyze ethical dilemmas and legal implications in a context where MTP is considered on the basis of prenatal diagnosis.

4.5.3 MTP versus prevention

In countries where MTP is legal, physicians may find it ethically problematic if they believe that this procedure in some cases merely replaces the use of available prevention methods. The scenario of the young mother requesting an MTP illustrates this point. Students should discuss the possibility that the young mother in the first case was not allowed to decide on prevention issues. They should reflect on the decision to provide information about prevention without involving the husband and they should discuss the gender issues involved.

Specific learning objective

Students are able to discern the ethical dilemmas involved when MTP is legal under the given circumstances but repeatedly used instead of prevention methods, including in situations where the woman may not be empowered to decide on the use of prevention methods.

Legislation concerning MTP differs across countries. The facilitator should be conversant with existing legislation and regulations of relevance to this issue in the concerned country. If necessary, these should be distributed among students as part of the training.

**Learning scenarios**

Request for medically terminated pregnancy not met

**Physician:** After a caesarean section, adequate spacing before the next pregnancy is recommended, because the operation requires a recovery, and the child requires sufficient attention from the parents. If the mother is pregnant too soon, it would be hazardous and also limit her attention to her child. I had a case where I suggested that the mother should participate in family planning. However, the husband was not very supportive and the wife became pregnant again only three months after the caesarean section. She pleaded, "Please help me, doctor. My child is still very young". I was not only concerned with the caesarean section, but also spontaneous delivery. It would be difficult if the mother became pregnant again while her child was only three months old. She gave various reasons such as her occupation, etc. From our perspective, it is difficult. How to deal with it from a religious point of view? Whether it could be aborted or not. That's where our dilemma lied. We suggested her to continue with her pregnancy. I explained to her about the indications for abortion, such as congenital anomalies. The couple did not take family planning seriously. She remained insistent. However, I kept suggesting to her to continue her pregnancy, unless there was bleeding or heart disease or another dangerous condition, in which case there was no other choice. But I knew for sure that it would endanger the mother to go through with the pregnancy because I had performed the caesarean section myself. However, if all proceeded smoothly, I would convince the patient that there would be no problem. I could easily have referred the patient to a colleague who usually performs abortion.

Think about this case and consider the following issues:

- Prevention has been advised following the caesarean section but has not been practiced;
- The husband has not cooperated to avoid pregnancy;
- The mother has a strong wish to terminate the pregnancy;
- The pregnancy may be dangerous for the mother, given the recent caesarean section.
How do you view the decision of the physician in this case?

How do you weigh the above factors?

Medically terminated pregnancy to prevent unauthorized abortion procedure

A patient had a caesarean section four months earlier. She conceived soon after and did not want to continue with the pregnancy. Initially, the doctor did not agree to an abortion, but ultimately the pregnancy was terminated after 7-8 weeks.

Physician: I could have explained to the parents to continue the pregnancy. However, I knew that they were desperate to get it terminated and would have gone to some unauthorized person to get an abortion done.

Think about this case and compare it with the previous case where the opposite decision was made. Here, the physician takes into account that an illegal abortion carried out by a quack will be dangerous for the mother. Discuss the decision made and the ethical implications.

The diabetic mother who refused a medically advised abortion

Physician: A young pregnant woman from a poor family came to the hospital. She had two spontaneous abortions previously. She was diabetic with complications such as nephropathy, hypertension and retinopathy. Her kidney function was very poor. She was advised abortion as it would be very risky for her to continue the pregnancy. Continuation of the pregnancy would further damage her kidneys. But she wanted to continue with the pregnancy at any cost. She would rather die than abort. Her husband did not mind an abortion and was even willing to adopt a child, but she said if she was not able to have a child of her own her husband would leave her. She was willing to risk her life.

Consider this case. What would you do as a physician?

The patient is exercising her autonomy. The physician knows that her decision would endanger her life but also indicates that she is mentally capable of autonomous decision-making. Should the physician set aside the patient's right to autonomous decision-making in cases like this?
Prenatal diagnostics and medical termination of pregnancy

A 24-year-old woman is referred for prenatal diagnosis at 32 weeks of gestation as the foetus has been detected to have duodenal atresia. There is a strong suspicion that the foetus may have Down syndrome. The doctor is undecided whether he should do amniocenteses to detect chromosomal abnormality or not. Medical termination of pregnancy is allowed till 20 weeks of gestation in this country.

Identify any ethical dilemmas in this case.

You decide to carry out an amniocentesis. Trisomy 18 is found. What will you do?

The illegal abortion of an anencephalic foetus

A diagnosed case of an anencephalic foetus in a 26-year-old mother comes to the doctor for termination of pregnancy. According to the law in this country, he cannot terminate this pregnancy.

The physician feels that he cannot let the mother go through the pregnancy knowing the condition of the foetus. The mother has been told by the radiologist that there is no head. She is herself a hospital employee. The physician is aware that he may be taken to court if he terminates the pregnancy. He discusses the situation with the radiologist and they agree to perform an abortion.

Summarize all factors that you think are relevant to make a decision in this case. How do you view the decision taken?

Do you think it made a difference in this case that the woman was a hospital employee?

The young mother requesting an MTP

Physician: We had a young teenage girl who delivered with us four months back. While discharging, we advised her to get a copper-T inserted for contraception. She refused contraception and came back with pregnancy. We had performed a caesarean section four months earlier on her. She demanded medical termination of pregnancy (MTP). From a medical perspective she should not produce another child so soon. She conceived despite our advice to the contrary. An MTP so soon after a caesarean section has its own difficulties.
There is a higher risk of perforation of the uterus, injuries, haemorrhages, etc., though in expert hands the complications are few. But still there can sometimes be fatal haemorrhage or rupture, leading to hysterectomy.

They never realize the seriousness of it. Nothing may happen in 99% of cases and some may feel happy that instead of contraception they just get an MTP done. The woman was told about the regular use of contraception and was also told not to conceive. But it's not just the woman; it's the man who is not able to control himself or doesn't want to use condoms. The woman has to face the consequences.

In this case the mother seeking termination of her pregnancy is a married adolescent girl. Who should make the final decisions in such cases, given that abortion is legal in this country?

Do you think this case raises an ethical dilemma? Explain why.

Does it make any difference that the girl has been advised to use contraceptives?

Does it make any difference that she may not be in control of decision-making concerning use of contraceptives?
ANNEX 1: THE SEAHEN PROJECT

South-East Asia Health Ethics Network (SEAHEN) was formed in 1997 to conduct a study commissioned and coordinated by the World Health Organization (SEARO). The objective of the project was to promote education of medical ethics as well as practical use of medical ethics in clinical decision-making and in health policy-making. The project was designed as an integrated research-cum-teaching project in six countries in the WHO SEA Region: Bangladesh, India (two sites), Indonesia, Myanmar, Nepal, and Sri Lanka. One of the important goals of the project was to develop this CD-ROM on "Teaching Health Ethics: Resource Materials from the WHO SEA Region" based on qualitative interviews with physicians in teaching hospitals in the above countries.

Based on the work of the SEAHEN group, a WHO documents series has been produced, which provides further background information on health ethics in the WHO South-East Asia Region.

Volume 1: Health ethics in six SEAR countries

Volume 2: Ethical dilemmas and resource allocation: Two questionnaire studies

Volume 3: Ethical issues in clinical practice: A qualitative interview study in six Asian countries

Volume 4: Teaching Health Ethics: Resource Materials from the WHO SEA Region (Available on CD-ROM)

FIELD-TESTING

Prior to its release, the resource materials have been extensively field-tested in seven teaching hospitals in Bangladesh, India, Indonesia, Myanmar and Thailand. A workshop was held in Bangkok on 16-18 August 2004 to review the findings of the field-testing and revise the materials accordingly. Presentations of the findings from the seven institutions as well as the workshop report are available on the CD-ROM "Teaching Health Ethics: Resource Materials from the WHO SEA Region".
ANNEX 2: TECHNICAL REQUIREMENTS

To benefit fully from the various facilities and options available in this CD-ROM, please note the following:

It is not required to be connected to the Internet to use the resources on the CD-ROM. However, the following software is required:

- Microsoft® Internet Explorer® 5.0 or later or Netscape® 5.0 or later;
- Acrobat Reader® v. 6 or later. You can download versions for other platforms at www.adobe.com.

There are no hardware requirements in addition to those needed to run the above programs. This CD has been optimized for a screen resolution of 1024 X 768 pixels.

Hints when using the CD-ROM

This CD has an autorun feature that will launch the programme automatically when the CD is inserted in the computer. In case autorun is disabled on your computer, you will need to open the file named "index.html" to start the programme.

Note that all text links on the CD-ROM are recognized by their blue colour and that, unless your computer is set up differently from the Windows standard, a hand will automatically appear when you drag the cursor over a link.

If you are using Microsoft® Internet Explorer®, you may press F11 to toggle full screen view on and off. This may be particularly useful if you use the CD-ROM in connection with an LCD-projector.

Note also that you may print handouts to students from the PDF-files located under each key issue. The complete teaching guidelines and learning scenarios are available as a single PDF-file under the SEAHEN entry (Volume 4: Teaching Health Ethics: Resource Materials from the WHO SEA Region).
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ANNEX 4: REFERENCES

This section contains references to literature about health ethics of relevance to the countries of the WHO SEA Region. Only texts available in English have been included. The list is in no way exhaustive or representative, and the texts have not been selected to present particular views. To increase access to a body of literature that otherwise might not be available during health ethics teaching in the Region many of the texts below have been included in full-text versions on the CD-ROM. In addition, facilitators are expected to make locally available literature accessible to students.

Examples of national legislation

Bangladesh

India
Consumer Protection Act, 1986
The Medical Termination of Pregnancy Act, 1971
The Mental Health Act, 1987
The Pre-natal Diagnostic Techniques (Regulation & Prevention of Misuse) Act, 1994
The Transplantation of Human Organs Act, 1994

Nepal
Nepal Medical Council Act of 1964

General overview


Codes of conduct

India: Code of Medical Ethics
Myanmar Medical Council Guideline for General Medical Practice
Nepal Medical Council Code of Ethics

Topics of health ethics

Doctor-Patient relationship


Patient autonomy and informed consent

WHO (SEARO) Health Ethics in South- and Southeast Asia document series
Volume 2: Ethical dilemmas and resource allocation: Two questionnaire studies


Truth-telling in serious illness


Issues of health policy and equity

WHO (SEARO) Health Ethics in South- and Southeast Asia document series
Volume 2: Ethical dilemmas and resource allocation: Two questionnaire studies


Special topics


U MYA TU: Humanism and Ethics in Medical Practice, Health Services, Medical Education and Medical Research

Research ethics

(Case studies)

"Bangladesh - An International Research Centre." Lancet 311 (8057): 202


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