Ethical Challenges in Everyday Practice

It’s often not the life-and-death ethical issues that physicians wrestle with; rather, it is the gray-area conflicts that don’t fit neatly into a traditional rule-based, codified approach. In this chapter some experienced physicians offer advice on how to prepare for these challenges.

**Chapter in Brief:**

- The very nature of ethical conflicts makes it difficult to devise firm rules or policies that fit the wide range of issues that crop up in day-to-day practice. However, there are guidelines that can help physicians navigate murky waters.
- When physicians feel unsure about how to deal with a situation, it can help to talk it out with experienced colleagues.
- Poor communication may not be the source of ethical conflicts, but it can exacerbate the problem, turning a minor disagreement into a major incident.
- When physicians take time to think about their reactions and place the situation in an ethical context, they may be able to identify the source of the conflict and devise a solution.

In cases of clinical and situational ethics, there are no simple rule books to refer to—no manual can cover all the situations that can arise during the patient encounter.

“In ethics, written codes really don’t work all that well unless you believe them before you read them. Then what they do is articulate your stance,” Faith Fitzgerald, MD, assistant dean of humanities and bioethics at the University of California-Davis Health System, maintains. “I don’t want to codify ethics because there will be situations where it is not easy—where you will be...
I have type 2 diabetes. This is...

my 24/7 glucose control

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Indications and usage
Levemir® is indicated for once-or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long-acting) insulin for the control of hyperglycemia.

Important safety information
Levemir® is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

Hypoglycemia is the most common adverse effect of all insulin therapies, including Levemir®. As with other insulins, the timing of hypoglycemic events may differ among various insulin preparations. Glucose monitoring is recommended for all patients with diabetes. Levemir® is not to be used in insulin infusion pumps. Any change of insulin dose should be made cautiously and only under medical supervision. Concomitant oral antidiabetes treatment may require adjustment.

Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. Levemir® should not be diluted or mixed with any other insulin preparations. Insulin may cause sodium retention and edema, particularly if improperly used or improperly used in improperly used hypoglycemia. Dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia in patients being switched to Levemir® from other intermediate or long-acting insulin preparations. The dose of Levemir® may need to be adjusted in patients with renal or hepatic impairment.

Other adverse events commonly associated with insulin therapy may include injection site reactions (on average, 3% to 4% of patients in clinical trials), such as lipodystrophy, redness, pain, itching, hives, swelling, and inflammation.

Whether these observed differences represent true differences in the effects of Levemir®, NPH insulin, and insulin glargine is not known, since these trials were not blinded and the protocols (eg, diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences in weight has not been established.

For your patients with type 2 diabetes, start once-daily Levemir®
Levemir® helps patients with diabetes achieve their A1C goal.3,5
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• Provides consistent insulin absorption and action, day after day.4,5
• Less weight gain.5*

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Levemir®
insulin detemir (rDNA origin) injection

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Levemir®
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INDICATIONS AND USAGE
LEVEMIR is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long-acting) insulin for the control of hyperglycemia.

CONTRAINDICATIONS
LEVEMIR is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

WARNINGS
Hypoglycemia is the most common adverse effect of insulin therapy, including LEVEMIR. As with all insulins, the timing of hypoglycemia may differ among various insulin formulations.

Glucose monitoring is recommended for all patients with diabetes.

LEVEMIR is not to be used in insulin infusion pumps.

Any change of insulin dose should be made cautiously and only under medical supervision. Changes in insulin strength, timing of dosing, manufacturer, type (e.g., regular, NPH, or insulin analogs), species (animal, human), or method of manufacture (rDNA versus animal-source insulin) may result in the need for a change in dosage. Combinatorial oral antidiabetic treatment may need to be adjusted.

PRECAUTIONS
General
Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. The first symptoms of hyperglycemia usually occur gradually over a period of hours or days. They include nausea, vomiting, drowsiness, flushed dry skin, dry mouth, increased urination, thirst and loss of appetite as well as acetone breath. Untreated hyperglycemic events are potentially fatal.

LEVEMIR is not intended for intravenous or intramuscular administration. The prolonged duration of activity of insulin detemir is dependent on injection into subcutaneous tissue. Intravenous administration of the usual subcutaneous dose could result in severe hypoglycemia. Absorption after intramuscular administration is both faster and more extensive than absorption after subcutaneous administration.

LEVEMIR should not be diluted or mixed with any other insulin preparations (see PRECAUTIONS, Mixing of Insulins).

Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy.

Lipodystrophy and hypersensitivity are among potential clinical adverse effects associated with the use of all insulins.

As with all insulin preparations, the time course of LEVEMIR action may vary in different individuals or at different times in the same individual and is dependent on site of injection, blood supply, temperature, and physical activity.

Adjustment of dosage of any insulin may be necessary if patients change their physical activity or their usual meal plan.

Hypoglycemia
As with all insulin preparations, hypoglycemic reactions may be associated with the administration of LEVEMIR. Hypoglycemia is the most common adverse effect of insulins. Early warning symptoms of hypoglycemia may be different or less pronounced under certain conditions, such as long duration of diabetes, diabetic nerve disease, use of medications such as beta-blockers, or intensified diabetes control (see PRECAUTIONS, Drug Interactions).

Such situations may result in severe hypoglycemia (and, possibly, loss of consciousness) prior to patients’ awareness of hypoglycemia.

The time of occurrence of hypoglycemia depends on the action profile of the insulins used and may, therefore, change when the treatment regimen or timing of dosing is changed. In patients being switched from other intermediate or long-acting insulin preparations to once- or twice-daily LEVEMIR, dosages can be prescribed on a unit-to-unit basis, however, as with all insulin preparations, dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia.

Renal Impairment
As with other insulins, the requirements for LEVEMIR may need to be adjusted in patients with renal impairment.

Hepatic Impairment
As with other insulins, the requirements for LEVEMIR may need to be adjusted in patients with hepatic impairment.

Injection Site and Allergic Reactions
As with any insulin therapy, lipodystrophy may occur at the injection site and delay insulin absorption. Other injection site reactions with insulin therapy may include redness, pain, itching, hives, swelling, and inflammation. Continuous rotation of the injection site within a given area may help to reduce or prevent these reactions. Reactions usually resolve in a few days to a few weeks. On rare occasions, injection site reactions may require discontinuation of LEVEMIR.

In some instances, these reactions may be related to factors other than insulin, such as irritants in a skin cleansing agent or poor injection technique.

Systemic allergy: Generalized allergy to insulin, which is less common but potentially more serious, may cause a rash (including pruritus) over the whole body, shortness of breath, wheezing, reduction in blood pressure, rapid pulse, or sweating. Severe cases of generalized allergy, including anaphylactic reaction, may be life-threatening.

Interictal Conditions
Insulin requirements may be altered during interictal conditions such as illness, emotional disturbances, or other stresses.

Information for Patients
LEVEMIR must only be used if the solution appears clear and colorless with no visible particles. Patients should be informed about potential risks and advantages of LEVEMIR therapy, including the possible side effects. Patients should be offered continued education and advice on insulin therapies, injection technique, life-style management, regular glucose monitoring, periodic glycosylated hemoglobin testing, recognition and management of hypo- and hyperglycemia, adherence to meal planning, complications of insulin therapy, timing of dosing, instruction for use of injection devices and proper storage of insulin. Patients should be informed that frequent, patient-performed blood glucose measurements are needed to achieve effective glycemic control to avoid both hyperglycemia and hypoglycemia. Patients must be instructed on handling of special situations such as interictal conditions (illness, stress, or emotional disturbances), an inadequate or skipped insulin dose, inadvertent administration of an increased insulin dose, inadequate food intake, or skipped meals. Refer patients to the LEVEMIR “Patient Information” circular for additional information.

As with all patients who have diabetes, the ability to concentrate and/or react may be impaired as a result of hyperglycemia or hypoglycemia.

Patients with diabetes should be advised to inform their health care professional if they are pregnant or are contemplating pregnancy (see PRECAUTIONS, Pregnancy).

Laboratory Tests
As with all insulin therapy, the therapeutic response to LEVEMIR should be monitored by periodic blood glucose tests. Periodic measurement of HbA₁c is recommended for the monitoring of long-term glycemic control.

Drug Interactions
A number of substances affect glucose metabolism and may require insulin dose adjustment and particularly dose monitoring.

The following are examples of substances that may reduce
the blood-glucose-lowering effect of insulin: corticosteroids, danazol, diuretics, sympathomimetic agents (e.g., epinephrine, abamectin [albendazole], isoniazid, phenothiazine derivatives, somatropin, thyroid hormones, estrogens, progestogens (e.g., in oral contraceptives).

The following are examples of substances that may increase the blood-glucose-lowering effect of insulin and susceptibility to hypoglycemia: oral antidiabetic drugs, ACE inhibitors, disopyramide, fribates, fluoxetine, MAO inhibitors, probiphenyl, salicylates, somatostatin analog (e.g., octreotide), and sulfonamide antibiotics.

Beta-blockers, clonidine, lithium salts, and alcohol may either potentiate or weaken the blood-glucose-lowering effect of insulin. Pentamidine may cause hypoglycemia, which may sometimes be followed by hyperglycemia. In addition, under the influence of sympatholytic medicinal products such as beta-blockers, clonidine, guanethidine, and reserpine, the signs of hypoglycemia may be reduced or absent.

The results of in-vitro and in-vivo protein binding studies demonstrate that there is no clinically relevant interaction between insulin determinants and fatty acids or other protein-bound drugs.

Mixing of Insulins

If LEVEMIR is mixed with other insulin preparations, the profile of action of one or both individual components may change. Mixing LEVEMIR with insulin aspart, a rapid acting insulin analog, resulted in about 40% reduced glucose AUC and Cmax for insulin aspart compared to separate injections when the ratio of insulin aspart to LEVEMIR was less than 50%.

LEVEMIR SHOULD NOT be mixed or diluted with any other insulin preparations.

Carcinogenicity, Mutagenicity, Impairment of Fertility

Standard 2-year carcinogenicity studies in animals have not been performed. Insulin determinations negative for genotoxic potential in the in-vitro reverse mutation study in bacteria, human peripheral blood lymphocyte chromosome aberration test, and the in-vivo mouse micronucleus test.

Pregnancy: Teratogenic Effects: Pregnancy Category C

In a fertility and embryonic development study, insulin detemir was administered to female rats before mating, during mating, and throughout pregnancy at doses up to 300 mmol/kg/day (3 times the recommended human dose, based on plasma Area Under the Curve (AUC) ratio). Doses of 150 and 300 mmol/kg/day produced numbers of litters with visceral anomalies. Doses up to 900 mmol/kg/day (approximately 1.35 times the recommended human dose based on AUC ratio) were given to rabbits during organogenesis. Dose-related increases in the incidence of fetuses with gall bladder abnormalities such as small, bilobed, bifurcated and missing gall bladders were observed at a dose of 900 mmol/kg/day. The rat and rabbit embryofetal development studies that included concurrent human insulin control groups indicated that insulin detemir and human insulin had similar effects regarding embryotoxicity and teratogenicity.

Nursing mothers

It is uncertain whether LEVEMIR is excreted in significant amounts in human milk. For this reason, caution should be exercised when LEVEMIR is administered to a nursing mother. Patients with diabetes who are lactating may require adjustments in insulin dose, meal plan, or both.

Pediatric use

In a controlled clinical study, HbA1c concentrations and rates of hypoglycemia were similar among patients treated with LEVEMIR and patients treated with NPH human insulin.

Geriatric use

Of the total number of subjects in intermediate and long-term clinical studies of LEVEMIR, 85 (type 1 studies) and 363 (type 2 studies) were 65 years and older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. In elderly patients with diabetes, the initial dosage, dose increments, and maintenance dosage should be conservative to avoid hypoglycemic reactions. Hypoglycemia may be difficult to recognize in the elderly.

ADVERSE REACTIONS

Adverse events commonly associated with human insulin therapy include the following:

Body as Whole: allergic reactions (see PRECAUTIONS, Allergy).

Skin and Appendages: Lipodystrophy, pruritus, rash.

Mild injection site reactions occurred more frequently with LEVEMIR than with NPH human insulin and usually resolved in a few days to a few weeks (see PRECAUTIONS, Allergy).

Other:

Hypoglycemia: (see WARNINGS and PRECAUTIONS).

In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, the incidence of severe hypoglycemia with LEVEMIR was comparable to the incidence with NPH, and, as expected, greater overall in patients with type 1 diabetes (Table 4).

Weight gain:

In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, LEVEMIR was associated with somewhat less weight gain than NPH (Table 4). Whether these observed differences represent true differences in LEVEMIR and NPH insulin is not known, since these trials were not blinded and the protocols (e.g., diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences has not been established.

Table 4: Safety Information on Clinical Studies

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Weight (kg)</th>
<th>Hypoglycemia</th>
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<tbody>
<tr>
<td></td>
<td># of subjects</td>
<td>Baseline</td>
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<td>Type 1</td>
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<tr>
<td>Study A</td>
<td>LEVEMIR</td>
<td>N=276</td>
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<td></td>
<td>NPH</td>
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<td>Study C</td>
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<td></td>
<td>NPH</td>
<td>N=257</td>
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<td>Study D</td>
<td>LEVEMIR</td>
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<td>Pediatric</td>
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<td>Study E</td>
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<td>NPH</td>
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<td></td>
<td>NPH</td>
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* Major = requires assistance of another individual because of neurologic impairment
** Minor = plasma glucose <56 mg/dL, subject able to deal with the episode him/herself

OVERDOSAGE

Hypoglycemia may occur as a result of an excess of insulin relative to food intake, energy expenditure, or both. Milder episodes of hypoglycemia usually can be treated with oral glucose. Adjustments in drug dosage, meal patterns, or exercise may be needed. More severe episodes with coma, seizure, or neurologic impairment may be treated with intramuscular/subcutaneous glucagon or concentrated intravenous glucose. After apparent clinical recovery from hypoglycemia, continued observation and additional carbohydrate intake may be necessary to avoid reoccurrence of hypoglycemia.

More detailed information is available on request.

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facing right versus right.”

In other cases, the struggle may be one in which one ethical principle—such as patient autonomy—collides with another, such as the physician’s responsibility to ensure appropriate resource utilization.

**Wide Range of Issues**

Richard Neubauer, MD, chief of internal medicine at the Alaska Native Medical Center in Anchorage, chuckles when asked how often he finds himself facing an ethical conflict or a situation. “After 30 years in practice, I can honestly say that I can’t think of a day that ethical issues don’t come up,” says Dr. Neubauer, who formerly chaired the ethics committee of the American College of Physicians and is clinical assistant professor of medicine at the University of Washington. Those issues range from minor to major—from resource utilization quandaries to challenging end-of-life care conflicts.

Dr. Fitzgerald, who frequently speaks on ethical conflicts in the care setting, remembers well her first ethical challenge in that realm. She was caring for a young woman with severe peptic ulcer disease, a Jehovah’s Witness and the mother of three children. “We wanted to transfuse her, and she said no,” Dr. Fitzgerald recalls. “So I did the usual thing physicians do—I said, ‘You don’t understand. You are very anemic, and you are still bleeding. We have to give you blood or you will die.’”

The patient told Dr. Fitzgerald, “Doctor, I understand very well. I just disagree. For you, it is my mortal life that is most important. For me, it is my immortal life that is important.”

“Her choices were not within my understanding,” Dr. Fitzgerald says, “but they were her choices.”

In the hospital setting, physicians who encounter conflicts as serious as the young woman’s choice to forgo life-saving treatment typically have ethics committees or consultants to help them work through the situation. But for the small-group or solo-practicing physician, on-the-spot help may not be available in a timely manner. Thus, young physicians who don’t have a good grounding in situational ethics may struggle to resolve even common ethical conflicts, notes Fabrice Jotterand, PhD, who teaches ethics in the departments of clinical services and
psychiatry at the University of Texas Southwestern Medical Center in Dallas.

“When doctors become residents, they see the importance of ethics; but it’s when they have their own practice that they suddenly hit the wall and say, ‘Wow, now I know why I need to know more about all of this,’” Dr. Jotterand explains. “That’s why I think it’s important for clinicians and researchers to have a foot in the humanities and find the right mentors. It helps later when they get stuck—because doctors have to make judgments in applying the knowledge.”

Sarasota, Fla., internist Frederick Turton, MD, former chair of the American College of Physicians ethics committee, says that despite his substantial grounding in ethics, he occasionally runs into situations in which he needs outside help. “I have gotten a good deal of support over the years from hospital ethics committees and from my own colleagues in the community,” he says.

Resources for the Practicing Physician

In her decades of teaching medical students and residents, Dr. Fitzgerald says, she has seen a broad spectrum in ethics awareness and the wide range of physician behaviors and views on ethical issues. She believes that, absent a serious character flaw, most physicians can increase their understanding of ethics and learn to address conflicts in an appropriate manner. But she thinks that learning curve can be challenging for physicians who don’t have a strong internal moral compass and didn’t have the opportunity to train or work closely with physicians of high moral character.

“The thing that teaches character and conduct is the mirror of character and conduct, and the thing you remember 20 or 30 years out is not what those physician teachers taught you,” Dr. Fitzgerald says, “but the manner of their telling. Patient stories and teacher behavior are the most enduring lessons you learn in medical school.”

She urges physicians who feel unsure of themselves when they encounter an ethical conflict in patient care to “find an ethicist or a physician who manifests ethical conduct” and spend time with that individual.

Articles and books on clinical ethics and bioethics can be use-
ful, she says, in providing a foundation in big-picture concepts and issues. But if they’re not written from the practicing clinician’s perspective, she observes, they may not be particularly helpful when a physician is in the exam room in the middle of a disagreement with an upset patient—or at the bedside of a patient whose distressed family is pressing for futile treatment.

“Pedagogues or philosophers who divorce themselves from clinical reality are often writing to each other,” she says. “They haven’t sat by the side of a vegetative patient.” Nonetheless, Dr. Fitzgerald encourages physicians to steep themselves in ethical topics and to ensure they have a working knowledge of current thinking on such topics as confidentiality, informed consent, patients’ rights, and end-of-life care, at a minimum.

Thomas L. Beauchamp and James F. Childress’s *Principles of Biomedical Ethics* (Oxford University Press, 1994), for example, first takes a broad look at respect for patient autonomy, non-maleficence, beneficence, and justice, then connects those principles to common clinical practice situations. As a basic primer, the *Encyclopedia of Bioethics* (MacMillan Reference Books, 2003) may help physicians who received little exposure to ethics during their training.

Busy physicians find it hard to carve out time for extensive reading or discussions with mentors, and are often, Dr. Neubauer notes, looking for practical guidance to help them through tough spots. Most physician organizations publish codes of conduct and position papers on a variety of ethical issues, but those statements tend to be general in nature—and may not be of much help in the middle of a particularly complex ethical conflict, Dr. Neubauer acknowledges. He and physician colleagues who write on ethical issues admit that it is difficult to make such guidance real for people.

“The challenge for ethics committees and ethicists is to make this feel like a living, breathing thing that’s important to physicians,” he says. “It’s hard to do that in a theoretical framework.”

**Few Easy Answers**

Dr. Jotterand, who frequently gives presentations to physicians on ethical issues in medical professionalism and emerging bioethics challenges, puts it this way: “That’s one problem with discussing ethical conflicts in individual cases: Each will be dif-
different. Clinicians say, ‘I have a problem and I want one solution’—a practical approach—but each case will be different, especially when cultural issues and family intersect.”

Despite that challenge, the ACP Ethics Committee has published not only manuals but also case studies, the latter based on real-life practice situations reported by physicians. One case study in the book Ethical Choices: Case Studies for Medical Practice (ACP Press, 2005), for example, looks at a conflict that physicians face increasingly: patients’ possibly unreasonable demand for specialist referral.

This sort of conflict is not uncommon, especially as patients become more assertive about co-directing or managing their own care. The competent physician, while trying to adhere to the generally accepted ethical principle that referrals should occur when the treating clinician needs assistance and a consult is in the patient’s interest, can get into a sticky situation, according to Lois Snyder, JD, the book’s author and director of the ACP’s Center for Ethics & Professionalism.

In her commentary on the case described above, Ms. Snyder maintains that the physician should not bow to a patient’s push for a “referral on demand,” but acknowledges one gray area that’s often a source of conflict: deciding who defines the welfare of the patient. The physician may have firm views on what’s medically indicated at one particular moment, but a patient’s pressure complicates matters.

At such times, physicians may find that the most effective approach is to help patients gain a more realistic grasp on expectations of care and better understand that “more care is not necessarily better care,” Ms. Snyder writes.

The case-analysis method can be helpful as a general approach in identifying common ethical dilemmas or conflicts.

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in clinical practice because it goes beyond the moral principles to incorporate context and patient preferences. In their book *Clinical Ethics: A Practical Approach to Ethical Decisions* (McGraw-Hill, 2002) authors Albert R. Jonsen, PhD, Mark Siegler, MD, and William Winslade, PhD, JD, propose a structured means of resolving ethical issues. The book also offers instruction on skills physicians can use to analyze ethically problematic cases they encounter in practice by sorting out the facts and values of each clinical case into four distinct topical areas: medical indications, patient preferences, quality of life, and contextual features.

Ultimately, the book’s authors contend, a structured approach in clinical ethics—that first identifies ethical features found in every clinical encounter and then looks at the problems that may arise when values are challenged—makes a good starting point for resolving conflicts. They write: “Clinical ethics relies upon the conviction that, even when perplexity is great and emotions run high, physicians, nurses, patients, and families can work constructively to identify, analyze, and resolve many of the ethical problems that arise in clinical medicine.”

**The Role of Effective Communication**

Many ethicists concur on one key point: Poor communication between physicians and patients may not be the chief source of ethical dilemmas that arise in everyday practice, but it often is a major contributor or an exacerbating factor.

Ezekial Emanuel, MD, PhD, an oncologist who chairs the National Institutes of Health’s bioethics department, thinks that effective communication is an overlooked resource in resolving ethical conflicts at the point of care. He also thinks that, unfortunately, it’s a skill in which physicians still receive inadequate training—a deficit that can turn a minor, possibly transient disagreement with a patient into an ethical conflict.

“If you start by saying to the patient, ‘It looks as if things have gone bad—how can we fix it?’” it causes the other party to reconsider the situation, Dr. Emanuel explains. “Suddenly most [individuals] become more sympathetic.”

Dr. Fitzgerald points to another conflict that can be solved with communications: when a patient’s relative asks the physi-
A Structured Approach to Ethical Issues

The four-topics paradigm proposed by Albert R. Jonsen, PhD; Mark Siegler, MD; and William J. Winslade, PhD, JD, in their book Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine, provides a method for organizing ethical issues that physicians most commonly face.

Medical Indications:
Consider each medical condition and its proposed treatment.
Ask the following questions:
Does it fulfill any of the goals of medicine?
With what likelihood?
If not, is the proposed treatment futile?

Patient Preferences:
Address the following:
What does the patient want?
Does the patient have the capacity to decide? If not, who will decide for the patient?
Do the patient’s wishes reflect a process that is
— informed?
— understood?
— voluntary?

Quality of Life:
Describe the patient’s quality of life in the patient’s own terms.
What is the patient’s subjective acceptance of likely quality of life?
What are the views of the care providers about the quality of life?
Is quality of life “less than minimal” [in patient’s view]? (i.e., qualitative futility)

Contextual Features:
Social, legal, economic, and institutional circumstances in the case that can
— influence the decision
— be influenced by the decision
e.g., inability to pay for treatment; inadequate social support

cian not to disclose a new diagnosis with a poor prognosis. Dr. Fitzgerald explains, “That’s a common one. The son of the elderly patient with cancer asks me not to tell his mother because it will take away her hope,” she says.

That sort of dilemma may be more easily resolved than some physicians think, Dr. Fitzgerald points out. “What do you do? You go to the patient and say, ‘Your family says that they want to be the keepers of all medical information about you; is that OK? Do you want me to tell you everything, or do you want me to tell your family?’” she says. In such cases, patients sometimes ask the physician to go ahead and tell the family member, to whom the patient will give decision-making authority. “Then you have honored autonomy,” Dr. Fitzgerald says.

However, Dr. Emanuel advises against assuming that improved communication alone will address or resolve most ethical conflicts. “That’s a mistake. We should not confuse ethics with communication. Ethics is about ‘what’s the solution?’” Dr. Emanuel says. “Communication is, once you’ve got the solution, how do you communicate it and move forward? Even if you have the right answer, it can be hard to implement it.”

Physicians also often struggle with ethical conflicts arising out of bias toward or prejudice against certain types of patients. Sometimes, too, those tables are turned, as when a patient’s racial or other prejudice interrupts care or complicates an important referral.

A second case described in Ethical Choices: Case Studies for Medical Practice looks at such a conflict: A patient who is referred to a specialist from another country asks his primary care physician (PCP) to find another doctor who is not foreign born. Even when the PCP explains that the specialist in question is highly qualified and has the PCP’s full respect and confidence, the patient persists in his demand for another specialist.

In this instance, the chapter’s co-author Errol Crook, MD, recommends that the PCP recognize the patient’s right to be prejudiced and explain the possible consequences of the patient’s changing specialists. If the conflict overly compromises the PCP’s own values and he does not wish to recommend another specialist, he may recommend that the patient transfer to another PCP. To honor his professional relationship with and obligations
Many physicians think that ethical quandaries and conflicts arise primarily out of major issues or extraordinary events—the life-or-death decisions, patients’ refusal to accept life-saving care, or requests of patients or families for futile care. Psychiatrist Ronald M. Epstein, MD, director of the Center to Improve Communication in Health Care at the University of Rochester School of Medicine and Dentistry in Rochester, N.Y., suggests that physicians in fact face many micro-ethical decisions and potential dilemmas in their daily practice lives, all of which warrant their thoughtful attention.

Following are examples of what Dr. Epstein refers to as “what-should-I-do” questions that practicing physicians may ask themselves frequently, each of which has an ethical dimension:

- Should I ask a colleague to take on one of my responsibilities when I am exhausted?
- In which order should I return my 10 telephone messages?
- When is it time for a medical encounter to close?
- What do I say to the patient when specialists disagree about the patient’s diagnosis?
- To what degree should I let my patients know of my own limitations and anxieties?
- How should I regard the recommendations of a colleague who is often too sure of himself?

Source: Excerpted with author’s permission from Lost Virtue: Professional Character Development in Medical Education, (Elsevier, 2006).

to the specialist, the PCP is advised to explain that the unfortunate incident will not affect future referral practices.

The situation described above might be reversed in the case of a physician who, based on previous personal or professional experience, may have a prejudice against certain types of patients. To prevent an ethical conflict that may arise out of that prejudice—an unwillingness to properly care for the patient or to openly address that patient’s concerns or questions—physicians should examine their response to their patients.

That’s something that many physicians don’t do often enough in their daily practice lives, observes psychiatrist Ronald Epstein, MD, director of the Center to Improve Communication in Health Care in Rochester, N.Y., who writes frequently on clinical prac-
practice ethics. “The fundamental ingredient is self-awareness in a couple of domains, and that’s not something that is necessarily taught in training. One [domain] is to understand when you actually do feel uncomfortable about a situation and try to understand why that’s the case,” says Dr. Epstein, a professor of family medicine and psychiatry at the University of Rochester School of Medicine and Dentistry. “It helps to try to unpack it, to figure out what’s making you uncomfortable about a situation right then.”

Thinking About Thinking

Simply stopping to recognize a potential disagreement, and avoiding responding immediately or negatively, could help resolve the situation before it becomes a conflict, Dr. Epstein advises. “It’s a matter of being engaged in a different kind of activity—what psychologists call meta-cognition, or thinking about your own thinking,” he explains.

To allow sufficient time for that process, Dr. Epstein recommends that physicians who think they’re headed for or in the middle of an ethically problematic exchange delay their verbal response. “When you feel yourself in a situation where your antennae are saying, ‘There’s something going on here that I need to deal with that I don’t understand,’ train yourself to stop, take a breath, and step back from the situation momentarily and just reassess how you’re thinking,” he says, describing a process called “stop, breathe, and be.”

“It allows you to paint a different perspective on the problem, so that you can say to patients, ‘Listen, I need to stop and think about this for a moment,’” Dr. Epstein explains. “In most cases, patients will usually say, ‘Well, of course you do.’”

One of the most effective ways for physicians to cultivate what Dr. Epstein calls “mindful practice” and to identify potential ethical issues before they pose professional or physician-patient conflicts is to engage frequently in reflective self-questioning and identify the personal values that might compromise judgment or affect behavior. He recommends the following questions as a starting point for that exercise:

- Is there an ethical issue embedded in this situation?
- How might my prior experiences affect my actions?
What am I assuming about this patient that may not be true?
What interfered with my ability to observe, be attentive, or be respectful with this patient?
Were there any points at which I wanted to end the visit prematurely?
Is there any relevant data that I ignored?
What would a trusted peer say about this situation?

Dr. Epstein offers a good example of a situation in which a physician’s personal preferences might interfere with his ethical duty to disclose information to patients. Researchers have found that while patients with cancer are in most cases told their diagnosis, patients with Alzheimer’s disease frequently are not.

“That may be for all kinds of reasons—perhaps the physician thinks the patient might not understand or that he would be too devastated,” Dr. Epstein allows. “But it might be simply because the physician is too saddened by this tragic situation. It could be a patient of 25 years and you don’t want to see them go. Sometimes you’re holding on harder than they are.”

Mindful practice requires, in Dr. Epstein’s view, an internal barometer—“some sort of ability to calibrate and understand when your judgment might be affected by forces beyond your usual level of awareness,” he says. “There’s nothing magical about this. We do it all the time—it’s often called a gut feeling.”

Dr. Turton has used some of these techniques, especially stopping to ask himself when he feels an ethical conflict bubbling up, how prior experience might be affecting his response to a certain patient. It’s a matter of “self-correcting” before a minor situation gets out of proportion.

“There’s always a patient personality type who pushes my buttons—and I can see them when they walk in the door,” he says. “I have learned to deal with it throughout the years by talking myself into how not to respond—and referring them to someone else when necessary.

“When you are in the room with the patient, you are always the professional, and they are always first—and that means dealing with your own problems on your own, not with the patients.”