

# MEDICAL ETHICS WITHOUT THE RHETORIC

Cases presented here involve real physicians and patients. Unlike the cases in medical ethics textbooks, these cases seldom involve cloning, bizarre treatments, or stem cell research. We emphasize cases common to the practice of medicine.

Most cases are circumstantially unique and require the viewpoints of the practitioners and patients involved. For this reason, I solicit your input on the cases discussed here at [council@aol.com](mailto:council@aol.com). Reader perspectives along with my own viewpoint are published in the issue following each case presentation. We are also interested in cases that readers submit. The following case is particularly relevant in these days when healthcare reform – and who is going to pay for it – is on everyone's mind.



**Mark Pastin, PhD**

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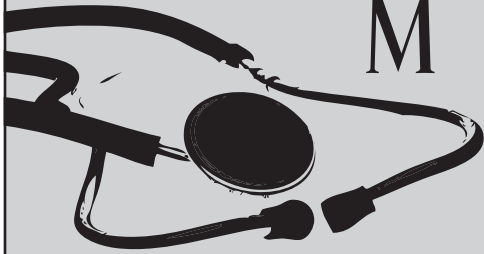
## CASE SIX EASE MY CONSCIENCE

A terminal patient is in great pain but, with the concurrence of the patient's family, refuses, for religious reasons, to allow the plug (on further therapeutic treatment) to be pulled. However, the patient requests that everything be done to reduce the pain to the maximum possible extent. The patient's physicians explain that the pain can be reduced and almost eliminated but at the expense of the patient's consciousness and, imminently, life. The patient and the patient's family find this consequence acceptable. The physicians, however, wonder if they are participating in an assisted suicide. Should the patient's wish be granted?

This is an actual case. Of course, there are any number of complicating circumstances and additional details; but please address the case on the basis of the information provided.

There will be an analysis of this case and a new case in the next issue.

**Your input is requested. Email your responses to: [council@aol.com](mailto:council@aol.com).**



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## CASE FIVE ANALYSIS

*In our case from the last issue, a patient is diagnosed with terminal cancer after learning that she is pregnant. The woman and her husband request that her body functions be maintained after she is legally dead until the baby is safely delivered. Her physician advises that this is a reasonable although not certainly successful course of action. The issue? According to the hospital where she is receiving treatment, the cost of maintaining her bodily functions would exceed \$500,000. A dead patient has no health insurance, and the couple does not have the money. Our question: What should be done by the various parties?*

**This case provoked many reader responses. One of the most thoughtful is the following (edited):**

"The patient and her family request that her body be maintained "alive," even after she is brain dead, until the baby can be delivered. This is a perfect case for this day and time. We have the technology to keep the OB patient alive until her baby can be safely delivered, but at what expense. Until now, we as a culture have not given serious thought to what health care is going to cost. Now we are. For decades, health maintenance organizations have sought to reduce health care costs, but it required diminished access to medical procedures, which led to numerous headline legal actions that resulted in patients receiving costly treatments, experimental treatments, and dying in the end.

We now are faced with living with the collective burden of realizing that if we spend the money

to keep her alive, how many others are going to be denied life-saving care? We are faced with deciding the good of the many as opposed to the good of the one. It may be the flip side of the coin where a healthy young adult becomes an organ donor due to a tragic accident and allows several others to have the gift of life through their death. Perhaps, in this case too, it would be the more humane thing to do to allow the demise of herself and her baby, so that others might live. We have lived under a false impression that there are no limits to what we can do and achieve. There have always been those limits. We just chose to ignore them. In the past, the cost of what we were doing ethically and financially was put on the back burner. Now, they are front and center, and we are having to make tough decisions on both fronts."

While I respect the reader's position, I disagree. The first question is how the hospital arrived at this cost estimate. Upon scrutiny, this estimate, like so many of the numbers used by rationing of care advocates, was based on the hospital's billing rates to an uninsured patient – its "rack rate" – a rate seldom if ever paid by anyone. The actual cost was much lower. I cannot find an ethical basis for not allowing this baby to be born. Even \$500,000 is barely the amount of some "patient satisfaction" surveys, which we seem to find socially acceptable. The reader is certainly right on one point – we tend to avoid these issues. In the end, the patient's insurance company agreed to provide a "contribution" in the amount of \$50,000 without admitting that there was coverage. The hospital agreed to sharpen its pencils on the pricing, and several providers contributed their services. So, while no solution was reached, the baby was delivered alive and healthy. In ethics, sometimes "no solution" is a better solution than a precedent-setting decision with unforeseeable consequences.