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COMMENTARY

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KAREN SCHNEIDER RSM, MD; MICHELE LANGOWSKI, MA, JD; PETER A. CLARK, S.J., PH.D.

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COMMENTARY

Do No Harm: A Global Dilemma in Health Care

KAREN SCHNEIDER RSM, MD; MICHELE LANGOWSKI, MA, JD; PETER A. CLARK, S.J., PH.D.

Keywords: nonmaleficence, beneficence, pediatric care, financial burden, dilemma.

One is confronted with many medical, ethical and financial challenges when acting as leader of a team of pediatric residents and nurses in a rural area of a developing South American country. The medications brought to this country are purchased through the generous donations of benefactors, while additional solicited money helps to finance laboratory testing, diagnostic imaging and surgeries for children. On this particular trip we had already encountered nineteen children in need of hernia repairs, two children with club-feet, one child requiring hospitalization for seizure control during the initiation of treatment for neurocysticercosis, and four children with congenital cardiac malformations. Eight of the hernia surgeries had already been completed and paid for during the first week of the mission.

Midway through the experience, I was asked by a Health Coordinator in a rural area to supply some morphine for Mr. F., a 60-year-old man dying of kidney cancer. The cancer had metastasized throughout his body and there was nothing more that could be done for him in the hospital so he was discharged and sent home to die. Mr. F's family was desperately poor, living in the campo in a wooden house made from sticks that have been woven together, with no electricity or running water. The family had already sold its six goats in order to pay for his hospitalization and medications. With no other resources the family was desperate, yet Mr. F's pain continued. He was lying on a mat in his house writhing in pain, occasionally crying, screaming, and unconscious. He had not had morphine for 5 days nor would his family ever be able to afford any more pain medication.

I began running out of money for the children's surgeries. We had prioritized the hernia surgeries and only those with obvious bulging hernias were repaired; older boys who wore diapers to hold up their bulging scrotums and girls who wore belts low around their hips to prevent the hernias from "popping out" when they did their chores. Two boys with unrepaired club foot, barely able to walk, were scheduled for surgery in a few days.

I gave the family of Mr. F. 100 soles, about \$30 US. It might buy him a week's worth of morphine unless his pain was very intense, then it would only give him a few days worth of relief. I looked into our medication supplies and gave approximately 25 tablets of dyphenhydramine (Benadryl), for its sedative effect. I had nothing else. I had run out of money and would need to borrow money for the children's surgeries.

As I walked away from the house I could still hear the man's screams. I thought, "this is barbaric, unreal, unnecessary." Why should this man have to suffer so without any pain relief? He could be days, weeks or months away from his death. He was pleading and begging for help, not for a cure, but to be relieved from his pain. I knew that if I had seen an animal in such pain I would not have felt guilty terminating its life. Yet this was a man. Under the circumstances, would it be ethical for me, as a medical professional, to help him terminate his life if he requested it? I had some potassium with me. Do the rules of conscience change in a resource poor country that cannot provide medical care for its people?

COMMENTARY – KAREN SCHNEIDER, RSM, MD.

This is a very complex medical case that has many aspects. First of all, the most basic question that most physicians would ask would be: "Is this my patient and if so what responsibility do I have?" The answer is simple, no, he is not my patient. I believe that I was shown this suffering man because I was considered a rich American more than a physician. The Peruvian physicians

had told the man and his family that there was nothing more they could do; he was dying. I believe the man and his family knew this and all they wanted was to relieve his suffering.

Second, whose responsibility is it to bear the burden of the expense for his medication? The obvious answer is his family, but they were poor and had already sold all of the goats that they could sell. Would the principle of subsidiarity state that his community, his church, the state or federal government is now responsible? Or, as an American physician am I now responsible because I have the education and expertise to manage his pain. Even though I did not have the funds available to me to pay for his pain medications could I have obtained the necessary funds from sources back in America?

Third, all things considered, even with adequate pain medication, how long would he have survived? Did the benefits of managing his pain trump the burdens of having less money to perform the necessary pediatric surgeries of the children waiting at the clinic? The money for this medical trip was donated by people for the expressed use of helping defray the costs of surgeries for children in this rural part of Peru. I had promised the benefactors that I would use the money for children's surgeries-- hernia repairs, cleft lip repairs and club foot repairs. They entrusted the money to me to be used for specific causes for the children. Was it ethical to take this money now and use it for a man who was dying of metastatic cancer? The money donated by generous benefactors in the United States had almost run out and I still had children who were coming to the clinic needing surgery. The American medical team still had two more days of clinic and two more days to encounter children in need of surgery. The surgeries would be beneficial and even life giving for these children. They would allow them to work in the field, walk to school, swallow without choking, take in the proper nutrition and smile a beautiful smile. Would the principle of justice allow me to redirect these funds?

There was one other option that came to mind that I was surprised that I would even consider. This man was suffering intractable pain. His family was in agony just watching him suffer. The wife pleaded with me to relieve her husband's pain no matter what it took to do so. Some members of the extended family and the children had left the house because they could not bear to watch him suffer. No one could sleep in this household. If he were an animal he would have been put out of his suffering. Should I offer a shot that would end his agony? Should any human person, in this day and age, because they are poor, suffer in the way this man was suffering? Should he be given the option of a shot that would probably kill him within minutes? Should a medical professional be allowed, in good conscience, to administer a lethal injection if there are not other viable options? I walked away from the house not offering the shot that would relieve him of his pain and suffering because I had been taught in North America that it was legally and ethically wrong. It was unethical to take a human life, yet wasn't it unethical to leave him in this condition? The ethical principle of beneficence seemed to be in direct conflict with nonmaleficence. I had sworn an oath to "Do No Harm." Yet couldn't doing nothing in this case be viewed as doing harm, i.e. sin of omission, not ending his pain. I was afraid to do what I felt I should have done, that is to end his pain and to give him peace.

What was I afraid of? I was afraid that if I used situational ethics in this one case and ended this man's life with an injection of potassium this behavior would continue. What would happen if I encountered another person in the next village in the same situation? Would I also inject potassium? Or if I walked into a cancer ward in Peru, where pain is not managed as it is in the USA would I be justified in ending the life of all those who wanted to be relieved of pain. It is too much of a slippery slope! My heart was pulling one way, my head the other. My head was right, thus no injection!

It has been 3 months since I saw Mr. F in his simple house on his dirt floor in northern Peru. It was weeks before I was not haunted by the image of his suffering. I wonder if he is still alive and suffering.

COMMENTARY – MICHELE K. LANGOWSKI, MA, JD

The case of Mr. F. highlights one specific, tragic instance of the growing population of medically underserved persons in pain, suffering from life-threatening illnesses and chronic disease, and the inequities that exist in the provision of medical and palliative care services in resource-poor developing countries. It is estimated that over two-thirds of the world's population do not receive adequate pain relief and palliative care. The disparities in access to palliative care and medical services in marginalized and developing countries means that millions are living, and dying, in agonizing conditions with their fundamental needs unmet. This is a global public health crisis. The physician in this case is dealing first hand with the realities of this crisis. Mr. F., who lives in a wooden hut without electricity or running water, is dying of kidney cancer, and is suffering unremitting, intractable pain without the financial resources to purchase morphine. The physician's moral dilemma is whether it would be ethical to help terminate Mr. F's life if he requested it, given the lack of resources available, or leave him to die an inhumane, inevitably painful death. At the core of this dilemma is the apparent collision of the physician's ethical duties of nonmaleficence and beneficence. To be clear, the physician is contemplating an act of active euthanasia, intentionally killing Mr. F. with an injection of potassium. Active euthanasia historically has been morally and legally prohibited in almost every country (with the exception of the Netherlands and recently Belgium). Medical professional codes, dating back to Hippocrates, have prohibited "mercy killing" as

well as physician participation in assisting patients to commit suicide. This is based in part on the principle of nonmaleficence (“above all, or first, do no harm”) and respect for human life, and the view that killing is incompatible with the physician’s role as healer and is contradictory to the goals of medicine. Nevertheless, despite deeply rooted ethical and legal prohibitions, physician-assisted suicide and to some extent active euthanasia are gaining social acceptances with calls to liberalize laws through statutory provisions arguing that claims of autonomy and compassion justify it.

If Mr. F. requested termination, in this instance we are dealing with a hypothetical because the physician poses the question, instead of giving of us the details of Mr. F’s request. Typically, the principle of autonomy is invoked to support a patient’s request for euthanasia. Autonomy means self-rule and supports the individual’s legal and ethical right to self-determination. Ethically the principle also requires that we respect the dignity of persons. Mr. F is extremely ill, frail, and in extraordinary pain. He is vulnerable as are most patients suffering from a serious or terminal disease. However, after five days without morphine or other palliative care measures, Mr. F is ravaged by pain, writhing, crying, and at times unconscious, so he is acutely vulnerable, and his decision-making capacity at this time is, at best, questionable. A request to terminate his life may actually be an appeal for relief from pain. The physician has not had any previous contact with Mr. F, so no relationship or knowledge of the patient to be able to interpret whether these wishes are transient or permanent. Would amelioration of pain change Mr. F’s views? We do not respect a patient’s autonomy or the dignity of the patient if we allow them to make important decisions, in this case life ending decisions, when they do not have the capacity to do so.

Mr. F. is screaming in pain, begging and pleading for help. Of course, the physician feels the moral weight of Mr. F’s suffering and wants to do everything possible to benefit him. The principle of beneficence requires as much, obligating physicians to provide the best care possible to benefit the patient, to act in the best interests of the patient, which includes preventing and removal of harm as well as to balance various benefits and harms. The physician provided Mr. F. with money for possibly a week’s worth of morphine, all the money the physician had left, and 25 tablets of dyphenhydramine for its sedative effect. However, confronted with the reality of Mr. F’s pain, elderly and dying any way, and the extremely limited resources available to ameliorate him, might compassion warrant the physician injecting Mr. F with the potassium? Killing the patient may be expedient, and some may argue it is compassionate, but it is not necessarily acting in accordance with the requirements of beneficence. Just because we are acting out of compassion that does not mean that we are acting in a morally appropriate way. Compassion is an emotion. It is essential to humane and caring relationships. If compassion motivates the physician to seek out alternative, maybe cheaper, palliative care measures available in the rural locale to help ease Mr. F’s suffering, then compassion has motivated the physician to do a charitable, morally praiseworthy action. But compassion for a patient’s pain is not a self-justifying reason to kill. Emotion alone does not determine the morality of an action. Moral judgments require a reasoned analysis; the act must be considered in light of the various ethical principles, duties, norms, and values involved and its effect on all of the ends or values must be weighed. For instance, if it is determined that compassion and beneficence allow the physician to kill Mr. F. under these circumstances, this could have the long-term negative effect of rendering many more similarly situated persons vulnerable. Millions of people in developing countries are in dire need of pain relief and palliative care services. If killing patients becomes an option in these circumstances, this could have the negative effect of thwarting efforts to provide therapeutic interventions to people in need through social, international and governmental public health initiatives, interventions that could otherwise enhance the quality of patients’ lives as well as lives of their families.

Rules of conscience do not change in a resource poor country, although, the way in which one fulfills his or her ethical duties as a medical professional may be far more challenging and difficult. If in the final assessment the physician makes the conscientious moral determination that termination of Mr. F is the only ethical option available, then the physician ultimately is obligated to follow his or her conscience

COMMENTARY – PETER A. CLARK, S.J., PH.D.

The case of Mr. F. is challenging because it confronts us with injustices that exist worldwide in the area of health care. If we believe that health care is a basic human right and that all people should be treated with dignity and respect, then how can we allow Mr. F. to suffer in pain when we know death is inevitable. Physicians, according to the principle of beneficence, have the medical and ethical responsibility to prevent and remove harm and to promote the good of their patients by minimizing possible harms and maximizing possible benefits. The principle of beneficence includes nonmaleficence, which prohibits the infliction of harm, injury or death upon others. In medical ethics this principle has been closely associated with the maxim *Primum non nocere*: “Above all do no harm.” Allowing a person to endure pain when said pain can be managed and relieved violates the principle of beneficence because one is not preventing pain and therefore not acting in the best interest of the patient. It also violates the principle of nonmaleficence because it is causing harm—and sometimes injury—to the person. In this situation the physician is confronted with both a medical and ethical dilemma that places beneficence in direct conflict with the principle of

nonmaleficence. The physician has limited medical resources available and limited funds. The medical team is in this developing world country to treat the numerous children that have presented with serious conditions that are treatable and correctable. With the appropriate surgeries these children can live a good quality of life that will benefit not only themselves but their families. In contrast, you have an elderly man who is dying from metastatic kidney cancer and is in intractable pain with no resources to control the pain. The dilemma confronting the physician is which situation takes priority both medically and ethically.

Physicians, as moral agents, have an ethical responsibility to treat patients in a way that will maximize benefits and minimize harms. Determining how to maximize benefits and minimize harms in this situation is more difficult because both medical resources and funding is limited. It would seem that supplying the medical resources to the children would bring about the greatest benefits long-term. However, allowing this man to suffer intractable pain violates the basic dignity and respect that every person deserves. The WHO estimates that 4.8 million people a year with moderate to severe cancer pain receive no appropriate pain treatment. In fact, the poor and middle-income countries of the world where 80% of the world's people live consume only about 6% of the world's morphine. Confronted with limited resources and with no viable options available, the physician is confronted with the possibility of giving the man an injection of potassium to terminate his life as a form of mercy killing. The rationale is that in a resource-limited country it would be more humane to terminate the patient. The problem with this rationale is that one needs a criterion for determining who should be terminated. This criterion would presume that we can draw a distinct ethical and medical line to assist those in making this decision. Would this mean that anyone experiencing pain that cannot be managed due to a lack of resources should be allowed to be terminated? Ethically, to allow for this is to open up the slippery slope and the ultimate result is the possible abuse of the most vulnerable in our global society. However, advocates for active euthanasia argue that we don't allow animals to suffer so why would we allow humans to suffer, especially in a situation where resources are limited or unavailable. Before reaching the conclusion that terminating this patient is the medically and ethically responsible action, all viable options must be explored.

First, was there any less expensive pain medication available that would control the pain to a certain degree for a longer period of time? There must have been a pharmacy in the location because of the surgeries that were taking place. Possibly a less expensive pain medication might have been available that would have controlled the pain to a certain degree for a longer period of time. In addition, a drug like dilaudid (hydromorphone) is more potent than morphine. For example, 1 mg IV dilaudid = 7mg IV morphine and the cost is about the same. If dilaudid was used the physician could have gotten additional equivalent doses. This is not the most ideal medical option, but it would allow Mr. F. to have his pain minimized longer and it would give him some quality of life. Second, did the physician exhaust all possible contacts to obtain morphine or other pain medications from clinics or hospitals in other parts of the country? Having been there a few times doing this type of medical work the physician must have connections in-country with other physicians and the medical establishment. Resources, such as morphine and other pain medications possibly could have been obtained from these other sectors. Third, there are nonpharmacologic methods to control pain such as positioning, massage, relaxation/meditation, heat/cold, etc. These methods could be taught to the patient and the patient's family to assist in pain management. Finally, if stronger sedatives were available this would help relax the patient and help control his anxiety which is a major component of pain. Benzodiazepines are more efficacious than benadryl and almost as inexpensive. This would increase the patient's quality of life and it would promote his dignity and respect.

Under the circumstances, the physician should not have given the patient an injection of potassium to terminate him. It is certainly unjust that all people do not have equal access to health care resources; however this is the reality of our present situation. As a matter of justice, we have an obligation to distribute the medical resources available in a manner that will bring about a reasonable balance of benefits and burdens. In a situation of scarcity, the issue of determining how to distribute benefits and burdens becomes a major concern. As long as the physician has acted in good faith to provide the best possible care with the resources available, then the physician has met his or her obligation. There is an ethical obligation to control a patient's pain and suffering, but the extenuating circumstances in this case limit the ethical obligation. The physician should attempt to control Mr. F.'s pain to the best of his or her ability with the limited resources available. This could be done by helping the patient and the family cope with the dying process by utilizing other options that would keep the patient as comfortable as possible. To terminate the patient directly would violate his basic dignity and respect, would open the door to possible future injustices and abuses against the most vulnerable in our society, and would violate the physician's obligation to do no harm to a patient. No physician can be obligated to violate his or her conscience even if termination would be the last resort. To compromise this basic obligation would be a grave injustice.