Physician heal thyself - Ethical Dilemma: A case report

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The case

The patient is a 83-year-old female with a history of long-standing diabetes and hypertension admitted to the hospital in January 2019 for exertional dyspnoea of New York Heart Association (NYHA) grade 4. Examination revealed- edema feet, elevated Jugular Venous Pressure (JVP), bilateral crepitations in the chest, and ejection systolic murmur grade 2/6 at the aortic area.

She was diagnosed with severe aortic stenosis in 2003 with a peak gradient of 80 mmHg and a mean gradient of 44 mmHg across the aortic valve. Aortic valve opening was 32 mm, and ejection fraction was 50%. At the time, she had NYHA grade 1 exertional dyspnoea. She was advised of aortic valve replacement as a treatment option. However, the patient and her family refused on the grounds of advanced age, frail physique, long-standing diabetes, and multiple drug allergies; thus, surgical treatment was perceived to be high risk.

By 2010 her activities became restricted due to NYHA grade 2 angina and dyspnoea. The surgical option, including Transcatheter Aortic Valve Implantation (TAVI), was discussed with the patient and the family but was again met with refusal. In the following years, she became progressively home-bound and went through bereavement. In spite of this, she maintained a reasonable quality of life, spending her time with either of her two sons.

In January 2019, 16 years after diagnosing severe aortic stenosis, she was admitted with congestive heart failure. She recovered with ICU treatment, but she was room-bound after discharge. In February 2020, she was admitted again and succumbed to cardiac arrest in the hospital.

Discussion

This case raises a few questions of clinical importance and ethical issues in clinical practice.

1. The first and foremost issue centers around the refusal to undergo surgery.

This patient's 2D Echo in 2003 was showing peak gradient of 80 mmHg and Doppler velocity of 4.5 m/s, predicting a 5-year probability of remaining free of cardiac surgery or death of less than 25%, even if asymptomatic. She became symptomatic in 2010, and surgery is recommended as a class 1 option in such cases as per American College of Cardiology/American Hospital Association (ACC/AHA) guidelines[1].

In Aortic Stenosis (AS), after the onset of heart failure, survival is < 2 years without valve replacement[2]. Despite this knowledge, the patient refused surgery.

The patient's right to refuse surgery is founded upon one of the four ethical principles of medical practice, i.e., autonomy, wherein healthcare professionals should not impose their own beliefs or decisions upon their patients[3,4]. However, the three other principles, beneficence (do good), Non-maleficence (do no harm), and Justice (equality and equity), need to be carefully balanced while addressing these difficult situations.

In this case, autonomy prevailed as the disease was purely of her own with outcomes that would benefit or harm only herself, not society. The question of justice would have risen had she refused the surgical treatment for financial reasons or lack of social support. There was a conflict between beneficence and autonomy; however, respect for the patient's autonomy surpassed the other principles in this case.

This conflict leads us to the second question:

2. What was the clinical decision-making model in this case?

Among the three prevalent clinical decision-making models, viz.,

a) Paternalistic model - This is an autocratic style of decision-making where the healthcare provider carries out the care from the perspective of knowing what is best for the patient and therefore makes all decisions.

b) Informed decision-making model - In this model, the healthcare provider is responsible for the transfer of information to the patient- which is the only legitimate contribution of the physician in the decision-making process. The patient is then responsible for consideration of all available options and making a choice.

c) *Shared decision-making model* - The hallmark of this model is its interactive nature, in which there is a two-way exchange of information- both doctor and patient reveal treatment preferences, and through negotiation and thorough deliberation, agree upon a treatment option. Ultimately, the final decision is that of the patients[5], as in this case.

In today's healthcare environment there is greater emphasis on patient-centered care that exemplifies patient engagement, participation, partnership, and shared decision-making.

This brings us to the final question-

3. How should one deal with refusal of care?

After assessing the patients' and caregivers' capacity and resolving information asymmetry, clinicians should try to understand the reasons behind refusal of care- creating a space for patients to voice their concerns. If the patient refuses treatment even after this, an informed refusal must be obtained by the clinicians, respecting the patient's autonomy. However, this does not absolve the clinician from the ethical obligation of harm reduction. Hence, the clinician's duty lies in identifying other medically acceptable options for the patient. This maintains the therapeutic alliance while promoting patients' health.

Thus, in this case, the patient continued her compliance to medications, with regular follow-ups for diabetic control, and survived with reasonable quality of life for 17 years after the diagnosis, a satisfactory outcome for both patient and clinician. Dealing with the refusal of care needs patience and maintenance of therapeutic relationship[6,7].

Conclusion

Clinical decision-making in health care should be based on a shared model, respecting patients' autonomy.

Ethical Consideration: Informed consent was taken from the patient.

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Conflict of interest: Nil

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