Ankit aggarwal case study sample

Sociology, Ethics

Every profession has its own ethical considerations, but the area of social work has some of the most heart-wrenching ethical stories, because when practitioners act unethically, either through neglect or through malice, the effects are so tragic. In this case study, the patient was a 52-year-old single man (never married). Because he had multiple handicaps, he had a social worker serving as his legal guardian. He did have two relatives in the area – two sisters. Both of them took care of their brother as much as they could, but they also had full-time jobs of their own to hold down. Over the past 20 years, the man's medical history included several major hypertensive cerebral hemorrhages, near the basal ganglia. Also, the patient had suffered from several convulsive seizures, resulting from excessive drinking. About a year ago, the patient was diagnosed with a carcinoma in the left kidney, but he refused to consent to any medical treatment. Later that year, more cerebral hemorrhages hit in his basal ganglia, and the physician had to administer a tracheotomy. The hemorrhages also left the patient with a number of neurological disorders.

About a month ago, the patient was admitted to a local hospital, and in an examination the cancerous kidney was noted once again. The question as to whether the surgery should take place was put to the patient, and he wrote down his agreement, with the proviso that the surgery would happen “ if it makes sense.” It was not clear, at the time, whether surgery was necessary. No metastasis had been detected yet, and so the surgery would not necessarily extend his life. On the other hand, going under a general anesthetic could place his neurological health at risk, given the seizures and hemorrhages that had already taken place. The dilemma, as will be seen, is

whether or not the kidney should be removed, given the neurological risks associated with the anesthesia that would be required. The dilemma, as will be seen, is the question of whether or not the patient should have any input on the decision to remove the cancerous kidney.

And so the doctors took up the ethical question – should the operation go forward? Did it “ make sense” as the patient indicated that it must before going forward? In a discussion with the hospital ethicist, two major issues came up: first, is it ethical to do the operation, given that the neurological outcome could be so tragic; second, with the limited available resources, would the operation be right? Other tertiary issues came up in the discussion as well: the ways to act according to the patient's wishes; the best way to involve the patient in the decision; the patient's actual best interests; ways to avoid additional strain on the patient's medical condition. The first meeting included the medical team, the ethicist, the patient’s sisters, and the patient's legal guardian. The group discussed a summary of the patient's medical history, concluding with a summation of the present situation. The ethicist decided that there was not yet enough information to determine whether or not the operation “ made sense” – particularly because of the risks of the anesthesia. As a result, the participants decided to talk to an anesthesiologist before making the decision about the surgery.

Before adjourning, though, the committee decided to remove the issue of limited resources for the equation. While no medical health care system has the resources to perform every procedure for every patient, in this instance, it was decided that he should have the best care available, according to the

ethics of the decision. The committee did spend a lot of time discussing whether or not the patient had actually tried to refuse the treatment, like he had the year before. However, the patient's guardian pleaded on his behalf that her ward, like all other people, had an intrinsic will to live, and that his last concrete input on the matter was to agree if the surgery made “ sense.”

At adjournment, the group sent the ethicist to make an evaluation of the patient to determine whether or not the patient could be kept informed and involved in the decision. However, before the evaluation could take place, the patient became much sicker and was moved to the intensive care unit. The ethicist was able to visit with him in there, but even with the assistance of a nurse, he was unable to communicate with the patient about even the simplest subjects. The ethicist concluded that the patient was too confused for meaningful communication and too weak to take part in this sort of discussion.

When the meeting reconvened, there were different people in the room. Except for the senior resident, all of the members of the medical team had changedeveryone was in attendance again. The legal guardian had had some holiday plans and had sent a colleague instead; however, the patient's sisters had been invited to attend in the guardian's absence, and they were both there. The ethicist was there. The major issue that had caused the decision to table the meeting had been the risks associated with anesthetizing the patient. After consulting with an anesthesiologist, the senior resident reported that the risk of the general anesthetic was significant – but also hard to quantify. The ethicist reported the patient's

inability to have a meaningful discussion about the surgery and recommended that the earlier expressed wishes be followed. Because the patient was not able to make verbal responses, and because attempts to interpret his nonverbal cues had led to stress on the patient's part, it was suggested that the patient be held out of the conversations. At this point, the legal guardian's colleague spoke out in favor of the operation, so that the patient would be able to live longer; at that point, the conversation turned to the identification of the “ best interests” of the patient. The sisters then weighed in on what they thought his wishes would be, based on their interaction with him over the past few years. As a result of his maladies, he had had the best outcomes in one specific rehabilitation institution; there, he had gained back some of his interest in interacting with people and with watching television in a wheelchair.

As a result of this discussion, the group decided to forego the operation, on the basis of the benefit that the rehabilitation institution had had for the patient. Because there was such a significant risk if the patient had general anesthetic, the committee feared that the surgery would inalterably damage his chances to have quality of life. If he did not have the operation, the carcinoma would remain, but given the lack of metastasis to that point, that did not represent as serious a health risk as the possible damage that would result from the use of anesthetic. The rehabilitation institution would be able to host him and, hopefully, have the same effect it had had before – giving him a sense of autonomy and enjoyment from life.

There are several commonalities between the purposes of ethics consultation and the guiding morals of health care and medicine. This does not mean that ethics is a morally neutral enterprise; on the other hand, it does mean that any ethical consultation must demonstrate its own worth – like any other treatment. The primary use of ethical consultation comes when it systematically analyzes a medical situation to find the ethical issues that lie beneath, to identify potential conflicts or options and bring them up for an open discussion. There is time to have ethical discussions in all but the most serious medical cases – in which the need to act provides the ultimate ethical imperative.

In the coming years, as medical expertise continues to develop, there will be more and more areas for practitioners to consider ethically. Consider, for example, the difference between limb amputation in the middle of the nineteenth century and today. In that time period, before the development of penicillin, a significant cut to an extremity, particularly if there was metal involved, led to amputation of that limb, because the known danger was gangrene. Many amputees suffered from a significant loss of quality of life, as a result of the lost limb, and many did not survive the procedure, because infection set in anyway, or blood loss ended up being the culprit. Nowadays, though, there are many more options open to doctors, and amputation happens much less frequently. The wealth of options means that ethical conversations must take place, to balance the interests of the patient, quality of life, safety, and access to health care resources.

With a growing number of options comes the challenge to standardize the methdology of ethical discussions about health care options. If one is going to have an ethical system of consideration that is fair, the process of having the discussion must be standard, so that all patients receive the same level of scrutiny. Ensuring this standardization will require commitments on the regional and local level, so that there is enough oversight to ensure the provision of fair models of care and ethics consultation.

There are four principles that must be present for an ethical discussion of a patient's medical situation (Gilliland). The first is a respect for a patient’s autonomy: unless there is a pressing need, the patient must be allowed to make his or her own medical decisions, in an autonomous fashion. In this present case study, the patient simply was unable to make a meaningful contribution to the discussion of his own care; indeed, the stress that would have accompanied a discussion of his care would have harmed his health to the point that even including him could have been considered unethical. It is clear that either decision will have significant effects on the patient’s health; if the patient had gone ahead with the surgery, there would have been severe risk of neurological damage, as has been established. However, the existing damage to the patient’s neurological system had already warranted the naming of a guardian for him, even into adulthood. Because the patient was not able to manage his own personal affairs (including his medical condition), it made sense to let the committee make the decision without the patient’s input – especially considering the stress that could have been involved. While this might seem more like an application of the paternalistic model for the physician-patient relationship, in which the physician is seen

as the expert, and the patient takes a lesser role, in the case of this patient, the analogy is suitable, because the patient cannot make decisions for himself. The second is a commitment to non-maleficence – in other words, a commitment to refuse to act maliciously toward a particular case, even when the medical facts about that case either invited a sense of scorn or provided the temptation to skimp in order to preserve resources for other cases. In this situation, all of the parties involved were committed to the best outcome for the patient. Even though there was disagreement about whether or not the patient should receive the surgery, particularly from the guardian's substitute, it was clear that when the committee decided to leave the question of resources out of the discussion, the only parameters left were ones considering the patient's best interest – health outcomes, as well as autonomy. There are far too many cases in which financial considerations come into play with the provision of medical care. While that might be a valid concern in the case of elective surgery, in this instance, allowing a question of resources to make the decision would have been cruel. A patient who has become an adult ward of the state, because of his own neurological condition, deserves the very best that the state can provide in terms of health care. When the balance of the question lies between a cancerous tumor and a potentially devastating neurological injury, the only question should be the patient’s best interests. Informing the patient would also have been cruel, in a way, because it would have given him information with which he was not equipped to deal. The third is a mirror of the second: beneficence – in other words, a commitment to act kindly toward the patient, to ensure that even if the best medical outcome was not possible, that a

commitment to quality of life and treating the patient with dignity will be upheld. Consider the arguments from both the sister and the guardian's substitute in the final discussion: both of them wanted to act kindly toward the patient. The sister had more knowledge of the situation and was aware of the availability of the rehabilitation facility, which is why her argument carried the day. No one in the conversation was motivated toward anything other than kindness toward the patient. One consideration that has long been part of discussions in medical ethics is the responsibility that physicians may or may not have to be completely truthful with their patients. In certain cases, it might be more damaging for the physician to tell the patient the entire truth about his or her condition. Consider the case of a terminal cancer patient. Even if the doctor’s opinion is that the patient has six months to live, letting the patient know that in specific terms can be harmful. First of all, there are many instances of patients living far beyond the expectations of their physicians in these sorts of cases, so if the patient has his or her affairs in order, then a different approach would be to discuss the pros and cons of aggressive treatment. In the case of this patient, the doctors did not bend the truth at all, because they told the responsible parties for the patient about the different options that were available. Leaving the patient out of the discussion turned out to be the kindest option. The fourth is justice – in this case study, the decision that was the greatest nod to justice was the call to remove the question of resources from the discussion. Once the committee decided that the patient deserved the best available care, regardless of cost, the die was cast in terms of making sure that his treatment could not be altered because of any material concerns.

In conclusion, Oon the basis of this and other ethical consultations that cover areas of medical care, it is possiblemight be well worth suggesting that there be to suggest a framework for standardizing these discussions. First must come a discussion of the interests of all of the individuals connected to the case. Obviously, the patient is the first person on that list; however, the patient's relatives, the medical providers, and ancillary personnel all come into play here. In cases like the one under present discussion, an ethicist would also be considered, as would a guardian. Second must come a consideration of the connection between the patient and relatives with the professionals. In what way can all parties interact to bring about the best outcome for the patient – and all other interested parties? Third should come a discussion of the patient's social context. In this present case, for example, the availability of the rehabilitation institution that had provided such beneficial outcomes for the patient in the past was a major factor in the decision to put off the surgery. For every case coming under consideration, the social context in which the patient will live after the surgery is important to discuss. Fourth should come a reflection on the specific legal and social ramifications of the process under discussion, including the political and cultural context. Finally, the discussion should include an acknowledgment of the overall principles that guide the ethical discussion.

While this framework might sound a bit vague, it actually would fit ethical discussions for a number of different professional contexts – including those outside health care and medicine. For each profession, it would be helpful to set up a more precise set of rules to guide ethical discussion so that care is standardized, and ethical considerations are made in the same way. If the

decision making process is not standard, then different metrics could be used on different patients, resulting in inconsistent patterns of decision making. While it is always important to save the life of a loved one, the emotional factors of such a situation are why a relative should only be one member of the decision making community. Oftentimes, the emotional factors have more to do with the interests of the family than the patient. There might be a patient who would not want to be held alive while in a vegetative state, even though the rest of her family might want her attached to machines as long as possible. In cases like this, it is beneficial to have some objective distance to provide perspective on the situation, and render a decision that truly balances the patient's best interest with ethical standards. In the case of this patient, had the rehabilitation institution not been available, it seems as though the guardian's urging to go ahead and have the operation would have carried the day, because the guardian's job was to push the patient's wishes. Because there were others in the room who remembered the positive outcome from rehabilitation, though, a decision was made that avoided the considerable neurological damage that the surgery might well have caused. The implications of this case for other patients who have too much neurological damage to make their own medical decisions are significant, as they are ultimately in the hands of those relatives, guardians, and doctors who make their decisions for them. The balance between keeping them informed and keeping them safe is a gentle one. This is a topic that deserves further research and study, both within the medical and ethical professions.

Works Cited

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