Medical decisions as seen by philosophers

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Clinical decisions by doctors faced with ethical dilemmas are discussed by medical philosophers in a very interesting manner. The principles underlying these decisions, and their interactions with the mental processes of decision makers have been discussed by Wulff et al [1].

Patient-oriented-utilitarianism

A doctor may act according to the principle of patient-oriented-utilitarianism (POU). He will do whatever, in his opinion, will have the best consequences for the patient. This is a common practice but the pathways of reasoning followed are very complicated. Alternative strategies on issues relating to treatment (drug vs. surgery vs. radiotherapy or conservative vs. radical or symptomatic vs. curative or OPD vs. hospitalisation vs. speciality clinic) or on how much to tell the patient (telling the truth on malignancy vs. not revealing it if a total cure has not been obtained vs. informing a select relative in confidence) are sometimes possible.

In each case, the possible outcome of each decision and its probability is thought of on the basis of the current knowledge of the clinician (such as his estimates of 60% chance of responding to drug therapy, 10% chance of recurrence, 90% chance of going back to work within six weeks) in the context of different illnesses. At the same time the utility of each outcome or its value to the patient in terms of the quality of life to be enjoyed is also worked out in the range of zero to one. Sudden death in operation or prolonged irreversible coma has a value of zero; complete recovery with no after effects and going back to same work as before has a value of one. Multiply the probability by utility and the product of each outcome is obtained. Add up all possible outcomes of a particular decision and you get the weightage for this decision. Now you select the one with the highest weightage. All this reasoning takes place in the clinician's mind, often unconsciously, before he makes his decision.

As admitted by the authors [1], no one will ever admit to the use of this procedure in practice. Perhaps something similar may take place in a conference of consultants and medical social workers. They may discuss the outcomes in terms of the efficiency with which the target organ functions, total body efficiency, financial drain, fragility of the family relationship, socialisation of the altered individual, the number of years ahead and so on. Consciously or unconsciously shaped, their decisions reveal the structure of POU. The data considered in arriving at the decision consists of the state of scientific progress at the time, results of clinical trials and the socio-economic environment of the patient.

In philosophical terms, the decision shows what IS in the world. Philosophers often quote Hume's law which states that one cannot derive an ought from an is. So inspite of all the brainwork, we may not get an accurate idea of what we *ought* to do in a given patient's situation.

Rule Utilitarianism

Another approach is that of rule utilitarianism in which a wider perspective is used to view one's own decision. What will happen if all clinicians make a similar decision (say the choice of an expensive test)? Will such a choice not be the draining away of the limited resources of the public hospital? What will be the result if each of us prescribes a particular 'latest generation' antibiotic, or the oven-fresh antidepressant or the most widely advertised nutritional supplement which has a marginal advantage over its predecessor? Such considerations will often lead to a choice of a less expensive, less heroic action.

Autonomy of the patient

The third approach takes into consideration the patient's autonomy: a right to make one's own choice, after listening to the doctor's advice. This is a facet of medical decision-making, which is gaining importance in the West. The doctor is no more considered as a guardian: he is treated as an adviser. The practice of paternalistic medicine is diminishing and patients are accepted as persons capable of deciding what is best for them. This parallels the changing parent-child relationship in a modern family. It is inevitable that this trend will progress in a modern consumerist society in every country. The individual's rights include the right to know the truth, regardless of consequences.

Paternalism

The principle of paternalism, where we are permitted to act on behalf of other people if we believe that such an act serves their interests best, is not to be condemned outright. There are subtle distinctions between its three subtypes: genuine, solicited, unsolicited.

In genuine paternalism, the father knows much more than the child because the latter is immature. Patients who are unconscious, delirious or mentally handicapped resemble such children. Their autonomy is greatly diminished and the doctor's paternalistic behaviour is

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justified. Solicited paternalism is also an acceptable attitude in its own right. Here, the patient has given his/her explicit or implicit consent i.e. the paternal assistance is solicited. Many patients feel lost when they are admitted to a huge modern hospital. They simply trust their doctors and follow advice. The readiness with which consent is given will depend on the nature of choices involved. A simple choice between different procedures may be left to the doctors by a patient seeking relief from cataract or prostatic enlargement or peptic ulcer. But in matters of renal transplant or coronary bypass, the patient and his family will, almost always, have the last word.

Serious ethical problems can be created only by the third type, i.e. the unsolicited paternalism. The patient's autonomy is disregarded by the doctor, whose intuition tells him that it is best to behave in a paternalistic manner under the given circumstances. Theoretically, from the Kantian point of view, it is always morally wrong to put aside the autonomy of any person but the decision to do so can be defended on utilitarian grounds, saying that autonomy is just one kind of good, to be balanced against other kinds of good (peace of mind, relief from monetary burden, quicker symptomatic relief...). The decisions may be disputed later, as the line between unsolicited and solicited paternalism is very thin. As Rawls [2] has suggested, the best test for a temporarily supportive, genuine paternalism is that on gaining autonomy, the patient must 'agree with us that we did the best thing for him'. The same applies to unsolicited paternalism. The intuitive must not be disputable.

However, expectations of patients and behaviour of doctors differ a great deal from country to country and culture to culture. Therefore, if unsolicited paternal behaviour is expected not to create any ethical and legal complications, such problems need extensive discussion.

Future quality of life

The last aspect of deontologist considerations (deontos=duty) is the assessment of future quality of life. The clinician's duties are threefold: determination of what is best for patient, determination of what is best for society and ensuring the autonomy of the patient. Having considered what is immediately 'best for the patient', it is always necessary to rethink in terms of the future quality of. life. This must be part of the duty to preserve life. Life of a 'certain quality' is to be maintained. Exactly what this quality implies is disputable. Cynthia Cohen [3] put it thus, "Human beings are reflective deliberators with the capacity to direct their lives according to their conception of well-being." She pointed out that we violate our belief in the value of human beings as reflective deliberators when we' insist on giving intensive medical treatment (in some tragic instances) to persons whose lives can regress to a state in which they bear no reasonable promise of reflecting their self-chosen values. There is a great onus on us to determine when life-saving treatment is not required. Such difficult decisions cannot be taken by single individuals. They should be the collective responsibility by specially constituted bodies created to handle such problems. Enlightened nonmedical members of society can help clinicians in such bodies.

References

1. Wulff HR, Andur Pedersen S, Rosenberg R: ***Philosophy of medicine - an introduction.*** Chapter 13. The ethical dimension of medical decisions. 2nd edition. Oxford: Blackwell Scientific Publications 1990.
2. Rawls J: A ***theory of justice.*** Oxford:Oxford University Press. 1971 p. 248-49.
3. Cohen CB:'Quality of life' and the analogy with the Nazis. ***Journal of Medicine and Philosophy*** 1983;8: 113-15.

Finding alternative housing for the VIPs won't be much of a problem, sir! Many of them will soon shifted to Tihar or hospitals!

Courtesy: Sudhir Tailang, *The Hindustan Times*

He hasn't been touched so far. But he feels the day of reckoning is nearing...

Courtesy: Sabu, *Indian Express*