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Ethical Decision Making: The Physician–Patient Relationship

“Integrity without knowledge is weak and useless, and knowledge without integrity is dangerous and dreadful.”

Samuel Johnson (1709-1784)

This year, *SpineLine* has published a series of articles on ethics and related subjects in spinal care. I would like to focus further on another ethical issue: decision making when a physician is discussing diagnostic and treatment choices with a patient.

Many view “ethics” not as a singular concept but rather as being part of social conventions (ie, mores), religious beliefs or even the law.¹ But actually, ethical decision making often sets the bar at a higher level than any of these related guides to human behavior. The study of ethics is an entire branch of Philosophy spanning hundreds of years and yielding a large and divergent body of thought on the true meaning and origin of ethical behavior.

For this editorial, however, I am employing a practical, general meaning of ethical decision making as that which is likely to bring about a best solution to a medical decision based on the options available. This is a variation of the Utilitarian² approach to ethical decision making in which the goal is to produce the most good (best clinical outcome for a patient) while producing the least amount of harm (minimizing the risks to that patient to achieve the best clinical outcome).

It should be noted that this approach to ethical decision making places a significant burden on the physician. The decision-making process is highly interactive between the patient and physician, but demands that the results be patient-centered.

It requires that the physician in this process put aside all other interests but the patient’s and lets the patient’s needs, in the context of the physician’s knowledge and training, dictate the appropriate test or treatment.

As an example, consider a young attending discussing treatment with a 60-year-old male patient who has bilateral foraminal stenosis at L4-5 and L5-S1. The patient has radicular symptoms on prolonged standing and walking and no significant back pain. His flexion/extension films reveal no listhesis and no instability. At this point he has failed to improve after a course of NSAIDs and back exercises and only transiently after transforaminal steroid injections. He is employed in office work but concerned about too much time off work. The patient feels, however, that he needs surgical treatment.

The surgeon in this interaction is a young, well-trained spinal surgeon with excellent credentials who is quite capable of performing any potentially necessary surgery on this patient. He is four years into practice, is still paying off his substantial debt from medical school/residency, and has a new home and mortgage, a wife and two young children. His skills are appreciated and he has recently accepted a “consulting” position with a major spinal implant manufacturer because of his enthusiasm and increasing use of their newest spinal implant. He, too, feels the patient needs surgery. The question is what surgery: a two-level bilateral decompression with

undercutting if necessary of the facets; a decompression and lateral transverse fusion; a decompression, lateral fusion and internal fixation; an anterior two-level interbody fusion; or a decompression, interbody cages, lateral fusion with internal fixation from the back or as a front and back approach? Clearly costs (and reimbursements) among these procedures and the potential for harms associated with them will vary greatly.

The public at large wants to believe in the altruism of its physicians (though perhaps fewer really do) and would hope that the doctor chooses the best procedure for the patient to relieve his complaints, get him back to work quickly and minimize the risk of harm from that procedure. Many, I would argue, would view such a decision as truly ethical behavior and would expect it. However, unless one has ever been placed into this very common scenario—as most spinal surgeons who are reading this have—one cannot appreciate the incredible moral integrity it takes to consistently make the appropriate choice with the patient, independent of one's own needs and desires. I say this in all honesty and without disdain. It is far too easy to convince oneself (and often the patient) that the more complex procedure is always the right choice and “in the long run” benefits the patient most. Choosing the lesser procedure in the example above will likely best serve this patient's needs and desires, but the surgeon will potentially pay a significant financial penalty for this choice. Ethical decision making does indeed place a moral burden on the care giver in many cases. But this is a burden we are bound to accept if we are to practice ethical medicine.

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Physicians are not infallible. We all have the same wants, needs and foibles as anyone else but we are being challenged to put those aside when it comes to making the “right” decision with our patients in their care. What tools do we have to meet this challenge? We have at least two potent tools to assist us:

First is the simple awareness, which this editorial seeks to point out, that a need for ethical decision making exists. That is, the public expects it and it is incumbent on us to make decisions in an ethical and patient-centered fashion. It *is* what we should do.

Second, all available high-level and up-to-date evidence must become mandatory to our decision-making process.

Medically appropriate decision making is ethically appropriate decision making. Utilizing evidence, as an adjunct to our experience and the patient's needs, is the self-correcting mechanism in this decision-making process. This best evidence will guide the care giver toward making decisions with the patient that foster an ethical physician/patient relationship. Other relationships the physician might have outside the physician/patient relationship will not and should not play a role.

In the scenario above, the recent systematic review and clinical practice

guideline published by NASS³ shows good support for a simple decompression in this patient who has leg-predominant symptoms and no instability. Doing more than this, the current evidence suggests, would expose the patient to an increased risk of harms with no clear indication that the outcomes from the surgery would be significantly improved. Following the evidence presented in the clinical practice guideline will greatly contribute to making an ethically appropriate decision with this patient.

Being mindful of the need for ethical decision making with our patients should assist us in finding additional means by which we can foster this process.

References

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