Medical Dissensus in End-of-life Decisions

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IN FAVOUR OF MEDICAL DISSENSUS: WHY WE SHOULD AGREE TO DISAGREE ABOUT END-OF-LIFE DECISIONS

DOMINIC WILKINSON, ROBERT TRUOG AND JULIAN SAVULESCU

Keywords
consensus,
withdrawing treatment,
intensive care,
medical ethics,
neuroethics

ABSTRACT
End-of-life decision-making is controversial. There are different views about when it is appropriate to limit life-sustaining treatment, and about what palliative options are permissible. One approach to decisions of this nature sees consensus as crucial. Decisions to limit treatment are made only if all or a majority of caregivers agree. We argue, however, that it is a mistake to require professional consensus in end-of-life decisions.

In the first part of the article we explore practical, ethical, and legal factors that support agreement. We analyse subjective and objective accounts of moral reasoning: accord is neither necessary nor sufficient for decisions. We propose an alternative norm for decisions – that of 'professional dissensus'.

In the final part of the article we address the role of agreement in end-of-life policy. Such guidelines can ethically be based on dissensus rather than consensus.

Disagreement is not always a bad thing.

INTRODUCTION

A year ago[1] I was involved in antenatal counselling for a couple, Sean and Susan Cooper. They were in the last trimester of pregnancy, and their foetus had been diagnosed with major congenital abnormalities. Among other problems, it appeared that the foetus had a congenital abnormality of his airway. If he were to survive, he would likely require urgent surgery immediately after birth for insertion of a tracheostomy. Each of the foetus' problems were potentially treatable, though they would require multiple operations. With surgery, the most likely outcome was that the infant would survive. His long-term functional outcome was difficult to predict, but he would potentially have normal intellectual function. As a counselling neonatologist, my role was to discuss management of the infant after birth. One question was whether or not it was appropriate to offer the option of palliative treatment at birth (with the expectation that the infant would die). I had personally come to the view that surgical treatment would be in the best interests of the infant; I did not feel comfortable withholding life-sustaining treatment. The obstetric team, however, had reached a different conclusion and felt that palliative care was a reasonable option. What ought I do in this situation? I discussed the case with other neonatal consultants. Most felt as I did that resuscitation (including surgery if necessary) should be provided. One other, whose judgment I respected, supported a palliative approach if that were desired by parents.

When a group of health care professionals are contemplating decisions about end-of-life care for incompetent patients do they need to reach *consensus*? One view is that such agreement is a necessary precondition of end-of-life decisions.

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[1] This case is a composite of several real cases encountered by DW. All identifying details have been omitted or changed.

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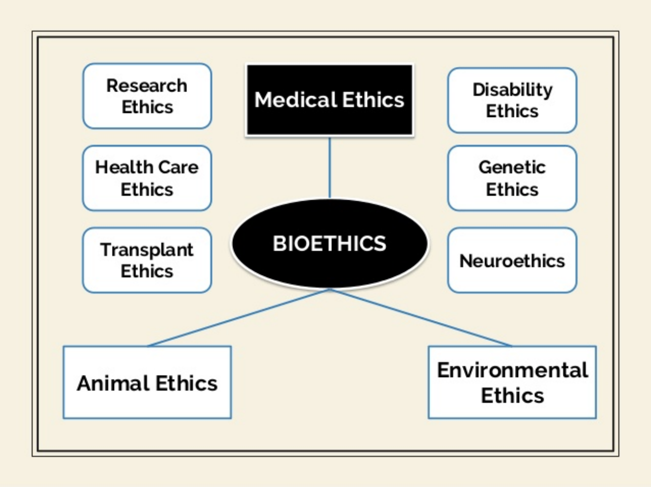
Conflict of interest statement: No conflicts declared

Dr. Derrick Au

CUHK Centre for Bioethics

2nd Bioethics Journal Club meeting (6.7.2017)

Bioethics: typically controversial



Medical Ethics

BIOETHICS

Research Ethics

Health Care Ethics

Transplant Ethics

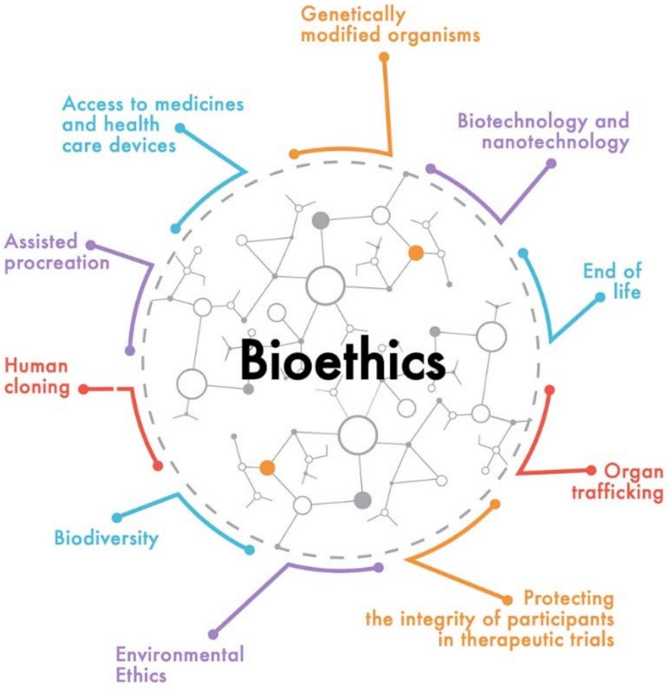
Disability Ethics

Genetic Ethics

Neuroethics

Animal Ethics

Environmental Ethics



Sample Areas in Applied Ethics

- Business ethics
- Bioethics
    - Study of typically controversial ethics brought about by advances in biology and medicine
- Decision ethics
- Professional ethics
    - Computer ethics
    - Journalism ethics and standards
    - Research ethics
    - Legal ethics
    - Marketing ethics
    - Medical ethics
    - Nursing ethics

Source: http://en.wikipedia.org/wiki/Outline_of_ethics http://en.wikipedia.org/wiki/Bioethics

Daniel Callahan, founder of the Hastings Centre

A Conversation with Daniel Callahan on "In Search of the Good: A Life in Bioethics”
daniel callahan speaks at hms的影片 ▸ 1:17:06
https://www.youtube.com/watch?v=jeB4mIQQZYE

“…As time moved along, over the early years I wrote articles on just about every issue in the field save for human subject research (which I found a great bore, even though it was surely important: how many articles can one read on ever- fresh formulations of “informed consent”?). I particularly enjoyed working up articles on radically different kinds of problems, taking a chance with new issues and ways of looking at ethics. I became known as an autonomy-basher, not because I objected to autonomy as an important human value but because I objected to an undercurrent trend that seemed to reduce ethics itself to nothing but individual free choice disconnected from an even more important question: what counts as a good or bad choice, a good or bad person, or a good or bad society? Those questions seem to make Tea Party–like autonomy zealots acutely uncomfortable.”

D. Callahan. How I Lost—or Found?—My Way in Bioethics
Cambridge Quarterly of Healthcare Ethics (2015), 24, 246–251.

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In the first part of the article we explore practical, ethical, and legal factors that support agreement. We analyse subjective and objective accounts of moral reasoning: accord is neither necessary nor sufficient for decisions. We propose an alternative norm for decisions – that of 'professional dissensus'.

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The foetus in 3rd trimester with major congenital abnormalities

- Dr. Wilkinson involved in antenatal counselling for the couple
- Personally considers resuscitation and surgical treatment would be in the best interests of the infant
- The obstetric team felt that palliative care was reasonable option
- Foetus: Multiple abnormalities Including congenital abnormality of airway
- Urgent tracheostomy required after birth
- Multiple subsequent operations required
- With surgery infant would likely survive
- Long term function difficult to predict
- Intellectual function potentially normal

Reflecting and analyzing the prevailing view on Professional Consensus Requirement (PCR)

- Analysis only focused on end-of-life decisions to discontinue or withhold potentially life-prolonging treatment
- Concentrate on incompetent patients without an advance directive
- Focused on medical or professional consensus (not consensus between clinicians and family)
- Acknowledge that in practice the followings may help resolve disagreement:
  - Further discussion
  - Further investigations to clarify facts
  - Ethics consultation
- Acknowledge that professional agreement is often desirable

The question

- Question phrased: **"Is such agreement (professional consensus) necessary for treatment limitation to be an ethically permissible option?"**

- Underlying question:

  Is PCR necessarily a better policy than allowing medical dissensus?

  [Or more mildly: Is allowing medical dissensus a viable alternative policy?]

For PCR

- The requirement of professional consensus has been adopted in a number of professional guidelines (e.g. Australasian Intensive Care Society Statement 2003; GMC guideline)
- PCR has practical and psychological value
- Protection for professionals (Bolam defence against negligence claim)
- Mathematically, the probability of a collective answer of arriving at the ‘correct’ answer increases as group size increases (if individual decision-makers has > or = 50% (N. Condorcet)

Reservations about PCR

Note that:

- The guidelines do not define ‘consensus’: Unanimous? Near unanimous? Absolute majority?
- PCR imposes the values of physicians upon the patient and the family
- Physicians’ decisions are often influenced by personal factors and views
- In one study, less than half of ICU physicians treated the (simulated) patient according to his wishes
- If unanimous or near-unanimous consensus threshold is used, PCR would make EOL decisions hostage to the most conservative decision-maker(s)
- A Bolam defense does not require all or even a majority of peers to endorse the course of actin (‘a responsible body of medical opinion’…)
- N. Condorcet: Probability of a collective answer being ‘correct’ will decrease if individual decision-makers has <50% of arriving at the ‘correct’ answer

Philosophical analysis

Subjectivism

- JS Mill argued that a person’s own judgment about which course of action is best for his life is likely to be better than the value judgment of others
- Consensus is not necessarily a guide to rationality nor to systematic justification

Objectivism

- Rational deliberation desirable
- J Rawls: the party to rational deliberation should be knowledgeable about the facts and the consequences of courses of action, but should also be reasonable (criteria provided) and have sympathetic knowledge of those human interests underlying the disagreement
- Professionals may have shared bias

In favour of and against a dissensus approach

For:

- Instead of seeing the single and only right course of action, examine whether there are a range of reasonable courses of action over which patients/families may choose
- Need not be simplistically providing the facts and asking what the surrogate would like
- If the aim is to seek what is in the patient's best interests, it is advantageous that professionals do not start with the same set of values

Against:

- Divergent professional opinions more burdensome for the families
- Concerns that it might lead to liberally limiting treatment
- May not actually resolve professional disagreements and simply take the question to a different level (e.g. whether palliative care at birth is a 'reasonable' options)

Dissensus: safeguards and application

- To mitigate the risk of decisions in favour of limiting treatment, the authors proposed:

  (i) only views after ‘reflection and discussion’ should be included;

  (ii) clinicians who endorse treatment limitation should be prepared to take over responsibility for the patient’s care.

- All options put forth to the families must be within the law.
- Sample clauses in policy /guideline adopting Professional Dissenus approach are provided.

Post-reading thoughts

- The authors’ arguments for medical dissensus seem to sway between ‘objective’ (getting at the ‘correct’ decision) and ‘subjective’ (giving the families or surrogate more room to choose based on patient’s values)
- The real concerns could have been addressed by ‘reasonableness’ ad defined by Rawls? (the party to rational deliberation should…(iii) have an open mind, (iv) making a conscientious effort to overcome his intellectual, emotional and moral prejudices.)
- If (iii) and (iv) are practiced, then the good scenario of Condorcet’s theorem applies, and there is little risk of families held hostage to professional shared bias.

Thank you for your attention