Doctors Describe Their Toughest Ethical Dilemmas

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First, Do No Harm

The world in which physicians practice is growing increasingly complex. Every day, doctors confront ethical challenges while contending with external players (patients, families, administrators, payers) and internal forces (biases, cultural norms, religious beliefs) that cast confusing shadows on their seemingly straightforward goal to do no harm.

As part of Medscape's Physician Ethics Survey 2016, we asked doctors to describe the most difficult ethical challenges they face. Although their stories are varied and unique, many doctors describe wrestling with the same handful of challenges: reporting impaired colleagues; caring for patients who don't try to help themselves or don't "deserve" treatment; prescribing "placebo-like treatments" to satisfy patients; undertreating pain; and physician-assisted dying.

Here's how they're grappling with these issues.

Reporting an Impaired Colleague

Even in situations where the choice seems clear—reporting an impaired colleague—physicians face inner turmoil. Although nearly all physicians say they would (78%) or might (18%) report an impaired colleague, the decision is fraught.

Reporting a colleague enables the impaired physician to get the help he or she needs and it protects patients, but doctors know it can also cripple a coworker's career, destroy a friendship, and result in professional backlash.

Many doctors describe the cost of reporting:

- "It jeopardized his benefits for his family, but he was harming patients."
- "I have done so twice. Both physicians I reported lost their medical licenses."
- "He has never forgiven me."
- "I have, and I have paid for that too."
- "I would confront them first, and I have done so. It is not fun."
- "He did not get the treatment he needed, and he lost his license."
- "Everybody crapped on me, and I was hated for doing it."

"Finding the right answer is easy; it's the actual doing that is hard," says Kenneth Goodman, PhD, director of the Institute for Bioethics and Health Policy at the University of Miami. "If you are of the view that your primary loyalty is to the patient, then the idea that friendship or your own self-interest could be a factor in your decision is really hard to defend. This takes moral courage."

Caring for 'Undeserving' Patients

Physicians don't check their humanity at the door. Neither do their patients. For many doctors, that simple truism is the source of frequent conflict and frustration. Says one doctor, frustrated by patients'

refusal to quit smoking, watch their diet, or take their medication as directed, simply "remaining engaged in the face of patient apathy" is a daily challenge.

But when patient behavior deteriorates from unhealthy to self-destructive and the medical resources in question are especially precious, the ethical stakes are higher. Physicians responding to the survey describe such situations as "doing a liver transplant on a patient who tried to kill herself" and "offering liver transplant options to alcoholics."

In these situations, Goodman says, doctors are unfairly being forced to grapple with an ethical dilemma because the process for determining who gets an organ has failed. "If someone is going to waste a liver, they ought not to get it. That is putting the physician in a position they ought not be in," he says. "Fix the process."

Still, many doctors say it is not the self-destructive patients, but the ones who willfully harm others, that present the greatest challenge. Doctors describe the emotional challenges they've faced in "giving 100% effort to a cop killer" and using precious healthcare resources to save enemy combatants in Iraq and Afghanistan "at the possible cost of our own troops."

One anesthesiologist writes, "During my residency, a nurse was raped and strangled. Her attacker was caught and brought to the operating room. I provided the anesthesia. It was very hard to decide how much anesthesia to provide."

Providing care to people who have committed abhorrent acts has always been and will always be an emotional struggle for doctors. But, as one anesthesiologist notes, the ethics are clear. In administering anesthesia to a prisoner who had thrown acid in the face of a young girl he had raped so that she couldn't identify him, the doctor realized, "The power of life or death is in those syringes. I did the right thing and administered the same safe anesthetic I would to anyone. Only God can be judge and executioner. We are to love our neighbors, even the unlovable ones."

Prescribing a Placebo-like Treatment

Doctors want to help their patients. They also want to keep them happy: Patient satisfaction is becoming an increasingly important component of physician compensation. At the same time, however, doctors want to be conservative in their prescribing habits, particularly with regard to pain medications.

One upshot of those trends is that many doctors (45%) say they have or would prescribe "placebos" and innocuous treatments to demanding patients. Another 38% said they would not, and 17% said "it depends." (To be clear, the question did not refer to providing a literal "sugar pill" or completely inert treatment, but referred to a treatment "unlikely to help the condition, but unlikely to harm," such as aspirin or vitamins.)

Prescribing placebo-type treatment presents a needling ethical dilemma. Unless a physician tells a patient that they are prescribing a placebo—and many say they would do so—they are deceiving the patient. But this also calls into question a physician's motivation.

One family physician summed up the point: "My first responsibility is to do no harm. If my perception is that the patient will suffer because of lack of treatment, then I should provide some sort of treatment that will not harm the patient. If I am providing placebo treatment so that the patient will be happy with me and come back to me as a patient, thus preserving my income base, then that is not an adequate reason to do so."

Many doctors say they advocate everything from vitamin B_{12} injections and vitamin C to yoga and complementary therapies, often couching their recommendations in such disclaimers as "It can't hurt" and "There's no evidence, but some people say it helps." They argue that these treatments help patients feel empowered. "Patients love having something to do. Just being told to drink plenty of water and get enough sleep and treat their symptoms makes them feel like we're doing something, so why not? We're alleviating suffering of a less medical sort," says a family physician.

A pediatrician agrees. "I do it all the time. Rituals, such as [get a] special massage or keep a diary or jump up and down three times, etc, help. I would call it being a healer."

But many physicians note that there is a self-serving element to soothing patients with innocuous treatments. "I do it all the time, thanks to patient satisfaction emphasis and ties to income, etc!" writes one doctor. "It's ridiculous, but patients are happier if you do something."

"Placebo is in its infancy," says Arthur Caplan, PhD, professor of bioethics and director of the Division of Medical Ethics at New York University Langone Medical Center. "I think it is going to be explored more because it is cheaper and has far fewer risks," but doctors opting to use it are going to have to find a way to do it without deceiving patients.

What's more, Caplan says, intention matters. Prescribing a placebo because you think it may help a patient is one thing. Prescribing it to simply appease a difficult patient is something else entirely.

Physician Conflicts Around Undertreating Pain

Overdose deaths involving prescription opioids have quadrupled since 1999.[1] Physicians have been blamed for contributing to the epidemic, causing state medical boards and federal agencies to crack down on prescribing practices regarded as overly liberal. At the same time, physicians are trying to alleviate suffering, including that of the more than 65 million Americans estimated to be experiencing chronic pain.[2]

In light of the current environment, nearly one half (47%) of the physicians surveyed say that addiction concerns and fear of professional repercussion would or might cause them to undertreat a non-terminally ill patient's pain. Nearly one quarter (24%) say they would or might undertreat a terminally ill patient's pain for the same reasons. That represents a seismic shift from 2010, when 84% of physicians said they would never undertreat a patient's pain.

Two family physicians' attitudes illustrate how the epidemic has divided the medical community. "Every single day, we get emails, etc about how the Drug Enforcement Administration is clamping down on narcotics and rounding up physicians who overprescribe them," writes one. "My patient cohort is very ill, and there is a ton of chronic pain. I ask you: What am I supposed to treat them with? NSAIDs? No way. It does not work, and most of them have renal failure. Am I supposed to refer to pain management? That's a joke. It never, ever works."

Taking the opposite stance, a colleague rejoins, "Doctors are under a great deal of scrutiny and no patient is worth risking my license for."

Chronic pain presents a particularly thorny problem. Some doctors say, the risk for addiction clearly justifies undertreating, because "addiction trades one source of suffering for another." Others cite Centers for Disease Control and Prevention guidelines released in March indicating that nonopioid therapy is preferred for chronic pain outside of active cancer, palliative care, and end-of-life care.[3]

"I don't believe that narcotics are indicated for nonmalignant chronic pain," writes an orthopedist. "They are for acute surgical, injury, and malignant pain. I don't believe that not prescribing narcotics is undertreatment."

Ethicists say that the solution depends upon physicians committing a significant amount of time to understanding the nature of each patient's pain and referring to specialists if necessary. "The ethical thing to do is to really know your patients," says Caplan. "We have to give doctors time to work out pain management. If you don't do that, then I think people are going to be undertreated."

Physician-Assisted Dying

Support for physician-assisted dying (also called "physician-assisted suicide") is growing. More than one half (57%) of the survey respondents believe that physicians should be allowed to help terminally ill patients end their lives, up from 46% in 2010 and more than one quarter (28%) believe that assisted dying should be allowed for irremediable suffering.

Even as support grows, the issue remains fraught. Many physicians describe assisted dying cases as the most difficult ethical challenges of their careers. They describe their struggles with "defining that line between assisted dying and providing comfort anesthesia"; "wrestling with the desire to assist dying in a suffering terminal cancer patient because of how I would be viewed"; and "denying physician assisted suicide for a terminal patient in the intensive care unit."

Both physicians who have participated in assisted dying and those who have declined to do so struggle. One immunologist recalls a gut-wrenching decision to withhold life support "from a newborn with a disease that was terminal but who could possibly have lived months to a few years with limited support," and an addiction specialist recounts declining to deliver a fatal bolus of opioid to a terminally ill young man. "His grandmother asked me to just empty the syringe in the IV. I explained that the end of Rhett's life was not my call, but it was very hard to not accede to the grandmother's wishes."

Once again, physicians' mandate to do no harm lies at the core of the issue. "Physicians are trained to do no harm, and killing seems like harm no matter what the circumstances," says Caplan. "So there's a tension." Difficult as that ambivalence may be for physicians, he notes, "It's a good thing. You don't want physicians to be too eager to do this."

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