Reflections about a clinical case

Hypothesis / Aims of study

There are different accepted ethical models with a variable number of principles. We are taking a widely accepted one, where the four principles are respect for autonomy, beneficence, non-maleficence and justice. In current times and western society AUTONOMY is the king, nonetheless we should balance all the others as they are as relevant.

Study design, materials and methods

Case report based on a claim.

Results

Mrs A, 58-year-old, fit and well (normal body mass index, no co-morbidities or constipation) was referred by her GP for the management of a pelvic organ prolapse, found at smear test, despite minimal symptoms. Findings were Stage I Uterus prolapse (Leading age at minus 2 cm from the hymen) no significant anterior or posterior prolapse, pelvic floor muscle tone 1/5 in the Oxford scale, poorly sustained contraction, ICIQ VS score = 6/53, sexual matters score = 0/58, QOL score 3/10. During the consultation Mrs A declined Conservative measures and requested surgery because “I want things to be right again”. Despite a lengthy consultation explaining benefits, risks, alternatives, likelihood of improvement and offer a referral to another colleague the patient left unhappy and complained.

This case touches on all ethical principles.

Beneficence – It was judge by the attending clinician that was not in patient’s best interest to have surgery without a 4-6 months trial of supervised pelvic floor muscular training as this would be effective in 50% of the patients.

Non-maleficence – A surgical intervention it is never without risk. The acceptability of the surgical risk rest in the correct indication for surgery. In this case was felt that the risks did not overweight the benefits

Justice – It would not be FAIR to spend a significant amount of public money on a procedure that may not be needed. If the patients decided to engage in medical treatment. Another example of this is Hysterectomy for Heavy Menstrual Bleeding when no other treatments are considered.

Patients Autonomy – She has the competence to make an informed decision.

Doctor’s autonomy – The attending clinician could not in Good Conscience provide a surgical treatment when they did not believe that the benefit outweighs the risks. To preserve patient’s autonomy a referral for a second opinion was offered but rejected.

Concluding message

It is uncommon that Doctors autonomy is placed above Patients autonomy, whenever this happens should be supported by strong reasoning and justification.