Ethical Conflicts *in the* O.R. Setting

by Ann Marie McGuiness, CST, CNOR, MsEd

PART 2

Editor's Note: This article is the second of two parts. The first half of this article appeared in last month's issue of The Surgical Technologist. *In that issue, the author presented an in-depth, comprehensive overview of the bioethical principles, morals, and ethics that form the foundation of our health care system.*

In this issue, the author continues this discussion with practical examples of ethical conflicts that surgical technologists may face.

In the operating room, the surgical technologist is primarily involved with assisting the patient in undergoing a therapeutic intervention to remove or correct a pathology. Providing the surgical technologist with an opportunity to investigate and examine some of the ethical issues that can and do occur in the operating room allows the examination of one's personal value system in relation to the moral and ethical positions commonly espoused in today's health care profession. While these values may differ, it is important that the surgical technologist be able to embrace the values of health care and be willing to support the patient and surgical teams in ways that conform to established societal norms.

The list of ethical issues in health care expands on a daily basis. Technology has provided the means to extend the life cycle beyond points that were once thought to be finite. People are able to survive under conditions that previously would not have supported life. Along with these incredible and far-reaching changes have come many challenges to beliefs and practices that were previously clear-cut.

When faced with an ethical dilemma, there are two approaches commonly used to determine the best options for that given situation. Under the utilitarianism system of ethics, one would describe the issue, list the possible solutions, and then choose the solution that benefits the greatest number of people. Under the deontological system of ethical decision-making, one would describe the problem, list the solutions, and compare the solution with the underlying principles of self-autonomy and self-determination. Patients would base their decisions on their needs, desires, and requests, regardless of any external factors or impact on others.

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Both of these approaches have benefits and drawbacks when applied to any given situation. A combination of both approaches, with the application of the concept of the reasonably prudent person—that action that another practitioners of equal education and preparation would undertake in the same situation under the same circumstances, is used in the health care profession to establish recommended standards of practice in ethical situations.

The following summary of ethical conflicts that the surgical technologist may encounter during practice is by no means comprehensive or exhaustive. Each clinical practice site will present its own unique ethical challenges. The purpose of this section of the article is to briefly touch on ethical topics that may be encountered when practicing in the surgical setting. It is also designed to assist you in examining the ethical issue and assessing the potential impact that a scenario involving this topic would have on you and your practice. Each topic, in and of itself, contains many more facets and details than can be contained in this article. Additional research and review may be required to clarify the concepts and concerns that should be considered when making ethical decisions.

Elective abortion

Elective abortion involves the deliberate termination of a pregnancy without medical indication. In the United States, first trimester (within the first 13 weeks of pregnancy), second trimester (between the 14th and 27th weeks of pregnancy), and even third trimester abortions are available upon request by the pregnant female. In some states, minors may also obtain elective abortion without parental consent.

First trimester abortions are performed by dilatation and curettage. The cervix is dilated, and a vacuum curette is used to evacuate the products of conception. Second trimester abortions involve either the dilation of the cervix and evacuation of the products of conception or the injection of concentrated saline solution into the amniotic sac, causing fetal death and expulsion of the products of conception. Third trimester abortions are commonly performed as dilation and extraction, where the fetal body is delivered, with the exception of the head. A sharp object is inserted into the back of the fetus' head, and a vacuum tube is used to extract the brain. The remainder of the fetal tissues is then delivered.

The ethical debate over elective abortion hinges on what individuals determine to be the fetal "point of viability"—that point in fetal development when a fetus can live independently of the mother, albeit with outside technical support. Many health care practitioners feel that viability is not reached until 20 weeks of gestation and is questionable up until the 27th week

of gestation. Others feel that life begins at conception and that any unnatural act that forces early death or delivery of the fetus constitutes murder. The ethical debate becomes complicated by today's technology, where neonatal intensive care units daily address the issues of premature infant survival for infants as young as 22-24 weeks of gestational age.

Surgical technologists need to examine their ethical positions on elective abortion prior to employment. Many institutions offer staff the option of not participating in elective abortions, provided that there is alternate staff available to provide services to the patient. The performance of elective abortions and the ability to choose elective participation are issues that are best discussed during the job interview process or prior to accepting a position as a surgical technologist.

Therapeutic abortion

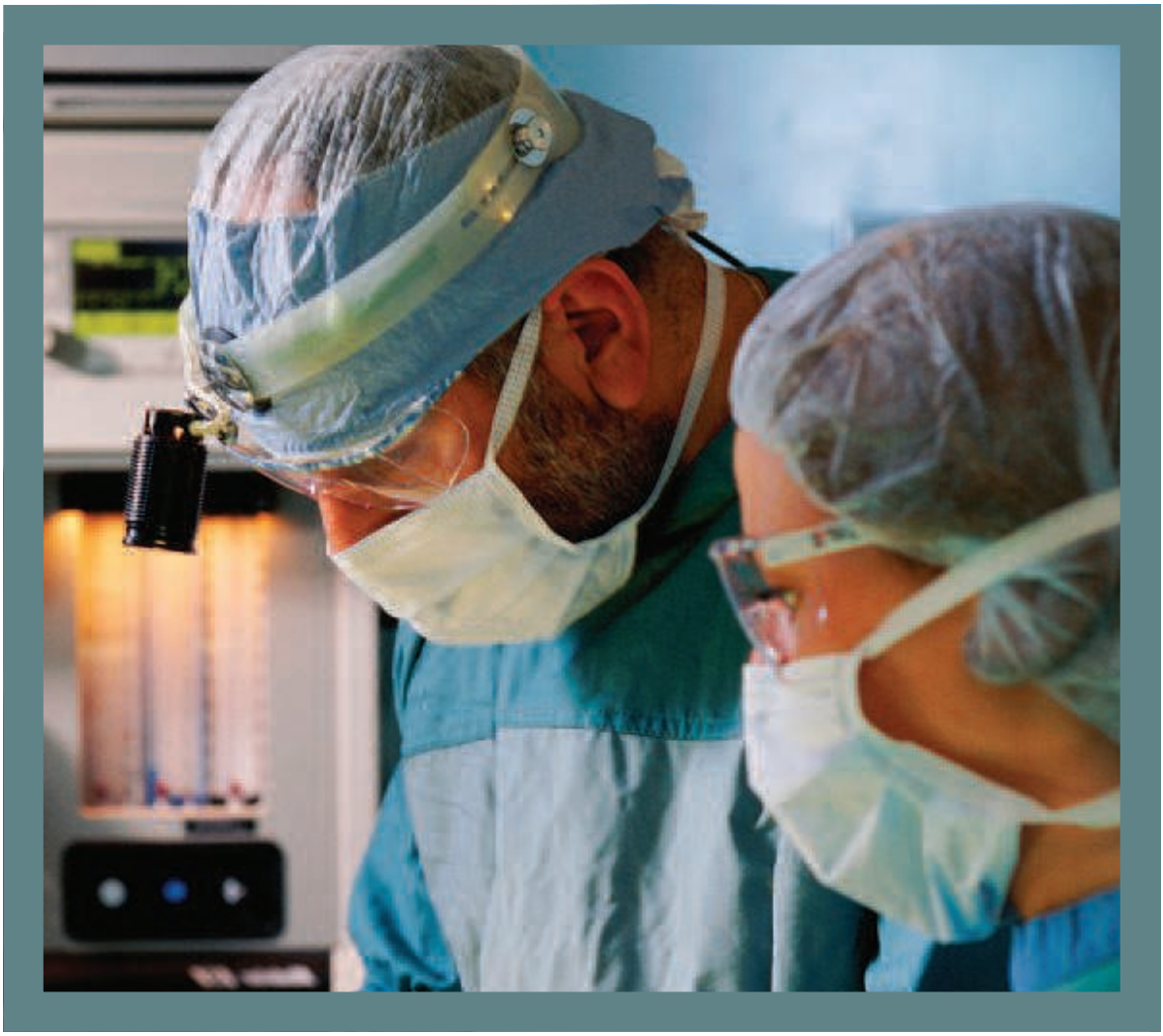
Therapeutic abortions are those semi-elective procedures performed to terminate a pregnancy when the continuation of the pregnancy has a significant potential of leading to maternal injury or death. Many of these abortions are performed during the second and third trimesters of pregnancy. The ethical considerations surrounding these abortions may be different from those of elective abortion, in that the risk to the mother may provide moral support to practitioners, supporting their performance and participation under these types of circumstances.

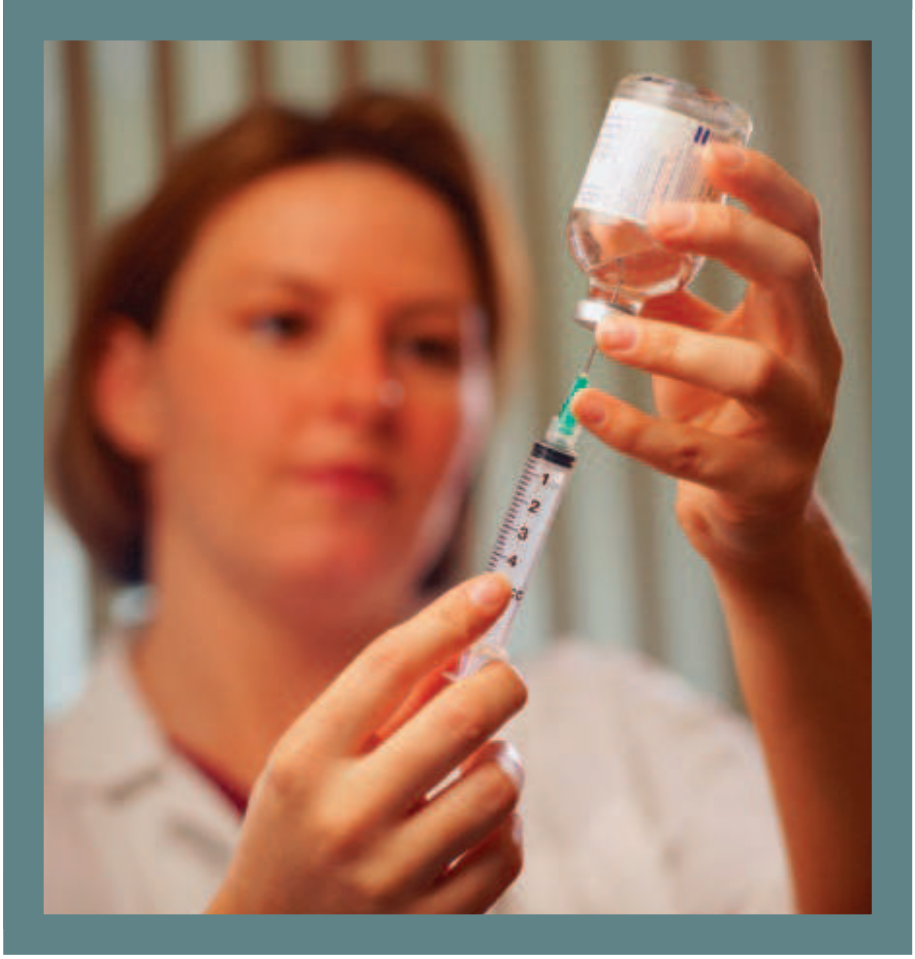
Elective sterilization

Elective sterilization is a procedure that can be performed on either the male or female patient. Male patients usually elect to undergo vasectomy, the removal of a segment of the vas deferens, effectively preventing the migration and ejaculation of sperm during sexual intercourse. For the female patient, sterilization can be achieved through occlusion of the fallopian tubes, removal of the ovaries, or removal of the uterus. The basic underlying principle of all of these methods is the prevention of contact between sperm and ova, thereby preventing conception.

Tubal occlusion and/or vasectomy, while not foolproof, are highly effective methods of birth control. Some religions, though, view any artificial interference with procreative abilities to be morally wrong.

On rare occasions, a court-ordered sterilization may be performed as part of a judgment in a legal case. The patient may not consent to





the procedure or may not be deemed competent to make decisions regarding self-determination.

Artificial fertilization

Today's modern reproductive technology allows for the fertilization of stored human eggs, sperm, and embryos, with subsequent implantation into a uterus for growth and development for the purpose of establishing a pregnancy. Genetic coding may soon permit us to manipulate human genes and change the course of human evolution by eliminating genetic diseases. Ironically, this technology also permits the conception of a "designer baby"—one with desirable features and attributes selected from a "pool" of embryos.

IVF, in vitro fertilization, involves the use of expensive medications and interventions. In the face of rising health care costs and dwindling economic resources, should this procedure only be available to those who can afford to pay for these services, or is every person entitled to avail themselves of this technology? Is the right to bear a child, regardless of the cost to society, more compelling than the more equitable allocation of monetary resources to meet basic health needs?

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Human experimentation

Each day, in operating rooms throughout the United States, experimentation on humans is occurring. While non-human trials of new medications and medical devices are undertaken before human trials are permitted, the actual outcome and long-term consequences of the use of these investigational agents remain unknown until in vivo human testing is done. In the 1980s, one example involved the implantation of intraocular lenses (IOLs), which were used to correct blindness caused by surgical aphakia. Patients had to sign special consent forms, and follow-up documentation had to be submitted to the FDA following the implantation of each of these devic-

es. It was only through human trials that the need to redesign lenses with laser ridges and to place lenses in the posterior rather than anterior chamber was identified and verified. The knowledge and insight gained from these early "experiments" permitted modification of designs and materials, permitting a wider application of this technology to a greater number of candidates. Without the "human" factor, this information may not have been detected as rapidly or effectively. Is it ethical, then, to use humans as "guinea pigs"?

Animal experimentation

Monkeys, pigs, and mice have all been used to predict the effect of products, devices, and concepts for use in the human body. While some people condone the use of animals for experimentation and learning, at what point does experimentation become animal cruelty? The administration of lethal doses and pouring toxic levels of substances into delicate animal tissues have all been performed in the name of scientific progress. Yet lives are saved daily by the knowledge gained by performing experimental surgeries on animals, many of whom die as a consequence of testing.

Organ donation/transplantation

The technology to support organ transplantation has developed dramatically to the point where many organs can now be successfully transplanted from donor to recipient. The demand for organ donations far exceeds the supply. The resources, both fiscal and tangible, needed to support one transplant patient are significant. The procedure, in and of itself, is costly, let alone the medical follow-ups and the lifetime supply of anti-rejection medications required. Anyone who has received a kidney, liver, heart, lung, or pancreas tells of the "double-edged sword"—death is exchanged for a life of chemicals used to keep the implanted organ from being destroyed by the body's own immune system.

Another area of controversy surrounding the ethics of organ transplantation is the determination of who will receive the organ. If you can pay for it, can you get an organ earlier than someone without the financial means to pay for it? While the buying and selling of organs is illegal in the United States, there are countries that will sell organs on the black market. Will genetic engineering permit the "growth" of human organs for transplantation? And if so, can society afford to support a population that will demand a significant portion of allocated health care dollars?

Substance abuse/recreational drug use

While it is acknowledged that the operating room is a high-stress environment in which to work, and that health care practitioners are susceptible to alcohol and drug abuse, an impaired practitioner has no place in a critical care setting. Even recreational use of these substances will lead to behavioral issues, such as avoidable errors and poor decision-making. Professional ethics dictate that practitioners be free of chemical substances that could impair judgment or functioning.

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The operating room also presents opportunities for the procurement of controlled substances. While controlled substances are usually secured, there exists opportunities for health care workers to obtain controlled substances illegally. This procurement is both illegal and immoral.

While "whistle blowing" can lead to personal repercussions, the surgical technologist has an obligation to report known substance abuse. The duty of non-maleficence states that decisions must be made based on preventing patient harm. More significant, though, is the fact that the

health care worker has now become a "patient" and is in need of the same intervention and care rendered to anyone with a disease.

Gender reassignment surgery

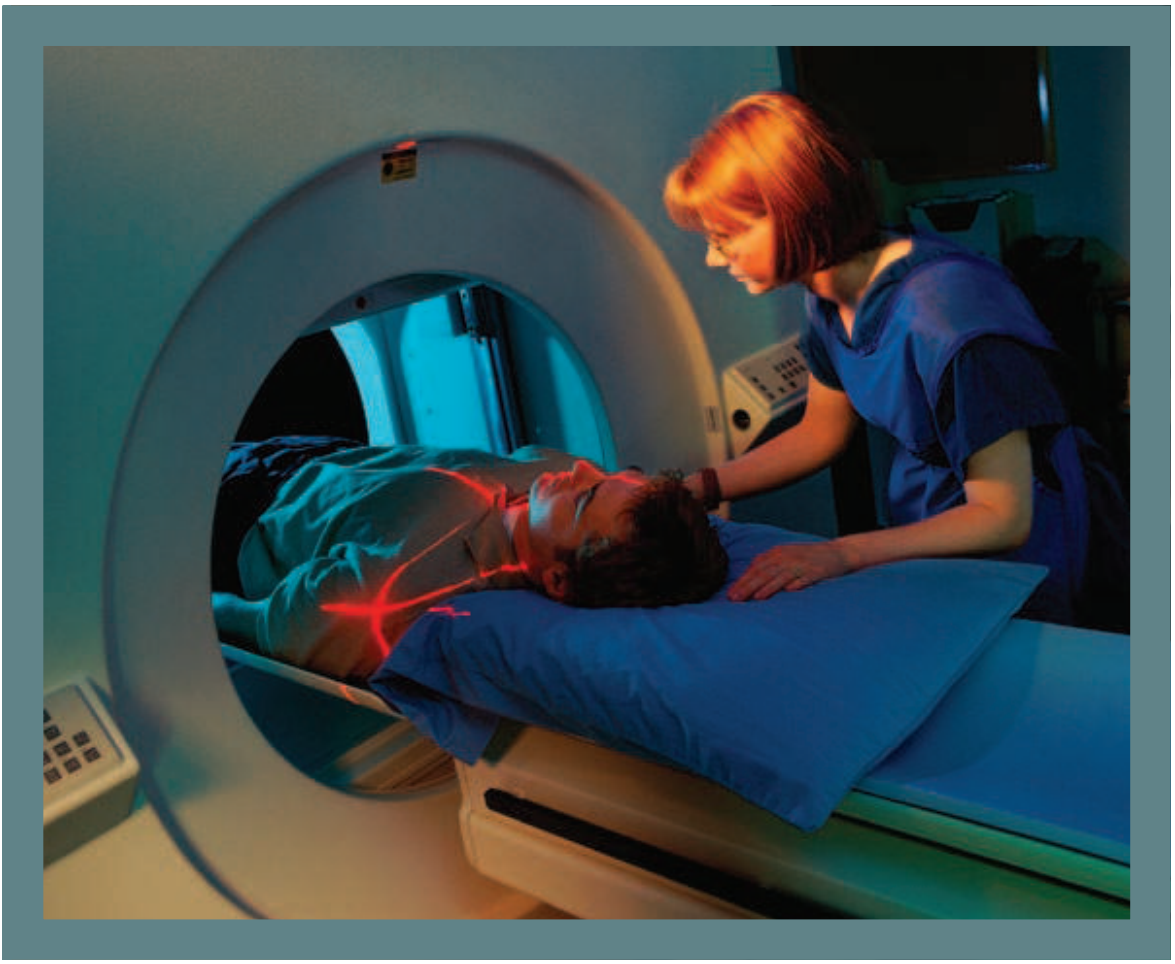
Gender reassignment surgery involves procedures that change a patient's biological sex. It is performed for the condition known as gender dysphoria, a psychological condition in which the individual believes that he or she is psychologically and emotionally the opposite sex. Gender dysphoria is diagnosed by a therapist or psychiatrist who is experienced in gender issues. Some individuals with gender dysphoria elect to undergo sexual reassignment surgery. Gender reassignment is also performed for individuals with ambiguous sexual characteristics and genitalia, commonly referred to as hermaphrodites.

Sexual reassignment surgery (SRS) involves the primary and secondary sex tissue development. Male-to-female SRS consists of the removal of the penis and the construction of a vagina and labia. Although surgical techniques differ among surgeons, generally the tissue of the penis is kept intact and fashioned into a clitoris, so that the patient can experience orgasm. Female-to-male SRS consists of a bilateral mastectomy and removal of the ovaries. A penis can be created using a surgical technique called phalloplasty.

Many individuals with gender dysphoria and ambiguous sexual characteristics live a life riddled with discrimination based on their issues of sexuality. The care of these patients in the operating room setting should not differ from that given to any patient presenting for surgical intervention.

Care of the HIV/AIDS patient

Acquired immunodeficiency syndrome (AIDS), first identified in the human population in 1982, infects an estimated 33 million people around the world. Individuals with AIDS require routine medical and surgical care as well as interventions to address the numerous infections that can result from an altered immune system. With reports of patients taking up to 17 years to seroconvert from HIV-negative to HIV-positive, it is imperative that health care providers protect themselves from accidental inoculation with HIV-infected bodily fluids.



The operating room, like many other professional arenas, carries an inherent risk of disease transference from patient to staff. You can not tell if a patient has AIDS by looking at them, by their age, or by any other external factors. Patients are not required to reveal their AIDS status, nor can

hospitals require AIDS testing for patients or staff. The treatment of HIV-positive and AIDS patients in the operating room should not differ from the care delivered under the established policies and procedures defined in the Centers for Disease Control's Standard Precautions. If standard precautions are followed without exception, health care workers will be provided with the maximum amount of protection possible against contracting this terminal illness.

Severely disabled newborns

The birth of a child is commonly a joyous occasion for many parents. When a baby is born with severe birth defects, such as anencephaly, the dream of a "perfect child" gives way to the reality that such babies are either delivered stillborn or die soon after birth. This tragedy affects not only the involved family; it extends its sense of loss and grief to the surgical team as well. Surgical deaths leave an indelible impression on the health care practitioner, whether preventable or not.

The health care team must address the needs of both the family and the neonate during this very stressful period. Time to bond, detach, and grieve may need to be provided in the O.R. suite. On those occasions when organ harvesting for donation can occur, the O.R. team needs to contain their own grief and move to provide for the issues associated with organ procurement.

Quality vs quantity of life

When is death preferable to life? This situation usually occurs when a patient has developed a terminal disease, and the pain associated with it turns each day into an "existence" rather than a life. Self-determination permits patients to choose which medical interventions they wish to have implemented during such situations. While some patients are compelled by religious or philosophical beliefs that death by any unnatural means is murder, others feel that life without meaning is nothing more than mere existence. In our society, suicide and assisted suicide are illegal. In the health care setting, though, individuals have the right to refuse treatments when the sole purpose of the treatment is to prolong life.

Refusal of treatment

Provided for in the AHA Patient Bill of Rights is the right to refuse treatment. A patient may choose to refuse any aspect of care, even that care that will bring about cure from disease. Patients may also choose to continue engaging in health-endangering activities. If the ethical duties of the health care conflict with the patient's desires, the O.R. team may feel that the patient is making "poor decisions." The ethical obligation of the health care team, though, is to support the patient in their decision, to the best of their abilities.

If you can pay for it, can you get [a donated] organ earlier than someone without the financial means to pay for it?

DNR orders in the surgical setting

Patients have the right to determine which, if any, extraneous measures will be instituted should they not be able to make these determinations at the time of the event. Do Not Resuscitate orders that were traditionally suspended in the operating room, due to the nature of the life support technologies commonly associated with general anesthesia administration (eg endotracheal intubation, use of a ventilator, use of medications to regulate blood pressure, etc), are re-evaluated at the time of surgery. While the compelling focus of our care is the preservation of life and the omission of harm, standing back and watching as a patient who chose DNR status undergoes cardiopulmonary failure and death can be emotionally and professionally taxing. Every death in the operating room setting is disquieting for the staff, due to the ethical conflict of medicine's

primary moral and ethical doctrine of nonmaleficence.

As surgical technologists, our professional responsibilities to the surgical patient extend beyond the instruments, equipment, and environments to the promotion of health and wellness. Our responsibilities extend to assuring the rights of our patients to expect and receive quality, equitable, and appropriate care, with respect to the patients' desires and wishes. We owe it to our patients to be an integral part of all aspects of their health care.

About the author

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