

Ethical Dilemmas in the Treatment of Acute Pancreatitis

Professor Eldar M. Gadžijev
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INTRODUCTION

Acute pancreatitis (AP) poses many professional as well as ethical dilemmas. Some of them are common, but each case has its problems that should be considered. Knowledge, technical ability, and ethical integrity are expected in surgeons, who should follow the four ethical principles (according Beauchamp and Childress):

- **Respect for autonomy:** respecting the decision-making capacities of autonomous persons, enabling individuals to make reasoned, informed choices.
- **Beneficence:** balancing the benefits of treatment against the risk and costs, acting in a way that benefits the patient.
- **Non-maleficence:** avoiding the causation of harm; all treatments involve some harm, but it should not be disproportionate to the benefits of treatment.
- **Justice:** distributing benefits, risks, and costs fairly; the patients in similar positions should be treated similarly.

ABOUT ETHICS

Ethics is an essential discipline in the practice of surgery and represents the surgeon's best understanding of moral responsibility. Ethics requires an ability to distinguish degrees of value or lack thereof and evolves as reasoned reflection on clinical experience (Tamerla Chavis and Joann Starr).

Physician's responsibilities are:

- explanation of the patient's disease,
- explanation of untreated natural history,
- recommendation of most appropriate treatment,
- discussion of risks and benefits,
- discussion of anticipated outcome and
- discussion of treatment alternatives.

In AP, the patient's consciousness – his/her awareness of the severity of the disease – may sometimes represent a problem. Is the patient competent to decide clearly what does he/she want? If he/she is not competent, a surgeon should consider what course of action is in the patient's best interest.

SPECIFICS OF ACUTE PANCREATITIS

AP is of benign nature, and therefore, there is a high probability of the patient recovering fully after the treatment. However, unpredictable (almost malignant) clinical course can occur with high mortality (3–17%) of treatment and with considerable costs. And because of its benign nature, AP poses several complex ethical issues. Patient autonomy and choice of treatment demands complex understanding and consciousness.

Diagnosing staging and severity

Like with all other pathologies, a rational use of diagnostic investigations and tools is expected in AP. Therefore, decisions regarding certain investigations should be reached after consulting other involved specialists. It should be clear that what is professionally competent is also ethically justifiable. And it is always necessary to define and determine severity of the AP, using criteria like Acute Physiology and Chronic Health Evaluation (APACHE) II score. Following the staging criteria, the severity of disease should be defined and appropriate treatment planned!

Initial treatment and the relations between involved specialists

Treatment of AP, always being conservative at the beginning, depends on the stage of the disease. In severe cases, the treatment should be in intensive care unit because the patient needs a complex support. Ethical issues sometimes emerge; they include who is responsible for the patient, or who should run the plan of treatment. Sometimes ethical problems may happen when there is a pressure from the intensivist doctor to operate the patient in the initial stage of disease because of some deterioration and supposed complication. In such cases, a sensible consultation and sober judgment are necessary. In an intensive care unit, both specialists are responsible for the surgical patient. Early surgical intervention is very rarely needed and has had poor results and high mortality. But we should keep in mind that complications such as bleeding ischemia, gangrene, and perforation are neverthe-

less possible. Decision-making may so be quite difficult. In such situations, the surgeon should also explain the situation to the patient and obtain consent after disclosure of all possible outcomes!

Feeding

It was accepted that inside 48 hours after admission, a nasoenteral tube should be administered. Despite the evidence of its benefit, enteral feeding still creates some dilemmas because of possible bowel distension and paresis. Therefore, some doctors would feel uncomfortable introducing it. But since its benefit needs to be weighed against possible damage, it can represent not only a professional but also an ethical dilemma.

Complications and treatment decisions

Within hours to days from the onset of AP, some complications may develop shock, pulmonary failure, renal failure, gastrointestinal bleeding, or multiple organ failure. A benign disease can become very serious, and appropriate decisions about how to manage the complications are crucial. Therefore, the treatment decisions should also consider the ethical view of the situation: how to inform the patient about becoming extremely handicapped, how to get his agreement with planned treatment, should his relatives be already involved, etc.

In biliary pancreatitis with cholangitis, endoscopic retrograde cholangiopancreatography should be performed within 24 hours, and patient's consent should be obtained before the procedure.

When timing the cholecystectomy, the necessity of the procedure should be explained to the patient and his/her consent obtained.

In necrotizing AP after infected necroses are confirmed, a step-up approach (percutaneous drainage followed by minimally invasive retroperitoneal necrosectomy) is recommended. Again, some ethical issues are disclosed. Some surgeons still prefer open necro-

sectomy, and as it is a benign disease, ethical concerns may arise because conflicting opinions may come from other colleagues.

Considerable ethical questions may arise in cases of pancreatic duct disruption with leakage. Decisions regarding treatment are often connected with ethical problems. Should the patient be treated endoscopically or surgically? When and what to do – distal pancreatectomy, pancreaticoduodenectomy (Whipple procedure)? How to manage the situation considering investigations and treatment possibilities in the institution, as well as the skill of the doctors involved in the treatment? Sometimes even transport to another institution should be considered and all these also raise ethical questions.

The timing of surgical interventions

A surgical intervention with minimally invasive or conventional open techniques is indicated when an anatomic complication amenable to a mechanical solution is present. In acute necrotizing pancreatitis, the necrotic phlegmon is excised to limit a potential site of sepsis. In ‘hemorrhagic’ pancreatitis, surgical control of bleeding is necessary. Depending on the situation and local expertise, this situation may require an interventional radiologist, an interventional endoscopist, or a surgeon (individually or in combination). Professional competence should include essential ethical principles (the four principles).

CONCLUSION

AP is a benign disease with an unpredictable (sometimes almost malignant) clinical course and therefore poses several complex ethical issues. When treating AP, surgeons should consider the four ethical principles: respect for autonomy, beneficence, non-maleficence, and justice. Rational use of diagnostic investigations and tools is not only a professional but also an ethical requirement. Relations with the intensivist doctor and other specialists sometimes generate ethical problems. A sensible consultation and sober judgment are necessary. Considerable ethical questions

may also arise when planning the treatment of complications.

UNEXPECTED COMPLICATIONS IN TREATING A JEHOVAH’S WITNESS PATIENT

Informed consent is obtained for a premeditated surgical intervention to remove infected pancreatic necroses in a Jehovah’s Witness patient. The patient refuses a blood transfusion during the informed consent process.

While performing debridement of pancreatic necroses, profuse excessive bleeding occurs, the patient deteriorates, and his blood pressure becomes difficult to maintain. Urgent blood replacement is needed. The patient is sedated and cannot participate in the discussion and amendment of the informed consent. The patient’s wife is not a Jehovah’s Witness and permits transfusion if necessary.

- a) Assume that the patient did not fully realize that he could die without a transfusion, and proceed to transfuse as clinically indicated.
- b) Since it is an open emergency procedure, transfuse.
- c) Transfuse on the wife’s authority.
- d) Transfuse and do not tell the patient.
- e) Do not violate the patient’s autonomy by transfusing even if that means the patient may die.