ISSN- O: 2458 - 868X, ISSN–P: 2458 – 8687
Index Copernicus Value: 68 . 16
PubMed - National Library of Medicine - ID: 101731606

International Journal of Medical Science and Innovative Research (IJMSIR)
IJMSIR : A Medical Publication Hub
Available Online at: www.ijmsir.com
Volume – 4, Issue – 4, July - 2019, Page No. : 153 - 159

Ethical Dilema in Paediatic Orthopaedic Practice in a Resource – Poor Country: Preliminary Case Series of Parental Decisions to Withdraw Orthodox Treatment

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Type of Publication: Original Research Article

Conflicts of Interest: Nil

Abstract

Ethical issues in medical practice in resource-poor countries are gradually becoming very important as components of medical best practices. Orthopaedic practice is no exception especially when dealing with a minor who is legally not in a position to offer any informed opinion. Five cases of parental decisions to terminal orthodox treatment of their children who have life threatening and limb damaging injuries are presented. Each demonstrates serious conflicts in doctor – patient relationship and the best interest of these children may not have been the final outcome in these situations.

Keywords: Ethics, minors, paediatric orthopaedics, discharged against medical advice (DAMA), and dispute resolutions.

Introduction

Ethics is a field of enquiry that deals with the principles and values that help define what is right and wrong and with the rights, duties and obligations of individuals and various groups [1]. The traditional ethics of medicine is beneficence, that is, acting in the patient's best interests. In health care ethics four commonly accepted principles from Beauchamp and Childress [2] are

1. Principle of autonomy
2. Principle of non-malfeasance
3. Principle of beneficence and
4. Principle of justice. These principles have been set out to act together to bring about good health standard and practices for the people.

Medical treatment entails risks. The physician recognizes that a good outcome is never certain, even in the most skilled hands but this is not always appreciated by patients. Bad results, real or perceived may result in disputes and civil litigations. The practice of orthopedic surgery in resource-poor countries often encounter cases that present dilemmas in management. The difficulty faced in such situations usually put the victims in precarious positions that eventual survival may be called to serious question. Such management dilemma is increased, when a minor is involved, as moral, emotional and sentimental issues come on board. The moral dilemma faced by orthopaedic surgeon while managing pediatric patients and their families has however not been given much mention in the literature [3].

On daily basis, patients present to doctors for one medical reason or the other with the expectation that one maneuver, prescribed drug or surgical procedure will bring relief to them. Amongst these patients are children

who usually present in company of their parent, guardian or care giver who has the task of giving consent to the doctor to do what he deems necessary for the child to be well. When patients present for medical attention physician are duty bound to use their knowledge of science to act for the good of the patent.

The need for consent to treat acting to do no harm (non-maleficence) and providing relief or solution (Beneficence) constitute medical ethics and demands that the physician act accordingly. Unfortunately, the orthopaedic surgeon in a developing country like ours runs into serious dilemma when the badly needed consent is not given but parents opt to have patients discharged against medical advice. When parents deny or refuse the much needed consent, the fiduciary responsibility of the surgeon or physician is evoked as he is obligated to hold the patients interests and wellbeing as paramount [4,5]. This is more so when an innocent child is involved, who may be exposed to possible permanent disability or even death.

This article has set out to highlight cases of consent denial by parents of minors which put the surgeon at cross roads in performing that all important fiduciary function without tipping the ethical table against himself. It therefore places consent first and most important of all ethical issues as the other ethical obligations of non-maleficence and beneficence can only come to play when it is given. Existing legal frame work in many developing countries like ours is not helpful to physicians in the quest for optimal care for minors. Consenting process in Nigeria, is believed to be poor [6].

Five Case Series

Patient 1

This was a seven month old child who was involved in road accident (RTA). The child was sitting on the mother's lap while the traffic mother ridding on the back of a commercial motorcycle. The cloth with which the child was wrapped got entangled in the spoke of the motorcycle and the child was pulled off the mother lap. He landed on the dirty road as the motorcycle stopped abruptly. A few minutes after the incident, the child was assessed in peripheral hospital where it was noted that the right upper of lib was swollen and the fingers were cold compared to the shoulder region of same upper limb. He was referred immediately to a tertiary centre where the child presented about 3 days after the referral. Review at the tertiary hospital revealed a toxic child who had not made urine in the last 24hrs. The right forearm was swollen, discolored, and without radial artery pulsation. Patient was resuscitated, placed on antibiotics and started making urine adequately 48hrs after presentation. The finger had become dark, skin now peeling with a very offensive odor. On requesting for consent to amputate the gangrenous forearm, the parents refused and opted to leave hospital with the child. All entreaties and medical explanations did not yield any change in mind, and they left against medical advice. Figure 1 shows the child on presentation 3 days after the injury and Figure 2 shows the child 4 days after admission in the hospital.

Patient 2

A 4 year child who was knocked down by a car on her way back home from school. She was taken to a native bone setter who tied her right forearm with flat pieces of woods and crepe bandage. She presented to the hospital after 3 days of treatment at the bone setter's place. She was already toxic, irritable, and very pale, with blister in the forearm and gangrenous tip of the fingers. Resuscitation was commenced and she was to have bedside fasciotomy under local anesthesia and sedation. X-ray of the forearm did not reveal any fractures.

The parents were counseled of the child's medical condition and consent for the proposed surgical procedure sought. Consent was denied by the parents as they insisted that they only came to the hospital for the gangrenous fingertip to be revived and the blisters dressed. The parents in their opinion felt that the fracture (which the child never had) had been reduced by the native bone setter. Every attempt made to make them see reason did not yield fruit as they signed against medical advice and took the child away. Figure 3 shows the child a few hours after presentation in the emergency room.

Patient 3

This was an eight month old child who presented at our children's emergency room (CHER) of our hospital after about one month illness. The child was said to have started having fever and was taken to a road side drug store where an intramuscular injection was given in the right gluteal region. Subsequently, a swelling developed in the area of the injection prompting and incision ad drainage of the swelling by same road side drug store operator. The incision and drainage, the resultant wound continued to discharge and expand. Patient was later taken to a private hospital where the wound was debrided and wound dressing continued. Wound however continued to expand prompting referral to a tertiary centre. On presentation at CHER, the child was assessed and found to be very pale and febrile. Evaluation of the wound revealed and extensive wound on the lateral aspect of the right thigh with proximal half of the femur exposed. Resuscitation of the child was commenced and wound debridement and further management using negative pressure wound therapy was proposed.

The parents of the child were counseled and the plan put across to them noting clearly that it was a procedure to be done in the theatre but it does not involve amputation in a way. The parents declined consent and opted to take the child away against medical advice.

Patient 4

This was an eight year old boy who presented with multiple sinuses in the right and left arms and thighs, low grade fever and inability to walk. Physical examination revealed a chronically ill child, moderately pale with protruding bone at the left shoulder. Multiple sinuses were noted in the right arm and the thighs. A working diagnosis of multiple chronic osteomyelitis was made and treatment protocol worked out. Patient was commenced on intravenous antibiotics, transfusion of blood and subsequent incision and drainage of pus as well as tissue was out with normal saline and daily wound dressing. The protruding sequestrated upper humerus was to be removed. Patient parents were accordingly informed and consent sought for the surgical intervention. Consent was declined by the parents and they subsequently took the child away, against medical advice.

Patient 5

An eight month old child who had febrile illness and was taken to a peripheral hospital where an attempt to set up an intravenous led to soft tissue loss and exposure of the distal third of the right tibia and fibula. On presentation, the child was acutely ill looking, febrile and moderately pale. Physical examination revealed a dirty wound measuring 3cm X 4cm in the distal 3rd of the right leg. The tibia and fibula were exposed and the wound was discharging pus. Patient was resuscitated and stabilized and was scheduled for wound debridement in the theatre. The parents of the child refused to give consent for the surgical procedure despite counseling that the intervention will not lead to amputation of the leg. Later the child was taken away against medical advice.

Fig 1. Patient 1 on admission 3 days after injury. Finger tips are gangrenous.

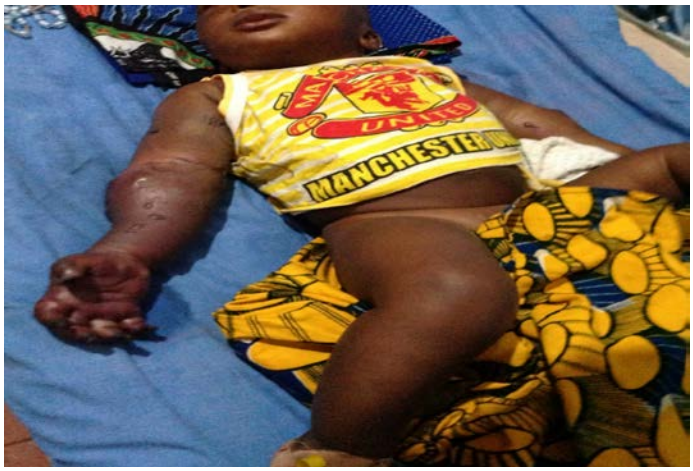


Fig. 2 Patient 1, 4 days after admission with desquamated skin and gangrenous fingers

Fig. 3 Patient 2 on admission 4 days after injury with swollen/gangrenous hand.

Fig. 4. Patient 3 on admission with the femur exposed.

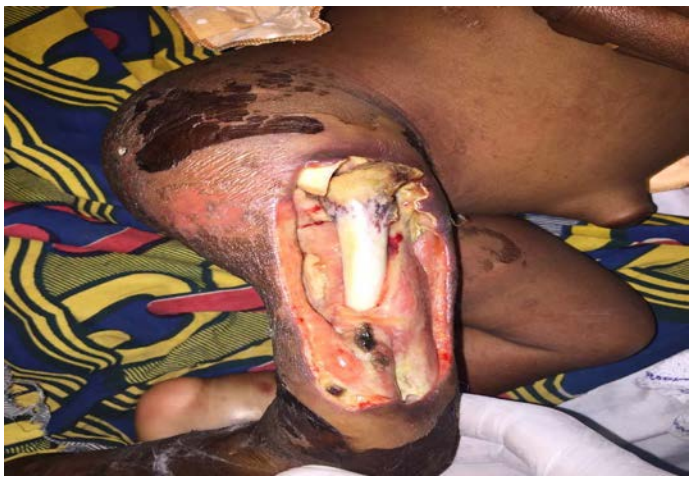
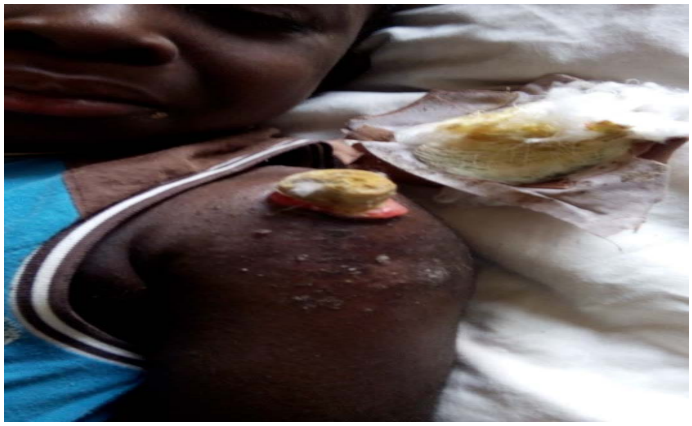


Fig. 5. Patient 4 on admission with left humerus exposed.



Discussion

In a developing country like Nigeria, combination of factors make application of health ethics principle difficult to implement. An analysis of the cases presented above shows that the physician in upholding the principles of beneficence and non-maleficence, evaluated the cases and outlined treatment protocol. There was also reasonable attempt to obtain the consent of the parents of the children in order to establish that duty to respect the autonomy of the patients via their guardians. Clearly, parents and guardians are bestowed with the responsibility and authority to make that vital medical decision on behalf of their children who are minors. This right and legal authority are exercised by the parents because they are perceived to care the most about their children and know

him or her most as young children are not able to make such complex decision [7]. In Nigeria, legal age for consent is 18 years but increasingly consent is being determined by the cognitive and emotional capacity of the person in question in the developed world [1].

As was pointed out in the cases presented, the parents of the children refused to give consent to the medical team to administer Medicare to them. They took that position despite the repeated explanations that the treatment to be given will bring relief to the children rather than harm them. Going by the principles of bioethics treatment would not continue in order to respect the principle of autonomy. The decision of the parents to deny the children care could be challenged in a different environment by seeking the intervention of the state child care agency or the court. Those services, in a developing country like ours, are nonexistent or at best rudimentary. It is acceptable that medical personnel have an ethical and legal duty to challenge parental decisions that are potentially dangerous to the child's health [7]. That is where the dilemma come to the orthopaedic surgeon who comes in contact with the cases presented. The surgeon understands that the child's health is put into jeopardy but he is so handicapped and cannot do anything meaningful to save the child. The physician faces a daunting task in attempting to provide succor to the child. Attempt at getting at any support may not yield good result. The effort usually is time consuming and time in the cases presented is usually in short supply as immediate intervention determines the end result of medical treatment.

Many reasons have been advanced for the improper or questionable medical decisions by parents in a developing country which may be related to just ignorance and or poverty. Financial constraints have been established to be the commonest reason why parent opt for their children to be discharged against medical advice as health care financing is often communally based due to lack of institutionally organized health insurance [8]. In a situation where the parents cannot pay the bills and there are no other social safety net to cushion the problem, leaving the hospital becomes the only option. In the presence of financial difficulty, the children getting proper medical attention is not guaranteed. Presenting late to the hospital ab initio may well be linked to not having the resources to take the child for immediate intervention as they stay back home hoping that events can turn around and obviate the need for hospital care. One of the other aspects to consider is that we are dealing with orthopaedic problems. In Nigeria, the traditional bone setters perhaps more than any other group of traditional care-givers enjoy high patronage and confidence by the society [9]. Indeed, about 85% of patients with fractures present first to or eventually end up in traditional bone setters [10]. The patrons of these service cut across every strata of the society including the educated, the rich and the famous [11].

Discharge against medical advice is encountered by health personnel all over the world [12]. Studies in different regions of Nigeria have reported paediatric DAMA rates from 1.2% to 5.7 % [13]. The dilemma of the health worker is ethical between respect for the parent's decisions (which is also legal) and the best interest of the vulnerable child-patient [14].

All said, it created a heart rending ethics dilemma for the orthopedic surgeon or any physician to come in contact with the cases presented and not be able to offer medical help to those minors due to inability to get over principle of autonomy in bioethics. It is however important to note that when DAMA becomes inevitable, observing a

standard process is important to protect the interest of the patient, and provide legal protection for the care-giver who may be at risks of litigation if the patient deteriorates after discharge [15]. The process involves assessment of capacity or decision taking ability of the parent, disclosure of all potential risks, provision of alternatives and proper documentation [16.

Conclusion

There is need to further develop medical bioethics in a developing country like ours. The principle of autonomy for minors for now seem to weigh significantly on the side of parents and guardians with very little for the surgeon or physician to do especially in emergency situations. The need for a health insurance as a fall back in situation of financial stress is very much needed in our environment. Other social welfare safety nets can only improve Medicare for the minors and give medical care givers better environment to practice at same time reduce the ethical dilemma they face each day.

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