

# Ethical Issues in the Management of Thyroid Disease

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## KEYWORDS

- Clinical ethics • Informed consent • Autoimmune thyroid disease • Thyroid cancer
- Radioablation • Adjuvant radioactive iodine therapy

## KEY POINTS

- The focus of this article is on clinical ethics issues in the thyroid disease context.
- In the context of thyroid disease management, clinical ethics dilemmas affect a wide range of health care providers: endocrinologists, primary care physicians, surgeons, oncologists, nuclear medicine specialists and technologists, genetic counselors, nurses, and physician assistants.
- In autoimmune thyroid disease, there are unique challenges to informed consent, and potential duties to warn in severe hypothyroidism.
- In thyroid cancer, the most common ethical issues revolve around truth-telling and advance care planning, and genetic screening for medullary thyroid cancer.
- Novel ethical issues in thyroid disease include end of life discussions in poorly differentiated thyroid cancers; priority-setting for drug shortages; and resolving clinical disagreement over standards of care.

## INTRODUCTION

Clinical ethics is a subspecialty of bioethics that deals with ethical dilemmas that specifically involve the provider-patient relationship. Clinical ethics issues comprise weighing therapeutic benefits against risks and side effects, innovative therapies, end-of-life care, unintended versus intentional harms to patients or patient populations, medical error, health care access, cultural competency, and professional virtues and integrity. Clinical ethics issues may also involve moral distress and there are distinct clinical ethics issues that arise in different thyroid disease management contexts and patient populations.

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Moral distress refers to a situation in which the health care provider knows the ethical course of action, but is constrained from acting on it; constraints may stem from patient/surrogate decisions; institutional power relations, regulations, or policies; or legal issues. Unresolved moral distress can lead to moral residue; this is a particular problem for health care providers with less moral agency, such as nurses, residents, or other health care trainees but also affects physicians in all specialties (see, in particular: Epstein EG, Hamric AB. Moral distress, moral residue, and the crescendo effect. *J Clin Ethics* 2009;20(4):330–42. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3612701/>).

This article reviews core ethical principles for practice, as well as the moral and legal requirements of informed consent. It then discusses the range of ethical issues and considerations that present in the management of autoimmune thyroid disease and thyroid cancer. In addition, ethical issues concerning vulnerable populations and resource allocation are explored.

### CORE ETHICAL PRINCIPLES

Thyroid practitioners need to understand core principles in medical ethics<sup>1</sup> that are often competing. The Principle of Respect for Persons, first articulated in The Belmont Report<sup>2</sup> (<http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html>) is a dual obligation of health care providers to respect autonomous patients, but protect nonautonomous patients. Although sometimes used synonymously with the Principle of Respect for Autonomy<sup>1</sup> (aka Principle of Autonomy), what distinguishes respect for persons from respect for autonomy is the explicit obligation to protect those who do not have decision-making capacity (**Box 1**). Both principles stipulate that care should be guided according to patients' wishes, values, beliefs, and preferences, which is determined through the process of informed consent. Both principles stipulate that autonomous patients (those with decision-making capacity) guide their own care. However, the Principle of Respect for Persons is inclusive of nonautonomous patients, and deals with patients without decision-making capacity. In these cases, this principle obligates health care providers to ensure there is a surrogate decision maker available to make decisions based on patient preferences, if known (substitute judgment), or, if not known, based on the patient's best interests. Informed consent (discussed later) supports both the principles of respect for persons and autonomy, and establishes whether patients are autonomous agents or whether patients require surrogate decision makers.

The Principle of Beneficence obligates practitioners to weigh therapeutic benefits over therapeutic risks, or to maximize clinical goods and minimize clinical harms. Beneficent care necessarily recognizes that there may be limits to autonomy when patients request (or demand) therapies or interventions that are medically inappropriate. However, respecting autonomy also necessarily recognizes that there may be limits to beneficence. Patients may request therapies that are potentially harmful, risky, or nonexistent. Practitioners need to use their clinical judgment to balance autonomy and beneficence so that attempts to satisfy one do not violate the other. Informed consent thus also supports the Principle of Beneficence by requiring truth telling: a full disclosure of therapeutic options to be discussed, and all associated risks and benefits. This process also entails a discussion of what is not an option or medically appropriate. Informed consent helps to educate autonomous patients or surrogates about what constitutes a beneficent care plan. The antiquated concept of truth-telling as a harm or beneficent deception<sup>3</sup> derives from a paternalistic model in which the practitioner used therapeutic privilege to withhold information from the patient in the belief

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