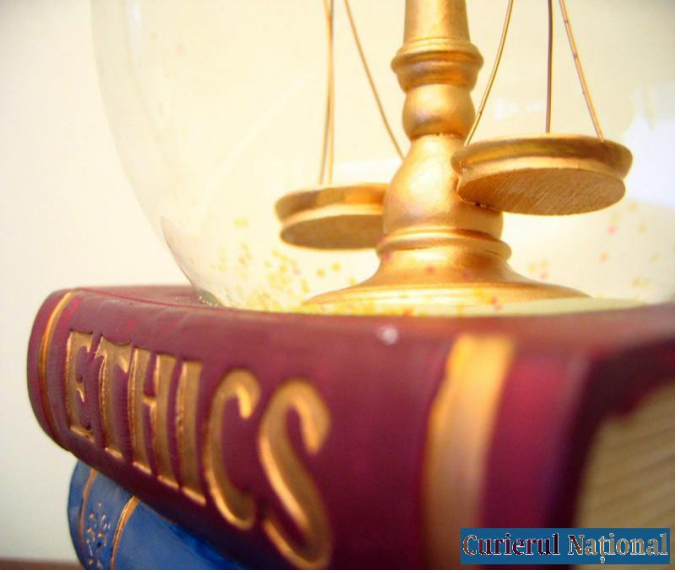
EQUITY, EQUALITY, VULNERABILITY

Carmen Anton, Emil Anton

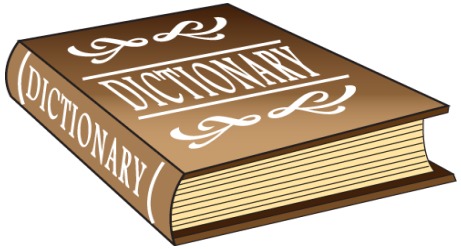


INTRODUCTION

The ethical dimension of medical practice is acknowledged as constituent part of acquired skills, hence the importance of being presented in this wayin the physician's career.

To understand better the notion of ethical competence,the relation between doctor and patient is discussed.

The oldest and most known code of conduct for doctors was issued by the Cos School and its most significant representative, Hippocrates (460 – 377 BC) by his famous oath taken at the school of medicine that compelled the future physician to its rules. Doctors transmitted this message and respected the principles in Hippocrates's oath along time.



DICTIONARY DEFINITIONS

•**EQUITY**, idea of justice based on equality before the law, principle of natural law founded on ethical rules which are higher than the norms of positive law.

•**EQUITABLE**, which is based on justice; right; fair.

•**EQUALITY** ♦ Principle according to which people enjoy the same rights and have the same duties stipulated by the rule of law. From Fr. égalité.

•**VULNERABLE** which has weak parts with defaults, that can be criticised.
◊ *Vulnerable point* = someone's weak spot; sensible, neuralgic point.
– From Fr. vulnérable, Lat. vulnerabilis.

ON THE RELATIONSHIP BETWEEN DOCTOR AND PATIENT AGAIN

Professor Jean Bernard, one of the pioneers of ethics in medicine said:
"Without knowledge, without science, the doctor cannot be useful; however, without his patient's love, he cannot fully play his role…"

This can be translated into three main principles from **the Code of Medical Deontology**:

- Respect of people's dignity;
- Respect of the patient's freedom;
- Absolute respect of the medical secret.

THE MEDICAL ACT AND ITS INTERACTIONS

•The medical act is the place of convergence for 3 factors: ***patient, doctor and society.***

• D.vonEngelhardt de Lübeckdesigned the following scheme for the main relations and interactions:

Medicine as science and practice

Patient/ disease	**Patient <-> Doctor**	**Doctor/ Medicine**
Economy	**Society**	**Philosophy**
Politics ->	**Society/ State**	**<- Art**
Law	**Theology**	**Culture**

The patient's engagement is double

•Towards doctor, which finally means to accept the therapeutic measures ("compliance");

•Towards his disease that needs to be dealt with as soon and as well as possible ("coping").

•The doctor's engagement towards the patient is traditionally towards Hippocrates's oath, yet things are much more complex nowadays.

•The patient and doctor are surrounded by society, family and other people that play a supporting and solidary role.

• Behind every doctor there are medical structures that rigorously determine the diagnosis and therapeutic measures applied. He doctor depends on the developments of medical sciences.

KRUKENBERG TUMOUR – OUTLINE

The source of Krukenberg tumours is as controversial as their definition.

•At first, Krukenberg describes 5 cases of ovarian tumours, primitive neoplasms and calls them "fibrosarcoma ovarii mucocellulares carcinomatoides"(ovarian fibrosarcomas/ carcinoma mucocellulare)(1).

• In 1973 WHO established the diagnostic of Krukenberg tumour based on 3 histopathologicalcharacteristics:
•Stromal interest
•Presence of "signet ring" mucocellular groups
•Sarcomatoid proliferation of ovarian stroma(2).

1. *Krukenberg, F.E. - Ueber das Fibrosarcoma ovarii muco-cellulare (carcinomatides). Archiv.fur Gynakologie,1896,50:287.*
2. *Serov, S.F., Scully, R.E. - Histologic typing of ovarian tumours. 9. World Health Organization (Geneva), 1973,17:8.*

EPIDEMIOLOGY

•Most Krukenberg tumours are primarily located at gastric level, between 70% (3) and 94% (4).

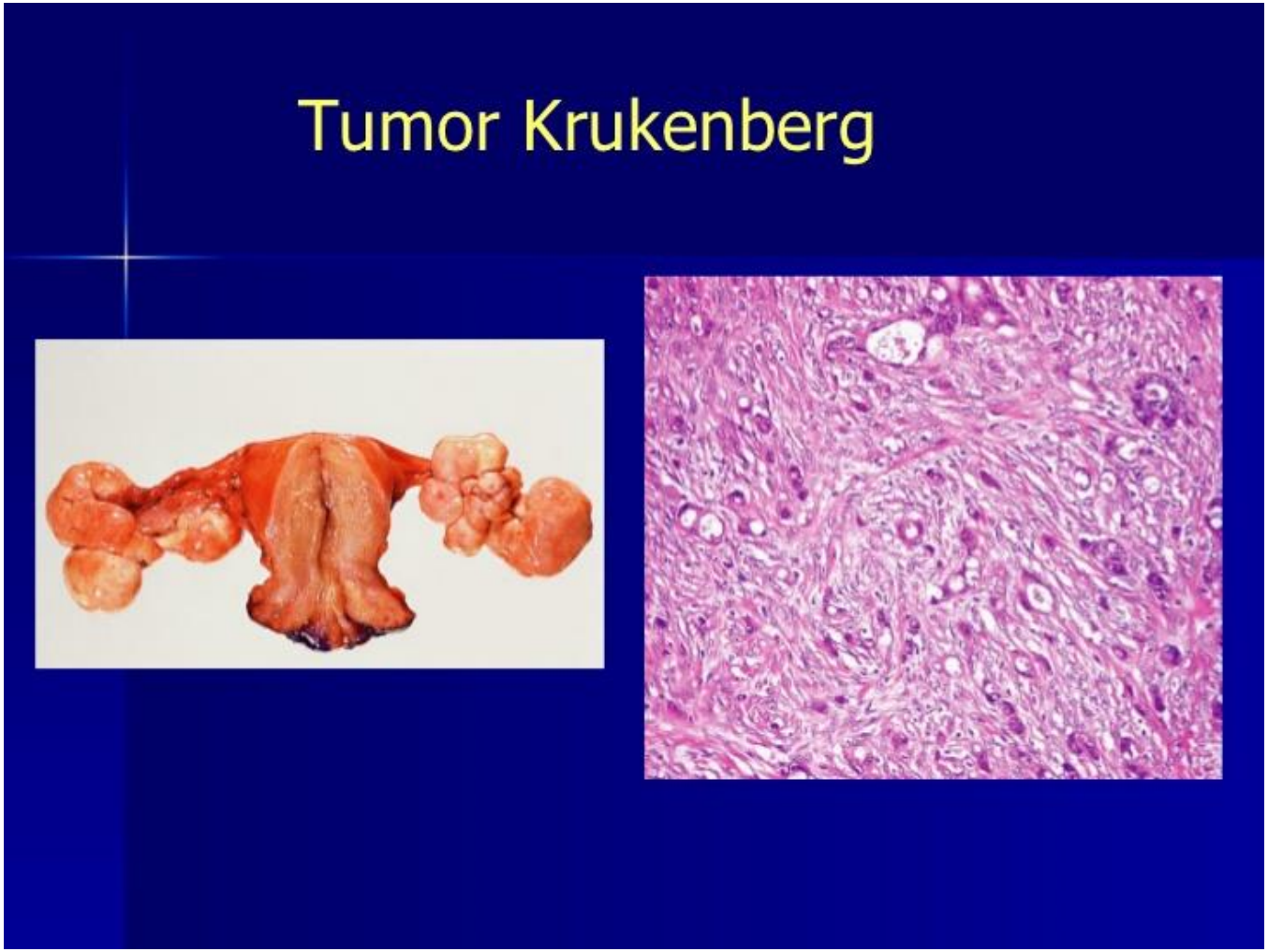
•Western studies show a lower frequency of the gastric origin, along with a low colon-rectal prevalence of 9-20% and appendicular one (7-8%) (5).

•Prevalence is of 2-8% for the mammary origin, 7% for the pancreas, 2% for bile ducts and lower for rare localization of the original tumour: bladder, small bowel, uterus, renal pelvis (6,7).

3. Yakushiji, M., TAZAKI, T., NISHIMURA, H., KATO, T. - Krukenberg tumors of the ovary: a clinicopathologic analysis of 112 cases. Nippon Sanka Fujinka Gakkai Zasshi. 1987, 39:479.

4. Hale, R. - Krukenberg tumor of the ovaries. Obstet. Gynecol., 1968, 32:221.

5. Kiyokawa, T., YOUNG, R.H., SCULLY, R.E. - Krukenberg tumors of the ovary: a clinicopathologic analysis of 120 cases withemphasis on their variable pathologic manifestations. Am. J. Surg. Pathol., 2006, 30:277.



6. Fox, H. - Metastatic tumours of the ovary. Obstetrical and Gynaecological Pathology, 2002.
7. Irving, J.A., LERWILL, M.F., YOUNG, R.H. - Gastrointestinal Stromal Tumors Metastatic to the Ovary: A Report of Five Cases. American Journal of Surgical Pathology, 2005, 29:920.

CASE REPORT

•ABPL patient aged 30 from Dagâţa,Iaşi county comes to the emergency room, at the triage of “CuzaVodă” Obstetrics and Gynecology Clinical Hospital of Iaşi

•The patient was delivered via the ambulance service, without referral, as co-insured person.

INITIAL DIAGNOSTIC

•At hospitalization, the diagnostic was established based on:
•Symptomatology (abdominal pain for 6 weeks, with low dark blood bleeding, positive pregnancy test 9 days before; 4

•Ultrasound scan (3-3.5 cm in size, homogeneous left parauterine, irregular in shape and separated by a tumour of 6,18 cm, left parauterine with polycyclic shape) is of:
•Hemoperitoneum (peritoneal flooding)
•Broken ectopic pregnancy

INTRAOPERATIVE

•**Surgical intervention is required in the emergency situation. When opening the peritoneal cavity, by median laparotomy, a quantity of approximately** 250 ml of blood is found.

•Dilaceration of the lower part of the uterus by a mass – possibly intramural ectopic pregnancy.

•After the ablation of the mass, suture of the lower part of the uterus is performed, and the product sent to pathological anatomy for analysis.
The enlarged left ovary is normally macroscopic, and enlargement may be interpreted as the existence of the gestational body at this level.

•After 5 days the patient is discharged and recommended to a consultation in a month.

EVOLUTION

•The anatomic-pathological result, after 3 weeks, is of avelositary immature trophoblast with hematic clot, corioepitelioma.

•After a month from hospital discharge, the patient comes to the emergency room of ,,Sf. Spiridon'' Hospital with left hemiplegia and intense cephalea.

•Emergency CT is recommended and the diagnostic given is supratectorial multiple cerebral metastases, 2 cysts of 2-6 cm at the level of the left ovary without the imprinting of external iliac artery wall

.

•Gynecologic exam is recommended and CT with radiocontrast agents.

EVOLUTION

At a later date the patient comes to the triage of the ,,Cuza Vodă'' Hospital in a severe condition with epigastric pain, HDS with hematemesis/melena, cephalea, vertigo, dispnea.

• CT with radiocontrast substance pointed out:

1. Gastric vegetative tumour at the level of great curvature
2. Krukenberg tumour – left ovary
3. Brain metastases
4. Left hemiplegia.

DISCUSSIONS

The complexity and rapidness in the unfortunate evolution of this patient that got as sick as possible two months after first seeing a doctor and was previously in her full health condition requires a case analysis from a medical view point in general and from an ethical and deontological one in particular.

•Thus, we can say that vulnerability is commonly shared by doctor and patient.

•The gastroenterologist, gynecologist and radiologist intervened in various stages of the diagnostic.

•The issue here is the stage diagnostic in a less natural order, yet with the observance of protocols and procedures due to the coexistence of two neoplasias, gastric and genital with insidious evolution and rapid reaching the state of metastasis.

DISCUSSIONS

•A peculiarity of the case was the existence of anexal mass with enlarged left ovary interpreted by the gynecologist as ovary with lutein cysts specific to choriocarcinoma and by the gastroenterologist as Krukenberg metastatic tumour.

•Another atypical aspect that determined lower chance equality of the patient coping with her disease was the decreased level of beta HCG out of the three determinations performed – only 600- 1800 UI/ l as opposed to hundreds of thousands, even a million UI/l in typical situations of trophoblastic disease with placental tissue as in this case.

•Moreover, anembryonic pregnancies that evolve towards corioepitelioma rarely behave as a broken ectopic pregnancy with hemoperitoneum.

CONCLUSIONS

•In this case, the doctor-patient interaction was respected and the professional competence which does not only mean hands-on knowledge of the field and prognosis, but also treatment plan.

- This also means:

✓ taking a decision in a vulnerable patient,

✓ considering the doctor's professional autonomy and the characteristics of the relation that brings together doctor and patient.

•*The case had an unfortunate evolution due to the late localization of the primary tumour at the gastric level where symptomatology and paraclinical exams remained undisclosed due to the superposition of a complicated ectopic pregnancy with peritoneal flooding.*

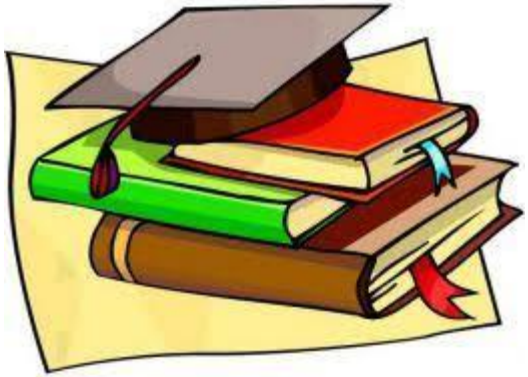
CONCLUSIONS

•There are more issues at stake:
• First of all, communication, opening up to others is essential

• Engaging in dialogue to exchange information and viewpoints and reach a consensus.

•The capacity for dialogue remains the central axis of the doctor's professional and ethical competence.

• In literature, several authors claim that only communication skills are important and engaging in a dialogue, as mentioned above, is much more than that, i.e. a means to give oneself to others.



CONCLUSIONS

•In the relationship with the patient, the doctor needs to know his possibilities and professional limits, respectively.

•We need to know that we depend on:

✓ heredity,

✓ the socio-cultural environment of origin,

✓ the education received,

✓ the ideology and religion we were brought up into.

TAKE HOME MESSAGES

•We need to practice with much critical spirit to know how to distinguish between differences of opinion or behavior and reach the soul and personality of the patient in order to build better relations based on mutual trust.

•This is the reason why the two opposite models of the doctor-patient relationship are brought into play, namely the **“paternalist”** and the ***“autonomy”*** one.

•But on the other hand, doctors need to know that, under the pretext of respecting the **“autonomist”** principle, they should not fall prey to a **“culpable indifference”.**

•The contractual relation between the health service and healthcare consumers replaces the relationship of trust which is essential to the decision of the two partners.

•This situation risks incurring doctors' avoiding responsibilities as they "feel" that they only need to observe the formal obligations of the law, hence the excessive autonomy claim that needs to be dealt with.

•The doctor-patient relationship is a science and an art that truly combines principles of ethics-morality-deontology in medicine.