

Reasons for presenting clinical cases of patients to the Hospital Bioethics Committee, in a Second Level Hospital

Motivos de presentación de casos clínicos de pacientes ante el Comité Hospitalario de Bioética, en un Hospital de Segundo Nivel

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Abstract

Hospital Bioethics Committees (CHB) are responsible for issuing suggestions to health personnel in difficult clinical cases involving bioethical problems and/or dilemmas. At world level, and also in Mexico, little related literature was found, sometimes generating a certain degree of uncertainty in health professionals for their resolution. Objective: to describe the reasons for the presentation of

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clinical cases of patients to the CHB in a second level hospital, from June 2007 to June 2018. Methods: observational, descriptive, retrospective and cross-sectional study; the sample was by convenience, obtaining 48 minute records. Results: the most frequent reason for presentation was: decision support for the limitation of therapeutic effort with 24 cases (50%). Thirty-four bioethical dilemmas (71%) and 14 bioethical problems (29%) were identified. Conclusions. It will help the treating medical services to identify and intervene in a timely manner, based on previous situations regarding bioethical dilemmas and/or problems.

Keywords: Bioethical dilemmas, bioethical problems.

1. Introduction

Bioethics constitutes an essential support for the resolution of dilemmas and/or problems that may arise in any health care process, as well as in the interaction between health personnel, patients, family members or society in general and the Hospital Bioethics Committees (CHB). The latter assist with a strictly consultative, guiding and educational character, without supplanting clinical decision-making functions, for the resolution of the same.

The CHBs have the attribution of deliberating clinical cases that are requested from a lay perspective to issue suggestions to health professionals, patients, their families and legal representatives, regarding difficult situations involving bioethical problems or dilemmas. The resolutions of the Hospital Bioethics Committee are essential to create procedures in the management of bioethical situations in the hospital setting, and these opinions can become a «source of law», especially when the contributions refer to non-legislated issues or, even, to legislated situations whose regulation is deficient or obsolete (2). This will also help to promote the philosophy and importance of teamwork with different medical specialties.

By learning about bioethical problems and dilemmas, CHBs will guide towards a change in the attitude of healthcare professionals when offering their work in the care of all patients, including those at the end of life, when a series of bioethical problems and dilemmas arise that place the healthcare professional, the family and the patient in conflictive situations.

No previous literature on bioethical problems and dilemmas, especially in adults, was found in Mexico, and the present review seeks to fill this gap in research, hoping to be a reference that will contribute to and motivate future research.

2. Theoretical framework

The word «bioethics» is a neologism created by Van Rensselaer Potter, who in 1970 published an article entitled *Bioethics: the science of survival*. Subsequently, in his book *Bioethics: bridge to the future*, around 1971, he defined «bioethics» as *the systematic study of human behavior in the area of life sciences and health care, as such behavior is examined in the light of values and moral principles* (3).

The physician's obligation is not to indicate to the patient a treatment that is not bad or incorrect, but to propose the best possible one (1, 9). This is achieved through the application of bioethical principles in decision making, principles that were obtained after deliberation by a group of experts in the USA in 1974, concluded in 1978 and pronounced in the Belmont Report in 1979 (3).

These principles guide health professionals in their activities and decision making. Among the main principles ones are (1, 3):

a) *Beneficence*. This refers to the obligation and responsibility to prevent, protect and act for the patient's physical, psychological, social and spiritual well-being; to provide a quality service, to avoid excessive therapeutics and unnecessary treatments, respecting conditions, creeds or ideologies.

b) *Non-maleficence*. Not to harm the patient physically, psychologically or socially. Not to put the patient at risk.

c) *Autonomy*. Capacity and right of the patient to make his/her own decision, and to respect it through the recognition of his/her dignity and freedom (informed consent process), providing the necessary information to make decisions in the field of health.

d) *Justice*. Giving to each person what he/she needs; making an adequate distribution of resources according to the patient's needs, without considering social class, economic solvency, creed or race.

In 1978, Warren T. Reich presented the first *Encyclopedia of Bioethics*, which encompasses the aforementioned bioethical principles (1).

In 1979, Tom L. Beauchamp and James F. Childress published the book *Principles of Biomedical Ethics* (3).

At the beginning, bioethics was dominated by Anglo-Saxon countries, but in the 1980s it spread to Europe, and in the 1990s to America and a large number of countries in the rest of the world (2).

For the National Bioethics Commission (CONBIOETICA), «bioethics» is the branch of applied ethics that reflects, deliberates and makes normative and public policy proposals to regulate and resolve conflicts in social life, especially in the life sciences, as well as in medical practice and research that affect life on our planet, both now and with respect to future generations (2, 7). Many bioethical problems and dilemmas are prevalent in medical practice today, which is why Hospital Bioethics Committees are more frequently convened (3, 17).

3. Importance of Hospital Bioethics Committees (HBC)

They emerged in the middle of the 20th century with the purpose of implementing formal mechanisms aimed at resolving dilemmas that arise in the practice of medicine (3).

In 1962, a report in *Life* magazine, under the title *They decide who lives, who dies*, publicized a committee (created in 1961 in Seattle, Washington State) to decide which patients had preference to benefit from the then recent hemodialysis machine. The committee was composed of nine members, two of whom were physicians; a priest, a lawyer, a housewife, a banker, a trade unionist, a civil servant and a surgeon. They were known as the *Life and death committee*. This committee was subjected to great pressure and criticism. Its work has been regarded as pioneering in bioethical deliberations (3).

In 1975, the need for multidisciplinary committees was formulated for the first time to guide decision-making on ethically complex issues involving conflicts of values. They were created to open a space for analysis, reflection, education and study of the elements that are part of a medical care process, or on the teaching given in the health area, in an environment of freedom and tolerance for a comprehensive systematic analysis. It is already known that in no case can they replace the responsibility of physicians towards patients or impose themselves on their decisions, but only have a consultative character (2, 7).

Furthermore, they are formed as autonomous, institutional, interdisciplinary and plural bodies; that is to say, they should be conceived as bodies that represent a collegiate body, with professional competence, high scientific and technical soundness, objectivity, impartiality and rectitude in their actions (2, 7). They should promote respect for human rights; recognition of the dignity of individuals; promote the education of health personnel; foster respect for patient autonomy through informed consent, among other actions that tend to improve the quality of health care (1, 2, 7).

They do not substitute functions in clinical decision-making; they do not endorse diagnoses of terminal illness; they do not make decisions regarding the initiation, change or suspension of treatments for patients who are in pain or who have been diagnosed in the terminal phase; they do not endorse the documents con-

taining the advance directives of patients in pain or who have been diagnosed in the terminal phase; they do not sanction medical negligence or the commission of any crime; they do not deal with labor, administrative, legal or personal matters; they are not activist or political groups; they do not review research protocols (2).

The sessions of the Hospital Bioethics Committee, which may be ordinary or extraordinary, must be constituted by means of an installation act, in a formal act with the respective authority, where minutes will be drawn up indicating date, time, purpose of the meeting, signatures of the attendees, agreements and consensus recommendations. The *quorum* must include the attendance of the president of the committee and the concurrence of half plus one of its members, considering the distribution of their skills, as well as not having conflicts of interest in the case under consideration. With respect to the recommendations, the consultants cannot be forced to act in accordance with the committee's recommendations (2, 7).

It is advisable that the case analysis be carried out considering the following common points of study (2, 3):

- Clinical data, diagnosis, therapeutic alternatives with benefits and risks; prognosis of survival, based on evidence, and physical, psychological, spiritual and economic costs, among others.
- Social background.
- Wishes of the patient or his/her relatives about his/her treatment.
- Conflicting values or doubts of those requesting the case review.
- Resolution alternatives.
- Consequences of the alternatives.
- Principles involved in each alternative.
- Suggestions.
- Basics of suggestions.

Its normative foundations are based on (4):

- General Health Law, Art. 41 bis, 166 bis and 316.

- Regulation of the General Health Law on the Provision of Health Care Services, Art. 68, 70 and 38 bis.
- Agreement by which the General Provisions for the Integration and Operation of Hospital Bioethics Committees are issued, and the hospital units that must have them are established, in accordance with the criteria established by the National Bioethics Commission.
- National Guide for the Integration and Operation of Hospital Bioethics Committees, fifth edition, 2015. Hospital Bioethics Committees use glossary terms for bioethical problems and dilemmas of clinical cases.

4. Terms used in bioethics

Truthfulness. Communication must be respectful, clear and appropriate to the person and his/her situation. The information provided should be given with sensitivity and raise aspects of their care according to their needs, preferences and life perspectives. Information should be given in a supportive environment and with privacy and confidentiality of health data. In addition, they should strive to be empathetic (4).

Problem. A proposition aimed at finding out how to obtain a result when certain data are known. There are two types:

- *Determined problem:* One that can have only one solution or more than one, but in fixed number (8).
- *Indeterminate:* That which can have an indefinite number of solutions (8), where one or more solutions are known since it is presented; for example, in the case of appendicitis, the solution is appendectomy; in the case of dehydration, the solution is to hydrate. Although there may be several solutions, it is still a problem (2, 8).

Dilemma. The situation becomes complex; it is no longer linear as in the problem. Here there are two opposing elements: there is a

conflict of interests, a confrontation of two values, and a *dilemma*. In everyday language, a *dilemma* is understood as a problem that can be solved by two solutions, but neither of which is completely acceptable or, on the contrary, both are equally acceptable. In health-care, when there is tension between ethical principles in the decision-making process, it is considered to be a bioethical *dilemma*. It is a situation of doubt between two alternatives and, when having to choose one of the two, the intervening parties may not be completely satisfied (17). A *dilemma* implies a choice: «between two evils, the lesser» (1).

Conflict. Conflict means confrontation, fight. Here the parties involved already feel aggrieved and dialogue becomes difficult, often non-existent. Conflict does not necessarily arise only between two people; it can occur in the patient himself, when he feels or is truly incapable of making decisions and thus creating an atmosphere of greater uncertainty around him, which can be manifested in very diverse and contingent ways by those around him, including health professionals (8, 9).

Slippery slope. R. Higgs states that *the slippery slope is a form of argument in which an action, in itself possibly permissible, may nevertheless lead to other similar actions considered undesirable* (3). This fact may be due to the fact that there is no clear way to prevent slippage from one action to others (8, 9).

Therapeutic obstinacy. Therapeutic distance or obstinacy is the unnecessary or futile prolongation of treatments that have no reasonable chance of benefiting the patient (2). It is the adoption of disproportionate or useless measures with the aim of prolonging life in agony (3).

Therapeutic futility. Futile comes from the Latin *futilis*, and means «of little importance», although the more exact synonym would be the designation of a potential treatment as useless. The meaning results from the indication of a treatment that may lack a benefit in relation to the expected consequences, rather than offering a

dignified death. It refers to a medical procedure that is not worth instituting (17).

Principle of double effect. It is common for terminally ill patients to present intense pain or other symptoms, such as respiratory distress, anxiety, agitation, mental confusion, among others. For the management of these situations it is generally necessary to use drugs such as morphine, which can produce a decrease in blood pressure or respiratory depression, or other drugs that reduce the degree of wakefulness or even deprive the patient of consciousness (3).

Critical situation. Situation of imminent risk of death; critically ill patients are those who, due to dysfunction or profound failure of one or more organs or systems, depend on advanced monitoring and therapeutic means for their survival (19).

End of life and palliative care. At the end of life there are challenges for the integral management of patients that are often accompanied by ethical dilemmas that involve all members of the health care team (2, 3).

Palliative care is an approach aimed at improving the quality of life and symptom management of patients, both adults and children, with chronic or incurable diseases, as well as the quality of life of their families. Its essence is to offer a comprehensive, multidisciplinary approach to provide prevention and relief of pain, suffering and other problems, whether physical, psychological or spiritual, associated with their illness (1, 2, 3).

All physicians need to know when palliative care services are indicated, how they can be accessed, and how, when and where to discuss with the patient and family members the many ethical issues that may arise during the course of the illness.

Sometimes, for one reason or another, suffering becomes intolerable for a particular patient (symptoms or situation become *refractory* to any palliative treatment) and the palliative care team, critical care team, family physician or specialist service physician must consider the use of extraordinary therapeutic measures or

options of last resort in the face of this suffering by means of a consent form (Table 1) (1, 3).

Table 1. Last resort options for dealing with intolerable suffering.

	Consent
Treatment of intensity proportional to the intensity of symptoms	Patient or representative
Failure to initiate or withdraw life support treatments	Patient or representative
Sedation in agony	Patient or representative
Voluntary and definitive interruption of intake	Patient only
Assisted suicide	Patient only
Euthanasia	Patient only

Source: Adapted from Quill, 2004.

The first two last-resort options are considered to be part of the limitation of therapeutic efforts, and their practice should not pose ethical problems. The option of *terminal sedation*, which consists of the administration of drugs with the aim of achieving palliation or elimination of a refractory somatic symptom through a profound and irreversible decrease in consciousness, in patients in whom death is foreseeably very near, is another matter. In countries where euthanasia and assisted suicide are decriminalized, they are performed by a physician, and their objective is to eliminate suffering through the death of the patient; however, in Mexico these options are not legal (1, 3).

Communicating an unfavorable diagnosis to a patient becomes a very human issue. Here again, bioethics and legislation protect the right to information and access to palliative care (3, 4, 8).

Bioethical reflection and action are fundamental to guarantee conditions of equity, justice and respect for human rights in all areas of health, from basic science to the adoption of technologies, or in the development of infrastructures or public policies, with health personnel being the main forger of dignified patient care.

5. Frame of reference

In *Ethical dilemmas in the practice of children's medicine*, reviewed by R. Ruiz in 2017, in Spain, a study was conducted whose objective was to analyze bioethical dilemmas from 80 articles. The most frequent were: palliative care in child medicine, parental stress due to emotional burden, lack of training in communication and child psychology in health personnel, suspension of life support measures, significant physical and psychological deficiencies, and dilemma between beneficence and autonomy (5).

For its part, in *Ethical dilemmas in guardian or family decision making*, reviewed in 2015 by R. Jhonson, in the United States, 45 articles on decision making and the basis for medical consensus in incapacitated patients were reviewed. It was found that guardians and/or family do not always predict patient preferences, and decisions are often made without patient participation. Sharing responsibility for decision making prevents moral and emotional distress for family members, as well as builds trust and enhances consensus (20).

In *Ethical Dilemmas in Everyday Medical Practice*, reviewed in 2017 by J. James, in the United States, a systematic review of 13 articles was performed, in which information on the most frequent ethical dilemmas of the 21st century in medical practice was analyzed. It was found that the main bioethical dilemma is associated with biological research and its application in daily clinical and medical practice (24).

In the research entitled *Bioethical dilemmas in palliative care of hospitalized older adults: nurses' experience*, published in 2012 by J. Bezerra do Amaral in Brazil, an interview was conducted with 10 nurses between 25 and 45 years of age, in a geriatric palliative care center, through a qualitative, exploratory and descriptive study. The following were identified as the main dilemmas: artificial prolongation of life, nutrition in terminally ill patients, denial of information and undesired effect or double effect (11).

Continuing with the investigation of bioethical dilemmas, in the study entitled *Ethical problems identified by nurses in relation to critically ill patients*, published in 2015 by L. Nunes, in Portugal, surveys were conducted to 166 nurses with clinical-surgical preparation, through a study with non-probabilistic and accidental convenience sampling, which collected information from 2007 to 2014. Ethical problems were found regarding the reporting of bad news, withholding information, end-of-life accompaniment, therapeutic obstinacy, communication and teamwork problems, consent, respect for the patient's decision, distribution of resources, work overload, respect for the person and professional confidentiality (19).

In the study *Bioethical dilemmas and their possible solutions in pediatric intensive care units in the Federal District (Mexico)*, by Ma. de la Luz Casas-Martínez, published in Mexico in 2013, a survey was designed aimed at experts on the main bioethical dilemmas faced by Pediatric Intensive Care Unit (PICU) services and on the procedures for their solution. The most frequent dilemmas were: therapeutic obstinacy with 32%, and the difficulty of establishing the diagnosis of a terminal patient, with 13%. The study concludes by emphasizing the need to include bioethics subjects in medical training, as well as the importance of assertive communication and the promotion of Hospital Bioethics Committees (23).

All physicians need to know when palliative care services are indicated, how they can be accessed and how, when and where to discuss with the patient and family members the many ethical issues that may arise during the course of the disease by means of a Hospital Bioethics Committee.

According to the framework, it is concluded that the bioethical issues and dilemmas of the clinical cases are mainly the following:

- Applicability of bioethical principles.
- Suspension of life support.
- Complex decision making.
- Feeding and hydration.
- Denial of information.

- Principle of double effect.
- Therapeutic obstinacy.
- Accompaniment at the end of life.
- Lack of training in communication and psychology in health personnel.
- Lack of training of health personnel on the diagnosis of terminal illness.

6. Justification

The clinical cases analyzed will provide a record of the main bioethical problems and dilemmas presented to a Hospital Bioethics Committee and how the suggestions have been ruled. This will set precedents that will make it easier for the health services of a second level hospital to identify and intervene in a timely manner, based on previous situations, and will be a quick guide for bioethical intervention in medical practice, for the benefit of the patient.

7. Method

a) Goals

General purpose

Describe the reasons for presenting clinical cases of patients to the Hospital Bioethics Committee in a Second-Level Hospital, from June 2007 to June 2018.

Specific objectives

- Describe the frequency of clinical cases of patients presented to the Hospital Bioethics Committee, from June 2007 to June 2018.
- Identify the clinical characteristics of the patients whose clinical cases were presented to the Hospital Bioethics Committee.

- Describe the frequency of the treating services that requested the intervention of the Hospital Bioethics Committee.
- Describe the reason for the most frequent clinical cases presented to the Hospital Bioethics Committee.
- Identify the type of bioethical problems and dilemmas in the clinical cases of patients presented to the Hospital Bioethics Committee.
- Describe the recommendations of the bioethical problems and dilemmas of the clinical cases of patients presented to the Hospital Bioethics Committee.
- Identify the number of days elapsed from the hospital admission record to the intervention of the Hospital Bioethics Committee.

b) Design

Observational, descriptive, retrospective, transversal.

c) Materials and method

Sample size

By convenience. The sample included all the cases of patients registered with the Hospital Bioethics Committee, 48 in total. The records of clinical cases and minutes that were presented to the Hospital Bioethics Committee were reviewed from June 2007 (year of formal establishment of the Hospital Bioethics Committee at the Dr. Manuel Gea González General Hospital) to June 2018.

Selection criteria

– *Inclusion criteria.* All records of clinical cases and minutes of patients whose care required the intervention of the Hospital Bioethics Committee at the Hospital General Dr. Manuel Gea González, from June 2007 to June 2018.

- *Exclusion criteria.* No exclusion criteria.
- *Elimination criteria.* No elimination criteria.

d) Description of the procedures

1. The Hospital Bioethics Committee (CHB) was asked for access to the records of the minutes of the clinical cases presented from June 2007 to June 2018.
2. The records of the minutes and clinical cases presented to the Hospital Bioethics Committee of the Hospital General Dr. Manuel Gea González were reviewed to identify the bioethical problems and dilemmas, and the reason why the Committee's intervention was necessary.
3. The suggestions issued by the CHB were identified.
4. The clinical characteristics of age, gender, diagnosis, dates of hospitalization, dates of minutes, file number, number of days of hospitalization, type of problem and bioethical dilemma, and the suggestions issued by the CHB were recorded in the Data Sheet.
5. The bioethical problems and dilemmas were classified and grouped according to frequency.
6. Frequency analyses were performed for the type of problems, dilemmas and suggestions from the minutes.
7. The final report was drafted and the results were disseminated.
8. Frequency tables and bar graphs were used in the results.

e) Ethical considerations

All procedures were performed in accordance with the stipulations of the Regulations of the General Health Law on Health Research. They were also performed with the signature of the commitment to confidentiality of the reports of the records obtained from the Hospital Bioethics Committee of the Hospital General Dr. Manuel Gea González (Title Two, Chapter I, Article 17, Section I), in a no-

risk investigation, which does not require informed consent from the patient and/or family.

f) Results

With the aim of analyzing the data obtained, graphic representations were made using descriptive statistics.

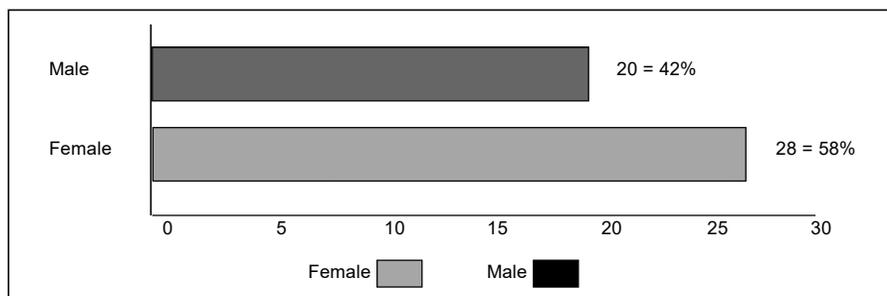
Table 1 refers to the age of the patients who presented cases to the Committee; Graph 2 to their gender, and Graph 3 presents the results of the percentages of cases that involved a bioethical dilemma compared to those that presented a bioethical problem.

Table 1. Clinical characteristics: age of the patients whose cases were presented to the Hospital Bioethics Committee.

Age range	Frequency	Percentage
0 a 30 days	8	17%
31 days to 17 years	10	20.8%
18 a 59 years	21	43.2%
Older than 60 years	9	19%
Total	48	100%

Source: Own elaboration.

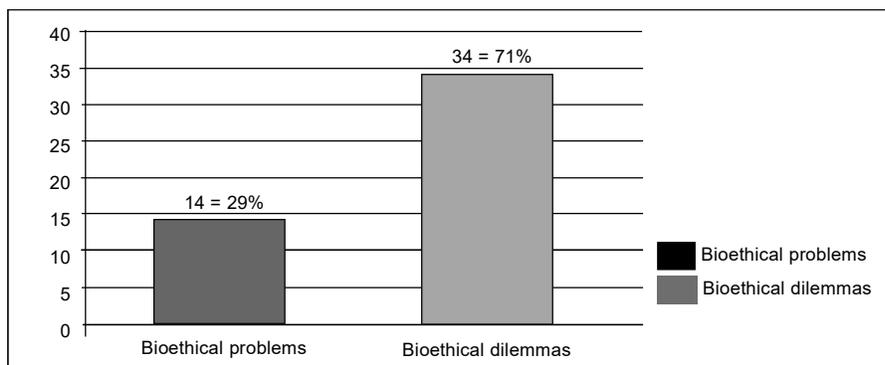
Graph 1. Clinical characteristics: gender of the patients whose cases were presented to the Hospital Bioethics Committee.



Source: Own elaboration.

The most frequent age range was between 18 and 59 years (adults), with 21 cases (43.2%), followed by the range between 31 days and

Graph 2. Frequency of clinical cases of patients presented to the Hospital Bioethics Committee, from June 2007 to June 2018.



Source: Own elaboration.

17 years (pediatric), with 10 cases (20.8%) (Table 1). The female gender was the most frequent, with 28 patients (58%) (Graph 1). Thirty-four bioethical dilemmas (71%) and 14 bioethical problems (29%) were identified, according to the minutes (Graph 2).

Table 2 lists the services that submitted cases to the Committee.

Table 2. Treating services requesting intervention in clinical cases presented to the Hospital Bioethics Committee.

Applicant treating services	Frequency	Percentage
Palliative care	13	27%
Emergencies	9	19%
Neonatal Intensive Care Unit (NICU)	8	17%
Pediatric Intensive Care Unit (PICU)	5	11%
Internal Medicine	4	8%
Intensive Care Unit (ICU)	4	8%
Gynecology-obstetrics	3	6%
Genetics	1	2%
Bariatric surgery	1	2%
Total	48	100%

Source: Own elaboration.

Table 3. Reasons for submitting clinical cases to the Hospital Bioethics Committee.

Reasons for presenting clinical cases to the hospital bioethics committee	Frequency	Percentage
Decision support for limitation of therapeutic effort	24	50%
Family or patient with denial about prognosis/lack of communication	7	15%
Refusal of treatment and / or voluntary discharge	6	12.5%
Interruption of pregnancy	4	8.1%
Withdrawal of hydration and feeding at the end of life	2	4.2%
Lack of knowledge of terminal patient management	2	4.2%
Lack of financial resources for treatment	1	2%
Denial of information to the patient	1	2%
Transfusion into Jehovah's Witness	1	2%
Total	48	100%

Source: Own elaboration.

Treating services that most frequently requested intervention were palliative care, with 13 cases (27%), followed by the emergency department, with 9 cases (19%) and, in third place, the Neonatal Intensive Care Unit (NICU), with 8 cases (17%). Table 3 shows that the most frequent reasons for presentation were the request for support in decision making for the limitation of therapeutic effort (50%), followed by the family with denial about the patient's prognosis/lack of communication (15%), and voluntary refusal of treatment and/or request for voluntary discharge (12.5%).

Table 4 identifies 34 clinical cases with bioethical dilemmas; therapeutic obstinacy was the most frequent with 13 cases (38%), followed by the difficulty in establishing the applicability of bioethical principles, such as autonomy and distributive justice, with 5 cases (14%), and the lack of training of health personnel on the diagnosis of terminal illness, with 4 cases (12%).

In Table 5, 14 bioethical problems were identified, mostly due to lack of knowledge of management guidelines and care protocols.

Reasons for presenting clinical cases of patients to the Hospital Bioethics...

Table 4. Bioethical dilemmas of the clinical cases of patients presented to the Hospital Bioethics Committee.

Bioethical dilemmas	Frequency	Percentage
Therapeutic obstinacy	13	38%
Difficulty applying bioethical principles: autonomy (4), justice (1)	5	14%
Lack of training in the diagnosis of terminal illness	4	12%
Lack of training in communication of health personnel	3	9%
Nutrition and hydration at the end of life	3	9%
Suspension of life support	2	6%
Complex decision making in pediatrics	2	6%
Denial of diagnosis, prognosis of the patient or family	1	3%
Denial of information to the patient	1	3%
Total	34	100%

Source: Own elaboration.

Table 5. Bioethical problems of the clinical cases of patients presented to the Hospital Bioethics Committee.

Bioethical problems	Frequency	Percentage
Lack of knowledge of the guidelines for management in the terminal phase	4	29%
Ignorance about the Federal Criminal Code of Mexico, Article VI, on abortion (termination of pregnancy)	4	29%
Respect for patient or family decision-making	3	21%
Lack of knowledge of the routine protocol in critically ill patients	1	7%
Lack of knowledge of surgical selection criteria	1	7%
Administrative problems	1	7%
Total	14	100%

Source: Own elaboration.

Table 6 (on the next page) lists the services that submitted cases to the Committee.

The suggestions for the resolution of the problems presented were also analyzed and are shown in Table 7 (on the next page).

Table 6. Suggestions for bioethical dilemmas in the clinical cases of patients presented to the Hospital Bioethics Committee.

Suggestions for dilemmas	Frequency	Percentage
Support family or patient decision-making to solve dilemmas	15	47%
Improve the communication process: family reunion, psychology, explain prognosis	8	22%
Assess diagnostic certainty	4	11%
Do not fall into therapeutic cruelty	4	11%
Inform the patient about their diagnosis, as a right recognized by NOM-168	1	3%
Withdrawal of food and hydration in the dying phase and in consensus with the family	1	3%
Transfuse if there is a risk of death in Jehovah's Witness	1	3%
Total	34	100%

Source: Own elaboration.

Table 7. Suggestions for bioethical problems in the clinical cases of patients presented to the Hospital Bioethics Committee.

Suggestions for problems	Frequency	Percentage
Initiate palliative comfort treatment in terminal patient	5	36%
Interrupt pregnancy if there is a risk of maternal death	4	28.5%
Respect the decision of the family or the patient	3	21.5%
Explain to the family the criteria for medical discharge	1	7%
Offer a second opinion at the insistence of the patient	1	7%
Total	14	100%

Source: Own elaboration.

A very relevant data is the number of days that patients have been hospitalized until the intervention of a Hospital Bioethics Committee, with an average of 8 to 14 days being the longest. The results are shown in Table 8.

The most frequent number of days from the date of hospitalization to the date of presentation of the clinical case to the Hospital Bioethics Committee was 8 to 14 days (27%).

Table 8. Number of days from the hospital admission record to the intervention of the Hospital Bioethics Committee.

Interval of N° of days	Frequency	Percentage
0 - 7 days	7	14%
8 a 14 days	13	27%
15 a 21 days	6	12.5%
22 a 28 days	8	17%
29 a 35 days	5	10.5%
More than 36 days	9	19%
Total	48	100%

Source: Own elaboration.

8. Discussion

During medical practice, it is possible that health personnel are faced with a situation of irreversible death of the patient and it is common to opt for excessive measures in order to keep the patient alive, to the detriment of his quality of life, with increased suffering and, sometimes, only prolonging agony.

In the present study, the most frequent bioethical dilemma was that of «therapeutic obstinacy» (38%), as shown in Table 4, similar to the 2013 Casas-Martínez study, which was conducted in the intensive care unit, and in which 32% of therapeutic obstinacy was identified (14).

Medicine has contributed considerably to the benefit of health, but limitations should be recognized when referring to terminally ill patients, and act accordingly. Allowing decision making, and doing so with consensus, will help to improve not only quality of life, but also the quality of death in those cases that merit it, and thus gain access to a «dignified death» without confusing this term with euthanasia, which is explicitly prohibited in Mexico.

To resolve these dilemmas, the support of CHBs is very useful, with functions such as the prospective review of specific problems;

bioethical education of healthcare personnel and the community, as well as the development of standards or suggestions for the discussion of bioethical problems and/or dilemmas.

Pediatrics is a very prone area for resorting to therapeutic obstinacy. The pediatric patient is not aware of his or her situation and has limited capacity to decide. It is the parents, guardians or even the medical staff in cases of extreme urgency who have to make decisions with responsibility, logic, impartiality, coherence and emotional stability mainly.

Complex decision making, such as the withdrawal of life support measures, is a serious dilemma in both adult and pediatric patients. In the latter because there is a belief that children should not die since they have a life ahead of them; therefore, the logical thing to do in these cases is to resort to resuscitation as a general protocol. Here the «interest of the child» is sought to serve as a guideline for parents, health personnel and others involved.

Therefore, it is valid «not to resort to disproportionate measures» both for the adult and for the child, as long as there is diagnostic and prognostic certainty of the irreversibility of the disease, in order not to fall into futile treatments or into therapeutic intemperance, which is sometimes difficult to avoid.

The physician must be able to coordinate a therapeutic plan with his health team and to communicate effectively with the patient and the family, trying to accompany them in the decision making process, which ideally should be without socioeconomic pressure and within a prudent time frame.

Respecting patient autonomy in decision-making improves the doctor-patient relationship, but it is important not to be guided by extremes, ranging from therapeutic obstinacy to patient abandonment.

The process of clinical and ethical deliberation is the reflective function that facilitates difficult decision making, in order to seek the best solution or, of all the options, the least harmful to the pa-

tient, emphasizing the implicit principles and values, as well as the circumstances, consequences and legal aspects.

For years it had been insisted that the physician should save the life of his patients at all costs, but in medical practice another reality is evident, especially when the time comes when therapeutic resources and medical efforts are confronted with the blunt and irreversible fact of death, due to a fatal disease or one that is incompatible with life, and from there arise the main bioethical problems and/or dilemmas. It is essential to work as a team with the other treating services for an integral management and, in addition, to highlight the importance of having Hospital Bioethics Committees in delicate cases, often with an urgent need for intervention, in which they will help, based on suggestions, to make decisions for the benefit of the patient.

Although the sample obtained in the present study –consisting of 48 clinical cases– is small compared to other studies, it nevertheless shows a satisfactory approach to the clinical cases presented in the last 10 years of the Hospital's activity, given the characteristics and circumstances, and in spite of limitations, given that the people who are frequently hospitalized there are of low economic resources and more prone to vulnerability. It should be emphasized that having an area such as the Hospital Bioethics Committee has contributed to the improvement of care and timely intervention, and its work also extends to several training sessions. For this reason, participating in a Hospital Bioethics Committee generates obligations and responsibilities, even when it is an *ad honorem* work. This allows shared and democratic decisions to be made through a broad, respectful and transparent debate. Such decisions, prudent and situated in a specific time and space, can not only avoid lawsuits for alleged medical negligence, but also demonstrate that a CHB is a guarantee of humanized treatment and respect for human rights.

The progression of a disease, mainly associated with symptoms such as pain, leads to the suffering of patients and their families.

Relief of suffering and cure of the disease should be considered as obligations of the medical profession (1).

Although not enough bibliographic references were found in recent years related to the subject, this study shows the challenge of promoting social responsibility, opening deliberations towards the community and health professionals.

With the advance of technology and science, health personnel will face complex situations in the bioethical field, and it is their responsibility to recognize and defend the dignity of the person, respect for human rights and fundamental freedoms.

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9. Conclusion

The present study will provide a record of the main bioethical problems and dilemmas of clinical cases presented to a Hospital Bioethics Committee and how suggestions have been ruled, which will set precedents that will facilitate the identification and timely intervention of the same by the treating medical services of a hospital environment, based on previous situations, and will be a quick guide for bioethical intervention in medical practice, for the benefit of the patient and his family.

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