

**A student asked me an ethics
question and I didn't know
how to respond**

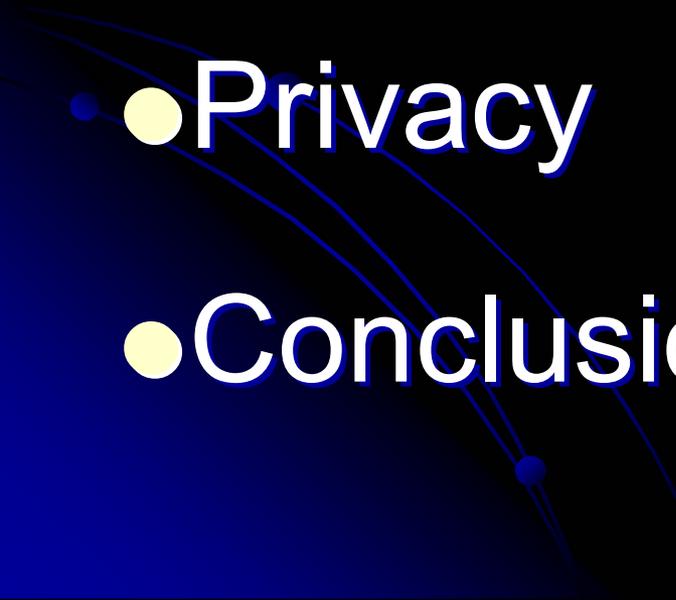
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Objectives for the session

- Raise awareness of major theories and principles of ethics in health care
- Have critically applied a framework for ethical decision-making to relevant cases in health care.
- Have explored some contemporary ethical challenges in health care and delivery.

Outline

- Theories & Principles
 - Consent
 - Privacy
 - Conclusion
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OVERBOARD By Chip Dunham



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Case

Consent on the ward

Dear Dr Horton,

Thank you very much for acting as our preceptor on the General Medical ward yesterday. I found the visits to patient bedsides very informative. I do however have one lingering question to do with consent. Can you please let me know whether the patients we met during rounds gave formal consent to having us there?

Sincerely, Amy (MD1 student)

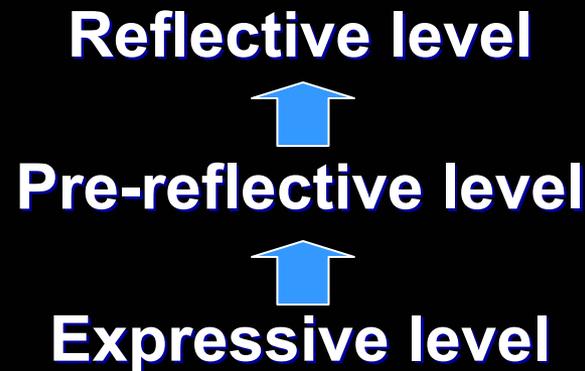
Philosophy is said to begin in wonder:

- “Two things fill me with ever increasing wonder, the **starry heavens above** and the **moral law within.**”

● Immanuel Kant

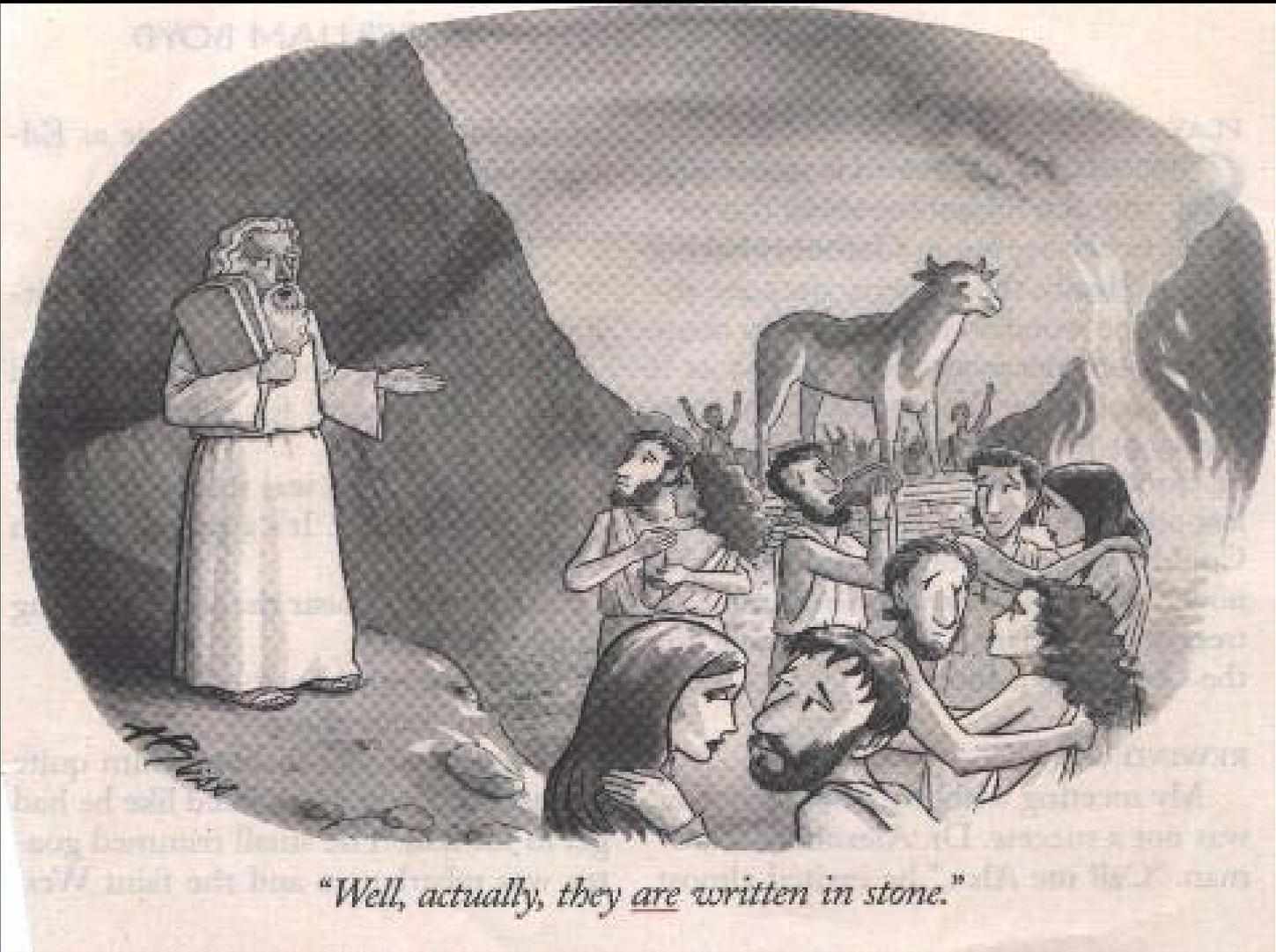
What can I know?

- Philosophy craves **clarity, distinctions, reasoned justifications** for the positions we hold.
- When it comes to moral thinking, knowledge consists in moving toward decisions that we can share publicly with relative confidence :



Three related questions prompt philosophical reflection

- What can I know?
 - How ought I act?
 - What can I hope for?
- 



"Well, actually, they are written in stone."

Principles of Ethics in Health Care

- Autonomy
- Beneficence
- Non-maleficence
- Justice
- Utility
- Veracity
- Other?

Problem:
which principles
are best?

Problem:
is there a defined
hierarchy between
principles?

Autonomy - Gk. *autos nomos*

- self rule, self law
- We show respect for the dignity of persons by honouring their wishes about their own lives.
- Makes most sense when we are talking about competent persons.
- Can be applied to the formerly competent or intermittently competent as well.
- My autonomy may conflict with yours.
- It may conflict with other values as well.

Beneficence/Non-maleficence

- Duty to **improve the condition** of others, and the duty to **do no harm** to others.
- Especially applicable to care of children and others incapable of directing their own care.

What can be done for this patient?

What are the benefits and burdens (to her) associated with this course of action/non-action?

How to do good?

- “You know, sometimes I feel like this. There I am standing by the shore of a swiftly moving river and I hear the cry of a drowning man. So I jump into the river, put my arms toward him, pull him to shore and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration and then just as he begins to breathe there is another cry for help. So back in the river again, reaching, pulling, applying, breathing and then another yell. Again and again, without end, goes the sequence. **You know, I am so busy jumping in and pulling them to shore, applying artificial respiration, that I have no time to see who the hell is upstream pushing them all in.**”
- Michael Yeo, *Concepts and Cases in Nursing Ethics*, Broadview Press Limited 1991 (p.261).

Justice

- Often equated with **fairness**.
- Deals with the distribution of **benefits and burdens between persons**.
- Also a matter of **access** to goods and opportunities.
- Consists in **treating like cases alike and responding to relevant differences**.
- Not merely **equal treatment but treatment as an equal** (eg. wheelchair ramps).

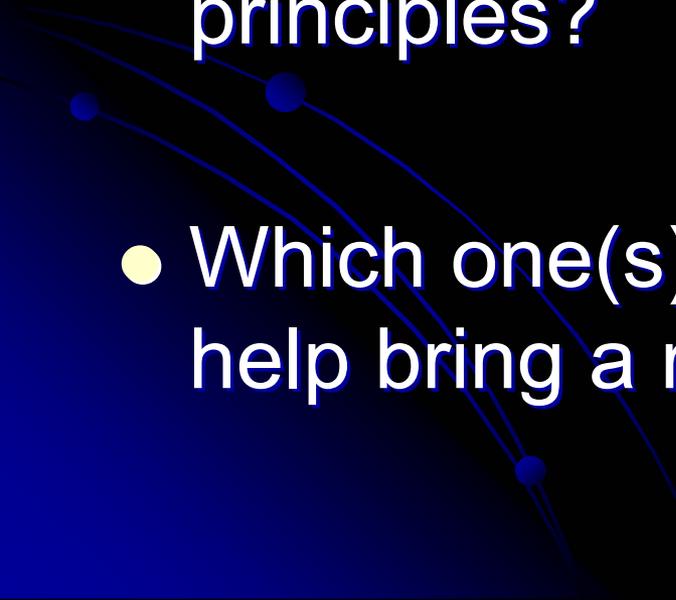
Can we be virtuous people under conditions of injustice? How?

The core ethical questions:

1. What does the patient want? (**Autonomy**)
2. What can be done for the patient and what are the harms and the benefits? (**Beneficence**)
3. Are the patient's requests fair and able to be satisfied? (**Justice**)

- Philip Hébert. *Doing Right: A Practical Guide to Ethics for Medical Trainees and Physicians*. Toronto: OUP, 1995, 11.

Case 1 Questions

- Which of the principles is relevant to the case?
 - Is there conflict between any of the principles?
 - Which one(s) ought to be given primacy to help bring a resolution to this case?
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Other theories of ethics

- Deontology
 - duty and intention based
 - praise or blame based on duty
 - Problem: which duty is required in a given context?
 - Problem: praise intention even if outcome was harmful
- Consequentialism
 - outcome oriented
 - praise or blame based on desirability of outcome
 - Problem: how do we know outcomes in advance?
 - Problem: praise bad intentions when outcome was accidentally good

Ethics of Care

- Feminist scholars e.g. Carol Gilligan.
 - "Caring" advocates decision making in a way that best supports the good of the individual in the long run.
 - An Ethic of Care requires us to assume responsibility for those who need our help, and to do whatever it takes to further their best interests.
 - Hence, sometimes we will interfere with the autonomous actions of others in order to preserve or enhance their future autonomy.
 - Problem: Ethics of Care can be criticized as a disguise for paternalism.
- Gilligan, Carol *In a Different Voice*; Harvard Univ. Press 1982

Paternalism

Interfering with the *self-determined decision* of a *capable* individual on the grounds that it is *in that person's best interest* to do so.

Virtue Ethics

- From Aristotle
- Emphasis upon moral character and habit rather than acts or outcomes of acts.
- Assumes people can act in a virtuous manner through careful training until they acquire the habit of always being virtuous.
- Behaving virtuously entails choosing the best approach to create happiness, or deliberating upon general principles until the best decision is reached.
- This theory rejects the reliance upon rules for resolving moral problems, for which it has been heavily criticized - if there are no rules to follow how do we know we are making the virtuous decision? The response is, we know because we are virtuous.
- A second criticism of virtue ethics is that there is no defined set of approved virtues, so it is never certain when one is behaving virtuously or not.

Informed Consent

- The right of a reasonably competent person to make a decision to permit or refuse a treatment, on the basis of relevant information.
- This right confers a duty on health care professionals to provide relevant information in a clear and non-coercive manner suited to the patient.

Informed Consent

- Rooted in principle of patient autonomy or self-determination
- Recognizes separation of persons and sovereignty over self.
- “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages.” Cardozo in *Schloendorff* (1914)

Elements of Informed Consent

1. Capacity

**3. Scope of
Disclosure**

2. Voluntariness

**4. Continual
consenting**

Elements of Informed Consent

1. Capacity

- Can patient at this time understand risks, benefits and alternatives, including non-treatment?
- May be compatible with other areas of non-competence eg delusion.
- May be variable, local.

2. Voluntariness

- Freedom from coercion, eg from medical personnel, family, etc.

3. Scope of Disclosure

- Professional standard
- Subjective standard
- Objective / Reasonable person standard
- What a reasonable person *in the same circumstances* wants
- **Significant and material risks**

4. Continual consenting

- Consent taking should be ongoing

Stamos v. Davies 1985

- Established case law in Canada wherein the physician has a duty to inform patient if something goes wrong.
- Justice Horace Krever wrote that if informed consent establishes a legal obligation to inform patient about what *may* go wrong, then surely there is a legal obligation to inform patient about a when things *do* go wrong.

Case

The homework assignment

A student assigned to your practice is found looking at a patient's file without first asking permission to do so. When confronted she responds "I didn't realize I needed to ask, I was just doing an assignment that requires us to report on the medical history of a patient."

Questions

- What is the case about?
- Who are the stakeholders in the case?
- Which of the principles is most relevant?
 - Autonomy, Beneficence, Non-maleficence, Justice
- What duties are relevant? What outcome would be most desirable?
- State a resolution.
- Consider criticisms.
- Conclude and justify.

Assistance Tool for Decision-Making in Ethics

DRAFT

1. Getting the story straight
2. Your initial reaction
3. Identify and classify the ethical problem(s)
4. Duties, Responsibilities and Outcomes
5. Alternative courses of action
6. Autonomy Scale 1-10
7. Values
8. Legal and professional requirements
9. Strategies
10. Justify your strategies
11. Anticipate criticisms & costs
13. Implement and document
14. Reflection and evaluation
15. Reconsideration

Privacy and confidentiality

1) protection of privacy

- creation and control of one's self identity
- protection and respect for patient autonomy

2) trust between patient and care provider

- the importance of candour in the therapeutic relationship

Exceptions to confidentiality

- when the patient is a danger to herself
- in the best interest of community or third party
- when required to by the police or judiciary
- when prior permission is granted by the patient
 - to employers and insurance companies
 - within a care-providing team or when consulting health care colleagues
 - *for research, teaching or audit?*

Consent and privacy

- Seeking patient consent can provide limited permission for appropriate access to information about patients.
 - *Is consent enough?*
 - Discretion is required to ensure the information cannot put individuals at risk.
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Case 1

- Mrs. Wright, a fifty-five year old woman with advanced multiple sclerosis, was admitted to the chronic care unit of a hospital. As part of the admission routine, a full diet was ordered. At lunch time, Nurse Klein observed that Mrs. Wright was eating very slowly and appeared to have difficulty swallowing some foods on her dinner tray. Mrs. Wright explained that she needed to chew the food well in order to avoid choking. After staying with her until she finished her meal, Nurse Klein told Mrs. Wright that she was going to fill out a special diet requisition for a soft diet.
- At dinner time when her food tray was presented, Mrs. Wright became very angry and upset. “I won’t eat that slop!” she asserted. “Bring me some real food that I can get my teeth into.” Nurse Klein patiently explained to her why it was best that she eat a soft diet and informed her about the risks of choking and aspiration. She also pointed out that the nursing staff would have limited time to spend assisting her with meals. Even so, Mrs. Wright was adamant. “It’s my life and I will live it the way I want!” she insisted.

- The next day arrangements were made for nursing staff to meet with Mrs. Wright and her husband. During the discussion it became clear that Mr. Wright supported his wife, and that the couple had thoroughly explored the options and were prepared to accept the consequences of their decision. They had also discussed the implications their decision would have on family members. Having realized that the Wrights were not going to change their decision, the nursing staff approached Mrs. Wright's physician and convinced him that it would be in her best interest to order her a soft diet. This only further angered Mrs. Wright.
- Michael Yeo et al, *Concepts and Cases in Nursing Ethics*; Broadview Press Limited, 1991.

Case 2

- Mr. Fontanez is an 82-year old who has been admitted to hospital with a diagnosis of cancer of the pancreas which has metastasized to the liver, spleen, and bone. Upon admission, it is noted that Mr. Fontanez has gangrene of the foot and has already lost two toes. He is in considerable pain, with the daily care and cleaning of the foot causing more pain.
- A surgeon is consulted and agrees with the attending physician that a partial amputation of the foot is the only hope for stopping the spread of the gangrene. Since the surgeon is the one who will do the procedure he approaches Mr. Fontanez for consent. He explains the procedure, tells him why it is necessary, and then asks him to sign the consent form for the operation. Mr. Fontanez refuses to sign. The surgeon carefully explains the consequences of not having the operation (continued pain and spread of the disease). However, Mr. Fontanez still refuses, saying, “No, leave me alone and let me die in peace.”