Medical Ethics

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What is Ethics?

- Philosophical study of moral behavior and moral decision making.
- Involves the analysis of moral language and the study of the process of moral deliberation and justification.
- It is the activity that studies how choices were made or should be made.

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What is an “ethical dilemma” ?

- An *ethical dilemma* is a situation where there is a major difference between family members, patient and family members, physicians and nurses, patient and physician, etc., about what “should”, “ought”, or “ought not” be done in a situation.

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Contemporary Bioethics

- Response to Renal Disease
  - World War II: Effective “temporary” dialysis developed
  - 1960: more permanent solution – non stick tubes (teflon) developed, 90% survival rate
  - 1962: Seattle Artificial Kidney Center opened, with three treatment slots. Who would benefit?
    - “God Committee” - 7 member volunteer lay committee: lawyer, housewife, state govt. official, labor leader, banker, surgeon
  - 1972: Universal funding
  - 1984: National Organ Transplant Act

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Contemporary Bioethics

1960's ….

- A rejection of paternalistic ethics
- Autonomy was initially considered supreme
- In addition to autonomy:
  - Beneficence: tied to compassion (Judeo-Christian-Muslim heritage)
  - Nonmaleficence: ancient maxim - "First, do no harm"
  - Justice: social and political connotation

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Contemporary Bioethics

- Tom Beauchamp, James Childress
  - 1979: Principles of Biomedical Ethics (1st edition) 2001: Fifth Edition
  - "Principles based, common morality theory"
    - Begin with common morality of society
    - Construct principles and rules from considered judgments
      - Coherence
      - Specification
    - How best to prioritize principles

Role of Principles

- Applicable to moral analysis of ethical issues
- Action Guides in clinical medicine
- Not absolute
- Goal to weigh and balance them in the situation at hand

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How Principles Apply

- Principles as self-evident values
  - Do no harm
  - Provide the most benefit to the patient
  - Patient must indicate a willingness to participate in the treatment plan
  - Medical benefits should be dispensed fairly
- Principles in conflict
  - Patient with acutely infected appendicitis
    - Balance do no harm with benefit of surgery

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How Principles Apply

- Balancing principles
  - Which principle carries more weight in a situation?
    - Do no harm or provide benefit?

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Moral Norms

- W. D. Ross (1877-1971), philosopher
  - *Prima Facie* duty (self-evident)
    - Must be fulfilled unless it conflicts with an equal or stronger obligation
    - Always binding unless a competing obligation overrides or outweighs it
    - Find the “greatest balance” of right over wrong
  - Actual duty
    - What should be done after weighing the competing prima facie obligations

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Major Principles

- Commonly accepted principles of health care ethics
  1. Principle of Respect for Autonomy
  2. Principle of Nonmaleficence
  3. Principle of Beneficence
  4. Principle of Justice
  5. Principle of Care/Compassion

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Respect for Autonomy

- Autonomy = self-rule
- Rational agents make informed and voluntary decisions
  - Patient's capacity to act intentionally, with understanding, and without controlling influences that would mitigate a free and voluntary act.
- Minimally, freedom from
  - Limitations, such as inadequate understanding that prevents meaningful choice
  - Controlling interference by others (manipulation, coercion)
- Patient Autonomy is the basis for Informed Consent

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Autonomy

- Illustrative Case
  - Respect for Autonomy:
    - Recognize and promote the autonomous actions of the patient
  - Jehovah's witness: a belief that it is wrong to accept a blood transfusion
  - Physician's obligation to inform patient of benefits and risks
  - Patient is free to choose and may give greater priority to religious belief

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Autonomy

- Illustrative Case
  - Physician has a *prima facie* duty to respect the autonomous patient choice
  - Physician also has *prima facie* duties to avoid harm, and provide benefit to the patient
  - By respecting the patient's wishes, the physician gives greater priority to respect for patient autonomy

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Autonomy

- Illustrative Case
  - If the patient were a ten year old and the parents were refusing a blood transfusion, there is legal precedence of going to court to override the parent's wishes, based on the right of the state to protect the lives of its citizens, especially minors, until they can reach the age of majority and make choices independently
  - In this case, the duties of providing medical benefit and avoiding harm would be given precedent over the principle of patient autonomy

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Nonmaleficence

- The provider ought not intentionally create needless harm or injury to the patient
  - Acts of commission or omission
- Negligence = the imposition of a careless or needless risk of harm on another
- Moral duty as well as legal duty

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Nonmaleficence

- Illustrative Cases
- Harm may be the lesser of two evils
  - Dying patient: decision to forgo CPR or life sustaining technology
  - Dying patient in pain: decision to offer appropriate pain medication
    - May hasten death, but the intention is to palliate the pain and discomfort

Beneficence

- The duty to be of benefit to a patient, as well as a duty to prevent or remove harm from the patient
  - Applied to the patient and to society as well
  - Nonmaleficence: a constant duty
  - Beneficence: a limited duty

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Beneficence

- A moral obligation to act for the benefit of others
  - Includes limiting harm to the patients
  - Not all acts of beneficence are obligatory
  - May be seen as a limited duty
    - Physician may choose to limit her/his practice
    - Does not have a strict duty to patients not in her/his care
    - May need to decide which to treat if both require treatments at the same moment

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Beneficence

- Illustrative Cases
  - Emergency Medicine
  - E.G., Patient is incapacitated and presumption is made that the reasonable person would want to be treated aggressively.
  - *Prima facie* duty to benefit the patient is given priority over the principle of respect for patient autonomy

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Beneficence

- Paternalism
  - Physician choosing to act in the physician's opinion of the patient's interest without consulting the patient or overriding the patient's wishes
  - Suicidal patient: a justified paternalism on behalf of saving the patient's life, when they are in danger of harming themselves – putting patient in a protective environment

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Justice

- Fairness, giving each one his/her due
- Grounds for allocating resources must be determined
- Persons who are equals should qualify for equal treatment
  - E.G., Medicare

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Justice

- Distributive justice in society
  - To each person an equal share
  - To each person according to need
  - To each person according to effort
  - To each person according to contribution
  - To each person according to merit
  - To each person according to free-market exchanges

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Limitations to Principles

- Challenge when two or more principles conflict: What is the actual duty?
- The principles do not provide a deductive system to identify a solution to a complex ethical dilemma
- Modern ethics seems to worship the principle of autonomy – even at the expense of other goods, E.G., the family or community BUT….this may be changing with population health.
- Justice is difficult to understand and apply

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Care and Compassion

- Allows genuine concern for the patient/family to assist in guiding actions (for those who will live with the decisions)
- What would you do/want done
- Allows unique solutions at times
- Assists in supporting other principles in decisions

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Overcoming Limitations

- Learning how to balance principles and determine which has a greater weight?
- Understand that the principles are abstract norms.
- *Seek assistance* from your Ethics Committee /ethics consult teams. – may be available in nursing homes. If part of hospital system may help in your office.
- Limitations of Ethics Committee

Determining Decision Making Capacity

- Cognition
- Capacity to Understand
- Conversation
- Consequences
- Consistency

Incompetency

- Legal Term
- Determined by the courts
- Not a physician determination

Medical Durable Power of Attorney

- Personal Choice
- Usually attached to Advanced Directive
- Often more useful than Advanced Directive alone
- Not a Living Will
- Patient needs capacity to complete

Guardianship

- Appointed by Court
- Requested by family member, institution, interested party
- Temporary initially
- Patient interviewed
- Not always necessary
- Many responsibilities of guardian
- Reversible
- PC630 in MI can be completed by any physician

Determining Decision Maker

- Medical Durable Power of Attorney/Guardian
- If patient with guardian they cannot make decisions
- Next-of-Kin (Michigan)
    - Spouse
    - Adult Children
    - One/Both Parents
    - Siblings
    - Nieces/Nephews

Physician Responsibility

- For activation of Medical Durable Power of Attorney: two physicians or one physician and a licensed psychologist
- For guardianship: one physician
- Need to have good understanding of patient capacity; family

In the office setting

- Make discussion of MDPOA/Advanced directives part of annual assessment (Medicare annual wellness visit)
- Have blank forms available
- Keep copy in patients chart once completed
- Know what advanced directive says
- Have appropriate next-of-kin
- Establish “form letter” for declaring patient without own decision making and MDPOA in effect

Case #1

The Ethics Consult Service is contacted because a patient in intensive care is consistently refusing dialysis – and physically resisting. He has been evaluated and, though alert and able to communicate somewhat, found not to have the capacity to understand the consequences of declining such treatment. The guardian has consented for dialysis.

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CASE #1

Case brought to Ethics committee as appropriate medical treatment and consented to, but patient may have to be restrained to do. What is in the patient's best interest in these circumstances?

What does respect for the patient's role in decision making mean in these circumstances?

How should "harm" be understood in a case like this and which is the greater harm – to treat or not to treat?

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Case #2

The Ethics Consult Service (ECS) is contacted because the surrogate decision maker for an incapacitated patient is expressing treatment expectations that appear to be at odds with the patient's own previously expressed treatment preferences.

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Case #2

There is a strong ethical standard that decisions to accept or decline treatment for an incapacitated patient who was previously capable of making informed decisions should be based on the best information available about what the patient had previously indicated she/he would accept in a situation like this.

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Case #2

What constitutes solid evidence of what the patient would want in these circumstances?

Whose responsibility is it to weigh / interpret the evidence?

What should be done in situations where the evidence is clear that the surrogate is acting contrary to the preferences of the patient?

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Resources

Resources

http://www.ascensionhealth.org/ethics/public/main.asp

http://depts.washington.edu/bioethx/topics/index.html

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United States Conference of Catholic Bishops. *Ethical and Religious Directives for Catholic Health Care Services.* 4th ed. Washington, D.C.; 2001

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