

Clinical Bioethics

Alexander R Nesbitt MD

Susquehanna Hospice and Palliative Care

May 2009

Frameworks for approaching ethics

- Character ethics/Virtue based ethics
- Principial/Principle based ethics

Character/Virtue based ethics

“What are the characteristics/virtues of an ethical medical professional?”

- Trustworthiness (fidelity) “Trust is confident belief in and reliance on the moral character and competence of another”
- Integrity (wholeness, faithfulness to core values)
- Conscientiousness (conscience) striving to know and do right
- Compassion
- Discernment (phronesis) practical wisdom, insight, judgement

Principial ethics

“The Georgetown Principles”

- Autonomy “auto” “nomos”= self rule
- Beneficence-seeking the highest benefit of the patient
- Nonmaleficence-do not do harm
- Justice-a fair chance for all



Beneficence

Nonmaleficence

Autonomy

Justice

The background of the slide is a solid brown color with a pattern of stylized, overlapping autumn leaves in various shades of brown and tan. The leaves are scattered across the entire area, creating a textured, organic feel.

Autonomy

Beneficence/Nonmaleficence

Justice

When principles conflict

Autonomy vs beneficence

“Beneficence provides the primary goal and rationale of medicine and health care, whereas respect for autonomy sets the moral limits on the professionals actions in pursuit of this goal”

Autonomy vs justice

Autonomy

Current primary principle in Western medicine ?

Limits to autonomy

Externally imposed limits

Cost, availability, clinical indication
(chemo, surgery, transplant...
or CPR, ventilator)

Limits to autonomy

Internal

Consideration of others; family, social or religious group

Authority not opposite of autonomy

Right to choose, right to refuse to choose

Gender, cultural issues

Communitarian, shared decision making vs individualistic, atomistic process

Necessary conditions for autonomy

- Liberty (free from controlling influences)
- Agency (will and capacity for intentional action or choice)

Capacity/Competence

Essential abilities

- To understand pertinent information
- To make judgements about information
- To intend certain outcomes
- To communicate wishes

Capacity

- Not constant or fixed
- Not absolute (not “either/or”)

Competent for what decision ?

“Threshold” of capacity for given
decision

“Sliding scale” of capacity/competence

Respect for autonomy

Active obligation

Working to NOT exert controlling influence

Working to foster and enable autonomous choice (information, understanding, support, time)

Incapacitated patient

Who decides ?

- Court
- Patient appointed agent
- Spouse or adult child not child of spouse
- Adult child
- Parent
- Adult sibling
- Adult grandchild
- Adult with knowledge of patients preferences and values

Essential characteristics of agent

- Ability to make reasoned judgement
- Ability to acquire adequate information and knowledge
- Emotional strength and stability
- Committed to patients interests
- Know the patients wishes and values
- Available

Principle of double effect

Action has good and bad effects; the bad effects are accepted in the provision of the good

Bad example-pain med causing premature death

Better examples

Opioids for dyspnea in CO₂ retaining COPD patient

Respiratory suppression in seizing patient from anti seizure meds

Futility

“Push back” against unrestrained autonomy
based on medical professional integrity

Failure of the promise of “the futility movement”

Move to policies to outline procedures for
resolving conflicts regarding futility e.g.
consultation, ethics committee, transfer
physicians, hospitals.

Quality of Life

Freighted term

Life unworthy of life; “lebensunwertes Leben”

Dangers of judging QOL for another

Disability data and perspective

Instability of care preferences over time

Strong bias in society, medical and general,
against life characterized by dependence,
incontinence, cognitive disability or profound
physical disability

Withholding and withdrawing life prolonging interventions

How are they different ?

How are they the same ?

General consensus in bioethical community

Ethically equivalent

Artificial nutrition and hydration

Medical intervention that can be accepted or rejected by autonomous choice of patient or agent?

Required basic human care that cannot be ethically withheld except in imminently dying patient?

General consensus in bioethical community

Medical intervention

Important dissent, strong feelings!

Controversial Topics

- Palliative Sedation
- Physician Assisted Suicide
- Euthanasia

Ethically unacceptable behaviors

-“Slow code”

-Progressive automatic escalation of opioid
not titrated to target symptom

-Imposition of medical professionals beliefs or
values re: controversial issue or decision
“becoming undue influence”.

Pseudoethical dilemmas or conflicts

- Related to knowledge deficit e.g. “if I give this patient morphine it will kill them and I will be committing euthanasia”
- Related to patient or family emotional, informational, or trust issues e.g “family insists on futile treatment”
- Importance of relationship with caregivers, resolution of “ethical” dilemma with talk, touch, time

Advance Care Planning

- Consideration, discussion and documentation of end of life wishes
- Discussion is the essential element here; patient in context of their loved ones
- Naming an agent, talking to the agent, values based discussion
- Different from document driven, “living will” approach

Centrality of personal relationship in practical clinical ethical decisions.

Understanding ethical principles is important.

Understanding the person is often equally essential to understand how to reach decisions that reflect and honor them.