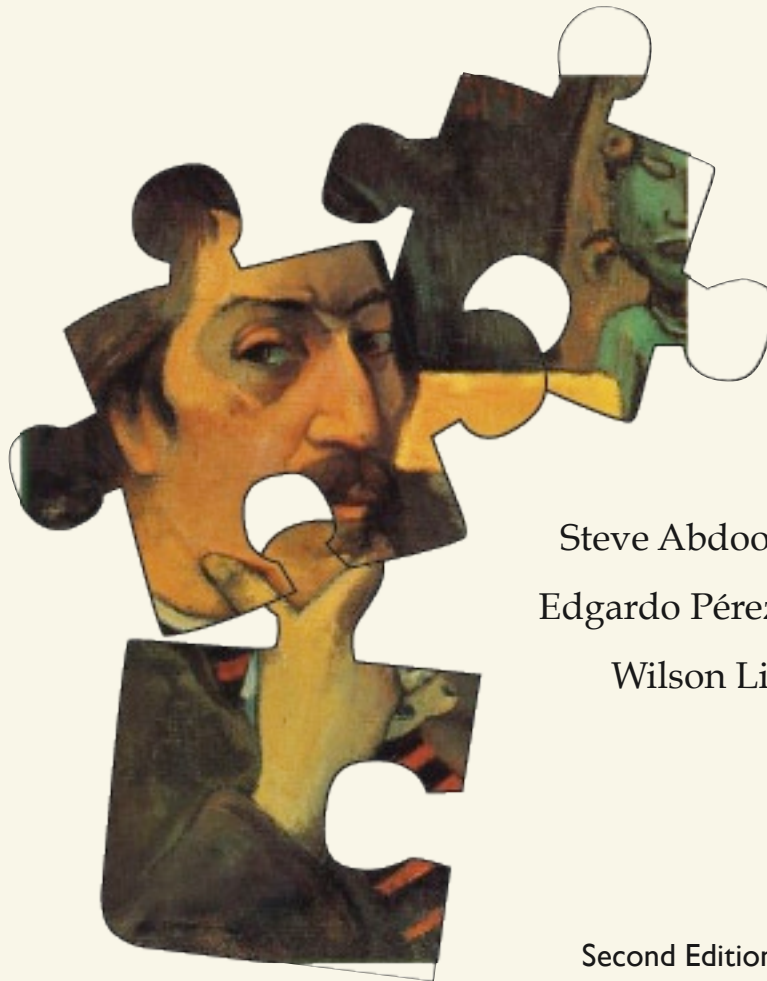


MAKING ETHICAL CHOICES

An Ethical Decision-Making Handbook for
Health Care Practitioners & Administrators



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Second Edition

Ethical Decision-Making Model

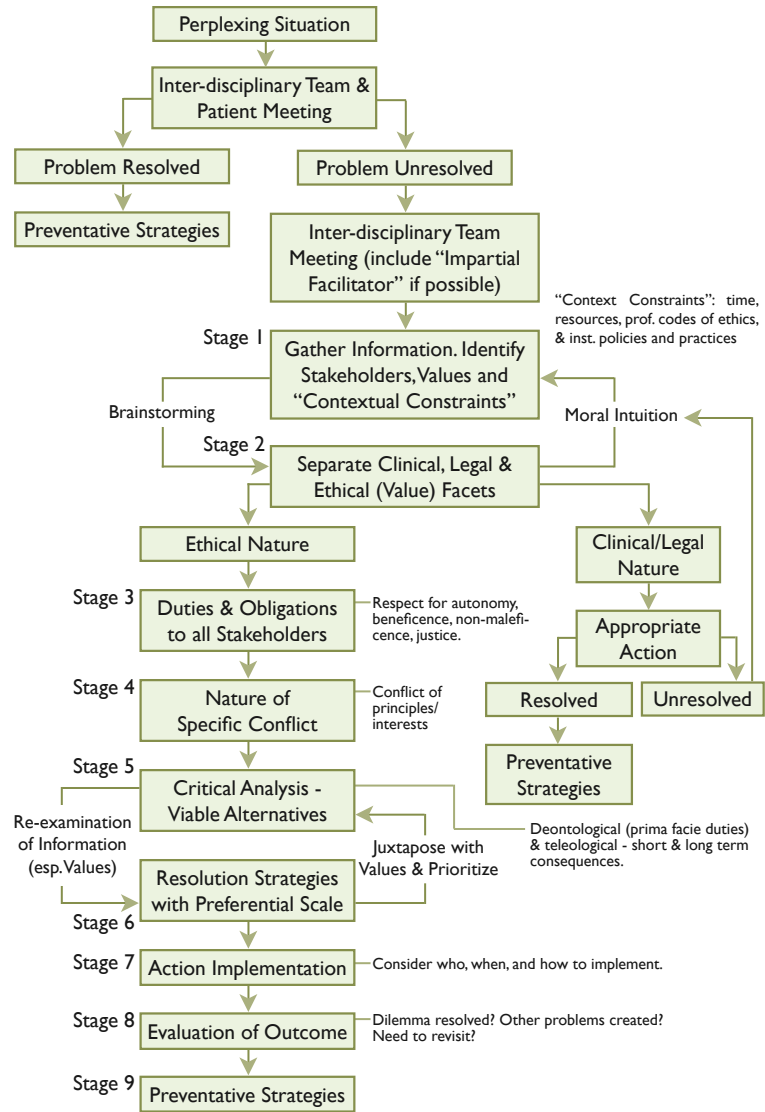
“But in order to pave the way for such a sentiment (that is, one that forms the basis of a moral judgement) and give a proper discernment of its object, it is often necessary, we find, that much reasoning should precede, that nice distinctions be made, just conclusions drawn, distant comparisons formed, complicated relations examined, and general facts fixed and ascertained.” David Hume⁶¹.

The process starts with disequilibrium in the integrity of the milieu.

In practice, a member of the team, the patient or a member of his/her family, perceives disequilibrium in the *milieu* – seemingly a dilemma has arisen. A member of the team is uncertain as to what the next course of action should be, or someone is unhappy/distressed with a particular situation, and appropriate help is sought – a concern or complaint is lodged, officially or unofficially. The situation has no clear alternatives, has far-reaching implications, involves a number of people (directly and indirectly), and has a perception of unresolvability through an identifiable clinical solution. The specific nature of the problem may or may not be identified at this point.

The matter is taken to the team for discussion. The lodger of the concern should be accorded full respect for his/her feelings and opinions. The situation should be treated with a sense of urgency and with full confidentiality. The primary person who lodged the concern/complaint should provide a description of the perceived difficulty to the team. Either the team offers a reasonable and ready explanation or solution to the satisfaction of the individual, or identifies the existence of a medico-ethical dilemma. If the existence of a dilemma is confirmed, then the team proceeds to the First Stage in the Ethical Decision-Making Process. Team involvement is a nothing less than a collective and collaborative process.

Making Sound Ethical Choices in Health Care: an Analytical Decision-Making Model



Stage One: Recognition of Dilemma & Comprehensive Information Gathering, Including Personal Values and Contextual Constraints.

Gather as much information as possible and, in so doing, ensure that nothing relevant gets missed. All judgements should be suspended, and members ought not to rush to conclusions. Moral intuitions play a great part at this stage. Brainstorming is very important in order to explore and generate a wide variety of possibilities and options. Professional and personal values, opinions, ideas, and feelings are voiced. It is imperative to foster an atmosphere of mutual trust, respect and co-operation. Remember that there may be ambiguity, uncertainty and perhaps fear, anxiety and resentment. Moral judgements made in a professional capacity would affect one's conscience, one's private sphere. Ideally, the team aims at arriving at consensus in decision, and this is only attainable when team players are satisfied that their respective positions have been heard, appreciated, and critically evaluated in the process, and they have in front of them a decision that they could live with.

1. DILEMMA

Q: Why is there disequilibrium in the patient-treatment team relationship *or* dissension amongst team members with regard to patient care and treatment?

Q: What is causing the qualm, uneasiness, or apprehension?

Note: Confirm that a dilemma exists. Something is amiss, and the team doesn't really know what to do. It probably doesn't even know exactly what is the problem. The team perceives at least two alternatives from which to choose, but cannot agree on a choice.

2. STAKEHOLDERS

Q: Who are the legitimate stakeholders, and what has each at stake?

Note: The primary stakeholder is invariably the patient. Other stakeholders might include significant others, health care professionals, the hospital, others (co-patients, society, insurance company, employer, etc.)

3. PATIENT'S VALUES, WISHES AND PREFERENCES

Q: What are the patient's values, wishes and preferences?

Note: If the patient is suicidal or homicidal or unable to care for

himself/herself (as defined in the Mental Health Act), then there is need to honour the duty to rescue and/or protect.

Q: Are there reasons to suggest that the patient may not be mentally competent to consent to, or refuse, care and treatments?

Note: The assumption is always that the patient is mentally competent. If the patient is unable to provide consent or lacks 'capacity', then one needs to follow an Advance Directive, proxy, or Power of Attorney for Personal Care. If none of these exist, then elect one (in accordance with the Mental Health Act). It is important to remember that a patient's seemingly irrational decision does not, by itself, constitute incompetence.

Q: Are there rationally justifiable reasons why the patient's preferences might be overridden?

Note: The onus is always on the health care professional(s) to justify any overriding of patients' values, wishes and preferences.

4. TIME

Q: Does this constitute an emergency situation (as defined in the Mental Health Act), and how much time is there to arrive at a decision?

Note: If classified as an emergency, then act with prudence to rescue and protect if unable to secure consent from the patient or Substitute Decision Maker, and if no Advance Directives are available. Further deliberation is required after the initial intervention in order to determine an ethically acceptable course of action. How might another reasonable clinician/treatment team act under similar circumstances? Casuistry can be extremely useful in an emergency situation, because it provides the team with past precedent-setting cases and their outcomes.

5. RESOURCES

Q: What are the relevant resources at the team's disposal?

Note: If the resources (expertise/competency or material) are inadequate or unavailable resources then a consultation and perhaps transfer to an appropriate clinician and/or facility might be necessary.

6. INFORMATION GATHERING

Note: There is a need to have a thorough case description (includes culture, religion, language, etc); medical and mental illness (includes history, investigations, severity, prognosis, etc); all therapeutic alternatives available to manage the condition, including probabilities of each with its risks and benefits, as well as the ramification of non-intervention. Clarify what information is factual and what is uncertain/undetermined.

7. PROFESSIONAL CODE OF ETHICS

Q: What guidance, if any, is provided by the applicable code(s) of ethics?

8. THE LAW

Q: What guidance, if any, does the law provide under these circumstances?

Note: It's usually very helpful to have a knowledge of precedent-setting cases (casuistry)

9. HOSPITAL POLICY & PRACTICES

Q: What are the institution's current policy and practices in these situations?

Stage Two: Attempt to Separate the Clinical, Legal and Ethical Components

Having gathered as much pertinent information as possible, the team proceeds to identify the nature of the difficulty. There are usually clinical, legal, social, policy and procedural considerations that are intricately interwoven with the ethical component in medico-moral dilemmas. Serious attempts should be made to tease these apart, within reason, in order to ensure clarity of consideration.

Q: What is the legal dimension to the dilemma?

Note: Consider if the law of the land has been, or stands to be, violated; for example: does the patient meet the criteria for dangerousness or is seriously vulnerable; has there been an allegation of child abuse or sexual misconduct; or does it involve a patient who is impaired to drive a vehicle/fly a plane?⁶² In medical practice, laws usually have qualifying phrases that allow for value judgements. Concepts like 'reasonable', 'sufficient', 'lawful excuse', and 'unwarranted'

are duly considered in courts of laws, “in an effort to give substance to the moral convictions of reasonable or common-sense people.”⁶³ This is especially relevant in the discipline of psychiatry, because of the extensive usage of elusive and ill-defined terms and concepts. If the dilemma involves a predominantly legal issue, seek direction from hospital policy, Risk Manager, or legal counsel, and act with team consensus ideally.

Q: What is the clinical dimension to the dilemma?

Note: Consider current medico-scientific data as they apply to the case. It is very important to heed Howard Brody’s caution that “With an ethical dilemma, we can have all the data in the world, and we still cannot arrive at an answer until we come to grips with our values and make some value judgements.”⁶⁴ If the dilemma involves a predominantly clinical issue, collaboratively (team and patient and/or Substitute Decision-Maker) determine the most appropriate course of action. Consider if you might benefit from a medical/psychiatric consultation. Act with team consensus ideally.⁶⁵

Q: What is the ethical dimension to the dilemma?

Note: It is important to remember that anything associated with values – rights and entitlements, duties and obligations, as well as justice and fairness – are inherently ethical. If the dilemma involves a predominantly ethical (value) issue, then progress to Stage Three. Consider a consultation from a Bioethicist (if available).

Stage Three: Pertinent Ethical Duties & Obligations

Specify the ethical duties and obligations that pertain to the case, noting how they apply. It is important to remind oneself that it is the patient who usually has most at stake. Values are only meaningful in a context of duties and obligations. Pertinent ethical principles include: (1) *Respect for autonomy* – to respect the individual’s right and liberty to make choices in accordance with his personal wishes, values and cherished goals in life). (2) *Non-maleficence* – to do or cause harms/evils to the patient (on balance with benefits). (3) *Beneficence* – to actively protect and promote the patient’s well-being and welfare, primarily as perceived by him/her. (4) *Distributive justice* – pertains to the just and fair distribution of finite health resources.

Please note the *prima facie* nature of these duties and obligations.

This means that it is possible to override a certain duty by another, provided that there are rationally justifiable reasons to believe that the latter should have priority under the circumstances.

Q: What is the role of each stakeholder?

Note: The role of each stakeholder should be identified in order to ensure clarity and consistency.

Q: What are the treatment team's duties and obligations to the patient, the patient's immediate family, potential patients, and society in general?

Note: Health care professionals' *primary* obligation is to their patients.

Q: Likewise, what are the hospital's duties and obligations to each of the above?

Q: What are the patient's special responsibilities in his/her care and treatment process?

Note: Responsibilities accompany rights, and these should be identified as they pertain to the issue at hand.

Q: What obligations exist to legitimate third party stakeholders (such as society and significant other/s) as they pertain to this case?

Stage Four: Identification of Specific Conflict

Having determined the specific duties and obligations that are pertinent, it becomes necessary to specify, as clearly as possible, what conflict exists, or whether there is a perception that someone is failing to discharge his/her obligations adequately and effectively.

Q: What is the nature of the conflict – might it be interpersonal or even institution-based?

Note: Consider if the dilemma might have resulted from personal conflicts within the interdisciplinary team, between the patient/significant other and the treatment team, or between the treatment team and the institution itself.

Q: What ethical principles or interests are in conflict in this situation?

Note: Consider if there might be a conflict between beneficence and respect for the patient's autonomy, or between respect for patient autonomy and a perceived obligation to society.

Q: Might the situation be such that a team member (or the hospital) is simply failing to honour a specific ethical obligation to a legitimate stakeholder?

Note: Health care professionals are generally very well meaning, but it is conceivable that sometimes they might fail to identify and honour specific duties and obligations to their patients, albeit unwittingly.

Stage Five: Critical Analysis & Viable Alternatives

Stages 5 and 6 are closely related. The team progresses to a critical analysis of the implicated duties and obligations. Further information gathering and clarification might become necessary. One needs to employ rationally justifiable means of 'prioritising' those ethical principles that conflict.

Individuals from the team share their rationales for the positions that they tend to favour. Following this, a brief re-examination of these rationales is crucial because, not surprisingly, they might very well become modified in the process.

Examine all viable alternatives, including the option of delayed and non-intervention. Take into account the foreseeable consequences, short and long term, of all viable possibilities. These necessarily include all anticipated goods/benefits as well as all anticipated harms/evils. The probabilities of these are also crucial considerations.

It would be easier to initially exclude the alternatives that are totally unacceptable. Develop a list of all ethically justifiable resolutions from the most desirable to the least. In so doing, juxtapose selected viable alternatives with pertinent ethical duties and obligations or principles.

Caution: Scrutinise for clarity, congruence, consistency, coherence, and adequacy.

Exclude deficient alternatives. The team needs to reach consensus. Dissenters might wish to drop out of the team at this stage of the process if their moral positions are hopelessly irreconcilable with the preferred alternatives.

Stage Six: Resolution Strategies with Preferential Scale

Rank the list of viable alternatives according to those choices that appear most desirable (according to the criterion already specified). This is a particularly important stage.

Making Ethical Choices

- Q: What choice is most congruent with the patient's wishes, values, and preferences, and what reasons, if any, exist to suggest that these should not be honoured?
- Q: What harms/evils should one be avoiding/preventing/removing? How realistic is this?
- Q: What benefits should one be aiming towards? How realistic is this?
- Q: Have any promises been made (that require honouring)?
- Q: Would staff be acting paternalistically, and is this rationally justifiable?
- Q: Would anyone be exploited in the process and, if so, exactly whom and why, and how can this be avoided?
- Q: What choice is most likely to offer the best overall consequences, short and long term?
- Q: What choice is most likely to prevent the most harm, short and long term, to stakeholders, especially the patient who invariably has most at stake?
- Q: Would any of the proposed choices violate the institutional policies and values, the law and professional codes of ethics?
- Q: What choice would all stakeholders be most willing to live with?
- Q: What choice would serve as a good example for others in a similar situation to follow?
- Q: What choice is most justifiable by appealing to universal ethical principles rather than personal preferences?
- Q: What do you honestly believe another reasonable group of individuals would choose given the same circumstances?
- Q: What if the staff and patient roles were reversed?
- Q: Is there consensus that the anticipated end justified the proposed means in this particular case?

Juxtapose each chosen and ranked alternative with the patient's values, beliefs and goals as determined directly from the patient (or from a duly elected substitute decision-maker). Rank order those alternatives that are most congruent with the patient's own moral position. It is important to remember that in health care practice most care and

treatments involve some harms/evils, for example, adverse effects. One must always weigh these anticipated harms/evils against anticipated benefits, before implementing a course of action.

Sometimes, a reasonable compromise is to undertake an acceptable course of action for a trial period, then reassess and re-evaluate efficacy and sentiments held by major stakeholders.

There should be a fair process for stakeholders to resolve intransigent disagreements and conflicts, and this usually involves an ethics committee, ethicist, or mediator.

Documentation is of paramount importance. Very careful documentation of the content of all meetings and proceedings, including names and roles of all participants should be undertaken.

Caution: Examine for clarity, coherence, consistency, congruence, and adequacy. Briefly check over the process to ensure that nothing pertinent was excluded.

Stage Seven: Action Implementation

Before you attempt to implement the consensually-arrived at decision, it is important to answer the following questions:

- Q: Who is most appropriate to implement the choices arrived at, and why?
- Q: When is the best time to implement the decision, and why?
- Q: When do you expect to see anticipated results?

Under most circumstances, no person should be expected to implement a decision that he/she cannot live with. However, this maxim must be tempered by the principle that no immediate harms/evils would befall the patient by one's non-participation. You do have certain duties and obligations to your patient, and these must be carefully considered when attempting to make a personal appeal to your conscience.

Stage Eight: Evaluation of Effectiveness

- Q: Were the effects from the intervention those that were expected, and did the decision resolve the specific dilemma that one was faced with?
- Q: Did the results occur within the time frame anticipated?
- Q: Are there other consequences that were unforeseen, and were new difficulties created? Might these require further

deliberation and intervention?

- Q: Was this decision the most ethically justifiable under the circumstances?

Stage Nine: Preventative Strategies

This is perhaps one of the most important stages in the process of ethical decision-making.

- Q: What can be learnt from the dilemma?
- Q: What factors contributed to the dilemma?
- Q: Are there problematic policies and procedures?
- Q: Is there a need to modify current policies/procedures/guidelines in order to prevent a recurrence in future?

It would be folly to believe and expect that the facility, clinician, or care team could foresee every problematic situation. Because we are dealing with rather elusive and changing phenomena such as values, convictions, expectations and desires, ethical quandaries will arise in the delivery of health care. However, once a dilemma occurs, we must deal with it ethically, promptly and adequately. We must then critically examine the entire circumstances of the situation in order to determine the best strategy to prevent a recurrence. In this regard, the patient's input would be invaluable.

Conclusion

Clinical practice continues to be replete with ethical quandaries. Individuals involved in health care systems and delivery – clinicians and administrators alike – are grappling with new medico-technological advances, changing societal values, attitudes, and expectations and a rapidly increasing awareness of limited resources.

This handbook offers a comprehensive, readily applicable and philosophically sound model that provides guidance in identifying and resolving ethical quandaries in the care delivery process, both administratively and clinically. In so doing, the authors have explored changing paradigms in health care delivery with their new moral demands and challenges, as well as far-reaching ramifications that eventually affect all stakeholders – patients, their families, clinicians, administrators and health care policy makers, and society at large.

Morally reprehensible decisions are avoided, and the chances of arriving at rationally justifiable choices are significantly increased. Litigation consideration is a very important factor, and because it is intimately intertwined with moral accountability in health care, litigious situations are greatly reduced with a patient-centred, multidisciplinary team approach.

This integrative, eclectic procedure initially involves a respectful, focused, perceptive and sagacious discourse amongst all stakeholders, then progresses toward a pursuit and reconciliation of common threads of moral agreements. Consensus is enhanced, and the facilitated decision is one that most, if not all, affected individuals could live with. In this way, no individual is coerced or compelled to act against his/her conscience. Allowance is left for dissenters to opt out should their moral positions be hopelessly irreconcilable with the decision of the rest of the team. (Prior to this, though, they would have considered their duties and obligations, not only to their patient(s) and significant others, but also to their colleagues and other stakeholders.)

An alluring aspect of this model is its democratic thrust toward decision-making in the clinical setting. It is consistent with liberal democracy's ethical norms and values. Major advantages to this democratic impetus are collaborative, legitimate and committed involvement by all pertinent players as well as shared responsibility throughout the decision-making process. Through this involvement, the values and opinions of all legitimate principals are duly considered and form a vital component of the decision-making process. Thus, the most rationally justifiable decision – the ethical choice – is yielded.