Unit 5 - Unit 5 lecture notes.

Professional Ethics (Athabasca University)

Professional Ethics – Ethics and Medicine

Virtue and Medicine

We will focus on the fact that virtues are essential to the good life.

It is uncontroversial to claim that persons should exhibit virtuous characters and seek to cultivate virtues in which they are deficient.

It is controversial to claim that professionals, in their particular roles as professionals, should be morally obliged to be virtuous.

Pelligrino's view is that physicians are professionally and morally obliged to act with compassion and dignity, to honour the medical profession, and to care for the sick as well as treat them.

Fritz Alhoff "Medical Ethics"

Of all the professions, medicine has the longest tradition of recognizing its ethical dimensions.

Hippocrates (doctor, teacher) most enduring legacy was the Hippocratic Oath.

The oath established four core values:

- Beneficence (ideas that physicians are supposed to help their patients)
- Nonmaleficence
- Confidentiality (physicians are not to share information gained through the treatment of patients)
- Honor (carry themselves honourably in order to preserve the integrity of the profession).

Relationship between physician and patient…

- Paternalistic? (i.e. parent – child type of relationship?)
- Partnership (friendship type of relationship)

We should also look at trust and confidentiality. Sometimes it may help if the patient is lied to, otherwise their condition would grow worse.

Informed consent, competence, and surrogate decisions.

Hippocratic Oath and Codes of Medical Ethics:

Traditional Hippocratic Oath: "I swear by Apollo Physician and Asclepius and Hygieia and Panaceia, and all the gods and goddesses making them my witness, that I will fulfill according to my ability and judgment this oath and this covenant: To him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male-lineage and to teach them this art – if they desire to learn it – without fee or covenant; to give a share of precepts and oral instruction and all the other

learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to medical law, but to no one else. I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice. I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly, I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art. I will not use the knife, not even on sufferers from stone, but will withdraw in favour of such men as are engaged in this work. Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves. What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about. If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honoured with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot."

Modern Hippocratic Oath: "I swear to fulfill, to the best of my ability and judgment, this covenant: I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow. I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism. I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug. I will not be ashamed to say "I know not" nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery. I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially I tread with care in matters of life or death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God. I will remember that I do not treat a fever chart, or cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick. I will prevent disease whenever I can, for presentation is preferable to cure. I will remember that I remain a member of society with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm. If I do not violate this oath, may I enjoy life and art, respected while I live and remember with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help." (Louis Lasagna – 1964)

CMA Code of Ethics

One important thing to note is that the Hippocratic Oath and medical code of ethics is that they must be open to revision in light of changes in the world, the community, or the profession itself.

If it is true that, with time and reflection, we come to better understand how basic moral values should be expressed by our rules, policies, attitudes, and actions, it would seem we are engaged in moral progress. Is it plausible to think that we are continually engaged in moral progress? Philosophers disagree on this point.

Patient-Physician Relationships:

At the heart of good healthcare is an appropriate and effective physician – patient relationship.

Different kinds of situations require different relationships. Defining an ideal physician-patient relationship provides a measure to evaluate such relationships and identify whatever exceptions to the rule there might be.

Four models of physician-patient relationships:

- Paternalistic
- Informative
- Interpretive
- Deliberative

These models are accessed according to the understandings each yield:

1. What are the appropriate goals of physician-patient interactions?

2. How should physicians' obligations be conceptualized and prioritized?

3. What should be the role of patients' values in decision making about matters of their own health?

4. What conception of patient autonomy should be employed within physician-patient interactions?

Pg. 453 – 463

Decisions in medicine are characterized by a struggle between autonomy and health, between values of the patient, vs those of the physician.

Four models are outlined, emphasizing different understandings of:

1. the goal of the physician-patient interactions

2. the physician’s obligations

3. the role of patient values

4. the conception of patient autonomy.

The models are Weberian ideal types (they may not describe any particular physician-patient relationship)

Paternalistic Model: (parental or priestly model)

- Patients receive interventions that best promote their health and well-being. Physicians use their skills to determine the patient’s medical condition, and to identify tests and treatments, and

then present the patient with selected information that will encourage him/her to consent to the intervention the physician thinks is best.
- This mode assumes there are shared objective criteria for determining what is best.
- The patient will be thankful for decisions made by the physician even if he/she may not agree with them at the time.
- Physician acts as the patient's guardian. Thus the physician places their interests below the patient.
- The concept of patient autonomy is patient assent. Either at the time, or later on.
- This model may be helpful in emergencies where the patient is unable to participate ina decision in a timely manner.

Informative Model:

- Scientific, engineering, or consumer model.
- Objective of the physician-patient interaction is for the physician to provide the patient with all relevant information for the patient to then decide what he or she wants.
- Physician informs patient of her disease state, nature of diagnosis and therapeutic interventions, risks and benefits of each.
- This model assumes that the patient's values are well defined and known – what the patient needs is facts.
- The physician provides those facts, and the patient then makes the decision. (physicians must provide truthful information).
- Many philosophers think that this analysis of first- and second-order desires provides important insights about what it means for persons to be autonomous and to exercise this autonomy.
- a person whose behaviour accords with her second-order desires is autonomous, but one whose behaviour does not accord with her second-order desires is not autonomous.

Interpretive Model:

- The aim of this model is to elucidate the patient's values and what he or she actually wants and to then help the patient select the available medical intervention.
- The physician provides the patient with information on the nature of the condition and the risks and benefits of possible interventions. The physician then assists the patient in elucidating and articulating his or her values to determine what medical interventions work best.
- Patient's values in this model may not be known. Physician works with the patient to reconstruct the patient's goals and aspirations, commitments, and character. The physician does not judge the patient – but helps the patient understand and apply them.
- communication between physician and patient is altogether directed at the patient's values, desires, beliefs, and self. The physician's role is limited to helping the patient interpret and understand himself.

Deliberative Model:

- Aim is to help the patient determine and choose the best health-related values that can be realized in a clinical situation.
- The physician must delineate information on the patient's clinical situation and then help elucidate the types of values embodied in the available options.
- The physician suggests why certain values are more worthy and should be aspired to.
- (extreme) the patient and physician engage in deliberations about the kind of health related values that the patient should pursue and recognizing questions of morality are beyond the scope of the physician-patient relationship.
- The physician acts as a teacher/friend engaging in dialogue on what course of action would be best.
- The physician indicates what the patient could do, but knowing the patient, also indicates what they should do.
- Patient autonomy is moral self-development as the patient is empowered to consider through dialog, health related values.

The deliberative model is endorsed by these authors as the best overall. Its conception of patient autonomy is both sufficiently complex and reasonably practical. Also, it includes a manner of shared decision making that gives expression to the evaluative judgments of both the patient and the physician. Their joint decision making is "constructed around 'mutual participation and respect.' "(458)

There is a fifth model, but it is not used widely – it is the instrumental model, which puts the patient's wishes below that of the good of society or the furtherance of scientific knowledge.

Clinical case using the 4 studies (page 456 – 457)

Emphasis has shifted from medicinal endorsements being physician based, to that of being patient based. (Canterbury, 1972 court case). The physician has a duty to provide medical facts to empower the client to make the right decision.

Shared decision making is the process "in which both physicians and patients make active and essential contributions. Physicians bring their medical training, knowledge and expertise – including an understanding of the available treatment alternatives – to the diagnosis and management of patient's conditions. Patients bring knowledge of their own subjective aims and values, through which risks and benefits of various treatment options can be evaluated"

Objections:

- **Paternalistic** model: widely used during emergencies. However it is rarely used for routine physician – patient interactions.
- **Informative** model: seems to have no place for essential qualities of the ideal physician – patient relationship. The informative physician is proscribed form giving a recommendation for fear of imposing his or her will on the patient and thereby competing for the decision making control that has been given to the patient. The informative model leans towards specialization and highly detailed factual information. Which could trend towards im-personalization and to much

specialization. Finally patient autonomy in the informative model seems philosophically untenable (as it requires the patient to have fixed values – many of whom don't).

- **Interpretive model:** With limited interpretive talents and time, physicians may unwittingly impose their own values under the guise of articulating the patient's values. Patients, under medical stress and uncertainty, would then accept such recommendations unquestionably. Autonomy viewed as self-understanding exclude evaluative judgment of the patient's values or attempts to persuade them to adopt the her values. By excluding valuative judgments, the interpretive model seems to characterize inaccurately ideal physician-patient interactions.
- **Deliberative** model: primary objection is whether it is proper for physicians to judge patient's values and promote particular health-related values. First, physicians do not possess privilege knowledge of the priority of health -related values in which people espouse incommensurable values. Second, the nature of the moral deliberation between physician and patient, the physician's recommended interventions and the actual treatments used will depend on the values of then articular physician treating the patient. However, the physicians recommendation should not depend on the physicians judgment of the worthiness of his/her patients values. (ie. the hand is broken; the physician can repair the hand; therefore the physician must repair the hand – as well as possible – regardless of the patient's personal values). Third, it misconstrues the purpose of the physician – patient relationship. (patients come for care, not to have their values revised). This could lead to unintended paternalism.

Preferred Model:

Emergency where delays could be lethal – paternalistic model

Patients who have clear but conflicting values – interpretive model

Where a one-time physician-patient interaction without an ongoing relationship – informative model.

Deliberative model works best:

1. more nearly embodies our ideal of autonomy

2. Our society's image of an ideal physician is not limited to one who knows and communicates to the patient relevant factual information and competently implements medical interventions. The ideal physician is one who integrates the information and relevant values to make a recommendation.

3. is not a disguised form of paternalism.

4. Physician values are relevant to patients and do inform their choice of a physician.

5. Physicians should not only help fit therapies to the patient's elucidated values, but should also promote health related values.

6. physicians may currently lack training and capacity to articulate the values underlying their recommendations and persuade patients that those values are worthy. This is due to the consequence of

specialization and avoidance of discussions of values by physicians that are perpetrated or justified by the dominant informative model.

Discussion in the past while focused on autonomy and paternalism.

(Canterbury vs. Spence)

Privacy and Confidentiality in Medicine:

Privacy, as defined by W.A Parent is, “the condition of not having undocumented personal knowledge about one possessed by others.”

Patients should expect their information to be kept confidential. In healthcare, patients are vulnerable.

Physicians maintain patient confidentiality so the vulnerability of patients is not compounded by a lack of control over information they wish to keep private.

Without trust or assurance that it will remain private, patients are less likely to divulge information that is necessary to resolving a medical issue.

Various legislation is now enforced to protect patients and others from having information disclosed:

Privacy Act (1983) (regulates federal government)

PIPEDA (Personal Information Protection and Electronic Documents Act) (2000, amend. 2005). Regulates private sector businesses.

In the USA:

HIPAA (Health Insurance Portability and Accountability Act) (1996) (esp. it’s privacy rule)

Central moral tenet is trust.

A question is whether breaching patient confidentiality is ethically justifiable” and further, if such breaches are ethically obligatory.

Prevailing thought: there are certain conditions under which professionals are justified in breaching client confidentiality and are, perhaps, even obligated to do so.

These conditions, generally, are as follows:

(a) the practitioner has reason to believe that a client presents a serious danger to a third party, (b) alternative measures taken by the practitioner to relieve her concern that the client will cause serious harm to the third party have failed, and (c) the practitioner fails to secure permission from the client to disclose to the third party (and/or to the authorities) the harm intended by the client.

Precedent setting case: Tarasoff vs. Regents of the University of Calif.

Some, such as Kipnis, say breaching a physician-patient confidentially agreement is never justifiable.

Truth telling and Deception by Physicians:

Traditionally, physicians have not been bound by an obligation to be truthful with patients. The history of Western medicine is more paternalistic - physicians determine what they should tell patients, usually on the basis of what they think will promote patients' best health outcomes. In the name of beneficence and non-maleficence, physicians have used their discretion about whether to tell a patient the truth about his condition or how much of the truth to tell.

Is it ever morally permissible for physicians to be untruthful with patients (or their families)? If so, under what conditions? Is it ever morally obligatory for physicians not to disclose the whole truth to patients?

The CMA code states that physicians should “provide . . . patients with the information they need to make informed decisions” and ensure that this “information exchange is understood.”

Not being truthful with a patient may take different forms. Here, we will concern ourselves with instances of not being truthful that are intended by physicians to mislead or deceive patients.

two ways that physicians may intentionally not be truthful:

- tell or indicate a falsehood to a patient or
- provide the patient with some relevant and true information while omitting other relevant and true information.

First, is it ever justifiable for a physician to lie to a patient?

Second, is it ever justifiable for a physician to deceive a patient by omitting pertinent information?

Thomasma argues that there are conditions that justify a physician's not disclosing the truth to a patient - but only temporarily. He discusses four conditions he considers important, and ultimately concludes that the truth should always eventually be told, but that sometimes temporary deception is justified.

Clinical Case Categories where Truth may be temporarily withheld:

- intervention cases where the immediate disclosure of the illness may make things worse.
- Long term cases where the patient needs to be motivated in order to get better and the truth revealed slowly once a relationship is built.
- Cases of dying patients where the truth can be avoided in order to help relieve mental anguish by circling around the question. Or it can be gradually revealed in a roundabout way.
- Prevention cases where quality of life takes precedence over the need to know.

In summary, Thomasma's view is that “At all times, the default mode should be that the truth is told,”[20] even though there are cases of justified nondisclosure. In other words, the default mode of full truth telling is important, but is not at all times the most morally appropriate action for physicians to take.

Informed Consent:

There is no significant disagreement over the idea that the practice of informed consent secures important benefits for both patients and healthcare professionals. Nor is there much disagreement that informed consent plays a vital role in realizing effective and just healthcare interactions.

What does proper informed consent consist in?

Is informed consent a genuine expression of patient autonomy or only a formality that protects healthcare professionals from litigation?

Patient's Decision-Making Competency:

In order to validly consent to a healthcare intervention or to validly refuse an intervention, a patient must show sufficient competence.

a sufficiently competent patient is one who is able to make reasonable decisions about whether or not to consent to a recommended healthcare treatment or an alternative treatment.

it is widely considered important that he decides in accordance with his own interests in so far as he understands his own interests and in so far as this understanding is generally consistent with his wider set of beliefs and values or, in other words, consistent with his person.

Judging competency in health-care:

Minimal standard:

Outcome standard:

Process standard: a process standard looks to the reasoning process by which patients arrive at their decisions to consent to or reject healthcare interventions. The outcome of a patient's decision making, that is, the content of his decision, is not important merely in itself, although it may enter into the whole process as a salient consideration.

it is neither reasonable nor useful to impose precisely the same conditions on every decision making situation.

When there are high risks, it is more important for the professional to ensure that the patient's reasoning is sound.

On page 506 of our textbook, Brock and Buchanan provide a suggested schematic for how patients' competency ought to be judged (Table 1).

Surrogate Decision Making:

patients are understood by healthcare professionals and their families or friends to be insufficiently competent to reliably consent to or reject healthcare interventions on their own behalf. Various reasons

can underlie such understandings. Patients may be too young to have sufficiently developed their powers of deliberation.

The view that Brock voices with Buchanan (discussed above) understands competency to be decision-relative.

cases of borderline competence be approached in the same way as all other cases because the conceptual units of measurement between competence and incompetence are on a continuum.

Who should be the surrogate, when a surrogate is needed?

- the person the patient has chosen or would have wanted as his surrogate;
- a family member who is close to the patient;
- a friend who is close to the patient;
- an institutional representative, such as the attending physician, the chief of service or chief of staff, or an institution's ethics board.

If a patient has provided a valid **advance directive** specifying his wishes, then his surrogate should make decisions for him on the basis of these declared wishes.

substituted judgment strategy should be used, especially if the surrogate knows the patient well.

In cases where there is no valid advance directive, a surrogate may substitute his own judgment or use a **best interest** strategy.

Best interest strategy should be 3rd choice.

Passive euthanasia, so long as it is limited to situations that meet certain conditions, is generally accepted as morally permissible in North American societies and in many other societies throughout the world.