Conceptual Tools for Navigating Ethical Decision-Making in Healthcare

Road Map

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I. Intuitions: A Starting Point

- Many of our ethical judgments are based upon *intuition*: what seems to us to be right or wrong in a particular case.

- Intuitions are a *starting point* for doing ethics—they can be indicators of what matters, ethically.

- But doing ethics can't *end* here, for at least two reasons:

    1) We often struggle to articulate *why* we have the ethical intuitions we do (e.g., why one course of action is preferable to another).

    2) Intuitions can be influenced by sources of *error* (e.g., bias, stubbornness, lack of sensitivity).

- Intuitions must be supplemented by ethical *reasoning*.

II. The Need for Ethical Reasoning

- Ethical reasoning involves careful reflection, involving:
  - Identifying different types of ethical considerations.
  - Articulating general principles that capture these considerations.
  - Balancing competing considerations as they arise in particular cases.
  - Developing specific guidelines for how to adjudicate such cases.
  - Identifying relevant similarities and differences across similar cases.

- Goals of ethical reasoning:

  (i) Systematic identification of general considerations that bear upon the rightness of an action.

  (ii) Guidance concerning how to arrive at an ethically justified decision in particular cases.

III. Broad Principles

- *Principlism* identifies four fundamental ethical principles that should guide decision-making in healthcare:
  - Autonomy: Respect the rights of rational individuals to make their own decisions.
  - Beneficence: promote the well-being of individuals (and society).
  - Non-Maleficence: refrain from harming individuals.
  - Justice: act fairly; fairly distribute benefits and burdens.
- The identification of these principles involves recognition that:
  - Each of these principles is *fundamental* and *distinct* from the others: none of the four principles can be subsumed under any of the others.
  - *No universal priority* of any of the four principles over any of the others.

IV. The Need for Specific Guidelines

- The four principles are general and abstract. For this reason, they don't offer clear guidance on the following:
  - How should we apply broad principles to specific cases?
  - How should we address conflicts among the principles?
  - When is it appropriate to defer to precedent (e.g., casuistry)?
- Complex types of cases:
  - Patient requests treatment of unlikely benefit.
  - Patient requests treatment where cost outweighs benefit.
  - Patient requests treatment that conflicts with physician's conscience.
  - Patient wants to leave AMA, and their capacity is uncertain.

V. Nuances of Decision-Making Capacity

(1) *DMC is a set of capacities/abilities*, including:

- Understand one's condition.
- Appreciate consequences (risks/benefits) of treatment options.
- Understand how treatment options (and their consequences) relate to one's values, preferences, and goals.
- Reason and deliberate about one's options.
- Make a decision based upon the exercise of the above abilities.
- Communicate one's decisions in a meaningful manner.

(2) *DMC may be partial*: one might have only *some* of these abilities.

(3) *DMC may come in degrees*: each of these abilities can come in degrees.

**Because of (1) – (3),

(4) *DMC is task specific*: one might have abilities for some tasks but not others.

VI. Conceptual Tools: *The Sliding Scale*

- "This approach allows standards of competence in decision-making to slide with risk" (Beauchamp & Childress).

Increased Risk → Increased Capacity

- The greater the *risk* of some treatment or procedure, the greater the capacity that we should require for the patient to consent to it.
  - Routine diagnostics
  - High-risk surgery
- The sliding scale can also be applied to variations in *complexity* of a decision.

VI. Conceptual Tools: *Positive vs. Negative Rights*

- Patient autonomy is composed of both positive and negative rights:

  Positive rights: goods or services (i.e., to be provided with something).

  Negative rights: non-interference (i.e., to not be treated in certain ways).

Q: Is the patient *refusing* some treatment or intervention, or instead requesting to be *provided* some treatment or intervention?

- Though patients have a broad (negative) right to *refuse* treatments, their (positive) right to be *provided* with requested treatments can be limited when those treatments would:
  - Be medically ineffective or potentially inappropriate.
  - Require a scarce resource.
  - Require someone else to violate conscience/professional integrity.

VII. Application:
(i) Limited Capacity

- We can apply the sliding scale:
- Some patients will be unable to assess the relative proportion of risks vs. potential benefits of certain interventions, and thus unable to assess which option best promotes their values.
    - Risky but potentially life-saving surgery.
    - Surgery that has little chance of prolonging patient's life.
- But they may be able to select *who* they wish to make decisions for them, along with other simpler decisions (religious minister, food/drink preferences, etc.).
- Allowing a patient to make the decisions they're able to make can help preserve a sense of control and dignity.

VII. Application:
(ii) Medically Ineffective/Potentially Inappropriate

- We can apply the distinction between positive & negative rights:
  - Medically Ineffective: unlikely to prevent deterioration or death.
  - Potentially Inappropriate: may achieve desired effect, but competing considerations justify not providing them (e.g., overly burdensome).
- Patients have positive rights to treatments that are consistent with commitments physicians have to provide beneficial care and do no harm.
- Patients *don't* have positive rights to treatments that conflict with these commitments.

VII. Application:
(ii) Medically Ineffective/Potentially Inappropriate

- We can apply the distinction between positive & negative rights:
  - Medically Ineffective: unlikely to prevent deterioration or death.
  - Potentially Inappropriate: may achieve desired effect, but competing considerations justify not providing them (e.g., overly burdensome).
- Pressuring/coercing physicians to provide such interventions can have broader implications due to the compromise of professional integrity:
  - Moral distress
  - Demoralization/indifference
  - Normalization of unlimited deference to patient/family preferences undermines the purpose of health care.

VII. Application:
(iii) Euthanasia & Withdrawing/Withholding

- We can apply the distinction between positive & negative rights:

- Although patients have a *negative* right to refuse life-sustaining treatment, they arguably don't have a *positive* right to be provided with interventions that are contrary to the standard of care or violate a physician's conscience.

    - Euthanasia is plausibly contrary to the purposes of medicine (restoring or preserving health & quality of life).

    - Furthermore, many physicians are morally opposed to euthanasia, and have a negative right not to be coerced to violate their conscience.

- <u>*Note*</u>: The grouping of withholding & withdrawing is complicated by a *potential* difference between a negative right to *refuse* a life-sustaining treatment and a positive right to have a physician *remove* it upon request.