Clinical Ethics Issues in Family Medicine

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Core Clinical Ethics Principles for Family Practice

- Respect for Persons and Patient Autonomy (e.g. consent and capacity; patient’s right to self-determination; special protections for patients who cannot consent)
- Beneficence: Weighing clinical goods over clinical harms (e.g. candidacy for certain medications or procedures)
- Nonmalefience: a specific obligation not to intentionally harm a patient, or engage in procedures where the clinical goods are not favorable. Includes “Duty to Warn” third parties if you know of imminent harm.
- Justice: The fair or just allocation of expensive or scarce resources; priority setting, access issues and rationing
Informed Consent: The 3 Components

- Disclosure of procedures, risks and benefits: reasonable person standard or material information a reasonable person would want to know.
- Decision-Capacity and competency: Patient must demonstrate "understanding and appreciation".
- Voluntariness. Patient’s decision must be free of coercive influences.
Barriers to Decision-Making Capacity

- Education, literacy and numeracy
- Language barriers
- Cultural Issues
- Mental health issues, including addictions, anxiety and depression
- Wide gaps in medical or science literacy
Current Challenges to Informed Consent

- Health and Education Disparities
- Religion
- Minors or very elderly patient needing surrogate decision-makers
- Erroneous Beliefs about Science and Medicine
- Misinformation and disinformation from the Internet and popular culture (e.g. “natural cures”)
- Somatization disorders

Barriers to Capacity – “understanding and appreciation” -- are the most common challenges to informed consent
Decision-Making Capacity

- “[T]he ability to understand information relevant to a treatment decision and to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.” (Bioethics for Clinicians)
  - Really a definition of an adequate degree of capacity for medical decision making
Capacity vs. Competence

- Capacity refers to an *ability*
  - “having capacity”
  - Capacity comes in degrees
  - May be task-specific

- Competence refers to a *property* or characteristic a person possesses
  - “being competent”
  - Competence (relative to a particular decision) is all or nothing.
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Capacity for what?

- Capacity is specific to a particular decision
  - A person may possess the capacity to make some decisions but not others

- Capacity can change over short periods of time
  - e.g. delirium, drugs, course of illness and treatment
Common Problems with Capacity Consults

- If you’re worried about a patient’s capacity to refuse treatment, you should also worry about his capacity to accept it
  - Worries about capacity go away when the patient accepts recommendation for treatment.
  - E.g., we worry about the patient’s ability to refuse treatment for chemotherapy but not his ability to accept it
  - This doesn’t make sense with regard to capacity
Why does capacity matter for Ethical Decision-Making?

Necessary for informed consent (supports beneficence, autonomy)
Necessary for substitute decision-making in case we need to remove autonomy from the equation
In the case of an incapacitated patient, the principle of autonomy is disabled.

The principle of beneficence/non-maleficence is enabled: requires that incapacitated patients be protected from making decisions that are harmful or that they would not make, if they had capacity.
Questions that Test Capacity

- Tell me what you understand to be the current situation?
- What are your treatment options?
- What will happen when you take this treatment? What makes you not want this treatment? Why do you want it?
- What other choices do you have?
- Tell me about the decision. How did you arrive at your choice?
- What questions do you have? What are you worried about?
Delusional Patients: Are they always incapacitated?

- Mr. G., 57, who hears voices, has strep throat.
- Ms. B., who is 86, is refusing cancer surgery.
- Mr. W., who is 33, goes to his family doctor because there is “something wrong with his leg”.
- Ms. A., who is 38, goes to her doctor a 7th time in 2 months because of “body pain” that has no origin, according to a recent series of diagnostic tests.
The Anorectic Patient

- Ms. R. is 5’9, and weighs 85 lbs
- Ms. R. is refusing to eat because she wants to look pretty, and does not want to be fat.
- Do we invoke autonomy or beneficence?
- Ms. R. otherwise wants to live a long life as a thin person, so the decision does not match her goals.

This refusal is based on (a) delusion/body image distortion. Other factors affecting decision is a physically unwell body. Ms. R. may have the capacity to make other medical decisions, such as taking an antibiotic, but cannot judge nutrition needs.
When Is Religion a Delusion?

- Most seem to think that adult Jehovah’s Witnesses have the capacity to refuse, on religious grounds, treatment involving blood transfusions.

- Children and The Harm Principle (J.S. Mill).

- Are we consistent in thinking about religious reasons for refusal of medical procedures, or insistence on futile medical procedures?
Autonomy-based decisions:

- Freely made (agency and independence)
- Authentic (the decision is consistent with what is known about the patient’s values, preferences & plans)
- Reflects deliberation (rationality), and
- Demonstrates moral reflection (deliberation about one’s values).
The more serious the expected harm to the patient from acting on a choice:
  - the higher should be the standard of decision making capacity
  - the greater should be the certainty that the standard is satisfied.

No single standard for capacity is adequate for all decisions.

The standard depends: (1) on the risk involved, and (2) varies along a range from Low/minimal to High/maximal.
Vitamins, Birth Control, or Surgery?

- Decision-making capacity can be reasonably low for patient to choose or refuse therapies with low risks.
- Decision-making capacity must be higher for patient to make decisions regarding riskier therapies or procedures.
Challenges to Beneficence

- Truth-Telling
- Disclosure of Error
- Procedures Performed by Trainees
- Reporting Unprofessionalism
- Crossing Practice Boundaries
- Innovative Therapy (when is innovation research?)
- Assessing Candidates for various therapies (using beneficence as a framework for rationing)
Challenges to Nonmaleficence

- Truth-Telling: Can it be harmful?
- Disclosure of Error
- Procedures Performed by Trainees
- Reporting Unprofessionalism
- Crossing Practice Boundaries
- Innovative Therapy (when is innovation research?)
- Inappropriate Candidates for Therapy (using nonmaleficence as a framework for rationing)
Challenges to Justice

- Discriminatory insurance practices
- Rationing based on financial resources instead of beneficence
- Health disparities
- Unethical healthcare system: “Health care is a human right” not reflected in current U.S. healthcare system

Ways to mitigate: community service; “Doctors without Borders”; “Partners in Health”.
Professional Virtues and Ethical Principles

- Honesty, truth-telling and disclosure of error
- Professional self-regulation and truth-telling about substandard practices observed
- Conflicts of interest or conflicts of commitment and self-interest
What is Virtue Ethics

Character traits of the “good physician”:

- Fidelity to trust
- Benevolent behaviors
- Intellectual honesty: admit what you don’t know
- Compassion (root word-- “co-suffering”)
- Truthfulness

“A virtue-based physician would recognize pro bono work as important”

Also requires a “community of virtue”

Can Virtue be Taught?