Ethics in Clinical Practice

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Learning Objectives

- ***Understand*** how ***&*** why clinicians & researchers can benefit from ethics education
- ***Review*** medical ethics principles & definitions
- ***Discuss*** how such principles apply in clinical practice and medical research
- ***Review*** strategies to identify & avoid ethical problems in these areas
- ***Know*** your resources & how to find additional information

Reasons for Ethics Education for … Mandates

- New Jersey licensure – specific CEU requirement
- California licensure requires completion of ***their*** ethics course
- AARC position statement
- Required by essentially all hospitals and health care organizations

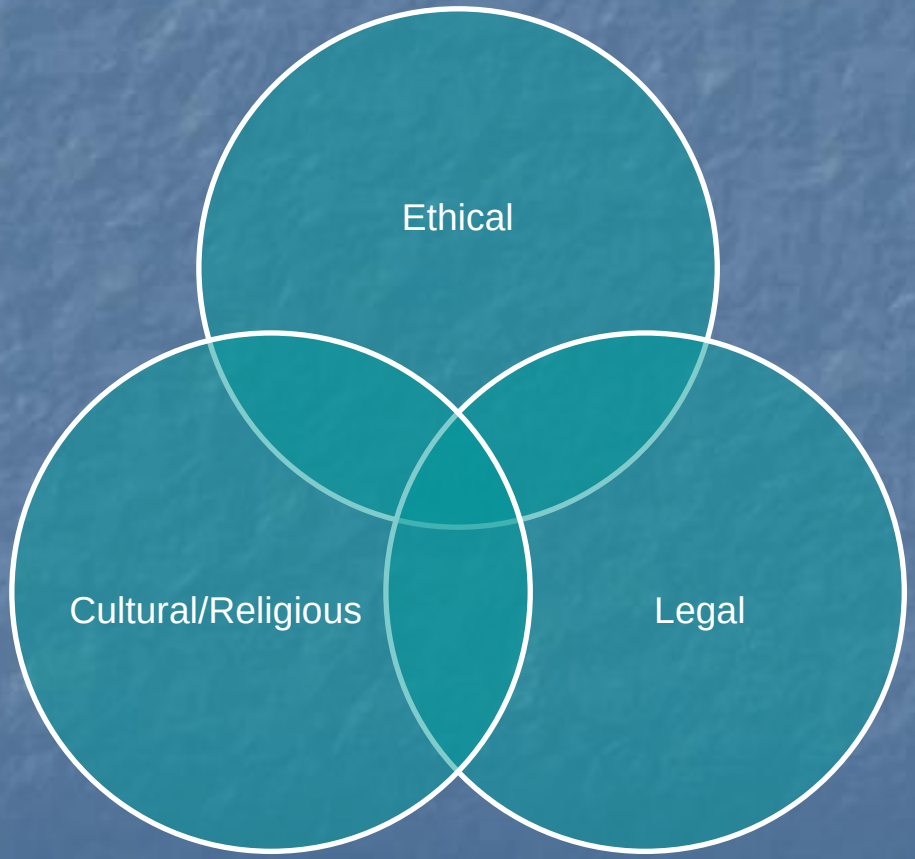
Better Reasons for RT Ethics Training

- We are Professionals…Adhering to a code of conduct!!!
- We encounter ethical dilemmas in our profession
- Guidance on how to apply ethical principles to:
  - Optimize patient care
  - Help avoid pitfalls
  - Improve morale & job satisfaction
- Identify current resources and additional references

Definition and Classifications of Medical Ethics

- Definition: "A system of moral principles, governing conduct…of persons in a profession…"
- Sub-Classes of Medical Ethics:
  - *Clinical-Focus of today!*
  - Research
  - Education

Ethical, Cultural & Legal Issues—Separate but can Overlap



Medical Ethics Principles & Concepts

- Autonomy
- Beneficence
- Nonmaleficence
- Justice
- Other Related Concepts:
  - Veracity
  - Fidelity

Autonomy

- General Definition: To be autonomous means to have self-governance or to **function independently.**
- Medical Definition: The right of the patient to govern their care
- In the US we hold autonomy to be most important!
  - Great respect for individual rights.
  - Law deems an individual's decisions about health care as a **right,** not a privilege!

Autonomy at the "Bedside"

- Patients should be told the ***truth*** their condition.
- They should be ***informed*** about the risks and benefits of treatments.
  - E.g., Informed of risks and alternatives for a endoscopy.
- Right to Die:
  - Refuse Treatment
  - Physician Assisted Suicide; legal in Oregon
- The ***right of refusal*** is **not** absolute:
  - Compulsory treatment if a third-party is at risk.
  - Direct Observation Therapy (DOT) for TB Tx.

Barriers to Autonomy

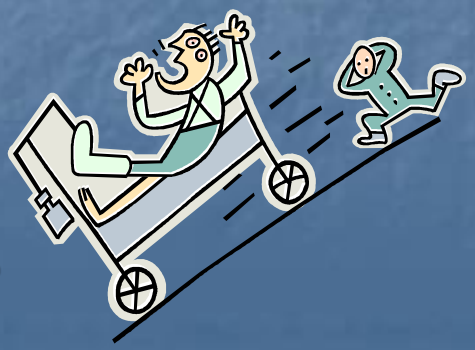
- Participation in certain provider networks.
  - May not reimburse for experimental drug.
- Restrictions on patient - provider communication in the form of gag clauses.
  - HIPAA may delay transfer of patient file to specialist chosen by MD.
- Independent judgment compromised by organizational policy.
  - Example: Xopenex not on hospital formulary

Beneficence

- Health care which is in the best interest of the patient.
- Beneficence relates to the providers "***fiduciary***" duty to his/her patients.
  - Fiduciary = position of high trust
- Will your action help or benefit the patient?
- Is often the reason people go into healthcare.
- Time mgt./workloads may interfere with this.

Nonmaleficence

- "Doing no harm"
- Will your actions harm the patient either by omission or commission?
- *Primum non nocere* - first of all do no harm.
- Actions or practices which avoid producing bad consequences.
- Examples: 1. Patient falls after bedrail left down.
  2. Surgeon leaves sponge in patient's abdomen.



The Beneficence => Nonmaleficence Continuum

- Do good (Highest standard) *Beneficence*
- Prevent/remove harm

- Do no harm (Lowest standard) *Nonmaleficence*

Justice

- Equity or fair treatment of stakeholders (e.g., patients)
- Two Types of Justice:
  - Distributive Justice: How equitably are health care services distributed at the societal (macro) level?
    - Universal Health Care
    - "Rationing"
  - Comparative Justice: How is health care delivered at the individual (micro) level.
    - Reimbursement or denial of individual care.
- Justice applies to:
  - Patients
  - Insurance Co's & Payors
  - Hospital Systems

Veracity

- An element of respect for persons.
- The opposite of the concept of medical paternalism.
- Dramatic changes in attitudes toward veracity over past few decades.
- Not considered by all bio-ethicists to be a foundational ethical principle.

Fidelity=Loyalty

- Robert Veatch, PhD (Georgetown Univ. Ethicist) defines fidelity as: ***"...the (ideal) patient-care giver relationship."***
- Special relationship between the patient and the caregiver.
  - Each party may feel some loyalty to another (e.g., homecare)
- Problems may arise when the relationship is too close and alters clinical judgment.
  - Example: Recommending futile tx. At end-of-life.

A ***Shift*** in Medical Ethics

1961

- Researcher *Donald Olken*
- 88% of physicians did not tell the patient the truth to patients with a malignancy.
- Beneficence
  - Paternalistic: Doctor knows best

1979

- Researcher *Dennis Novak et al*
- 98% of physicians told the truth to patients with a malignancy.
- Autonomy
  - Respect for patient's right to self determination.

Respect for Persons Dominant Theme

- Significant case law to support the change in philosophy.
  - *Natanson Case (1960)*: Pt sued her MD for failing to inform her of the risks of radiation tx.
  - *Roe v Wade (1973)*: Abortion for non-viable fetus
  - *Karen Ann Quinlan (1976)*: Right to be removed from life support - a ventilator.
  - *Terry Schiavo (2005)*: Right to have nutrition/hydration removed.

Conflicting Influences in Medical Ethics

- Positives
  - The desire to do good!...What brought many of us into medicine!!!
  - Desire to positively influence outcomes & make a difference.
  - Compassion
- Interference/Negatives
  - Health care is a business and hospitals do fail!
  - US health care = 18% GDP
  - Excessive use of technology
  - Patient care "Silos"

Ethical Conflicts & Moral Distress

- Moral Distress:
  - Awareness of proper ethical action & principle, but inability to act on it
  - A major contributor to poor employee "morale"
- Moral Distress in Respiratory Care
  - MD's orders conflict with professional or personal values.
  - Disagreements with surrogate decisions makers
  - Providing futile care
  - Perception of "Unsafe staffing"
  - Actively or passively participating in deception

Key Legal Documents

- ***Living Will & Advance Directives***: Medical care wishes if patient becomes critically ill and incapacitated.
- ***Durable Power of Attorney-Medical:*** (POA-Medical). Appoints an authorized person (surrogate) to make medical decisions, it patient unable.
- ***Do Not Attempt to Resuscitate (DNAR):***
  - Preceded by a documented discussion with patient or surrogate decision maker.
  - Signed and dated by physician.
  - Newer Term: ***Allow Natural Death (AND)***

Case 1: Right to Refuse

- A 17 year-old patient with advanced cystic fibrosis indicates that she does not wish to live this way and wants to discontinue therapy.
- Suggestion Action: Inform the nurse & attending physician. Under the ***mature minor doctrine***, the patient may be deemed sufficiently mature to refuse treatment.
- Main Ethical Principle(s):
  - Autonomy-Patient right to self governance
  - Fidelity-Clinician's responsibility to report patient's wishes.

Case 2—Right to Refuse Limited

- A patient recently diagnosed with TB is placed on isolation and multiple ABX therapy. Once the patient is deemed non-contagious and scheduled for discharge, he indicates "I'm not gunna take no more TB drugs, I'm cured."
- **Suggested Action:** Patients deemed a threat to themselves or others can be mandated to receive therapy. Therefore in this case, the physician should be notified and the patient may be mandated to participate in "Direct Observation Therapy" DOT, with criminal charges if they don't comply.
- **Ethical Principles:** Autonomy ***vs*** Justice.

Case 3 Futile Care

- A patient has profound head injury and catastrophic multiple system failure. However, the family wants to continue treatment and refuse a DNAR order.
- **Suggested Action:** Communicate with the attending physician and suggest a palliative care consult.
- **Ethical Principles:** Beneficience, fidelity, veracity & justice

Case 4- Futile Care (Part 2)

- The patient described in Case 3 (severe head trauma) deteriorates and codes for the second time in three hours. ACLS is again applied for 10 minutes but the patient has not responded.
- **Suggested Action**: request a palliative care consult; consider asking family members to observe CPR.
- **Ethical Principles:** Veracity, fidelity & justice.

Case 5 - Resuscitation Confusion

- A "Code Blue" is called for a 90 year-old patient in apparent acute distress. The patient has a valid Advance Directive, which indicates she does not wish to be resuscitated, ***if the situation is irreversible.*** The daughter who has POA-Medical and wants her mother to be resuscitated.
- **Suggested Action:** Unless the condition is known to definitely be irreversible, CPR should be begin. DNR status should promptly be confirmed. If resuscitation efforts continue, the situation should be re-assessed.
- Ethical principles: Autonomy, Beneficence, nonmaleficence

Case 6 – Extubation & End-of-Life

- You are given an order to "extubate" an elderly patient who seems cognitively in tact and has just clearly indicated he does not want to be re-intubated. The patient's daughter is the POA and wants everything done, including re-intubation.
- **Suggested Action:** Request to the physician that DNR/DNI status be clarified and documented prior to extubation. A competent patient over-rules a POA every time!
- **Ethical Principles:** Beneficence, nonmaleficence, fidelity.

Case 7 - Informed Consent

- You observe a physician attempting to obtain consent for an endoscopy from a moderately sedated patient.
- **Suggested Action:** Tactfully suggest that consent be obtained from a surrogate.
- **Ethical Principle(s):** Autonomy, veracity, fidelity (patient should be informed and may decline)

Case 8- Patient Discharge

- An uninsured, three-year old patient is in the ER with cold symptoms, mild fever, stridor, retractions and other signs of moderate distress. After one Albuterol treatment and one racemic epinephrine treatment, their condition improves somewhat, but they remain in some distress. The attending physician wants to discharge them with an Albuterol MDI/spacer. You firmly believe that they should be admitted. What should you do?
- **Suggested Action:**
  - If in your ***professional judgment*** the patient should be admitted, then explain your position to the doctor.
  - If that fails and you believe that the patient may be in jeopardy, consider escalating your concerns (e.g., nursing supervisor) .
- **Ethical Principle(s):** Beneficence, Nonmaleficence, Veracity, Fidelity

Case 9 - Home Oxygen Reimbursement

- You work for a home care company and are asked to qualify a patient for home oxygen reimbursement via pulse oximetry.
- **Suggested Action:** Recommend that the patient be qualified (via SPO2 or ABG) by an independent third-party.
- **Ethical Principle(s):** Nonmaleficence, justice

Take Home Messages- Avoiding Ethical Problems

- Actively Participate in Your Training.
  - Mandatory compliance training
  - Ethics CEU training
- Know Your:
  - Practice Guidelines
  - Policy/Procedural Manual
  - Licensing "Scope of Practice"
- Know your limitations…ask for help!
- If it doesn't feel or look right, it may not be…!
- Know your resources
  - Hospital Ethics Committee
  - Compliance officers
  - Palliative care team
- If you have questions…or need add'l info…***Ask***!

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