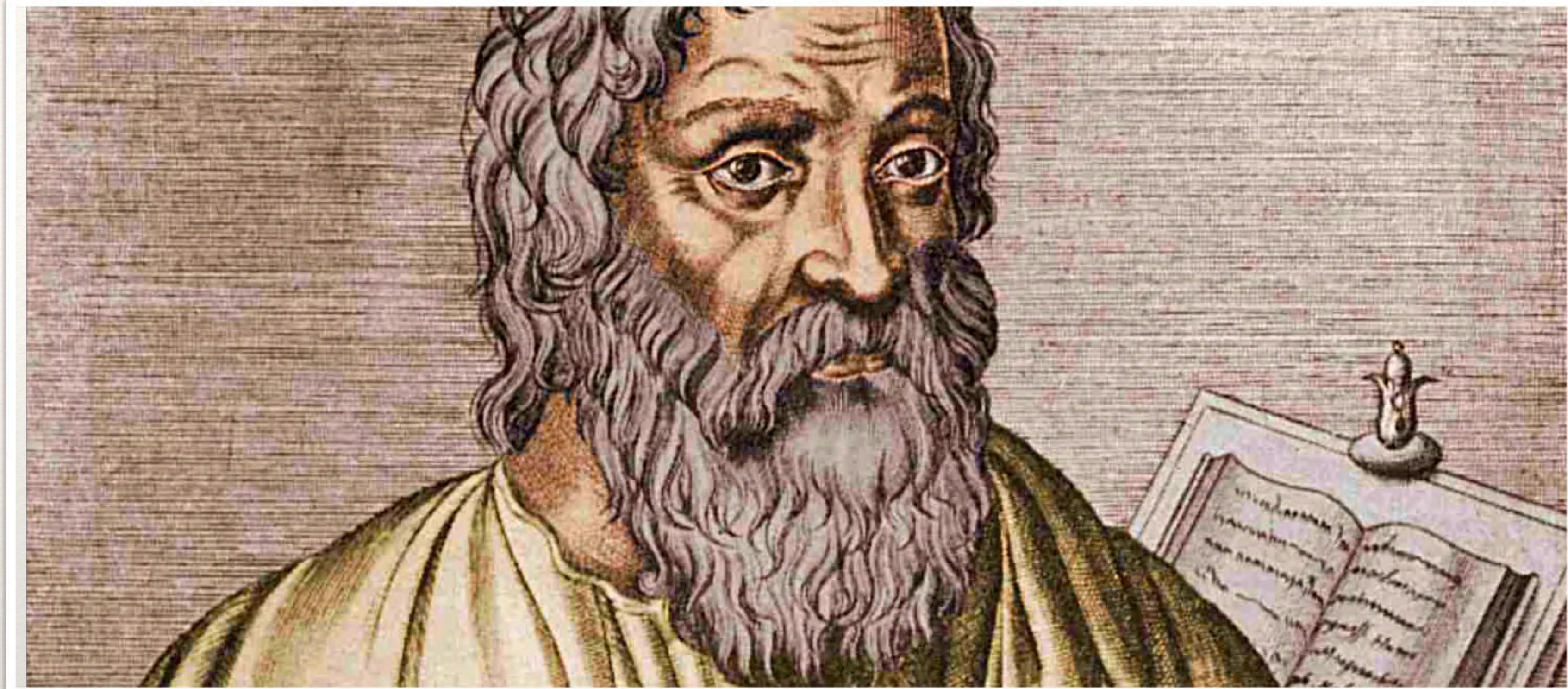


When Ethical Principles Collide: Case Studies in Ethics

Karsten Roberts, MSc, RRT-ACCS
Hospital of the University of Pennsylvania

Conflicts of Interest

I have no real or perceived conflicts of interest that relate to this presentation.

Objectives

- Define the four ethical principles
- Apply ethical decision-making to case studies

MORALITY VS. ETHICS

- Morality
  - Shared beliefs about right and wrong conduct in a culture or society
  - Composed of our values, duties, character
  - Personal morality vs. shared/group morality
- Ethics
  - A discipline that studies and provides an analysis of morality

Ethics is how we should act in consideration of others, not how we feel or believe.

PRACTITIONER BIASES

- Prior experiences with similar patients
- Prior experiences with physician
- Personal feelings about end-of-life care
  - Religious beliefs
  - Moral obligations
  - Personal value system

Barriers to Moral Agreement

- Different sets of beliefs
- Lack of understanding
- Fluctuating role of physicians
- Loss of relationship
- Complexity of health care environment
- Economic influences
- Racial and gender bias
- Defining futility
- Inflated expectations
- Fear and loss of trust

6 STEP PROCESS: ADDRESSING ETHICAL CONFLICT

1. Gather relevant information
2. Identify the type of ethical conflict
3. Determine the ethics approach to be used and apply the code of ethics for the profession
4. Explore practical alternatives
5. Describe and support your intended action
6. Evaluate the outcomes and process

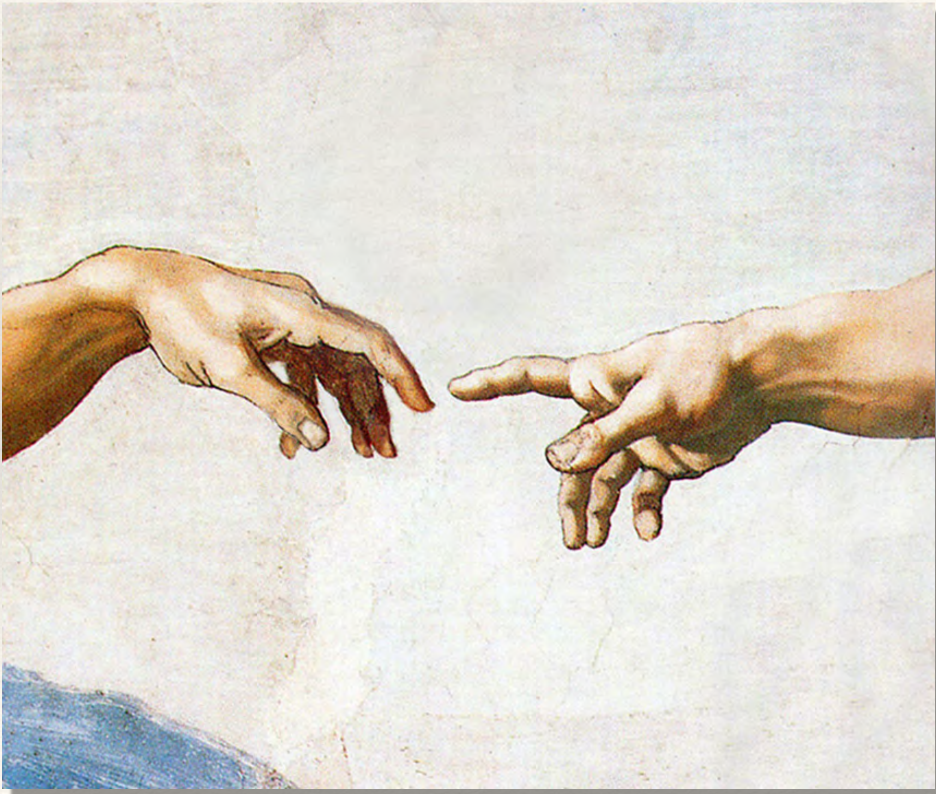
Ethical Principles

- Autonomy
- Beneficence
- Non-Maleficence
- Justice

Autonomy

- Self-rule; free from influence
- High priority: Independence
- Consider beliefs, desires, and decisions
- Family coercion?

Autonomy



- Patients' right to choose
- Informed Consent
- Confidentiality (HIPAA)
- The Dentist

Beneficence

- Promote "good"
- Remove harm
- What are long term outcomes?
- Minimize the causation of evil or harm versus promote good

Non-maleficence

- Avoid needless harm
- Protect patients from harm
- Commission and Omission
- Carelessness or unreasonable risk

Beneficence and Non-maleficence

Beneficence

- promote well-being
- positive steps toward prevention and removal of harm

Non-maleficence

- Do no harm
- intentional avoidance of harm

….act in a manner that cultivates benefit for another, and at the same time protects that person from harm.

Justice

- Treat others equally
- Giving individuals what they deserve
- Treat others fairly

"Individuals should be treated the same, unless they differ in ways that are relevant to the situation in which they are involved."

Types of Justice

"Fairness"

- Distributive: People seeking what they believe they deserve
- Procedural: Fair distribution? Acceptance of Imbalance
- Restorative: An apology? Putting things right? Payment?
- Retributive: Punitive. To dissuade future wrong doing.

SOCIAL DETERMINATES OF HEALTH

Economic Stability

- Poverty
- Employment
- Food Insecurity
- Housing Instability

U.S. Department of Health and Human Services

Office of Disease Prevention and Health Promotion

SOCIAL DETERMINATES OF HEALTH

Education

- High School Graduation
- Enrollment in Higher Education
- Language and Literacy
- Early Childhood Education and Development

U.S. Department of Health and Human Services

Office of Disease Prevention and Health Promotion

SOCIAL DETERMINATES OF HEALTH

Health and Health Care

- Access to Health Care
- Access to Primary Care
- Health Literacy

U.S. Department of Health and Human Services

Office of Disease Prevention and Health Promotion

SOCIAL DETERMINATES OF HEALTH

Neighborhood and Built Environment

- Access to Foods that Support Healthy Eating Patterns
- Quality of Housing
- Crime and Violence
- Environmental Conditions

Office of Disease Prevention and Health Promotion

SOCIAL DETERMINATES OF HEALTH

Social and Community Context

- Social Cohesion
- Civic Participation
- Discrimination
- Incarceration

U.S. Department of Health and Human Services

Office of Disease Prevention and Health Promotion

Moral Distress

Definition: When a HCP feels certain about an ethical course of action but is constrained from taking that action

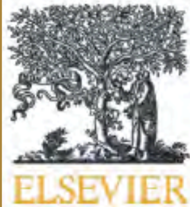
- Full life support versus Comfort measures
- Consequences of moral distress: burn-out and attrition
- Regardless of professional level

Journal of Critical Care, (31), 178-182

Contents lists available at ScienceDirect

Journal of Critical Care

journal homepage: www.jccjournal.org



Moral distress in intensive care unit professionals is associated with profession, age, and years of experience☆

- Survey of 1400 Canadian HCP (Nurses/RT/Physician)
- Highest levels of moral distress: Non-physician HCPs
- Highest ranked items: cost restraint and end-of-life care

Conclusions: Moral distress….is lower with older age for other non-physician professionals but greater with more years of experience in nurses, and is associated with tendency to leave the job.

Mrs. Kendrick

Mrs. Kendrick was admitted through the ED with acute onset hypoxemia and shortness of breath. She was found to have pneumocystis pneumonia. She was intubated and transferred to the Medical Intensive Care Unit for treatment of ARDS.

Mrs. Kendrick

After being pharmacologically paralyzed, she was placed in the prone position on-and-off for one week. It was determined that in order to survive Mrs. Kendrick would need a lung transplant, however, her religious beliefs dictated that she could not receive blood products and she was therefore not a candidate for the transplant or VV ECMO.

The patient's POA, a 23 year old daughter, wanted everything done, except resuscitative efforts.

Mrs. Kendrick

- Hypoxemia: How low can you go?
- Mechanical versus manual ventilation
- When do you stop?

In the case of Mrs. Kendrick….

- What is the definition of Autonomy?
- How do we do good?
- What constitutes doing no harm?
- Was patient treated fairly?

Mr. Smerdyakóv

Mr. Smerdyakóv was a 95 year old who suffered stroke in 2009. Since that time his family had diligently taken care of him at home. He was tracheostomized and frequently admitted to the hospital for various infections.

The family was considered “difficult” by many of the nursing staff, respiratory therapists, and house staff. The family was often found to be making changes to the environment of care.

Mr. Smerdyakóv

Mr. Smerdyakóv was full code and was unable to wean from mechanical ventilation. He was not lucid, his daughter and nephew were the primary decision makers. The family refused palliative care and their religious beliefs centered around the sanctity of life.

Given his advanced age, multiple complications, and overall decline, medical care was considered futile by the physician teams caring for him.

Mr. Smerdyakóv

- Avoid needless harm
- Commission vs. Omission
- Carelessness vs. unreasonable risk

….act in a manner that cultivates benefit for another, and at the same time protects that person from harm.

In the case of Mr. Smerdyakóv….

- What is the definition of Autonomy?
- How do we do good?
- What constitutes doing no harm?
- What kind of justice is being sought?

Summary

- What happens when a patient does not have autonomy?
- Beneficence and non-maleficence are inseparable.
- Fair treatment sometime includes the wishes of loved ones.

Thank you.

Karsten Roberts, MSc, RRT-ACCS

Karsten.Roberts@pennmedicine.upenn.edu