ETHICS

The Executive Committee of the Board at its recent meeting resolved that CPD providers be encouraged to develop multiple choice questions based on the information in the ethics article hereunder and submit it to a CPD accreditor for approval.

ETHICS IN THE EMS

Part 1 in a series of articles by Martin J Botha

INTRODUCTION

Clinical ethics is a practical discipline that provides a structured approach for identifying, analyzing and resolving complex ethical issues in clinical medical care. Medical care is inherently an encounter between human beings and the Health Care Provider’s (HCP) work is thus inextricably embedded in a moral context where the willingness of the HCP and patient to espouse moral values will foster a sound ethical relationship. (Jonsen, et al., 2006:1)

Ethical decisions are probably amongst the most onerous in the context of emergency medical care. The technical mechanistic resuscitation interventions are scientifically validated and protocol driven and decisions can thus be effected rapidly. Ethical decision-making on the other hand demands a significant thought and deliberation – a luxury not afforded the rescuer during most emergency resuscitations. Despite the abstract moral philosophical nature of medical ethics, it is possible to scaffold practical reliable ethical decision-making in the emergency. This series of articles will integrate and apply current ethical conceptual frameworks to selected resuscitation and emergency medical quandaries and illustrate these with practical examples and experiences we all struggle with.

BACKGROUND


In support of this, the Health Professions Council of South Africa (HPCSA) Continuing Professional Development (CPD) rules were amended on 13 July 2007: a practitioner must now accumulate at least thirty Continuing Education Units, of which at least five must be on human rights, ethics and medical law, within every year. Furthermore, the HPCSA in November 2007 resolved that all practitioners are obliged to ensure that ethics and human rights CPD activities form an integral part of their CPD portfolio as from January 2007. All of these resolutions entrench and cement the study of ethics.

TERMINOLOGY AND DEFINITIONS

Ethics can be defined (Microsoft Encarta 2006) as the “study of morality's effect on conduct; a system of moral principles governing the appropriate conduct for a person or group; according to common
standard of justice: regarded in terms of what is known to be right or just, versus what is officially / outwardly declared to be right or just.”

Morality (ibid.) in turn relates to issues involving right and wrong and how individual people should behave; it is derived from what one’s personal conscience suggests is right or wrong, rather than on what rule or the law says should be done. It embraces how one ought to behave decently and honourably, and what is good or right, when judged by acceptable standards of the average person or society. It infers being able to distinguish right from wrong and to make decisions based on that knowledge, and based on personal conviction, in the absence of physical proof.

CONCEPTUAL ETHICAL FRAMEWORKS

In this section, current conceptual ethical frameworks pervading clinical ethics will be examined. Schüklenk (in Ernest, 2001:7) maintains that the main ethical rules-of-thumb consist of three competing, partially overlapping conceptual ethical frameworks. Many decisions within healthcare practice are ethical decisions requiring ethical justifications.

Good ethical theories are action-guiding, helping HCPs make decisions grounded in widely acknowledged ethical frameworks, rather than relying on strong feelings, flipping coins or other unreliable equally capricious mystical methods. Furthermore, patients will subscribe, consciously or unconsciously to one or another of these frameworks, and in order to understand patients’ decision-making, these ethical frameworks ought to be understood. Patients are also entitled to know what ethical frameworks guide their management; however in the context of an emergency these issues are seldom relevant.

Principle-based bioethics approach

According to Schüklenk (in Ernest, 2001:8), the most popular, although theoretically the least sophisticated of the three frameworks, this system of principle-based bioethics comprises four major prima facie principles: i) autonomy, ii) beneficence, iii) non-maleficence (derived from primum non nocere – the maximum of medical ethics), and iv) justice (Beauchamp & Childress, 2001:12, Jonsen, et al., 2006:18).

These principles concern respect for the choices people make, the obligation to help, but not harm them and other parties, and the requirement to act in a fair and equitable manner with regard to the distribution of medical burdens and benefits. A disadvantage that critics of this approach identify is the lack of hierarchical ordering of principles which renders ranking of these principles in any given situation arbitrary. (Ernest, 2001:8)

Utilitarian concepts

The second key framework within contemporary bioethics identified by Schüklenk (in Ernest, 2001:9) is the consequence based theory, judging the rightness or wrongness of a certain action exclusively by its consequences. Utilitarian modes of reasoning are best suited to problem-solving in bioethics according to Schüklenk (ibid.) – their action-guiding principle is singular and unambiguous, providing a clear procedure for decision-making. The basic utilitarian premise directs that both individual action
and public policy should maximise utility (in terms of happiness or preference-satisfaction) for the greatest number of people. This pattern of analysis forms the basis of traditional forms of reasoning in public policy, and indeed is prevalent in every triage decision we make.

Utilitarians controversially reject two distinctions: intention / foresight, and acts / omissions.

Acts and omissions

This doctrine holds that “in certain contexts, failure to perform an act, with certain foreseen bad consequences of that failure, is morally less bad than to perform a different act which has the identical foreseen bad consequences...there is a moral difference, between acts and omissions, with the same total consequences” according to Glover, 1977, (cited in Ernest,2001:10).

Reasons posited in support of the acts and omissions doctrine are that acts tend to generate harmful by-products which omissions are not likely to generate. It is also argued that agents have a greater degree of moral responsibility for the consequences of their acts than they do for the consequences of their omissions, e.g. in the debate on voluntary euthanasia, it is argued that it would be ethically unacceptable to actively kill someone, while it might be all right to refrain from providing life-sustaining treatment. Arguably consequences of both of the abovementioned options might be the same to the patient – viz. the death of the terminally ill patient. Again the intersection between clinical ethics and the medico-legal standpoint is underscored. (Ernest, 2001:10)

Intentions and foresights

Schüklek (in Ernest, 2001:10) suggests that this distinction also has a direct bearing on the ethics of voluntary euthanasia. The morality of actions can be affected by whether certain consequences can be foreseen but not intended. It is possible that the death of a terminally ill patient may be foreseen as a consequence of too high a dose of morphine, without intending his death (also beneficence versus non-maleficence). The genuine intention may well have been to relieve suffering, without wanting to terminate the patient’s life – yet the patient’s death was a foreseen consequence of the action. The net outcome of both actions are identical argues Schüklek (ibid.); hence the moral question is whether the fact that one merely foresees a certain outcome but does not intend it, should make a difference for the ethical evaluation of the action.

These acts / omissions and intentions / foresights are important in terms of motives and responsibilities for action – both of which utilitarians ignore, focussing exclusively on consequences as criteria for judging an action (Ernest, 2001:10). Many utilitarians – rejecting the acts and omissions doctrine – require that they judge a person who could, but didn’t act, to save the life of a starving child, in the same manner as someone who actively killed a child. If the consequences of an act or omission are identical, so would be the utilitarian’s evaluation of the act, or act of omission. If one thinks that motives do matter, and that there is more to the moral status of an act than its consequences, one is bound to disagree with this view. (Ernest, 2001:11)

Deontological bioethics

The word “deontological” is derived from “deon” – the Latin root for duty or obligation (Ernest, 2001:11). Kant – a German philosopher – proposes that the Kantian moral agent is quite different
from the utilitarian agent who acts in order to satisfy interests or desires. Kant was concerned with
the motivation of action, and argued that duty alone should motivate morally adequate action. An
“action done from duty has its moral worth not in the purpose to be attained by it, but in the maxim
in accordance with which it is decided upon.” (Ernest, 2001:11) These maxims are constructed as
absolute imperatives – Do not kill, etc. Furthermore Kant developed Categorical Imperatives, most
influential of which demands that the moral agent never treat other people as mere means to ends
(however noble these may be) but rather always as ends in themselves, e.g. using people as subjects
in research trials. This requirement may well be the foundation of informed consent procedures –
competent prospective research subjects give first person voluntary informed consent prior to being
enrolled in a given protocol.

The differences between Kantian and Utilitarian decision-making are illustrated in the very different
answers to the question of whether it is ethically justifiable to let one ‘innocent’ human being die in
order to save ten similar others, who are in need of organ transplants. Kantians are unconcerned
with consequences of actions, but rather with the question of whether one can consistently wish to
be treated by other rational agents in the same manner as one desires to act in a comparable
situation. Kantians also defend absolutist positions, such as the rejection of voluntary euthanasia,
irrespective of the suffering this may cause in individual cases. (Ernest, 2001:11)

The health care professional-patient relationship

Schüklenk (in Ernest, 2001:11) submits that much of the bioethics literature is devoted to ethical
problems in the context of the health care professional (HCP) – patient relationship, since the HCP is
at the centre of efforts to improve the well-being of patients – a type of contractual agreement
similar to that between a customer and a professional selling professional services. A contract usually
includes protections to the contract partners, so that if contract terms are breached by one of the
partners, (e.g. substandard treatment, or not paying the due fee), legal recourse can be sought by the
party who feels wronged. The advantage of this model is that it breaks with the authoritarian models
of the physician assuming an all-powerful, God-like position. Instead, it requires respect for the
patient’s autonomy, first person voluntary informed consent to treatment, and an agreement
between doctors and patients about a given proposed course of action. Schüklenk (in Ernest, 2001:12)
makes it clear however that the emergency situation and incompetent patients constitute notable
exceptions. Informed consent requires not merely uncoerced consent, but consent based on
information, the implications of which one has understood.

Informed consent comprises the key issue in bioethical ethics; it is indubitably considered a pre-
condition for any interaction between HCP and competent patient and is important because
otherwise patient autonomy would be violated. A respect for patient autonomy requires the HCP to
allow them to live their lives as they see fit. Individual autonomy is of intrinsic and instrumental value
– autonomy is the foundation of respect for persons according to the Neo-Kantian view. Utilitarians
agree that personal autonomy is of instrumental value – it is necessary to satisfy one’s own
preferences, desires or interests. (Ernest, 2001:12)

Some argue that the HCP-patient relationship should be governed by the practitioner’s professional
duty of beneficence (i.e. to contribute to the health of the patient). However, medical paternalism is
also easier to justify on the basis of such a model. This incorporates an overriding obligation of the
doctor to treat their patients to the best of their ability – this traditional attitude has been challenged by claims of patients’ rights to medical care and doctors corresponding obligations to respect these rights. (Ernest, 2001:12)

Schüklenk (in Ernest, 2001:12) notes that bioethicists have attempted to address ethical concerns of the HCP-patient relationship against the backdrop of the principle-based approach. This is problematic, since simultaneous conflicts arise: having to respect autonomy, having to act beneficently, having to act justly. Since this principle-based approach is based on prima facie principles, it is theoretically impossible to override one or another of these principles in favour of a more important principle. However, such overriding seems only to be possible by recourse to a higher order ethical theory that resolves such conflicts. At best, principles could function as deontic constraints on actions. Human rights based approaches to health care have met similarly focussed critique, i.e. no higher ordering of rights. Schüklenk (in Ernest, 2001:12) asserts that a conscious decision needs to be made which entails more than just mindlessly memorizing ‘the’ principles or simply claiming that a “right” has been violated.

Concurring with Schüklenk, Van Niekerk (2008) argues in favour of the development of an “ethics of responsibility” in the biomedical sciences. This view contend that the more traditional approaches to moral theorizing, such as deontology (rule morality), utilitarianism and virtue ethics, have proved themselves inadequate to appropriately deal with the moral conundrums yielded by both shifts in the cultural context within which moral deliberation nowadays takes place, and by recent developments in biomedical science. Van Niekerk (2008) proposes that “responsibility” presents itself as a more adequate category for moral conceptualization and deliberation than biomedical ethics’ traditional concern with “right” and “wrong” or “good” and “bad”. An ethics of responsibility is characterized by, amongst others, a commitment to appropriate knowledge of the case in hand, the development of lucid, accessible and accountable arguments for and/or against a position, acknowledgement of fallibility, but also the courage to make decisions and accept consequences in view of considered and publicly defensible arguments, even if by hindsight, it appears that mistakes were made in the process.

Akin to reaching a diagnosis and formulating a management plan, Jonsen et al (2006:2) propose consideration of an ethical problem via analysis of 1) the medical indications, 2) patient preferences, 3) quality of life, and 4) contextual features (socioeconomic, legal and administrative context). This practicable and applied approach can scaffold assessment and deliberation of an ethical problem. Jonsen et al (2006:2) goes on to argue that while ethical decisions often call for recognition of conflict of principles (e.g. when the principle of beneficence conflicts with the principle of autonomy), ethical reflection goes further to consider the actual circumstances relevant to that particular case, related to the abovementioned four signposts.

Now that several approached to ethical thinking have been presented, where do you stand? Which model do you find most attractive to help you think about and solve ethical issues? More than likely you will adopt the best from all the above to influence your ethical problem-solving. This will be further impacted and affected by your religion, values, morals, upbringing and worldview.

In the next article in the series I will explore the HPCSA professional and ethical guidelines, and suggest a strategy for ethical reasoning in an emergency situation.
In a nutshell...

- Ethical decision-making in the emergency relies on a practical structured approach.
- Everyone registered with the HPCSA requires 5 ethics CEUs per year.
- Ethics is concerned with morality and how this affects conduct; it’s about what one’s conscience dictates to be right or just versus what is officially / outwardly declared to be right or just when judged by acceptable standards of the average person or society or rules / laws.
- Principle-based bioethics approach comprises four principles: i) autonomy, ii) beneficence – do maximum good, iii) non-maleficence – do no harm, and iv) justice.
- The utilitarian approach considers consequences, judging the rightness or wrongness of a certain action exclusively by its consequences and so guide decisions clearly. This view suggests that the maximum good for the maximum number of people is always the paramount issue. Triage is an example of this strategy, something we do often in our emergency care practice.
- The intersection between clinical ethics and medico-legal requirements is crucial to consider.
- Deontological bioethics proposes that duty or obligation should motivate action, and categorical imperatives should dictate ethical conduct.
- An example of a categorical imperative is that we should never treat other people as mere means to ends (however noble these may be) but rather always as ends in themselves, and another: do unto others as you would have them do unto you – the golden rule.
- The health care professional-patient relationship provides another approach to ethical problem-solving – a contractual agreement of sorts.
- The advantage of this model is that it disarms the authoritarian models of the health care provider assuming an all-powerful, God-like position. Instead, it requires respect for the patient’s autonomy, first person voluntary informed consent to treatment, and an agreement between providers and patients about a given proposed course of action. An emergency, where consent is not possible to obtain, constitutes a notable exception.
- The “ethics of responsibility” is another perspective that has evolved to better deal with moral conundrums as compared to the more traditional approaches to moral theorizing, such as deontology (rule morality), utilitarianism and virtue ethics. Embracing a responsibility to make reasonably defensible decisions involves a commitment to appropriate knowledge of the case in hand, and the development of clear and accountable arguments for and/or against a position.

REFERENCES


Microsoft Encarta 2006.

Professional and Ethical Rules. Health Professions Council of SA. 2006. www.hpcsa.co.za [Date of access: 15 February 2008]