1

# ETHICS AS A PROCESS OF REFLECTION

- Beginning to think about ethics
- What is ethics?
- Absolutism/deontology
- Consequentialism/utilitarianism
- Libertarianism
- Proportionism
- Communitarianism
- Some cases to start with
- Principlist frameworks
- Relativism
- Casuistry
- Choices to be made when reflecting on cases
- Cases to ponder

## OBJECTIVES

The first chapter explains what ethics is, acknowledges the considerable theoretical tradition of ethics, and starts you on an ethical exploration of practical health care situations. The general approach in major ethics theories is explained, with a practical introduction of how theories are applied to case studies, and the arguments that might be advanced under each theory or framework. You are encouraged to reflect on your own values, and to nominate which theories you are most comfortable with. By the end of this chapter you should be able to define and

Oxford University Press Sample Chapter

**Morals**
Significant lessons prompting reflection to identify virtuous, right, or acceptable course of conduct.

explain the following concepts: ethics, **morals**, bioethics, medical ethics, reflection, good, norms, ideals, and values. Note that these concepts are added to a glossary, which will grow in size as you work your way through each chapter and your understanding of ethics increases. You will also have encountered the ethics theories of deontology, absolutism, utilitarianism, consequentialism, libertarianism, proportionism, and communitarianism, and casuistry, relativism, and principlist frameworks.

## BEGINNING TO THINK ABOUT ETHICS

This book is about ethics. You don't need to be an ethicist to understand ethics in the health context, and you don't need to have learnt a lot of philosophy to be able to think about ethics as you work in your health profession. This book is written so that the information it contains can be used in a practical way in your everyday work. It starts with you, the professional carer or student, and examines the way professional work and your interaction with your clients or patients is shaped by ethics.

Ethics is a tool that is meant to be used in practical situations. As more than an abstract introspective pursuit, it helps us reflect on real-life issues, and it is also a process that can be applied to real concerns and situations as they unfold.

The common theme followed in this book is that health care ethics is not only about setting acceptable standards, but is also about reflecting on what you should aim for in your work as a health care professional. It is about reflecting on optimal standards and pursuing those standards. Ethics is a reflective process of analysing and examining moral issues and problems.

**Reflection**
A process of thought and analysis on past, present, or future issues, applying deep and serious consideration.

The book is written in an interactive way. Dotted throughout, you will find individual and group exercises that will help you think about particular issues, standards, and styles of ethical **reflection**. Tutorial-type triggers and case studies are also included. You will encounter ethics theories and frameworks in each chapter. The way in which they may guide practical reflection is highlighted through examples and exercises. As you work through the exercises, you will become more familiar with key ways of identifying ethics issues in health care and working to resolve them. In this framework, the philosophical aspect of ethics becomes a tool that you, as a health care worker, can use to reflect on ethics as it applies in your profession and in your clinical work.

You will not be an expert in ethics after working through this book, but you will be considerably more informed. The book starts you on a path of ethical reflection and encourages you to consult with others so that you do not face ethical challenges alone. At times when you are faced with complex challenges you will naturally want to consult with colleagues who are interested in ethics. Your reading will equip you to recognise ethics issues in situations, and also recognise opportunities for discussion.

Oxford University Press Sample Chapter

## WHAT IS ETHICS?

Ethics helps you to decide what to do in routine and complex or difficult situations. It acts as a guide, a reasoned 'voice'. Thinking and reflecting is the hallmark of ethics because it is an active process.

Ethics in health contexts is sometimes simply called 'ethics'; at other times it is called 'bioethics' or 'medical ethics'. You may like to choose a definition of ethics that you understand best from the following options:

- **ethics:** 'ways of understanding and examining the moral life'.[1]
- **bioethics:** 'a popular contraction for "biomedical ethics", which is the study of moral value in the life sciences and in their clinical application'.[2]
- **medical ethics:** 'the analytical activity in which the concepts, assumptions, beliefs, attitudes, emotion, reasons, and arguments underlying medico-moral decision making are examined critically'.[3]

**Ethics**
Reflective process of analysing and examining moral issues and problems.

**Bioethics**
Reflective ethics process applied to the health care context and life sciences.

**Medical ethics**
Specific term for ethics in the medical and biomedical context.

Some of the suggested forms of reasoning and reflecting that you will encounter in this book have a philosophical basis. In philosophical thinking, arguments are examined and analysed, underlying assumptions are tested, and arguments are carried through to extremes to test their robustness and practical application. Ethics as a discipline makes use of critical reflection processes, and also relies on practical lessons to be learnt from others. You learn from the experiences of others and you share your experiences with them, so that the collective experience of situations grows. As you gather experience, you draw on past reflections and experiences to guide you. You draw on collective ethics experience and individual ethical reflection as you decide how to act professionally and ethically.

So remember that ethics is a process of reflection. We will start with small steps, and gradually build your options for analysis and reflection. The focus of the book is to think about the health care of individuals, and that means thinking about how it is that people come to be in a position to provide care, how resources are available to allow them to fulfil that aim, and then how a process of care, with its ethics issues, unfolds. The idea of applying ethics to health care contexts is contained in the title of the book, *Ethics for Health Care*. You learn it as a tool to help with the job of health care. The idea of ethics is that an optimal standard is aimed for. There is an impetus to aim higher than the basic minimum of social responsibilities. The common process of the reflection is that moral issues are identified and examined. A moral reflection has many connotations. To some it means to reflect on a lesson that has been handed down in significant religious texts, to strive to distinguish between right and wrong, and act accordingly, given that lesson. It can also be a practical lesson learnt from past experience and reflection, again reflected on in terms of significance and importance. The term 'moral' is used in a broad sense in this book to mean a reflective examination of values and objectives, including reference to lessons, with an examination of the implications of thought and action for oneself and others.

Oxford University Press Sample Chapter

Ethics, as it is understood in this book, takes as its starting point the fact that, first and foremost, you are an individual. You were a unique individual before you began your training, you are an individual at work, where you are also a health care worker, and you are an individual outside work. There are very different people in this world, and one of the things that distinguishes us from each other is the way we choose to live our lives. Since you bring much of yourself to your work, it is worthwhile thinking about the sort of person you are as we begin our discussion of 'professional' ethics.

### EVERYDAY ETHICS

Take a minute to think about how you live your life. Try to identify, in your own words, one fundamental value or principle in the way you live your life, and in the way you live alongside others.

Many of the philosophers whose work we draw upon in professional ethics actually wrote more about individual ethics (that is, about the ethics of decisions made by individuals) than about group standards or **norms**.

**Norms**
Accepted standards, which can be used to judge conduct.

Early philosophers thought about how we should live our lives and relate to others. They thought about the structure of our society; about what we, as individuals, owe to our society; and about what we can, and should, expect in return. They also thought about our higher duties to God. Nowadays, religion is often separated from professional ethics, but if it is a large part of how you live your life it would be artificial for you to ignore it. You will see comments and exercises from many early philosophers dotted throughout the book. Try this one now.

**PAUSE & REFLECT**

When you think about how you try to live, think about the virtue you aspire to. What is that virtue? How would you define it, and how do you know if you have achieved it?

As an important early philosopher, the key feature of Socrates' discussions was the way in which participants were encouraged to elicit and question beliefs. Some of the central values that Socrates espoused were justice, courage, and pity.[4] He tried to define them through reflection and discussion, like the reflection you just undertook for yourself. This reflection process is appropriate for our professional lives too. Justice and courage may be listed as two of the modern nurse's virtues, as nurses advance their clients' interests and attempt to maximise the autonomy of their clients.[5]

**Values**
Concepts given worth or importance in life and interactions, making up a value-system.

Our **values** form our ethics standards and they determine what we expect from others. In some ethics frameworks, virtue and the formation of central values is paramount. There is a sense of a moral self-development. We probably apply this notion of moral self-development, without thinking about it, in our own lives. We

Oxford University Press Sample Chapter

do not, for instance, expect children to be rational and moral in the way in which they relate to others and the world because we know that some of this is learnt. We gradually teach them what is expected, what we value, and what we hope they will value. As they grow older, they begin to recognise, in abstract, that it is not just the fact that these values are advocated by parents and guardians that makes them desirable as guides for life. They come to value these virtues themselves.

In ancient Greece and Rome there were designated forums for debating what was right and virtuous, and for reasoning about why that was so. Learned people were trained to reflect and to hold monologues or debates challenging others to refine their thoughts, actions, and reasoning. Socrates and Plato led this tradition, and there was an expectation that people who rose to prominence in society would learn to reflect and debate personal and social ethics. Plato was Socrates' student and Aristotle's teacher. Plato emphasised that winning a debate was not the purpose of the discussion. The purpose was to search for the truth.[6]

When a person becomes a member of a profession, they become one of the people who help define the ideals of the profession. They bring their own ethics to the profession, and their ethics is influenced by what others have defined as appropriate ethical standards for that profession. It is a fluid process of sharing thoughts and of learning to work together towards common goods. (Bear in mind that the word '**good**' is used as a noun here; that it is a thing or concept, not an adjective.) The process of reflecting on professional caring, identifying important aspects of caring, and debating what professionals should aim for continues the tradition of ancient debates, albeit in a different guise. You may like to consider whether you care enough about your **ideals** to defend them against others. In professional debates, we would do well to remember to keep discussion constructive, as is urged in Plato's tradition, and not simply use ethics as a tool to score points off our colleagues. The reflection process is more important than keeping score.

**Good**
A desirable end or object.

**Ideals**
A standard or concept of excellence which is aimed to be met.

What you have done so far is to start to reflect on what you value, how you live, what you strive for, and how your values are part of the way you live up to your professional responsibilities. Personal reflection on professional responsibilities has become integrated with health care, and health care ethics is generally seen as a modern phenomenon. Much has been written about the fact that technological innovation and development in health care has led to an exponential increase in ethical dilemmas, and many of those involved in health care wonder if and how we should put such advances to use.[7] Medicine and health care present such ethically stark issues that it is very useful to use ethics as a tool to unravel the issues and work out, in a reasoned

Oxford University Press Sample Chapter

fashion, what to do when faced with those issues in practice. On the other hand, even before great technological advances, the daily aspects of health care were the subject of ethics reflection. It may just be that, now that technology (including technology associated with health care) has such a high profile, ethics also has a higher profile.

You could think about ethics in health care as really being about three things: individual ethics and values, group ethics and values, and professional ethics and values. Writers on health care ethics vary in their approach. Some concentrate on individual virtue, others on group notions of ethics, or on philosophical analysis of ethical stances and values. This book gives you a wide range of exercises to do on your own or in groups so that you can experiment with these approaches. All of the approaches share a common purpose: to assist health care workers to make ethical decisions, and to monitor their own and others' practices so that the health care process is 'ethically aware'. They also potentially assist the people who plan and receive services. Ethics is becoming a joint effort, and reflection on ethics is increasingly consultative. More on this is included in Chapter 10. Throughout this book you will see examples of informed ethics debate and reflection in contemporary debates on health care, and in practical contemporary health policy and guidelines. These are the product of collaboration and joint discussion between professions and the community.

Let's start to look at what is ahead for you in learning about ethics theory and frameworks throughout the book. The emphasis for you will be on using aspects of the theories in an applied way rather than on learning them by rote.

## ABSOLUTISM/DEONTOLOGY

Deontology works with the notion that there are certain absolute rules that must be followed, or upheld, regardless of the consequences. It classifies acts according to whether they must be done (because they are necessary to uphold a particular rule or rules), or are intrinsically wrong (and therefore must not be done). The rules are commonly thought to be handed down from God, such as the sanctity of life. The rules translate into duties, and an example of this is included in Chapter 2. The moral importance of acting and not acting is the subject of an exercise in Chapter 4, and you will be asked to decide which protagonist in the story, Alex or Alice, is responsible for the harm that befalls their father.

You will find the doctrine of 'double effect', a classic deontological tool which can help with this decision, in Chapter 4. The responsibility for something bad occurring, even though a good was aimed for, is a key issue for health care workers.

The question of what constitutes personhood (and life) is addressed in Chapter 6. As the discussion in that chapter shows, deontological positions are prominent in this debate on the defining characteristics of personhood and life. The discussion contrasts these deontological positions with outcome-based positions, particularly in relation to the creation, genetic manipulation, and ending of life.

Oxford University Press Sample Chapter

Deontology is in direct opposition to relativism, in which the question of what to do is defined not with reference to strict rules but with reference to the relevant acceptable boundaries for a particular context or culture, which by definition are relative; that is, they are fluid and can change.

## CONSEQUENTIALISM/UTILITARIANISM

Under consequentialist or utilitarian theories, which are teleological and focus on contributions to desirable goals, the 'right' thing to do is that which maximises the good. The outcome of an action is what is ethically important. The greatest good for the greatest number is pursued, whether that good is a specific utility, felicity, or happiness.

These utilitarian assumptions are discussed in Chapter 3. Under utilitarianism, the question of how to share a limited good is often one of how to maximise distribution. It is possible to reject such utilitarian assumptions when making ethical decisions, as you will read ethicists did when responding to the hypothetical scenario on predictive cancer testing discussed in Chapter 3.

Modern consequentialists' views on obligations to care and work, even in situations of some danger, are described in Chapter 4. This is an illustration that in some frameworks one's own interests do not necessarily receive priority if the greatest good for the greatest number is the prime consideration in the issue at hand.

To look at the effect of the manipulation of life, as is done in the case of two sisters in Chapter 6, when one sister is conceived in the hope of providing genetically compatible regenerative tissue for the other, is to acknowledge the fact that ethically problematic decisions affect not only the individuals immediately concerned and their families, but also whole communities.

## LIBERTARIANISM

Libertarianism places the personal freedom of the individual at the centre of analysis. That freedom is claimed as a right, unless there is sufficient reason to limit it. Patient freedom and autonomy are explored in Chapter 4.

John Stuart Mill is referred to throughout the book as a libertarian (a philosophy closely related to liberalism) philosopher. His thesis, 'On Liberty',[8] has been used in policy debates to decide when a person's liberty can be infringed, such as in the mandatory blood testing exercise described in Chapter 5. The only acceptable reasons for limiting liberty are if a serious and imminent risk is posed to another individual, or if the fabric of society is threatened. These reasons are used, at strategic points in this book, to explore the health care worker's role in fostering self-determination and in being aware of similar rights to liberty that are held by others. The classic Mill thesis is echoed in modern libertarian writings, some of which are noted in Chapter 4.

Oxford University Press Sample Chapter

## PROPORTIONISM

Proportionism acknowledges rules and values, but does not regard them as universal. It is quite a pragmatic theory, which, without using binding principles as a guide, takes into account the human nature of the person, the situation, and the intention behind the person's actions. A broad idea of the good is aimed for.

Doing the best one can is a common pragmatic approach to ethics. The proportionist would require that the best is pursued in full knowledge of the ethics choices and practical alternatives.

Proportionism is essentially a compromise between the extremes of absolutism and relativism.

## COMMUNITARIANISM

Communitarianism places the community at the centre of a value system and its corresponding ethical analysis. While the individual members are acknowledged, it is the good of the community, its goals, and the threats it faces that are the key considerations. Communal and public goods are emphasised, and community views must be sought to unravel difficult issues.

The process of seeking and acknowledging community views is discussed throughout this book. In Chapter 2, a comment by a former Director-General of the World Health Organization (WHO) is included to show that professional ethics takes place within a community context, and an expectation that the values of the community should be respected.

The fact that there are many different community values in relation to informed consent is noted in Chapter 4, so it is important to be able to check what the relevant values are. The processes that make community views on ethics known are outlined in Chapter 10.

## SOME CASES TO START WITH

The reflective exercises that you will be asked to do throughout this book are intended to galvanise you towards your own preferred ethics theory. Your own reflection on ethics is a continuing process that is only just beginning. As it develops, it will be moulded and tested by the challenges you will face in your work as a health care practitioner.

A number of cases are provided in this chapter as a starting point for your practical ethics reflection. As you reflect on your first reaction to each case, think about the values and concerns that are prominent for you. Later, when you use the cases for

Oxford University Press Sample Chapter

revision and you read back over your notes in the book, you should be well on the way to recognising which ethics theories you favour and identifying the ethics tools that are useful in your ethical reflection on your health care work. This process of reflection is the start of routinely integrating ethics in your own health care work.

The process of reflection is well suited to groups. If you have finished your training and are working, you may like to do a few of the exercises with some colleagues in an informal group, or as part of a professional development program. If you are training, you may have a group of colleagues and students around you, in which case you are fortunate enough to have a ready-made group for ethical reflection.

Now you might like to consider the following case studies. After each case study is set out, the aspects that might be focused on under different theories are explained. It is up to you to ponder the key elements and think about how a solution to each problem might be arrived at. As you think, be reassured that you will learn more about how to analyse the cases in detail as you work through the book. If you return to these cases as a revision exercise, you might also reread sections of the book to bolster your analysis, your argument, and ultimately the ethics position that you recommend.

## EXERCISE 1.1 MULTIPLE ISSUES

### CASE ONE

When you first met Ms Tan, she was 14. She has a slight mobility disability, from a congenital spinal problem, and a mild intellectual disability. With the aid of an interpreter (English is her second language), you arrived at a course of treatment and management for her recently diagnosed asthma in close consultation with her other health care workers and her parents. Now, three years later, Ms Tan returns. She has left school, is working part-time, and has more ambitious life priorities, in keeping with a young adult. She asks for your help in continued treatment, but also in gaining more independence from her family. She feels that they closet her because of her medical problems.

Patients rarely have just one medical or health concern. Their social context is also complex. How you define 'health' will lay the foundation for your reaction to this case with Ms Tan. You should first consider whether your definition of health is as broad as the WHO's, which includes the physical, social, and mental aspects of life. The definition of health, and the good to aim for as a health care worker, is a central focus of Chapters 3 and 4.

Deontological theory would emphasise the duties owed to Ms Tan as an individual, especially the duty to further good for her and limit harm coming to her, particularly intentional harm. There may be some rules that would preclude doing what she wants—for example, you might think that the process she has asked for is fundamentally wrong.

Oxford University Press Sample Chapter

If you adhere to the ethics theories that place the most weight on patient autonomy, such as libertarianism, upholding Ms Tan's choices will be important to you, even if you do not agree with the choices she makes. You will be concerned with establishing that Ms Tan is competent to make certain relevant decisions and life choices. The issue of competence is covered in Chapter 7.

Ms Tan's cultural and family contexts are especially relevant with regard to proportionism and communitarianism. Both theories balance goals, such as life and health goals, with individual variation and choice in relation to these goals, according to cultural and societal limits.

The question of whether allowing the choices she wants to make will result in good for her, her family, and society is a key factor in utilitarianism. This is because the good that is aimed for also has a societal context—that is, it has ramifications beyond Ms Tan as an individual.

So while all theories rely on an obligation to care on the part of the health worker, they give startlingly different reasons for the existence of that obligation.

## EXERCISE 1.2 COORDINATING CHOICES

### CASE TWO

You are involved in a coordinated-care program, in conjunction with many different health care providers in your local area. The money available for care is controlled by a central coordinator, in this case a nurse, and the money is hypothetically capped for each chronic health problem. Your client, Mr Helm, is in his mid-forties and has many complex medical problems resulting from a car accident that happened five years previously. This accident left him with internal injuries. A new drug has just finished being tested and has been registered. There is a possibility that the drug could significantly help your client, but it is not known if the results, as published in your professional journal, apply to him. The drug is also very expensive. Mr Helm does not know about the new drug. He comes to see you as part of ongoing rehabilitation, and expresses dissatisfaction with the current treatment plan. He wistfully says that he wishes there was something else he could try.

Coordinated care places emphasis on working as a team. In relation to any particular client, the objectives of care, arrived at by the team, are crucial. Discussing what each member of the team is aiming for is important, as is discussed in Chapters 2 and 3 (coordinated care is discussed in Chapter 3).

Libertarian theories, in particular, would allow as much choice as possible to be made by the individual patient. The professional may be obliged to promote such a choice if they adhere to libertarian or other autonomy-based theories. Apart from questions of ability to make treatment and life decisions, apparent in case one, there is

Oxford University Press Sample Chapter

an issue of information disclosure here. The professional holds information that may be relevant to the patient's choice. The importance of the patient knowing the relevant information before treatment decisions are made is discussed in Chapter 4. Paternalism, which contrasts sharply with libertarianism, may be at work if the practitioner is withholding so much information that it effectively nullifies patient choice.

Deontology would ask whether the possible treatment really is better for this client. Research is essentially a balance of risks and benefits, as discussed in Chapter 12. This is the case in drug development and research too, as outlined in the section on drugs in Chapter 8. Is a new untried treatment better than the myriad treatments and side effects currently available to Mr Helm? This value judgment clearly needs to be made with professional clinical expertise and with the relevant medical facts available.

In the case study of Mr Helm, the facts given are scant. If the risks include significant harm, the ethical obligation to care may translate into an obligation to protect rather than chance further injury. The chance of further injury can be hard to predict in situations where complex conditions are treated with multiple powerful drugs. You may like to consider whether you are sufficiently knowledgeable or skilled to deal with that drug, or with the combination of it and other medications that Mr Helm is currently taking (and will, no doubt, continue to take). The limits of skill are a central issue in caring, and this is the subject of a reflective exercise in Chapter 2.

The obligation to provide the best available treatment is double-edged. You may have an idea of what is best, but is it 'available'? Certain utilitarian theories hold that a good should be available to the greatest number, giving society the ethical authority to limit the availability of resources. Under these theories, limiting the access that certain individuals have to certain resources is justifiable if those individuals consume 'too much' of the health care budget.

## PRINCIPLIST FRAMEWORKS

Principlist frameworks for decision making are a modern phenomenon. They are tools for summarising, in shorthand and in a thematic way, the obligations and aspirations of health care workers. These frameworks are a facilitative naming of principles, and rather than providing an answer or sole principle to follow, they foster exploration of various aspects of a health care role.

The principles themselves are ideals that guide health carers in their work: to care, to do no harm, to respect integrity and autonomy, and to share resources fairly. Different principlist frameworks are described in Chapter 2, together with the different principles that are named, including those of Beauchamp and Childress—beneficence, non-maleficence, autonomy, and justice—and Gillon—respect for autonomy, beneficence, non-maleficence, and justice.[9] Chapter 2 uses the principles of Beauchamp and Childress as a tool to summarise issues in a vignette on general

Oxford University Press Sample Chapter

practice. They are also an essential part of the exercise requiring you to summarise your code of ethics. In Chapter 12, the similarly constructed principles of beneficence, respect for persons, and justice are also used to highlight key ethics concerns in health care research.

These principles can be shown to be compatible with diverse ethical theories, as is shown in Chapter 2. Some thought needs to be applied in situations in which the principles conflict though, as different theories would prioritise the principles quite differently. For instance, while libertarianism's central value—individual freedom—emphasises autonomy, communitarianism's concern with achieving good for all (in a fair manner) emphasises justice. Drawing the line at harm that is unacceptable (even when the patient has indicated a willingness to be harmed, or there is a good that must be promoted) emphasises beneficence. Because the principles used in principlist frameworks are summarising principles, they should not be used alone. You can use a principlist approach in combination with any of the ethics theories outlined above.

FROM THEORY TO PRACTICE

### Making the abstract knowable and then relevant to clinical practice

Contributor: *Alix G. Magney*

At face value clinical ethics seems intuitive: be kind to patients, make good decisions. But each of the terms 'kind' and 'good' are value-laden and unspecific in their meaning. Beginner students don't understand why they need to 'learn' ethics. In essence the problem is that students don't know enough to know that they really need ethics. As one medical student said, 'Ethics is abstract; shades of grey, not like a list of things you have to learn'.

The challenge of teaching ethics is making the abstract knowable and then relevant to clinical practice.

I firmly believe in learning the theory first and immediately applying it. For example, when teaching the Principle Approach—autonomy, beneficence, non-maleficence and justice—I ensure that the students have a clear and plain understanding of the terms. In small groups they are asked to analyse a public health scenario with at least five stakeholders using the four principles. They are asked to adopt a role and debate the issues that have arisen. In a large class discussion we evaluate the concerns of the various stakeholder groups.

The value of this exercise is that the students learn that the Principle Approach is more than a list of abstract terms. It is a valuable tool for drawing out the ethics concerns of any situation.

Using the Principle Approach students elicit issues and examine a range of perspectives from each of the stakeholders. It is imperative that they apply all the principles to every

Oxford University Press Sample Chapter

stakeholder because in doing so they come to recognise the entirety of the stakeholder position. Furthermore, the inherent efficacy of the approach becomes apparent to the user.

Through the application of the Principles, students appreciate the significance of each of the terms. It is one thing to say autonomy is 'an individual's freedom to choose'. In reality, valuing individual choice can be confronting, particularly when you don't agree. Autonomy is a weighty term and comprehending and truly respecting someone else's autonomy requires you to have tolerance, empathy, and grace.

Quite often students are scared of using words if they think they are going to pronounce them incorrectly. I get the entire group to chant the terms out loud, so that they get used to saying the words. I also insist the students use the terms when they are explaining their positions to the class.

Learning needs to cement the words and their meaning in the minds of the learners.

## RELATIVISM

Relativism is mentioned in Chapter 2. It is an example of an approach to the search for minimum acceptable standards that is often conducted when two groups differ on the appropriate course of action in treatment.

Relativism is not compatible with deontology, in which rules are universally applied, but it can be used in combination with other moral theories, such as utilitarianism or communitarianism. Relativism takes note of the rules or values that are appropriate for the context in which decisions are made.

## CASUISTRY

Casuistry is also a pragmatic addition to ethics. It emphasises the importance of understanding value-laden decisions in their appropriate factual context and culture.[10] Legal reasoning, such as is discussed in the context of informed consent in Chapter 4, is very close to casuistry. It starts with the facts and context, and relates them to precedent. Precedent is law derived from previous decisions in cases involving the same or similar circumstances. To apply precedent in a legal context is to use a type of case-based legal decision making that applies certain legal principles derived from an accumulated history of case law to the particular facts of the dispute. Each new case tests whether the same precedent applies, given the slightly varied facts and circumstances.

## CHOICES TO BE MADE WHEN REFLECTING ON CASES

The next two cases highlight the different approaches you can use to begin your analysis if you make use of the various models of ethics analysis.

Oxford University Press Sample Chapter

## EXERCISE 1.3 SPECIFIC REQUESTS

### CASE THREE

A 15-year-old girl, Karen, who is doing her Year 10 exams soon, comes to see a general practitioner. She says she feels tired but can't sleep, and is very worried that she won't do well in her exams. Karen asks for sleeping tablets. She does not want her parents or her normal doctor to know that she is seeking medical treatment.

The most common starting point for ethics analysis is the principlist model suggested by Beauchamp and Childress, which uses the principles of beneficence, non-maleficence, autonomy, and justice. Once you separate out the issues into these four categories, or try to brainstorm what might be a concern in each of the four, you will have made a good start to recognising the complexity of the case. For Karen, autonomy and the decision-making process will loom large. Once you have the issue tagged under autonomy, you can start to identify what is problematic about it. You might look to the sections on competency and decision making, as in Chapters 4 and 7, or to those of confidentiality in Chapter 5. The purpose of care might be discussed, and you could consider the options that may be open to the professionals who see Karen. Just stating the existence of an issue does not solve it. You will need to explore each issue and discuss if the issues are in conflict: such as if a patient's choice (autonomy) conflicts with the needs and resources available to others (justice).

The ethics theories and frameworks are very helpful in deciding how to resolve conflicts between the shorthand principles.

The Beauchamp and Childress model has appeal partly because of its simplicity, and partly because it can be realistically undertaken by any interested party. Professionals can readily use it. So can patients themselves, if they wish, or their family. It is useful for policy makers and administrators too, as it includes big-picture issues of resources alongside the potential complexities of individual circumstances and situations. It is quite useful in 'macro' community-type decisions, as well as 'micro' individual issues.

Thinking about the practical casuistry approach in the case above, given this situation of a teenager asking to be treated, independent of her family or guardian, and seeking a specific short-term 'fix' to what may be a larger complex problem, the usual approach of the clinic may well largely determine how her request is handled. An 'acceptable' course of action may already be defined by other experienced team members, and even if the ethical reasons remain unarticulated, actions by team members in the past in similar situations could guide the person treating the 'Karen' who presents as a patient this time. Tea room chats and team meetings provide a wealth of lessons learnt from past cases, and these stories are the material of casuistry.

Oxford University Press Sample Chapter

## EXERCISE 1.4 CARE AND UNDERSTANDING

### CASE FOUR

An 87-year-old man, Mr M, is in a nursing home, in reasonable health for his age apart from forgetfulness of recent events and chronic hip pain. He was admitted after the death of his wife from cancer. The local GP said Mr M had been about to have hip surgery but postponed it to a few weeks after the funeral. The nursing home is preparing Mr M for the trip to hospital for a hip replacement. Each time the process is explained to him, he forgets by the next day. The operation is booked for one week's time.

What should the nursing home staff do, and why?

Two models that summarise issues into meaningful clusters that will be presented for you are those by Jonsen, Siegler, and Winslade,[11] and the rules of thumb by Jennett,[12] both included in Chapter 4. These are clinically focused, and seem to be compatible with an analysis undertaken primarily by the clinician. If you were to start with Jonsen, Siegler, and Winslade's model in your analysis, you would first try to understand the 'medical indications', or what the medical situation facing the patient is. Then you would look for evidence of client preferences, consider quality of life, and finally contemplate contextual features like the resources and so on. Note that you would summarise the issues in a different sequence from that if you were using Beauchamp and Childress's model. Some of the same issues would appear of course. The primary starting point is the health or medical issue to be dealt with, so the process is driven by the health carer, and seems in that sense to be favouring a carer's view of the important features to consider. This is similar to the 'enhanced autonomy' model you will read about in relation to decision making (Chapter 4), in which the decisions to be made are limited to those judged to be appropriate by the clinician. This seems a sensible emphasis, given that the health professionals are making themselves available to offer benefit to their patients.

If you were to apply Jennett's rules of thumb, which are explained in Chapter 4, you would explicitly consider whether to apply a specific action or treatment option. So it is important to identify the likely treatment options, and then analyse each one. You would consider whether the proposed treatment is appropriate, or rule it out if it is unnecessary, or likely to be unsuccessful, unsafe, unkind, or unwise. Some of these models emphasise judgments of care and likely benefit, some emphasise likely harm, and some emphasise questions of resources and justice. So, again, the elements that you would discuss if you used Beauchamp and Childress's principles appear in your analysis. Notice again, though, the emphasis on care issues, and a clinician's interpretation of those issues. There is little explicitly on autonomy built in to this rule-of-thumb analysis, except that each treatment is an option or choice potentially to be offered to the patient.

Oxford University Press Sample Chapter

A relativistic approach would cast your net for gathering up issues to ponder a little bit wider than either of these models, or at least, it would emphasise the personal, cultural, and community context of the issue, and acknowledge diverse perspectives on the definition of the ethically tricky issues and their resolution. Given his view of the facts, Mr M's own preferences are important, but not more so than those of the health carers or indeed the community that is effectively providing the health care options under contemplation.

## CASES TO PONDER

The following cases invite you to think through developing scenarios. It is quite routine in health care for situations to develop over time, and for different ethical challenges to emerge at different points of the process of care. Make your preliminary notes on these cases now, then, as you work through the book, look back here occasionally to add your suggestions for how to analyse the emerging ethical issues.

Remember that when making your decisions in the future, you can rely on a rich tradition of reflection and analysis that can be found in the ethics writings of others. Listen well to learn from the thoughtful decisions that have been made by those who have worked in health care before you or who work alongside you, and actively reflect on your practice. The wisdom that you will build will serve you well in making robust decisions in your everyday practice.

### EXERCISE 1.5 WORRIED ABOUT MUM

#### CASE FIVE

Ms B has recently moved from the country to an outer suburb of a large city, to take up a student place at a college. She has two small children, and is receiving a government study subsidy and family support benefits. She is enrolled in a diploma course, and hopes eventually to be able to support herself and her children, for whom she is the sole carer. Ms B wants to arrange routine immunisation for her children and visits a local GP. She takes their previous record of immunisation with her, which is entered in the back of the children's 'child health book'. This book, kept by Ms B, contains entries of the child health nurse visits from when they were babies, and the immunisations they had received. The children are examined, and a history of their health and previous illnesses is taken by the GP and noted in their new medical records. Both children appear to be well, and are given the vaccines that are due for them according to the government-recommended immunisation schedule. This is only done after checking that they didn't appear to have been given any of them previously, both by asking Ms B and by reading the entries in the immunisation record page of the book.

Oxford University Press Sample Chapter

Ms B is advised when to bring the children back for their next booster. A record of immunisation is entered into the 'child health book', and also in the GP's own records. The GP bulk-bills for the children's consultation, asking for no money from Ms B directly for either the consultation or vaccines, noting the Medicare and pension card that Ms B has produced to the reception desk earlier. The GP also asks Ms B whether she already has a GP for her own health needs since she has moved. The GP has noticed that Ms B appears to be thin, tired, and withdrawn, and that her teeth look chipped and damaged and her gums look swollen. She doesn't appear to be well. Ms B replies that she hasn't been to a GP as yet because she hasn't been sick. Then she volunteers that she was in an 'accident' in the country and is waiting for dental care. She says she can't afford to go to a private dentist, and had been on a public waiting list a while back, but hadn't heard yet that an appointment was available. The GP offers the number for a more local public dental clinic, and suggests that if Ms B rings, she may be able to have her appointment moved to that clinic.

Ms B returns at the next scheduled time. The children have a cold and can't be immunised that day. The GP examines them and rules out more serious febrile illnesses, but explains that the process of immunisation can have more serious side effects if a child is unwell, so it is safer to return the next week.

A week later, when Ms B returns with the children, she apologises that she has forgotten to bring their health books. The GP suggests that Ms B drops the book in to reception some time, or just to bring it along at a subsequent visit, so the details can be updated from the GP records. Both children have recovered, and receive their next booster. Ms B volunteers that a date for her dentist appointment hasn't been set yet, but that it seems possible to move it. She seems resigned to wait her turn. The GP worries that there may be more gum deterioration in the meantime, but feels that public dental care is really outside her control. She suggests that Ms B come for a check if she feels she has unusual tooth, mouth, or jaw pain, or for other health issues.

Ms B continues to return at the relevant times for the children, but does not present as a patient herself. The GP continues to worry about Ms B's overall health, particularly given Ms B's heavy study workload and sole caring responsibilities.

## EXERCISE 1.6 CONFUSION AND DECISIONS

### CASE SIX

Lian is a new graduate in nursing and Dr S (Phil) has just finished his specialist physician medical training. They will be working together in a public hospital inpatient ward. It is a new posting for both Lian and Phil. Lian is quite young, having gone straight from school to uni, and is just 21. Phil is older, with six years of undergraduate medicine training, a year as intern, then two as registrar before starting his postgraduate training. He is 32.

*(continued)*

Oxford University Press Sample Chapter

Jan, an experienced social worker, is part of the ward team, but is also on call to three other wards with elderly patients. She has been in her position for almost 15 years. On a break in the tea room they cross paths, and Jan takes the initiative to welcome the newcomers. They chat easily about new developments in the field, and Jan comments on not only how the changes have improved patient outcomes and potential quality of life, but also on how families bear a large carer responsibility. Phil mentions a new technology he heard about at a conference the previous month that is being developed and trialled as an alternative to a particular operation. He is hoping it might become available for trial at the hospital. Lian mostly listens, but feels lucky to be part of such a pleasant ward dynamic. She has heard that some places aren't as ideal. She lets Phil and Jan know she is a new graduate, and might have to ask lots of questions. The others encourage her to let them know if she's not sure of anything and hasn't had a chance to ask her supervising nurse. She thanks them.

The public hospital budget is stretched. Three of the beds are effectively closed, and there is pressure to discharge patients in a timely manner so that other more seriously ill patients can be admitted. Jan is worried that the time needed to check that home care arrangements are in place is being curtailed, and that sending sick people home in that circumstance is potentially dangerous and stressful for family members. Lian is just run off her feet, doing a few double shifts to cover for other staff when they are sick. Fewer casual staff are being called on to help given the budget situation. She feels like she is on a steep learning curve. Dr S is busy, in clinics, operating, on ward rounds, testing procedures, and some private consulting, but enjoys the pace.

Mr I has been admitted overnight, dazed, confused, and ill. He will be having a series of tests and has been given a bed on the ward. Lian introduces herself when she comes on shift. Mr I says he just wants to sleep. Lian checks the tests that he is booked in for, and explains to Mr I that he will be coming and going from the ward, with the orderlies and a nurse if necessary, for the tests the doctors want done. She tries to disturb him as little as possible, but makes sure that he is ready and gowned when the orderlies are expected. He seems a bit confused to her, calling her Nina repeatedly. He doesn't refuse to go for the tests, but he doesn't seem happy. From her reading of the notes, Lian can see that Nina is one of his daughters. Lian puts her observation of confusion in the nursing notes as well as the routine observations (temperature, blood pressure, and so on) she records. Some of the family visit, including Mr I's elderly wife and his son. They comment that 'Dad seems a bit out of sorts'.

Throughout the day, there is some progress in identifying the cause of Mr I's current illness, with test results ruling out some of the more serious possibilities, but still identifying a condition likely to become very serious if not eventually corrected surgically. Some stabilising medication is discussed among the doctors, then Dr S meets with Mr I and family members who are present in the ward at the time of his ward round. This time, it is a daughter, Kim. The medication is discussed, and orders for it are written into the notes. Lian starts the medication regime straight away in conjunction with the supervising nurse.

Oxford University Press Sample Chapter

The possibility of Mr I undergoing an operation, as soon as he is sufficiently stabilised, is discussed with Mr I, who is advised to think about this.

The next day, Dr S returns on his ward round to see some further progress in Mr I's condition. He seems to be almost stable enough for the operation. However, Mr I seemingly has no recollection of his discussion about an operation. Dr S was hopeful about scheduling it for the more urgent list, to be done any time within a month, but feels uneasy that Mr I is not retaining or understanding what was said yesterday in their consultation. No family member is present. Phil puts a call in to Jan for a social/competency assessment as part of the consent process. He wonders if it is a temporary problem or a more long-standing one, and plans to seek more structured family input if need be, after the competency assessment. When an operation is raised, Mr I objects.

Mr I seems more lucid as the next day approaches. He tells Lian he doesn't want an operation, and he also doesn't want to be resuscitated if 'anything should happen'. Lian lets Phil and Jan know and the request is entered into the notes. A process is put in place to double-check that this is what he has decided, having understood current treatment plans, management options, and the implications of not pursuing active treatment, and that he is competent to make such a decision. Dr S is then confident that Mr I understood the relevant information and is competent to make such a decision, concluding that his earlier confusion was temporary, and related to having been quite ill. He records the clarification of Mr I's decision not to pursue invasive treatment and his 'do not resuscitate' request.

The family asks Lian why nothing is happening, and if an operation is still likely. A meeting is arranged for the family and Dr S, who discusses the options, but also Mr I's request to refuse further invasive procedures and resuscitation. They are distraught, and ask to be the decision makers. They say 'He doesn't know what he is doing. He wouldn't do it, just give up. It is against our culture and religion.' Jan spends some time with them, assuring them that if he changed his mind it would be different, but that respecting his views and wishes is the utmost priority. They are assured that the medication will keep him fairly stable for as long as possible, and he will be reviewed in the outpatient clinic periodically by the doctor. Plans are made to discharge Mr I into his family's care.

Phil comments in the tea room that Mr I would be a candidate for the new procedure he had been talking about a few days earlier, if the research trial was under way as an alternative to the operation that was standard now. Of course, he would have to consent, he says, with a shrug of his shoulders and two raised hands.

## SUMMARY OF KEY ISSUES

- Theoretical traditions
- Reflection on practice
- Joint responsibilities in professional life.

Oxford University Press Sample Chapter

## SHORT NOTES

1 Gillon, *Philosophical medical ethics*, p. 2.
2 Moreno, *Deciding together*, p. 4.
3 Gillon, *Philosophical medical ethics*, p. 2.
4 Collinson, *Fifty major philosophers*, p. 16.
5 Beauchamp and Childress, *Principles of biomedical ethics*, 4th edn, p. 465.
6 Collinson, *Fifty major philosophers*, p. 21.
7 Spicker et al., *The use of human beings in research*.
8 Mill, 'On liberty'.
9 Beauchamp and Childress, *Principles of biomedical ethics*, 4th edn; Gillon, *Philosophical medical ethics*.
10 See Brody, 'The four principles and narrative ethics', p. 211.
11 Jonsen et al., *Clinical ethics*.
12 Jennett, 'Quality of care and cost containment in the U.S. and the U.K.'.

Oxford University Press Sample Chapter