Integrating ethical decision making into everyday clinical practice:
Principles and practice of Ethical Decision making

Dr Stephen Louw
Roadmap

• Quick overview – moral theories and 4 principles

• Deductivism contrasted with Case-based (Casuistic) moral reasoning

• How to integrate ‘ethics’ into your trust – some suggestions
Why is it important to be confident in ethical analysis?

• You will encounter ethical challenges in your career
• You are encountering them now, all the time
• Being conversant with Ethics equips you to
  – recognise and delineate ethical issues
  – be more confident in discussing them
  – choosing the best option
  – being able to justify your decision
The most noted moral theories

• Virtue Ethics (virtues & moral character)
• Consequentialism (the best outcomes)
• Deontology/Kantianism (obligations, duties & rules)
• Liberal individualism (Rights-based theory)
• Communitarianism (Community-based)
• Ethics of Care (relationship-based)
‘The Four Principles’ approach to ethical analysis
Beauchamp and Childress

“The common morality contains a set of moral norms that includes principles that are basic for biomedical ethics.”

• Respect for autonomy
• Nonmaleficence
• Beneficence
• Justice (a group of norms for distributing benefits, risks and costs fairly)

• Beauchamp Tom L, Childress James F: Principles of Biomedical Ethics, 5th Ed, OUP
Moral Reasoning
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_How do we get from the ‘theory’ to the ‘practice’ of ethics?_

- Arguing from theories to principles to the case (deductivism)

- Case-based analysis (‘casuistry’)
Deductivism

Moral theory

PRINCIPLES

Rules

Individual case
An example of deductivism

• Your service does clinical research. It is suggested that you ‘lean on’ patients a bit more to get them to consent to clinical trials.

• *Deontology* states that persons are ‘ends’ and should never be treated as a ‘means to an end’

• Key relevant *principle* in medical ethics:
  – Autonomy – this determines a process of *fully* informed consent, free from any pressure

• In terms of autonomy: You conclude that you have an absolute duty to ensure that patients are free from coercion when giving consent.
An example of deductivism

• Key relevant *principle* in medical ethics (for this case): autonomy

• In terms of autonomy: You conclude that you have an absolute duty to ensure that patients are free from coercion when giving consent.

• **NOTE:** here the principle of autonomy is *determinative*: it drives the logic of the argument towards your conclusion.
Critique of deductivism

It is practically very difficult, in clinical ethics, to argue from moral theories to individual cases - the constraints of formal deductivism are too unforgiving - besides, it will take all day to do formally!
Moral Reasoning

*How do we get from the ‘theory’ to the ‘practice’ of ethics?*

- Arguing from theories to principles to the case (deductivism)
- **Case-based analysis** (‘casuistry’)
Moral reasoning - the unrealized place of casuistry in medical ethics. Louw SJ, Hughes JC

Case-based reasoning (Casuistry) (1)

Jonsen & Toulmin. The Abuse of Casuistry. 1988

- USA Congressional National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (1975-8)

- 11 commissioners (of varying backgrounds and training) found that they usually agreed in their practical conclusions

- Commissioners soon developed “moral taxonomies” for classifying the morally significant similarities between various kinds of research cases = the casuistic mode of moral thinking
The locus of certitude lay in a shared perception of what was specifically at stake in particular kinds of human situations.....

But...

Serious differences of opinion arose when individual commissioners explained their individual reasons for agreeing to a collective recommendation

‘The moment [the debate] soared to the level of “principles”, they went their separate ways.’

This caused Jonson and Toulmin to realise that the Commissioners were most adept at arguing in terms of case-based reasoning (casuistry)
Case-based reasoning (casuistry)

- More commonly used in ethics
- Forms the basis of ‘English Common Law’
- Is less ‘abstract’ than deductivism
Case-based reasoning (casuistry)

How to do it

– *Immersion* in the details of the case
– *Interpretation* and comparison with previous similar cases
– *Conclusion is ‘provisional’* – ‘presumably so.’
– *Consider exceptional circumstances* (‘rebuttals’)

....This is a much more ‘practical’ approach to ethical analysis
Casuistry (5)


• **Immersion** in the particularities of the case specifically and into the realities of the clinic generally

• **Interpretation** – theories have to be interpreted to apply to a particular case; theories are treated as *informative*, not as *axiomatic*
Case-based reasoning (Paed transplant)

An example

- *Precedent case*: It is generally accepted that in children with end-stage disease on an ITU, the parents may be approached to request donation of organs when the child’s treatment is withdrawn.

- *New case*: In the instance of a child with a beating heart, the question arises whether it is reasonable to withdraw treatment and allow the heart to stop (i.e. allow the child to die), then to remove the heart for transplantation...
Case-based reasoning (Paed transplant) 2

• Here the details of the case should be explored
  – how will death be defined;
  – is there a moral difference between removing a heart and a kidney;
  – how will the child die in the heart donation situation v the kidney donation situation

• Here the closeness of the similarity with the precedent case(s) should be carefully considered

• Here the *principle* of non-maleficence and the duty to respect life are *informative*, but not deemed determinative.
Casuistic reasoning: Anorexia (1)

• An anorexic patient
• Wishes to die by starvation – this is an autonomous decision: able to argue coherently with the clinical staff....
• Psychiatric opinion is that patients with anorexia are not necessarily ‘free’ to make decisions
  – In a sense they are being ‘coerced’ by their obsession to be thin
Casuistic reasoning: Anorexia (2)

Here is a typical case:

- 32y old woman, “E”; anorexia nervosa, alcoholism, depression
- Sexual abuse as a child
- Eating disorders since age 15 – in hospital etc for 6 years
- Placed under Compulsory Mental Health Act section X 10
- Advance decision refusing resuscitation or life-prolonging treatment signed in July and Oct 2011
- March 2012 – detained under Mental Health Act, refused tube feeding; refused to eat; over past 2y BMI 11 – 12.
- Describes her life as “pure torment”
Casuistic reasoning: Anorexia (3)

• She knows death will follow; pleads for an end to treatment and respect of her wishes

• Discussion with parents who think she should be allowed to die....
Casuistic reasoning: Anorexia (4)

• Options:
  Allow E to die
  Forcibly feed E against her wishes

• Even with prolonged feeding, her likelihood of recovery is estimated to be 20%

• Discuss
FRAMEWORKS...

Practical clinical ethics framework to be used in CEAG discussions

1. What are the relevant clinical and other facts (e.g. family dynamics, GP support availability)?
2. What is the goal of the analysis? To explore an issue/to get unstuck/to make a case/to decide for yourself/other
3. What are the key ethical questions?
4. What does the law / professional guidance say about each of these questions?
5. List the available options in relation to each question in the form of propositions (allowing ‘for or against’ arguments)
6. What are the morally significant features of each option?
6. For each realistic option, identify the moral arguments in favour and against – if opinions are stated, they should include the ethical reason for that opinion.
7. Consider previous decisions on similar cases taken by CEAG or recognised authorities.
8. Clearly choose the acceptable options, based on the relative merits of these arguments using the following tools. Are there any key terms the meaning of which needs to be agreed e.g. ‘best interest’, ‘person’?
   - Are the arguments valid?
   - Consider the foreseeable consequences (local and more broad)
   - Do the options ‘respect persons’?
   - What would be the implications of this decision applied as a general rule?
   - How does this case compare with other cases?
9. Review this decision in the light of what subsequently happens, and learn from it.
Casuistic reasoning: Anorexia (5)

- Taken to Court
- The Hon Mr Justice Peter Jackson (High Court):

  E does not currently have capacity

Re E (Medical treatment: Anorexia) (Rev 1) [2012] EWCOP 1639 (15 June 2012)
The Hon Mr Justice Peter Jackson (High Court):

- “E's case has raised for the first time in my experience the real possibility of life-sustaining treatment not being in the best interests of a person who, while lacking capacity, is fully aware of her situation.

- She sees her life as pointless and wants to be allowed to make her own choices, realising refusal to eat must lead to her death.

- Her situation requires a balance to be struck between the weight objectively to be given to life on one hand and to personal independence on the other.”

Re E (Medical treatment: Anorexia) (Rev 1) [2012] EWCOP 1639 (15 June 2012)
Casuistic reasoning: Anorexia (6b)

The Hon Mr Justice Peter Jackson (High Court):

“48. There is no doubt that E has an impairment of, or a disturbance in the functioning of, the mind or brain in the form of her anorexia.

Equally it is clear that in terms of MCA s. 3(1) she can understand and retain the information relevant to the treatment decision and can communicate her decision.”

Re E (Medical treatment: Anorexia) (Rev 1) [2012] EWCOP 1639 (15 June 2012)
Casuistic reasoning: Anorexia (6c)

The Hon Mr Justice Peter Jackson (High Court):

“49. However, there is strong evidence that E's obsessive fear of weight gain makes her incapable of weighing the advantages and disadvantages of eating in any meaningful way. For E, the compulsion to prevent calories entering her system has become the card that trumps all others. The need not to gain weight overpowers all other thoughts.”

Re E (Medical treatment: Anorexia) (Rev 1) [2012] EWCOP 1639 (15 June 2012)
Casuistic reasoning: Anorexia (7)

• In October on the day she signed the document she was “sectioned” and had not had any formal capacity assessment...
• “medical, social work and legal professionals were all confused about whether or not she had capacity” in July 2012
• Concluded: Pt did not have capacity then either.
Casuistic reasoning: Anorexia (8)

• Now: Consider the following case:

• 60 year old man (‘Robert’) - treated for depression; “borderline personality disorder”; alcoholism.
• Several previous parasuicide episodes
• Not actively dying of any physical condition at present....
Casuistic reasoning: Anorexia (9)

• Tells doctors that he wishes to die. Very matter of fact about it. “Life is intolerable…”
• Assessed to have capacity, i.e. understands the nature of his condition, his options, consequences of his decision.
• Demands to be allowed to die.
• Initially sectioned under MHA, and treated for depression.
Casuistic reasoning: Anorexia (10)

• Casuistry:
  – Is Robert’s case a close (enough) match with that of E?
  – Even though Robert can be said to have capacity in terms of the criteria of the MCA, should this be disregarded because of his ‘weakened state’?
Casuistic reasoning: Anorexia (10)

• Is a person with normal cognitive faculties, but with a depressed mood, capable of making an autonomous decision?

• .....is the ‘burden of depression’ a form of “compulsion” that renders them less than autonomous?
Casuistic reasoning: Anorexia (11)

• Recent publications:
• Patients with psychiatric conditions are able to “understand” but are unable to “appreciate” the reality of a potential positive outcome if treatment were accepted.

Decision-making capacity for treatment in psychiatric and medical in-patients: cross-sectional, comparative study. GS Owen, G Szmukler, G Richardson et al.
Depression and decision-making capacity for treatment or research: a systematic review Thomas Hindmarch, Matthew Hotopf and Gareth S Owen. BMC Medical Ethics 2013:14:54.
MacArther Competency Assessment Tool

• Goes further than the simplistic 4 steps of the MCA:

• We must also assess

“the degree to which patients are understanding the information and recognising (“Appreciating”) the relevance of the information to their own situation.”

(MacArthur Competency Assessment Tool)

In Depression and decision-making capacity for treatment or research: a systematic review Thomas Hindmarch, Matthew Hotopf and Gareth S Owen. BMC Medical Ethics 2013:14:54.
Casuistic reasoning

• Casuistry causes us to:
  – consider previous similar cases and challenges us to decide whether the same moral conclusions should apply to the current case
  – attempt to be consistent
  – attempt to clarify our justifications for our decisions.
Case-based reasoning (casuistry)

How to do it: the full Monty...

– **Immersion** in the details of the case
– **Interpretation** and comparison with previous similar cases
– **Conclusion is ‘provisional’** – ‘presumably so..’
– **Consider exceptional circumstances** (‘rebuttals’)

*Risk: “intuitive drift”*....
• Integrating ethical decision making into everyday clinical practice:

Principles and practice of Ethical Decision making

….. 7 (quick) steps:
Step 1

• Establish a Clinical Ethics Advisory Group (or Clinical Ethics Committee) – “CEC”

• ...be sure to have ‘opinion leaders’ on your CEC – even if they do not have ethics training
Step 2

• Ensure that your CEC is linked to all aspects of Clinical Governance at Trust Level
  – Clinical Standards Committee
  – Adult and Child Protection
  – Policies review group (restraints, DNAR etc)
  – Take a leadership role in MCA and DoLS group
  – Liaise closely with the Medical Director
  – Send minutes to Clinical Directors
Step 3

• Offer to support ethics teaching and training for medical students and nurses and young doctors – at induction and during the year

• Offer to attend Departmental M&M meetings, Clinical Governance and audit meetings (“in order to ‘give an ethics perspective’ “)
Step 4

• Offer to give a lecture (at least annually) at a general meeting (including managers) in your trust – e.g. on “Professionalism” or “Ethical implications of the Francis Report” or “Facing up to a paninfluenza epidemic” etc ....

• Support the establishment of Schwartz Rounds in your trust – and speak up ‘from an ethics perspective’ at these meetings
Step 5

• Make your CEC available for urgent ‘bed-side’ ethics consults – be sure not to disempower clinicians....

.....“I am simply here to help us think through the ethical implications of the different courses of action open to the clinical team”...
Step 6

• Provide an ethics framework (e.g. the UKCEN frameworks) to ITU trainees and Older Peoples Medicine trainees – i.e. “high risk areas”

• Encourage “ethics-speak”: Not “in my opinion”…

• ….but “based on this ethical principle, I think it follows that….”
Step 7

• Encourage trainees to do at least one ‘medical ethics-type audit’ as part of their PDP in their F1/F2 years

• Encourage Educational Supervisors to consider domains of “ethical behaviour” when they comment on “Professionalism” in their End of Year reviews.
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