Catholic On Call handbook
Chapter 1- Decision-making in health care

Medical ethical principles

Ethics is the science of the morality of human acts or **Moral philosophy**. It is derived from reason and collective experience. Adding Divine revelation to this is **Moral theology** or applied ethics. The norm of morality is conformity to human nature, right reason and God's commands. It is objective, intrinsic and unchanging and is not judged by majority, custom, human law, altruism, expediency, feeling or consequentialism. Evil is the absence of any good that should be present.

The Natural Moral Law, is a code of moral conduct that conforms with human nature. A radio is for listening to, not for hammering a nail into the wall. Dogs bark, ducks quack. “The normalcy of a thing’s functioning” (Maritain). It obliges us to do good and avoid evil. The 10 commandments, except for the third, which is Divine positive law, outline some of the tenets of Natural Law.

Conscience, the judgement of reason (Catechism n.1778), operates within the limitations of intellect, knowledge and freedom. It can be true or false, lax, doubtful or scrupulous. A tender or delicate conscience is our goal. We are bound to follow our conscience - going against it may be sinful even when doing an act that is not morally wrong. Later enlightenment has no retrospective effect on an act done when conscience was in error.

An act is judged morally by its intrinsic nature and meaning, its purpose and its circumstances. If any one of these is evil then the act is evil and the person doing it is evil. However, knowledge and free will may mitigate, aggravate or exonerate one's guilt through ignorance (vincible and invincible), fear, concupiscence (antecedent and consequent), threat or violence, habit, temperament and mental disorders. They do not however absolve us from striving to overcome these weaknesses or to avoid unnecessary occasions of sin.

“True law is Reason, right and natural, commanding people to fulfil their obligations and prohibiting and deterring them from doing wrong. Its validity is universal; it is immutable and eternal” (Cicero; De Re Publica, III, 33).

There are 2 common principles relevant to medicine in deciding on moral action. These are the principle of double effect and the principle of formal and material cooperation.

Principle of double effect

If an action produces 2 effects one morally good and the other morally evil, it may be done if it fulfils the following conditions :

1. The action itself must be morally good or indifferent
2. There must be a good effect comparable to the evil effect
3. You must have the good intention to seek the good effect
4. There must be a proportionately serious cause for doing that action (there is no reasonable way of avoiding the evil effect).
5. The good effect must not be attained by means of the evil effect.

Corollary

A morally evil act cannot be done even to obtain a good effect. To claim it could would be to say the **evil** act is a **good** thing to do. Good and evil would become indistinguishable. And since all evil actions have some good effects (that’s why people do them), the evil is cumulative. The

Machiavellian (N. Machiavelli, 1469-1527) model accepts what people do, rather than what they ought to do, and may lead to this. Any appropriation of evil must be viewed in the light of the principles of co-operation. Pragmatism is “what works is good” and democracy is “governance by the mob.” While useful as tools of governance, they are insufficient even misleading as moral or ethical surrogates.

The Catholic MO/HO:

The Catholic MO/HO's encounter with this principle is diffuse and ubiquitous. Examples of possibly licit action are irradiation for cervical cancer in a pregnant woman with the risk of abortion, and increasing dosage of morphine to overcome tolerance when used for pain control although life may unintentionally be shortened. Abortion or contraception for claimed benefits are examples of evil acts to obtain good effects. It is illicit to deliberately kill a baby to save the mother's life or to use the morning after pill, an abortifacient, because intercourse was not sought. It is however licit to remove healthy organs to save the entire body such as oophorectomy for breast cancer.

Principles of cooperation

There are 9 ways of co-operating with evil - concealment, counsel, command, consent, provocation, praise or flattery, partaking, silence, defence of the evil.

The main divisions of co-operation are :

<u>Formal co-operation</u> is willing participation

a. explicit ("Yes, I'm happy to...")	**immoral**
b. implicit("I'm personally opposed, but...")	**immoral**

<u>Material co-operation</u> with the circumstances around the immoral act.

a.	immediate	eg employment in an abortion clinic	**immoral**
b.	mediate	eg in a hospital that does not require co-operation for a sufficient reason and if scandal can be avoided.	**may be moral**
a.	proximate	eg using products from embryonic stem cells	**may be immoral**
b.	remote	eg recovery room nurse	**may be moral**
a.	necessary	(the evil couldn’t occur otherwise eg anaesthetist)	**immoral**
b.	contingent or free	(others will still do the evil act)	**may be immoral**

Interactive factors

Accomplice vs Hostage or Taxpayer

Frequency	(a hospital notorious for abortion and/or sterilisation)
Gravity	(abortion vs condom distribution)
Proximity	(assistant surgeon vs recovery room nurse)
Necessity	(the only anaesthetist, dispensing poisons)
Limited freedom of choice	(eg legal injunction)
Scandal	(incitation of another to sin by example, command etc)

Application to Modern Corporate Partnerships - there are five basic principles:

1. Co-operation must be mediate material, never formal or immediate material.
2. We can only do together what all partners agree to be appropriate. This means that while the partnership need not be Catholic, it must nevertheless observe the Ethical and Religious Directives as respecting the "corporate conscience" of the Catholic partner.

3 Morally illicit procedures cannot be provided on the Catholic campus.

4. Any morally illicit procedure(s) provided on the campuses of non-Catholic alliance partners must be excluded from the new Alliance Corporation through separate incorporation (governance, administration and finance).
5. All publicity should be straightforward, i.e., the need to form an alliance for the survival of a worthy apostolate should be made known, the good achieved by rationalising health care must be to the patients' benefit, immoral procedures must be excluded from the partnership (while these services may still be available on the campuses of some partner[s]), and this publicity should also appear in the promotional literature of the Catholic hospital. The observance of these principles should issue in a morally sound and scandal-free partnership that will contribute to the Catholic health care tradition.

Examples

1 [O&G as a HO] I clerked cases admitted for abortions and ligations and tried to counsel if possible. As for the procedures of taking pre-op blood tests and signing of consent forms, I did not do them myself but called upon a colleague to do so. The same applied to bloods and consent for Caesarean sections at which ligation would be simultaneously performed. I have scrubbed out of theatre when after LSCS, a ligation procedure was to be done. I would try to find out the ops to be done before scrubbing in.

[Polyclinic] I inform the head of the Polyclinic and the nurses at the Family Planning room not to send me any cases for prescription of OCs or insertion of IUCDs. If I happen to see them because they were not triaged or if I see them for postnatal check-ups and they ask about family planning, I will give a general overview of different family planning methods available and try to reinforce that life is a gift and that family planning should be reserved for situations of real difficulty. I try to dissuade patients from the abortifacient methods especially and appeal to their conscience in not killing a life, especially for the Christians and Muslims. I try to keep a stock of NFP pamphlets and encourage NFP if FP is strongly desired. If they still insist on an artificial means of contraception, I will ask my next-room colleague to see the patient and take the next case from him as an exchange to even out the caseload.

For unwanted pregnancies, I try to counsel and offer alternatives & ask them to go back and discuss with the father of the child. If they still insist on an abortion, I'll tell them why I'm convinced I cannot refer them and again exchange the case with a colleague.

2 I think there is provision for the medical doctors to declare their religious or moral convictions as they start their postings in the OG department. With regard to trainees, they are interviewed beforehand and the department heads and senior staff are aware of their convictions. Medical students should be conscious of what is happening in the OG theatres and not be too naive. I think they are very well informed nowadays. Should they be in a situation as such, it is only polite and acceptable to the senior doctor for the student to speak up that they wish to be excused. I am sure the senior doctor understands or will eventually understand. There is no need for further explanation in the OR.

3 Supporting patients' illicit or harmful lifestyles and treating life style diseases eg STDs involves co-operation with evil. We must distance ourselves from the evil by not prescribing Viagra without pathology, or drugs of addiction or any contraception and by reporting patients where civil laws have also been broken.

No one would want to live with a lie in his soul, yet we can blind ourselves enough to do so at times. Thus, if we do have a lie in our soul, if we have chosen an explanation of our meaning and life that is contrary to the natural law, if we say of what is wrong, that it is right, or if we say of what is good, that it is bad, and live accordingly, then the last thing we want to hear is the truth. The truth *becomes dangerous to us because we have committed our lives to a lie and from this lie in our soul, our actions follow when we act on it." (James V. Schall, S. J.)*

Communication, compassion and empathy

Competent patients have a right to information and the truth, and uncertainty may be hard to bear, so the realities must be confirmed or refuted and then communicated as soon as reasonably possible. But while we should be honest, we don't volunteer information for which they have not asked, because that means they're not ready for it yet (Kubler-Ross).

Indeed, some patients may not want to know or relatives may demand that the patient be not told. This isolates the patient rather than protects him. A balance must be struck between relatives' fears and patients' needs and shift towards the latter with time. Care, patience and sensitivity for both patient and caregivers are needed for trust to develop and for earthly hope to transpose into an eternal hope. If asked about statistical chances say in effect, "50 percent live 1 year, another 35 percent live 2 years, and another so-and-so per cent live two and a half years.... the last 1 per cent is for hope" (Kubler-Ross).

Our responsibility does not stop at telling the patient, which is only the beginning of the journey with him as he passes through the 5 stages of dying - denial, anger, bargaining, depression and acceptance. Continued love, closeness and warmth will relieve his fear of loneliness and suffering and of losing autonomy and control.

Responsibility for health care

The primary responsibility for safe- guarding and maintaining one's health so far as that is reasonable belongs to each person in his or her own right. It follows that each person is primarily responsible for making decisions concerning his or her own health (and that of any incompetent person for whom he or she is also responsible). Since people sometimes need to seek help and advice in order to make reasonable healthcare decisions, this responsibility may at times be best exercised in consultation with others.

Information giving

To enable patients or their representatives to make healthcare decisions responsibly, healthcare practitioners should take care to explain clearly and accurately the patient's condition, the nature of the treatment options, the patient's prognosis with and without treatment, and the risks and harms inherent in any proposed treatment that the patient would be likely to think significant in making a decision. Where the decision to be made is a serious one, patients may be encouraged to have the assistance of a relative or friend and, if they desire, to seek a second opinion.

Decision-making capacity

In the context of health care a competent person is someone who is able to understand the diagnosis and what is proposed and to evaluate healthcare options. Sometimes a patient's capacity to make his or her own healthcare decisions is reduced, either partially or entirely, temporarily or permanently (e.g., by immaturity, mental illness, feelings of fear and vulnerability, sickness, pain, ignorance or confusion). For this reason, healthcare practitioners may need to assist patients to make their own decisions, and in some cases may need to assess the patient's competence to make decisions. A clinical diagnosis of a mental health disorder (such as depression) relevant to a patient's decision-making capacity should be made by a healthcare professional with appropriate expertise. If the patient is either temporarily or permanently incompetent, or reduced in his or her ability to understand or make decisions, the patient's family, primary care givers or those legally appointed (either by public authorities or by the patient's own prior decision) to represent the patient should be consulted.

Consent

Except in the case of an emergency, physical and/or psychological tests or treatment should not be administered to any competent patient until all relevant information has been disclosed and considered, and the patient's free and adequately informed consent has been given. Care must be taken to ensure that the patient is competent to consent, and is not being coerced or intimidated.

Except in the case of emergency, physical and/or psychological tests or treatment should not be administered to an incompetent patient until all relevant information has been disclosed and considered by the patient's legitimate guardian or representative, and the consent of that representative has been given. The decision of the patient's representative(s) or guardian(s) should be based on a judgment about what is in the patient's best interests. In making these judgments, those concerned should take into account not only the patient's medical condition and prognosis but also, in the first instance, the patient's previously expressed and reasonable wishes, and then the views of the patient's family and relevant others.

In the case of emergency, if consent cannot be obtained, healthcare practitioners should act in the patient's best interests, following the patient's previously expressed and reasonable wishes and taking into account the views of the patient's family and relevant others.

Truth-telling

Patients need to be able to rely on their practitioners to communicate truthfully and sensitively with, and to be accessible to, them. They need this for many reasons, for example, in order to fit their health care into the rest of their lives, in order to be able to consent in a free and adequately informed way, in order to be able to prepare for death. Although it is wrong to lie to patients, the information-giving process may need to take place over a period of time rather than all at once. On this matter, as on others, practitioners should be sensitive to individual and cultural differences.

Privacy and confidentiality

The privacy and the confidentiality of the patient's relationship with a healthcare professional are integral to any healthcare relation- ship. Information gained in the course of a healthcare relationship should be shared only with those in a therapeutic relationship with the patient on a 'need to know' basis. Respect for confidentiality will not normally inhibit/exclude the patient's family and/or friends from participating in the care of the patient. While healthcare practitioners should support the patient's family and friends in their efforts to care for the person who is ill, they should not fail to respect the patient's right to decide who shall be privy to healthcare and other personal information. Conversations with family and others should give priority to the patient's wishes and must not exclude the patient from discussions or decisions about his or her own health care.

Much healthcare information is stored in medical files, electronic records, healthcare databases and genetic registers. To the extent that records identify a patient they should be treated as confidential and should only be accessible to those in a therapeutic relationship with the patient, unless he or she has consented to further access. In some situations it may be appropriate for healthcare professionals to encourage patients to share information for the sake of the health of others. In rare cases it may be morally or legally necessary for healthcare professionals to divulge confidential information in order to prevent serious harm to the patient or to others. Appropriate forms of protection of healthcare information should be implemented to ensure patients have confidence in the system of recording and maintaining information.

Though clinical education depends in part on the generosity of patients who are willing to be seen by students, the patient's wishes should always be sought and respected.

Legitimate healthcare interventions

Medical interventions will normally be therapeutic, that is to say, they will be oriented to the health of the patient. Healthcare professionals should have a clear understanding of the purpose for which an intervention is proposed: for instance, to provide diagnostic or prognostic information, to save a life, to improve or to maintain the patient's health by curing an illness or slowing the course of an illness or stabilising the patient in a reasonably satisfactory condition, to relieve pain or other symptoms of illness, to nourish and sustain the patient. Healthcare professionals should try to ensure that patients clearly understand the purpose of a proposed intervention.

Futile and overly burdensome treatment

Treatment may legitimately be forgone if it is either therapeutically futile (i.e., makes no significant contribution to cure or improve- ment) or overly burdensome (i.e., the benefits hoped for do not justify the foreseeable burdens of treatment). This is the same as saying that treatment may legitimately be forgone when it is judged to be "extraordinary" or "disproportionate" rather than "ordinary" or "proportionate".

The benefits of treatment include preservation of life, maintenance or improvement of health, and relief of discomfort. They do not include deliberately shortening the life of a person who is sometimes wrongly described as "better off dead" nor exploiting a person's body for the benefit of others. The burdens of treatment to be properly taken into account may include pain, discomfort, loss of lucidity, breathlessness, extreme agitation, alienation, repugnance and cost to the patient. In some cases, the burdens of treatment may also include excessive demands on family, carers or healthcare resources. Judgments about the futility of a treatment outcome must be distinguished from judgments about the "futility of a person's life": the former are legitimate, the latter are not.

Quality of Life

Good health presupposes the sanctity of human life, that is, the truth that every human being is of unconditional worth. Care should be taken with the use of the concept or term 'quality of life'. This concept is used in two quite different ways, one which is consistent with a recognition of the unconditional worth of every human being, the other which denies this truth. It is consistent with the principle of the sanctity of human life to recognise that the burdens a life-sustaining treatment may impose on a patient may be such as to make it permissible to omit that treatment. It is not consistent with the principle of the sanctity of human life to claim that the value or worth of the life of one human being can be measured, or compared with that of another, or to claim that the value or worth of a human life can be in any way reduced by illness or disability.

Refusal of treatment

Patients have the moral right to refuse any treatment which they judge to be futile, overly-burdensome or morally unacceptable, and such refusals must be respected. In addition, healthcare practitioners may not override any refusal of treatment by a competent patient who is not mentally disturbed, clinically depressed or suicidal, irrespective of whether or not they agree with the patient's refusal. There is, however, an obligation to prevent suicide when this is possible.

Unreasonable requests

Sometimes patients may request a test or treatment or place conditions on their treatment which a healthcare professional or facility judges to be unreasonable. Health- care practitioners should endeavour to explain to the patient why they think the desired test, treatment or conditions are unreasonable, and thus why they are not obliged to comply with the patient's request or, in some cases, undertake further care of the patient. However, if there are medically and ethically sound alternatives, they should offer the patient the opportunity of a second opinion and arrange for the patient to be cared for by another suitable practitioner.

Medical power of attorney

Patients should be encouraged to talk with their family, doctors and other relevant people about their hopes for, and fears of, treatment, and to communicate to them their wishes about treatment should a situation arise in which they are unable to make their wishes known. Patients and residents in care should be informed of their right to appoint someone to make decisions on their behalf should a situation arise in which they were unable to do so themselves.

The role of the family and others

The patient's family and emotional ties should be respected and supported. When a patient is unable to participate in treatment decision making the views of family members and relevant others should be taken into consideration when health care is recommended and administered. In the case of conflicting judgments people should be helped to reach an understanding of the decisions which have been taken.

Minors and decision-making

Parents have the primary responsibility for the health and well-being of their infants, young children and adolescents. Until a child is able to take legal and moral responsibility for his or her own healthcare decisions, treatment should not be administered (except in the case of emergency) without consultation with, and the consent of, the child's parent(s) or other duly-appointed guardian(s). A child's ability to understand healthcare decisions, and thus to agree to treatment, depends on his or her level of understanding and maturity. This competence normally develops over time and thus must be (re)assessed in relation to each proposed medical intervention. Whenever possible both parents and child should be assisted to understand proposed treatment options and their consequences and implications. Where appropriate, the agreement of a child to treatment should be sought. If parents refuse life-saving treatment for a child, emergency treatment should be given and a court order or the appointment of a guardian may be appropriate.

Non-therapeutic interventions

Persons with the maturity to make decisions freely and with under- standing may allow themselves to be subjected to procedures which are not therapeutic for them and which involve some risk to their own life and health, for example, in tissue donation and research. Because such decisions should be motivated by generosity, they may not be imposed on a person, nor made on behalf of those unable to give consent. In some cases the question arises whether a young child who is unable to give consent may be subject to a minor, non- therapeutic intervention conducted with a view to a critical intervention that is expected to be therapeutic for another family member (e.g. obtaining bone marrow to treat a sibling with a terminal illness such as acute leukemia). Out of respect for a child's personal bodily integrity great caution should be exercised in this matter. Parents or guardians, taking into account a child's fears and lack of under- standing, should never expose their child to a non-therapeutic intervention which carries a significant risk or which the child, if he or she were competent, might refuse on reasonable grounds. Similar restrictions apply to non-therapeutic interventions on other people who are not competent.

Self-medication

At times, patients admitted to healthcare institutions or residents in aged care facilities may already be using alternative treatments or prescribed treatments and medications unrelated to the condition for which they were admitted to the facility. While staff should not become involved in such "self- medication", neither should they interfere with a patient's use of these medications unless their use is illegal or undermines the patient's health care. Patients should be asked if they are taking any medications or alternative treatments, and informed that it is in their interests to make this known to healthcare practitioners.

Undergoing tests

Since decisions about whether to undergo certain tests may have significant consequences not only for the person being tested but also for his or her relatives and others, healthcare practitioners should provide advice and assistance to help individuals to make these decisions. Tests should only be undertaken when the results will be of use in the health care of the person being tested (or relevant others), or when they are required by law for public health reasons.

Because of the seriousness of the information which may be obtained through some testing (e.g. testing for HIV, Hepatitis C, genetic status), counselling should be offered about the implications of the possible results before such tests are undertaken. The results of such tests should not be divulged to others for purposes that are not of a therapeutic benefit for the person tested, unless both concerned have consented to this use, or others are endangered, or there is a public health requirement.

Bedside allocation issues

In providing care for an individual patient, healthcare practitioners should be aware of the need to be just in the way they allocate health- care resources at the bedside (such as allocating time and attention and in the use of expensive therapies). However, no one should be denied basic or ordinary care.

References
Code of Ethical Standards for Catholic Health and Aged Care Services in Australia 2001.