ETHICS IN THERAPEUTIC RELATIONSHIPS

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DYNAMICS OF THERAPEUTIC RELATIONSHIPS

This module will explore ethical aspects of the therapeutic relationships with between healthcare providers and the clients we serve. As healthcare providers, when we enter into a therapeutic relationship with a client/patient, the goal is appropriately directed toward meeting the client's needs. To be sure, we are usually financially compensated for such services, but the interaction is clearly one-sided in that the focus is strictly on meeting the client's needs. It would be most inappropriate for a provider to have an expectation that a client should meet the provider's personal needs other than in a strictly abstract sense of professional growth, intellectual stimulation, etc. This one-sided focus is in distinct contrast to our relationships with family or friends where the expectation that both parties will participate in a more egalitarian sense is appropriate.

In the context friendship and family relationships, it is appropriate to have an expectation that the interaction should meet the meet the social or emotional needs of both parties. Friendship implies an equal relationship. In fact, we are typically critical of any personal relationship wherein one party acts to meet their own needs within a without regards to the needs of the other person. Anne Frank in her famous book, *A Diary of a Young Girl,* commented that she could not truly consider her relationship with a particular person to be a friendship. Frank comments that a friendship requires mutual sharing between two people whereas this particular relationship was strictly one-sided. Frank would share her feelings with this sympathetic listener who, in turn, never shared anything about her own feelings. Similarly, therapeutic relationships are strictly one-sided. The interaction is focused on meeting the client's needs. It would be most inappropriate for healthcare providers to seek to meet their own emotional or social needs within the context of such a professional relationship.

It does sometimes happen that two persons who meet within a provider-patient context discover that there is a basis for friendship. Under such circumstances, it is wise to terminate the professional relationship, via transferring the client to another provider, in the interest of pursuing the friendship. A failure to do so sets fertile ground for issues of a conflict of interest. It is relatively benign and not particularly uncommon for persons to pursue friendships with same-sexed individuals who were introduced in the context of a provider-patient relationship. None-the-less, in such instances, it is wise to terminate the professional relationship.

One needs to be particularly cautious, about entering social relationships with opposite-sexed persons with have had origin in the setting of a patient-provider relationship. There are implications and overtones inherent in this situation which are not present in the former example. A healthcare provider who is known to "date" patients would be subject to considerable censure regarding ethical conduct. In the rare instance where such a situation would arise, it is imperative from an ethical standpoint to terminate the professional relationship and transfer the patient to another provider. Even where the dating relationship progresses to a permanent union in the form of a marriage, it is generally frowned upon to provide healthcare services to family members. As an example, Medicare and Medicaid will not reimburse services provided to family members. Similarly, providers may never legally prescribed controlled substances to family members. General wisdom holds that, in such instances, one cannot be sufficiently objective when providing healthcare to family members. Professionals may certainly participate in the process of healthcare decision-making for family members. Primary responsibility for providing the healthcare, however, would best rest with a non-relative, objective provider.

PRINCIPLES OF ETHICS

The course text introduces the key concepts inherent in any discussion of biomedical ethics: *autonomy, informed consent, beneficence, nonmaleficence, veracity, confidentiality, justice and fidelity*. These concepts form the cornerstone on any issue or debate involving medical ethics. One cannot evaluate any issue without a firm understanding of what is inherent in each of these principles of ethics. We will look briefly at some of these concepts here. The text covers these topics in far greater detail.

Autonomy: the ability of persons to make choices about their own lives and health. Often it is spoken of as a right of autonomy meaning something regarding which persons are entitled to. Autonomy is closely related to the concept of freedom and implies that the individual is (or should be) free to make their own choices. Persons have autonomy to chose what type of treatment they want for a particular healthcare problem. Women have autonomy to carry a pregnancy to term or seek an abortion. Autonomy need not strictly apply to healthcare. It can be used in any context where we speak of a right of a person to make choices about their lives. For example, in the United States we have the autonomy to marry people of our own choosing whereas in some countries marriages are strictly by arrangement.

We will look at the concept of autonomy in greater detail in subsequent course modules. We will consider autonomy in terms of whether we have the right to end our lives when illness makes life unbearable. Do we have a "right" to die? One form of the right to die concerns **euthanasia** or "mercy killing." Should this practice be legal? Is it covertly performed regardless of its legal status in some healthcare settings? We will also consider autonomy in terms of **end-of-life issues,** specifically as it applies to **advanced directives**. Advanced directives are legal documents which advise heath care providers of a person's intentions should that person become unable to make decisions in his own behalf. For example, an advanced directive may state that a person who had severe brain damage from a stroke with no hope of recovery does not want to be intubated or have a feeding tube inserted so as to prolong his life. In yet another module we will look at **medical futility** which addresses what are a patients right's and what are the family's rights in situations where that person becomes severely ill or impaired no hope of recovery. The famous case of Karen Ann Quinlan concerns whether her family had the right to have her removed from life-support so as to avoid prolonging her life in a vegetative state.

Certain concepts act against autonomy. **Paternalism** refers to a concept wherein healthcare providers make choices on behalf of the patient under the misguided notion that said healthcare provider knows "what is best" for the patient. It may be the family members who are acting in a paternalistic manner and deciding what is best for the patient without allowing the individual to make his or her own choices in the matter. We appropriately manifest paternalism when we tell a six year old child that he may not play with matches. We are guilty of inappropriate paternalism when we make decisions on behalf of patients because we believe that we are more knowledgeable than is the patient in matters concerning that patient's health.

Dependency refers to a state wherein the individual is incapable of acting independently on their own behalf. The dependency may be justified i.e. the infant is dependent upon the mother to feed him or it may be inappropriate as when we foster dependency in another person. Persons sometimes make others dependent upon them for selfish reasons. Not uncommonly one person attempts to keep another individual dependent out of a fear that if the individual in question were to become independent, they will abandon the provider of the services in question. An insecure husband may try to prevent his wife from working out of a fear that she will become independent and leave the marriage. A healthcare provider may foster dependency in patients out of an inappropriate desire to feel "needed."

Coercion refers to forcing someone to do the bidding of another. In China, women are permitted to have only one child. Noncompliant individuals can be coerced into having an abortion. We can coerce people by using force against them or simply by threatening to use force. It is not necessary to actually

use force against another. The threat can be adequate to constitute coercion. In fact, a threat can be very subtle. Telling someone he or she will not be permitted to sit in the lounge with other patients unless he takes a certain medication is a form of coercion. Inappropriately rewarding a person for doing something can also constitute coercion (sometimes called bribery). As an example, affording excessive inducements to a person in an effort to encourage that person to participates in a research study - esp where that study carries hazards - is a form of coercion. An even more blatant example of indirect coercion occurs in some third world countries where extremely indigent people are offered significant financial inducements in exchange for donating a kidney or other organ. Many have held that given the degree of indigence of the donors, this practice constitutes coercion.

Noncompliance is a somewhat controversial term which denotes an unwillingness of a patient to participate in healthcare recommendations. Traditionally, patients who have made healthcare decisions which are at odds with what is recommended by their care providers are labeled as non-compliant. person who fails to follow a diabetic diet which has been prescribed for that individual is said to be non-compliant. A person who does not take hypertensive medications is similarly labeled. Currently, the terminology carries distinctly negative connotations, In its classic sense, the term carries connotations that blame for any negative consequences falls exclusively on the patient who has failed to follow a prescribed regimen. Some now argue that any such failure may also be a reflection of the healthcare provider's ability to convince the patient of the value of the prescribed regimen. Still other instances of putative non-compliance may result from extraneous circumstances having little to do with issues of knowledge deficits or a patient's acceptance of the regimen in question. For example, a patient may not have sufficient funds to purchase prescribed medications or the side effects may be so undesirable as to prevent the patient from taking the medication as directed.

Most importantly, the terminology tends to negate a patient's rights of autonomy. A person who is both knowledgeable and capable of following a prescribed regimen may have made an informed decision not to do so. Perhaps a given person believes in alternative health modalities of treatment, preferring to purse this avenue of therapy as a first choice. Another possibility is that a person might hold that the hazards of a particular prescribed therapy outweigh the benefits. Indiscriminate use of the term non-compliance to describe any patient who fails to conform to healthcare recommendations has overtones of paternalism. At very least there is a tendency to view such terminology as being judgmental or else that which constitutes negatively "labeling" a patient.

The expectation is clearly that providers will render healthcare in a manner which is non-judgmental and as much as possible free of ethnocentric bias. **Ethnocentric judgment** refers to the practice of evaluating another's behavior strictly in terms of one's own culture or value system. It does not account for cultural variability which might influence the actions or beliefs of other individuals. Maintaining an objective, non-judgmental approach in providing healthcare can be challenging for both the novice and seasoned provider alike. It is a goal to which most providers ascribe but also one which can be elusive especially when significantly challenged by extraordinary circumstances.

It can be frustrating for a provider when an informed and otherwise enabled patients irrationally refuses to follow healthcare recommendations - often with dire consequences. This author can recall one particularly distressing case where a 28 year old women diagnosed with cervical cancer at a stage when it was totally curable, did repeatedly refuse to consent to a simple procedure to remove the lesion from her cervix. Predictably the tumor metastasized, resulting in a protracted terminal illness fraught with all the unpleasantries of end-stage pelvic cancer and eventually culminated in her untimely death. The woman's nine-year old child was left without a mother and her elderly parents were heartbroken. Her divorced, alcoholic husband, whom she regarded as unfit to parent the child, was awarded sole custody of the boy after her parents were unsuccessful in their custody suit to raise the child. Several years later, an office visit revealed that this child was frequently hungry due to his well-intentioned by misguided step-mother who had unsound notions regarding the proper diet for an adolescent boy.

At times, circumstances will present wherein it can be challenging to remain non-judgmental. Giving way to emotion or indignation, however, will serve only hamper our ability to effectively provide care for those patients who seek our help with healthcare concerns. In the case cited above, the woman with cervical cancer continued to require healthcare services throughout the protracted course of her illness, particularly for pain management and hospice care at the terminal stage of her illness. During the time-frame directly preceding her death, she became severely cachectic and experienced profuse pelvic bleeding from invasive extension of the tumor. Her pain had become significant and she was experiencing profuse vaginal bleeding yet even at that stage, she remained as firmly entrenched in denial concerning the true nature of her illness as she was when we first met her - an attractive, active and vibrant young woman with early curable cancer. During the course of her illness which spanned years, the patient's family required considerable support, as well. We could provide therapeutic interventions in this setting only to the extent that we remained free of judgement and bias which would otherwise have hampered our ability to provide the care which was so critically needed in this instance.

Informed consent implies that a person must be provided with all of the information necessary to make a rational decision. For example, it is not sufficient to obtain consent for surgery intended to treat a given healthcare problem if the surgeon fails to advise the patient of alternate, non-surgical modalities of treatment - perhaps a medication which would accomplish the same end. Similarly, the informed consent mandates that a person must be advised of all hazards and risks associated with any proposed course of action. A surgical candidate must be advised if a proposed procedure carries risks that the post-operative results may be even more debilitating as compared to the patient's preoperative status. As an example, an endarterectomy (surgically removing blockage from the carotid artery) can significantly improve cerebral circulation but it also carries a high risk of stoke during surgery. Informed consent dictates that a patient must be so informed during the consent-obtaining process.

We will look at this concept in greater detail during other course modules which specifically address this issue. Noteworthy in this regard is one particularly notorious case - the Tuskegee Syphilis Study - where principles of informed consent were blatantly violated, with devastating sequella . Numerous other such cases which will come to light in subsequent modules.

Beneficence refers to the concept which dictates that healthcare providers are expected to act in ways which benefit the patient. Beneficence suggest that the goal of the relationship is to help or provide benefit to the client, although benefit need not be interpreted strictly in terms of prolonging life. Particularly in a hospice setting, benefit might be construed as helping a seriously ill, end-stage patients to achieve a peaceful and pain-free death. Regardless of the circumstances, beneficence carries the connotation that the services provided will be that which directly helps the patient.

Beneficence is at the very core of dynamics govern the provider-client relationship. The expressed goal of the relationship is to provide benefit to the client. Benefit to the provider - salary, intellectual or spiritual fulfillment, professional advancement, etc. - is considered to be secondary consideration especially if such self-interest is pursued at the expense of a patient. Providers who act in their own self-interests to the detriment of a client would be harshly censured by peers and colleagues.

It is interesting to note that beneficence as the underlying principle governing interaction, does not uniformly apply to all genre of interaction within society. For example, the goal and motivator for the provider of certain services within a business context may be to garner personal or corporate wealth. The client may, indeed, benefit from the services but the fundamental motivation underlying the interaction is a desire to enhance the personal or corporate wealth of the provider. Providers of business and financial services are not necessarily morally corrupt pursuing such goals. That motivation which underlies a given business relationship may be perfectly appropriate in the setting in which it occurs. The same dynamics when applied to provider-client relationship within a healthcare setting would be most inappropriate if the primary underlying dynamics were not that of benefit for the client.

Issues of beneficence in healthcare settings has less to do with altruism on the part of providers than with expectations for accepted standards of care. Beneficence does not dictate that a healthcare provider necessarily be altruistic nor that an individual engaged in business pursuits be self-serving or unethical. The issues have less relevance to the personal characteristics of the parties providing the service than it does with the underlying principles which govern the interaction.

The true key to the issue of beneficence is the proverbial "rules of engagement" as it applies to provider-client interaction. A stunning illustration is a conversation which occurred between this author and the parole office of a mutual client. The conversation centered about the health status of this particular individual. The office was citing numerous examples of recidivism among the various parolees she supervised. An innocently offered comment held that "It must be frustrating for you in that you are working so hard to help these individuals only to find that they return to their old habits." This remark was abruptly interrupted with a sharply-offered comment. "Let me make one thing perfectly clear. My job is *not* to help these people. My job is to catch them violating their parole and returning them right back to jail!" Clearly this officer did not perceive beneficence to be the underlying rationale for her relationship with the individuals she served. A healthcare provider who offered a sentiment analogous to what the parole officer shared would be harshly censored.

It is important to note that the motivation and attitude expressed by this parole office may not necessarily reflect the professional standards for all persons who serve in this capacity. Conceivable her statement might be censured by her peers, as well. Moreover, in fairness to parole officers, it is also important to point out that not every healthcare provider necessarily acts with beneficence. Certainly, the actions of Charles Cullen, the notorious nurse who admitted to killing dozens of patients during the course of his duties, speaks to an example of healthcare practice which has no basis in beneficence. The importance of citing the parole officer's statement, however, is that it so dramatically illustrates the concept of beneficence, or more accurately the lack thereof, as an underlying motivator for services provided.

Nonmaleficence refers to the concept that providers must refrain from acting in a manner which will bring out harm patients - either directly or indirectly and intentionally or unintentionally. This principle has its origins in the Hippocratic Oath which states "first of all, do no harm." Arguably, this imperative carries greater weight then all other ethical principles. Providers are expected to refrain from initiating any interventions which could bring about harm to clients - actual or potential. As an example, conducting research which poses hazards to patients clearly violates this principle. Similarly, initiating unnecessary interventions for personal, economic or academic gain would be contrary to the mandate of nonmaleficence. The injunction to avoid inflicting intentional harm to patients would seem self-evident. Barring persons who have engaged in criminal activities involving patients, one might expect that there would be virtually no controversy on this count.

Surprisingly, however, there have been blatant violations of this mandate, some of which have involved prominent researchers and/or prestigious institutions. As an example, in 1963, physician researchers injected live cancer cells into twenty-two elderly and senile patients hospitalized at the Brooklyn Jewish Chronic Disease in an effort to study the immune response. The notorious Willowbrook scandal involved events at The Willowbrook State School for the Retarded (Staten Island) which occurred between 1955-1972. During this time frame retarded children institutionalized at the Willowbrook State were deliberately infected with the hepatitis B virus in the interest of developing a vaccine. Worse yet, the policies designed to encourage parental consent have been viewed as being consistent with subtle coercion. The most blatant and famous dereliction of responsibility concerning nonmaleficence occurred with the Tuskegee Syphilis Study. In the interest of studying tertiary syphilis, indigent sharecroppers in Macon County, Alabama were denied treatment for their disease even after curative penicillin was available. These cases will be pursued further in subsequent modules.

The principle of nonmaleficence enjoins providers from effecting harm as a consequence of doing good. In the previous examples, the benefits obtained from the research clearly did not outweigh the harm to the subjects involved. The distinction may not always be as apparent. Accepted treatments and interventions commonly involve hazards or risks. Whether the interventions are ethical would depend on the degree to which the perceived benefits for the patient outweigh the risks involved. There are side effects associated with most commonly used medications, however, in the majority of cases the benefits to the patient who takes the medication significantly outweighs the adverse effects associated with using the drug. Prescribing or administering the drug, then, would be deemed appropriate given that there were no major contraindications for its use in that particular patient.

Certain patients have conditions which would contraindicate the use of medications intended to treat problems they are experiencing. For example sumatriptan (Imitrex), effective in treating migraine headaches, can cause serious consequences if administered to patients with certain cardiovascular disorders. Prescribing or administering the medication to persons with cardiovascular disease would be in clear violation to principles of nonmaleficence. It is unethical to avail such persons of the medication even though it is quite likely to relieve the migraine pain and will most likely not result in cardiovascular sequella. The potential for harm in these cases is sufficient to contraindicate the medication.

The fact that it is ordered or administrated with an intent to benefit the patient is irrelevant in such instances. Providers would be expected to refrain from interventions which pose significant hazards to the patients unless the potential good clearly outweighs the risks involved. In this instance, prescribing a less effective medication for purposes of relieving the migraine pain would be appropriate. Superior relief from transient migraine pain does not warrant risking potentially fatal cardiovascular events in persons who are not candidates for this medication. By contrast, chemotherapy carries significant risks for patients who take these agents to combat cancer. In this case, the hazards of untreated disease far outweigh the risks of the medication and the administration of chemotherapy would be deemed appropriate.

Medications are commonly withdrawn from the market even where they are highly effective for the purposes intended. This scenario is particularly common where similar agents, associated with less inherent risk, also exist. There is no question that rofecoxib (Vioxx) effectively relieves pain and carries less risk of gastrointestinal complications than traditional NSAIDs. None-the-less, on September 30, 2004, this medication was withdrawn from the market, secondary to evidence that it significantly increased the risk of cardiovascular events in patients taking this medication. Given that other agents are available to treat pain and inflammation, once its hazards came it light, the use of this medication was no longer considered appropriate. A particularly disturbing aspect of the rofecoxib (Vioxx) case is the issue of allegations suggesting that the manufacturer may have been aware of the hazards but suppressed the information in the interest of pursuing corporate profit. If subsequent evidence supports such claims, clearly individuals responsible for these decisions would be in clear violation of the principles of nonmaleficence.

Veracity concerns issues of truthfulness. In the context of provider-client relationships, it refers to being honest and forthright in information provided to patients. Veracity can involve not only what information is provided to patients but also what information is withheld from them. Not uncommonly, key information, particularly as it concerns informing patients regarding terminal illness, is not shared with patients. Typically such action is taken in the interest of protecting patients perceived harm which will result from their having knowledge of this information.

There is considerable controversy surrounding the issue of whether providers should withhold information from their patients. Traditional wisdom has supported this practice but in the current cultural milieu of healthcare, withhold information in the interest of protecting a patient is viewed negatively in terms of paternalism. There is also considerable cultural influence surrounding this issue. The current

view in the United States and in much of Europe holds autonomy and informed consent as inviolate patient rights. Interestingly, this view is not universally held in other parts of the world. Ruth Macklin (1999) sites very dramatic examples drawn from a variety of cultures which contradict the western views of the doctor-patient relationship. Macklin sites examples of cultures wherein there is virtually no physician-patient communication concerning ongoing treatment. In Egypt, for example, patients who ask questions of their physicians are viewed as "impolite." Similarly Mexican physicians may not perceive a need to share any information with a patient or their families over the entire course of an individual's hospitalization. In developing countries, a kickback system is common place and underlies the relationship between healthcare providers and their patients.

Within our own culture, the issue of veracity in provider-client relationships can problematic. It is an area which can be fraught with dilemma. Much has been published concerning the ethics surrounding whether to advise patients regarding terminal illness. This module will examine issues and obligations of healthcare providers in this regard? When, if ever is it permissible to be deceptive with patients? This issue has been sometimes framed as a potential conflict between the principles of veracity (being truthful) and nonmalfesiance (doing no harm). The latter would be a relevant consideration where it might be supposed that advising the patient of particular information would result in considerable distress for that individual. While this perspective is commonly supported, more and more evidence points in the direction that the vast majority of patients prefer truthfulness. They prefer veracity even where the information is unfavorable including but not limited to advising patients about terminal illness.

Given that certain excepts unquestionably exist, it is generally in the patient's best interest to be truthful and forthright. Persons need to plan for the various contingencies imposed by their illness. Typically patients facing impending death, will want to get their affairs in order to protect loved ones who will survive them. Still other persons will want to actively plan in their future care while they are still sufficiently well to do so, particularly in planning advanced directives. Advanced directives provide for the naming of a person designated to make health care decisions on their behalf once the person is no longer able to do so. Unless special circumstances would dictate otherwise, providers who intentionally and routinely withhold information from patients are on very tenuous legal and ethical grounds. Family members often express concerns that the truth will devastate a patient who is perceived being unable to handle an unfavorable prognosis. Experience rarely supports this conclusion. Well meaning family members can often be quite paternalistic in this regard. Their efforts to "protect" the patient may actually result in increased frustration and distress for patients who suspect that the facts are other than what they are being told.

A particularly cogent issue concerning veracity centers about its implications within the context of the ever-growing managed care environment. Health Maintenance Organizations (HMOs) have posed unique problems for the health care provider in with respect to veracity. Many HMOs have promulgated the so-called "gag clause" which is a contractual requirement to restrict what information providers can discuss with the patients. Most typically, the restriction enjoins providers from advising patients of more more expensive treatment options as compared to that which is preferred by their insurance company

Fidelity is an ethical principle which pertains to the concept of keeping promises i.e. faithfulness. State licensure and national certification processes grant healthcare providers the exclusive right to practice within their profession. In accordance with the 10th Amendment to the United States constitution, professional is licensure is typically legislated at the state level. Licensure assures that only persons duly recognized will have the right to professional practice within the specified capacity. Licensure speaks to an individual having met the minimum criteria of competence for practice within a given profession. Certification attests to excellence in a particular field. It may or may not be a prerequisite to state licensure within a given profession.

In exchange for the protection to professionals provided by licensure, the practitioners of a given profession incur a responsibility to maintain fidelity to the accepted standards of practice for that field. Practitioners have inherent responsibilities uphold standards of the profession. On entering a provider-client relationship, professional practitioners incur responsibilities to the clients they serve

CONCEPTS OF ETHICS

Ethics: various writers and philosophers throughout history have attempted to define, determine and describe ethics. Some philosophers have developed a theoretical framework which attempts to describe or interpret social morality. Ethics addresses morality within a given culture or societal framework Burkhardt and Nathanial (2002) define ethics as follows:

> (Ethics is) the study of social morality and philosophical reflection on its norms and practices. Moral issues are those which are essential, basic or important, and deal with important social values or norms, such as respect for life, freedom and love; issues that provoke the conscience or such feelings as guilt, shame, self esteem, courage or hope; issues to which we respond with words like ought, should, right, wrong, good bad (p. 24).

One characteristic which universally comes forth in any discussion of ethics is the notion that *there are no easy answers* when addressing such issues. Many of the dilemmas which will come up in the context of this course, within professional practice and within society at large are complex. They do not have readily apparent solutions which are applicable to all of the problems arise. In general, there is no "quick fix" for dilemmas which arise in the context of ethics.

In fact, for some situations involving ethics, there would appear to be no satisfactory solution for a given problem which arises in this context. When such a situation arises, it is described as an **ethical dilemma**. Both sides of the issue at hand can be said to be equally right and/or equally wrong. No clear-cut solution evident. Which of two equally deserving and critically ill patients should get the single available ICU bed? What of the individual who is faced with the unpleasant choice of violating obligations of confidentiality owed to one patient or revealing confidential information to an innocent third party in an effort to prevent certain harm to that individual which would otherwise ensue.

Consider the case of a nurse who provides care for a patient with known HIV disease. The nurse subsequently comes to learn that a close friend is about to enter a sexual relationship with this individual who has not advised the friend of his HIV status. What are the nurse's ethical obligations in this instance? The nurse cannot ethically meet obligations to one individual without violating ethics in relating to the other. Perhaps HIV patient would tell the nurse's friend prior to engaging in sexual activity? Perhaps he would not do so? If the nurse maintains obligations for confidentiality, an innocent and unknowing individual may contract HIV disease? Would it matter if the potential victim were not a friend of the nurse? Would this change any of the dynamics? The nurse has professional ethical obligations to maintain confidentiality in a provider-client relationship. The nurse is also bound by the ethics of nonmaleficence - in this instance to prevent harm to innocent third parties? What should the nurse when facing this dilemma?

We will look at ethical dilemmas in further detail during this course. In a subsequent module, we will examine the issue of autonomy and the right to die. This particular module looks at the famous ethics case involving Dax Cowert, a 23 year old previously athletic, attractive man who in 1973 was severely burned, disfigured and blinded in a freak accident involving a ruptured natural gas line. He sustained burns to over 80% of his body; both of his hands were lost to the fire. Experiencing excruciating pain and facing a life as a blind and disfigured man, he refused treatments demanding that he be allowed to die. Could his care givers ethically comply with his requests? This case which provides one of the best examples an ethical dilemma. Moreover, it illustrates that in this realm, there are *no easy answers.*

Ethical dilemma: an ethical dilemma involves two competing moral claims. We cannot satisfy one moral claim without violating another moral principle. Related to the ethical dilemma, is the **practical dilemma**. In this scenario a moral (ethical) claim competes with a nonmoral (one which does not involve ethics) claim. Nonmoral claims are sometimes perceived as self-interest issues which arise in the course of professional practice. Case Study 1 illustrates a practical dilemma. It depicts Mary Anderson, a nurse who is advised that she must stay on duty beyond her shift to cover for another nurse who has called in sick. Staying on will mean that Ms Anderson must disappoint her child with whom she has made plans for holiday activities. She faces a dilemma. Should she stay on duty to cover her ventilator-dependent patient? If she remains at work, she will disappoint her child whom possibly she has disappointed in the past with similar work-related emergencies. What should Anderson do? How shall she resolve this dilemma.

Through out Case Study 1, we see a variety of interpersonal dynamics, all common in healthcare settings. What is clear, however, is that regardless of the extraneous circumstances, *moral claims take precedence over non-moral or practical claims*. Regardless of the pressures surrounding the lives of the various characters presented, ethics demands that moral responsibility outweighs self-interest. More specifically, Mary Anderson has an ethical obligation to remain on duty until her relief arrives. In order to do so, she must disappoint her son with whom she has a standing promise relating to after-work activities. In this scenario, Anderson is facing a practical and not an ethical dilemma.

To be sure, any nurse does have certain obligations to her family. Ms. Anderson has certain responsibilities and obligations which she owes to her child. The conflicting obligations for Ms Anderson, as depicted in the scenario, are not of equal weight. She has an unquestionable ethical obligation to her ventilator-dependent patient, particularly where no one else is qualified to assume those responsibilities. She has a moral obligation to remain on duty until the night nurse arrives. Anderson's promise to participate in Halloween activities with her child is grounded in self-interest rather than representing a true moral claim. The harm (disappointment) which will befall her child cannot compete with the harm which will ensue if she abandons the dependent patient on the ventilator.

Anderson may well be facing a larger, overall moral issue which centers about whether she can meet her obligations to her family while employed in her current capacity. Anderson is employed in a setting wherein she is frequently called upon to extend her shifts to cover for unanticipated staffing emergencies. In this light, she needs to decide whether employment as a ventilator-qualified nurse in her current setting is compatible with her obligations to her family expectations as she (and they) perceive them. This question, however, need not be resolved on the evening when she has been called upon to provide services to the patient in question. She is ethically bound to stay on duty until Sue Ellen Jackson can relieve her. Subsequently, she can certain terminate her employment at Mercy General and seek employment in a less demanding capacity, if such is her preference. From a legal standpoint, if Anderson does leave her patient unattended before Jackson arrives to relieve her she can be charged with **professional abandonment** and loose her licence to practice nursing..

Closely related to the concept of ethics is the notion of **morality**. Morality deals with issues concerning what is considered good or bad, right or wrong with a given culture. Morality defines the standards by which members of a particular group or culture are expected behave. It is important to emphasize the role of **culture** within this context. Morality reflects a value system and this concept cannot be separated from the culture which has given rise to it. What is regarded as acceptable and moral behavior in one culture can be regarded in an extremely negative context within another.

We seek striking examples of the integral relationship between culture and morality within current world events and politics. Events occurring within the middle east have brought dichotomy of ideologies into the public view. Perhaps no event in recorded history more clearly illustrates the impact of culture on morality than the events surrounding 9/11. These terroristic events which the west would hold as being the very embodiment of evil at its most fundamental core, are viewed as spiritual acts by certain factions within the middle eastern societies.

Subsets of persons within a given culture may have vastly different concepts of morality. As an example, the mainstream culture within the United States would tend to view unwed teenage pregnancies as a significant problem. The traditional views would hold that rising teenage pregnancy rates represent a serious problem; one which has significant social impact. Resources have been allocated in an effort to identify the underlying causes and reversing the trend. Certain factions within our society, notably the teenagers themselves - particularly those living within inner city, indigent settings - commonly view these pregnancies in a positive light. Within this setting, childbearing is commonly perceived as source of pride and prestige. Far from accidentally becoming pregnant, many of the teenagers where intentionally seeking this status. Clearly there were divergent views held by subsets within a given culture with were at odds with the mainstream ideology.

ETHICAL THEORY AND PHILOSOPHY

A variety of theorists and philosophers have attempted to define and/or catagorize ethics. It is far beyond the scope of this discussion to delve into the various philosophical interpretations of ethics. At best, we can consider a few of the important concepts which have developed in an attempt to define or explain the concept of ethics.

Naturalism: a view of morality which defines ethics in terms of human nature and psychology. Proponents hold that there is *universality in moral judgement*. This view holds that under similar circumstances, most person's moral interpretations will be alike. This view would appear to have little validation when viewed in light of the current events occurring in the world today. *Sympathy* is said to be a key motivating factor in this belief system

Rationalism: a view which holds that absolute truths govern morality and these are not dependent upon human nature. Such philosophy holds that morality has independent origin the universe or in the nature of God. It can be known only through human reasoning. This view would have wide appeal to persons who are deeply rooted in religious or spiritual belief systems. From a practical standpoint, the various religious traditions are at considerable odds with one another hence. This discordance then poses a significant problem inherent in this perspective. With respect to morality and ethics, which version of God and religion is correct? Clearly, there can be no universal agreement on this count.

Utilitarianism: aka **consequentialism**: a view which holds that an action is judged as good or bad in relation to its consequences or end result. Actions are neither inherently good or bad. That action(s) which brings about the greatest good i.e. the greatest utility or usefulness is deemed to be the "right" action. This view was advocated by the 19th century philosopher Jeramy Bentham (1748-1832) and also by John Stuart Mills (1806-1873). It is from this value system that we have derived the commonly used phase - *the end justifies the means*. Some have criticized this viewpoint as somewhat hedonistic. It purports to maximize happiness or pleasure (good) and minimize evil (bad). Proponents of this philosophy do not necessarily interpret these polar opposites according to common connotations of the terms. A significant risk inherent in this philosophy is that the rights some could be violated in the process of maximizing the happiness of others.

Deontology ethics based on an obligation to act in accordance with duty or obligation, without regard to achieving virtue or bringing out good consequences. Duty is the basis of morality. Professional codes of ethics have their origin in this philosophy. Deontology suggests that ethics are derived from fulfilling moral obligations i.e. duty. Following laws is key. The outcome of any action is less important than is the strict adherence to the law.

One proponent of this theory, Immanuel Kant, advocates the concept of a **categorical imperative**, defined as moral rules which are do not admit exceptions. The rightness or wrongness of an act is a function of its nature and not of its consequences. The rules would universally applicable. Under this system, no action can be judged as right or wrong which cannot reasonably become a strict

This philosophy is attractive for many and described as the "foundation for many contemporary beliefs" (Burkhard and Nathanial, 2002, p 2). Critics hold that it is rigid and exceptionless and offers no benefit in choosing between conflicting alternatives. Moreover, strict adherence to rules regardless of consequences could have negative consequences. (Burkhardt and Nathanial, 2002)

ETHICAL ISSUES AFFECTING HEALTHCARE

Professional Ethics and Health Maintenance Organizations Rarely can one conceive of a more clear-cut conflict of interest then so-called "gag clauses" inherent in some managed-care contracts. In limiting communication between the provider and the patient, a conflict in ethics becomes readily apparent. The provider has a contractual obligation to the insurance provider which is clearly at odds with that which is in the best interest of the patient. HMOs commonly bar providers who do not comply with rules set forth by the organization. Once barred from serving as an approved provider, patients who are insured by the HMO will not be covered if they consult blacklisted provider. Not uncommonly, a provider barred by one HMO may not be accepted by any others within a given geographic area. At first glance, it would appear that a provider given a mandate by an HMO to refrain from communication about most costly alternative therapies, should have no place in dealing with said organization. In reality, however, the facts may not be quite so clear cut.

The prevalence of HMOs have been steadily rising over the last 10 years. Currently, HMOs hold a 80-90% market share for all persons with healthcare insurance in many geographic areas. These dynamics would translate into serious economic survival issues for any provider who either elected not to accept HMO insurance plans or who was barred from being a participating provider. Even more disturbing is the fact that many HMOs have tied financial incentives (or penalties) to performance under the terms of the contract. Providers may be awarded financial incentives for cutting costs measures such as restricting the numbers of referrals to specialists or prescribing less costly medications. Similarly, providers may be financially penalized for rendering care which is medically sound but deemed more costly. The net effect of managed care insurance plan is to reward participants who provide less healthcare services to the nsured clients. Marc Rodwin (1995) explores these issues in *Conflicts in Managed Care,* an article which details the hazards inherent in managed health care and proposes remedies designed minimize compromises to patient welfare.

Confidentiality Ethical practice dictates non-disclosure of private information encountered in the course of providing professional healthcare. Professional codes of ethics typically include statements requiring members of the profession to hold client information in confidence. Disclosing such information to unauthorized third parties, including family members of adult patients, is considered a serious infraction of professional ethics. There can be significant legal ramifications, as well. Clients whose confidentiality has been violated in this manner may be entitled to substantive compensation for damages incurred as a result of breech of professional trust. Individual practitioners who violate patient confidentiality would also be subject to censure by professional practice boards and could conceivably forfeit the right to practice.

There are several exceptions to requirements to maintain confidentiality. Confidentiality may be legally breeched where it is necessary to avoid preventable harm to innocent third persons. Public health policy may mandate the disclosure of certain information obtained in the course of professional practice. Information provided to professional practice boards in the course of adjudicating allegations of misconduct may also constitute valid exceptions. Similarly, providing information in the context of a court subpoena would exempted from the usual constraints. Barring such circumstances, profession practice ethics mandates that healthcare providers maintain strict confidentiality of any information obtained in the course of professional practice.

Distributive Justice. No discussion concerning ethics in healthcare is complete without consideration of how to distribute scarce resources within a society. Scare resources would be defined as any resource where the demand would exceed the supply for a given population. As an example, the demand for donor kidneys far exceeds the supply of such organs.

Healthcare delivery is an area replete with issues of scarce resources. Commonly there is insufficient trained personnel, supplies, hospital beds or medical equipment to meet the demands of all of the persons needing these services. Administrative personnel face decisions on a routine basis in deciding which of several patients should get an ICU bed. Nursing shortages have become quite critical with significant ramifications for society's ability to patient care. Periodically emergency rooms within hospitals become overwhelmed. The community demand for service is beyond that which the ER or hospital can provide resulting in a need to divert admissions to other institutions. At various times, the supplies of vaccines esp influenza are inadequate to meet the demands within the community. The list of examples can be endless.

With competing requests for service, ethics becomes a cogent consideration in developing criteria for allocating scare resources. Numerous proposals have been put forth by a variety of persons in an attempt to come up with equitable distribution of limited resources. Common theories include the following

- To each equally (egalitarian theory)
- To each according to need (socialist theory)
- To each according to merit
- To each according to social contribution (Nietzsche theories)
- To each according the individual rights (libertarian theory)
- To each according to individual effort (work ethics theory)
- To each as he would be done by (spiritual theory)
- To each according to the greatest good to the greatest number (utilitarian theory)

In a subsequent module which addresses the allocation of scare resources within society, we will look at these issues in greater detail. Within the United States, the work ethics view has been the traditional modality distribution, which philosophy dates back our Puritan founders. Under this theory persons are rewarded in proportion to their effort within a society.

The United States has considerable numbers of social entitlement programs which are based on a combination of needs theory (socialism) and utilitarianism (that which does the greatest good). Social security and medicare would be examples of distribution of resources based upon entitlement programs. Socialized medicine programs, in effect in Canada and most of Western Europe, are other examples of entitlement programs. Much attention has focused about whether one or another form of nationalized health care is appropriate for the United States. Considerable controversy surrounds this topic which is hotly debated in the current political and socioeconomic arena. Strong emotions and arguments have prevailed on both sides of the issue.

Aside from issues of national health care entitlement, other social entitlement programs within the United States has engendered considerable political debate. Particularly controversial issue currently centers about the future of certain popular entitlement programs notably social security and a variety of programs designed to provide assistance to indigent persons. The legislative outcome of these debates will have significant ramifications for both providers and patients in the healthcare setting.

CONCLUSION:

As you read through the articles and chapters for this module, consider how they may relate to this issues raised in this overview. The ethics of therapeutic relationships is a complex phenomenon which has many facets as well as subtleties influencing healthcare delivery. Each of the articles listed below will explore some aspect of this relationship. Consider how the information presented relates to the general principles and dynamics as they pertain to therapeutic relationships within a healthcare setting. Each professional must find a modality of practice which satisfies both accepted standards for professional ethics and personal ethics and also the personal value system for that individual.

READING ASSIGNMENTS

Module 1 - Ethics of Therapeutic Relationships

REQUIRED READING

Burkhardt

- Chpt 1 - Social, Philosophical and Other Historical Forces Influencing the Development of Nursing
- Chpt 2 - Ethical Theory
- Chpt 3 - Ethical Principles

Glannon

- Rodwin, M. *Conflicts in Managed* Care - p. 48
- Macklin R. *The Doctor Patient Relationship in Different Cultures* - p 82

Articles

- Poulson, J. - Bitter Pills to Swallow *New Eng J Med* 333;1844 (No 25: July 181998)

  * Note: If you were moved by Dr. Poulson article, Bitter Pills to Swallow, be sure to read her two additional articles which were published in the *Canadian Medical Association Journal.* See "Recommended Reading for the full reference to these articles. Sadly, Dr. Poulson lost her battle against breast cancer and died on Aug 28, 2001

- Annas G. J. - Informed Consent, Cancer and Truth in Prognosis. *N Eng J Med* 330:223 (No 3: Jan 20, 1994)

  Be sure to read the commentary by Nuoko Miyaii who discusses how these issues are viewed in Japan. Dr. Miyaii's commentary appears after the reference list for the original article

- Pearson S.D. - Ethical Guidelines for Physician Compensation Based on Capitation. *NEJM* 339:689-693 (No 10: September 3, 1996)

- Blumenthal, D. - Doctors and Drug Companies *NEJM* 351:18 (October 28, 2004).

- Hollerman WL, Hollerman, MC and Moy, GM. Continuity of Care, Informed Consent and Fiduciary Responsibilities in For-Profit Managed Care Systems. *Archives of Family Medicine* 9:21 (January 2000).

- Lifton, R.J. Doctors and Torture. *NEJM* 351;5 (July 24, 2004)

- Groopman J. God at the Bedside. *NEJM* 350;12 (March 18, 2004)

- Groopman J. A Great Case. *NEJM* 351;20 (Nov 11, 2004)

- Bedell et al. The Doctor's Letter of Condolence. *NEJM* 344;1162. (No 15: April 12, 2001)

SUGGESTED READING

- Cantor, J and Baum K. *The Limits of Conscientious Objection - May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception NEJM* 13:19 (Nov 4, 2004)

- The Days That Will Still be Mine - Jane Poulson *CMAJ* 158 1633-6 (1998)

- Dead Tired - Jane Poulson *CMAJ* 158:1748-50 (1998)

- Tribute to Martha Jane Poulson - compilation from various websites

  The first two articles are companion articles. Dr. Poulson also wrote "Bitter Pills to Swallow " (see Required Reading), published in *N Eng J Med* where it speaks to veracity from the perspective of the doctor, now patient. These three articles do not directly relate to veracity but describe her subsequent experience with aggressive breast cancer. Sadly, this diabetic woman who was the first blind woman to every graduate from a Canadian medical school, lost her battle against the cancer. The tribute was written by various persons who were her colleagues and saddened by her loss

- Should Doctors Tell the Truth: Honesty in Medicine - James F Drane http://www.uchile.cl/bioetica/doc/honesty.htm

- Veach R. When Should the Patient Know? The Death of Therapeutic Privilege - Glannon p. 54

- Jackson J. Telling the Truth - Glannon p. 61

- Bloche, M.G. Fidelity and Deceit at the Bedside. *JAMA* 283:14 p 1881 (April 12, 2000)

- Kassirer, J.P. Managed Care and the Morality of the Marketplace *NEJM* 333:50-52 No 1 (July 6, 1995)

- Studdert D.M. Financial Conflicts of Interest in Physicians' Relationships with the Pharmaceutical Industry. *NEJM* 351:18 (Oct 28 2,004)

- Feldstein, B.D. Toward Meaning - *JAMA 286;* 1291 (No 11: September 19, 2001)