

Chapter 1

A Model for Ethical Problem-Solving

Learning Objectives

1. Apply a stepwise process to systematically resolve an ethical problem in a clinical case.
2. Delineate the steps in a five-step model for ethical decision-making.
3. Distinguish between clinical and situational information necessary for sound ethical decisions.
4. Define ethical principles commonly encountered in clinical practice such as respect for autonomy, beneficence, nonmaleficence, and veracity.
5. Analyze courses of action to determine which are morally justifiable.

After the determination of the source and meaning of ethical judgments, what kinds of actions are right, and how rules apply to specific situations, the question remains: What ought to be done in a specific case or situation? Physicians and other health professionals often go through the process of determining the correct action in a specific case unconsciously.

Furthermore, if asked, they would be hard-pressed to articulate just what steps they went through to arrive at a sound and justifiable decision. There are many normative models for resolving ethical problems in the

health science literature,¹ but all require critical thinking and should result in a choice that is morally justifiable. Decision-making, whether in ethics or any other area of life, is often thought of entirely in terms of its anatomy or structure—that is, the steps one should follow and the component parts of each step. However, ethical decision-making is more than just following steps; it involves an appreciation of the complexity of the components of each step such as what really comprises gathering information and how the steps relate to each other. The majority of this book addresses the “function” of how general ethical principles apply to ethical problems in health care. Here, a framework is offered that includes those principles and a stepwise process to systematically resolve ethical problems in particular cases.

The Five-Step Model

The five steps provide the structure for the decision-making process and are linear; that is, they should be carried out in the order listed below:

1. Respond to the “sense” or feeling that something is wrong.
2. Gather information/assessment.
3. Identify the ethical problem/moral diagnosis.
4. Seek a resolution.
5. Work with others to determine a course of action.

The steps in the model outline a process, a way of making judgments about what should be done in a particular situation. Additional steps could be added and much elaboration could be included within each step, but the basic framework is sufficient to focus moral judgments and simple enough to recall and apply in actual clinical practice.

Application of the Model

The five-step structure will be applied to Case 1-1 to illustrate the process of decision-making.



Case 1-1 Disclosure of a Terminal Diagnosis

Richard Dossey, a 68-year-old architect, was admitted to the oncology service after having an emergency operation in another state while there on vacation. According to Mr. Dossey, the surgeon at the hospital told him that he had gastric cancer but assured him that “a few cycles of chemotherapy should successfully treat the cancer.” When he was stable enough to travel, arrangements were made at the hospital where the operation took place to have Mr. Dossey admitted to a hospital in his home town. Mr. Dossey then flew home on a private jet accompanied by his wife.

Sashi Jajoura, MD, the oncologist who was now attending Mr. Dossey, read the surgical report and was shocked to discover that there were

significant lymph node metastases. She knew that despite attempts to improve quality of care, survival rates for gastric cancer remained poor—around 10% overall 5-year survival for patients with advanced disease, positive margins after resection, and advanced age. In essence, postoperative chemoradiotherapy might offer some additional time, but it was unlikely that any therapy would result in a cure.

Clearly, the information in the pathology report in Mr. Dossey’s clinical records from the hospital where he underwent the operation did not mesh with his reported understanding of his prognosis. Meanwhile, as Dr. Jajoura determined the best course of palliative treatment for Mr. Dossey, he developed acute renal failure. A sonogram revealed bilateral hydronephrosis, probably caused by the primary tumor that had extended to the ureters. During this crisis, Dr. Jajoura informed Mr. Dossey that he was acutely ill as a result of kidney failure. She also informed him that the probable reason for his kidney failure was the cancer.

Dr. Jajoura then discussed the plan of treatment with Mr. Dossey, proposing that catheters be placed into the ureters through small bilateral incisions and a presurgical computed tomography (CT) scan. She explained that, postoperatively, he would be a candidate for chemoradiotherapy. Also, because Mr. Dossey’s creatinine and blood urea nitrogen (BUN) levels were rising quickly, she asked him if he had prepared an advance directive and if he had specifically thought about a do-not-resuscitate order should his heart stop beating or if he should stop breathing.

Though stunned, Mr. Dossey said he would like to talk to his wife, his adult son, and the pastor at his church about his prognosis and the proposed treatment. He then angrily burst out: “That surgeon lied to me!”²

The next day, Mr. Dossey told the clinical nurse specialist and the staff nurses that he wanted to go home that day without treatment and without any more diagnostic tests, saying, “I know the doctors aren’t going to agree with me, but I want to leave anyway.” When the nurses asked his wife and son about Mr. Dossey’s decision, both responded in unison, “He has always made his own decisions. We support him in this decision.” Dr. Jajoura asked Mr. Dossey to consent to the CT scan to determine the extent of the cancer, but he refused and stood by his request to be discharged.³

Questions for Thought and Discussion

- Reread Case 1-1. At what point in the case do you get a clear sense that something is “wrong” ethically speaking?
- What additional information or clarification would you like to have about Mr. Dossey’s clinical status? Situational factors?
- What is the primary ethical problem in the case?
- At this point in the case, what should Dr. Jajoura do?

Commentary

This case is complex but reveals potential ethical concerns. As the physician involved in the case, Dr. Jajoura will need to decide what she should do and why. The five-step model can help Dr. Jajoura and the other members of the health care team involved in Mr. Dossey's care to work toward a justifiable resolution.

1. Respond to the Sense That Something Is Wrong

The first step in the ethical decision-making process is to respond to the intuitive sense that something is wrong in a given situation. Unlike obvious physical signs and symptoms that clinicians are used to looking for in patients to determine what is wrong, such as a change in breathing pattern or a rise in blood urea nitrogen (BUN) or creatinine, there are no objective signs that one is involved in an ethical problem. It is obvious that urgent care areas such as the emergency department and intensive care units can be fraught with stress and emotion. It is obvious that Mr. Dossey's case is full of emotion: he was described as stunned, angry, and determined. Dr. Jajoura was "shocked." Do these emotional signs indicate that an ethical problem is in progress? The answer, as is often the case in ethics, is yes and no. Just because people are emotionally upset with each other or under a lot of stress does not necessarily mean that an ethical problem is involved. However, heightened emotional sensitivity along with "stress and tension intrapersonally or interpersonally . . . and ineffective communication patterns such as avoidance, nagging, or silence" are often warning signs that one is involved in an ethical problem.⁴

In Mr. Dossey's case, Dr. Jajoura responded to her feeling that something was not right as soon as she saw the discrepancy between his optimistic statement that "the cancer should clear up" and the grim reality of his diagnosis. She proposed an operation to correct the acute renal failure, and Mr. Dossey wanted to be discharged without treatment. Dr. Jajoura may also feel angry and frustrated with her surgical colleague at the other hospital who seems to have withheld from Mr. Dossey the bad news about his prognosis. These negative emotions and interpersonal conflicts are indications that an ethical problem may be present. This first step in the decision-making process merely requires one to respond to the feeling that something is wrong. One should then move on to the next step.

2. Gather Information

There is an old saw in ethics: "Good ethics begins with good facts." Clearly, to make an informed decision one must have the facts. To organize the numerous facts in the situation in which Dr. Jajoura is involved, one can classify them into clinical and situational information.⁵

Clinical information deals with the relevant clinical data for the case in question. The following types of clinical questions are relevant when reviewing a case: What is the medical status of the patient or patients involved in the situation?

Medical history? Diagnosis? Prognosis? What drugs are involved, and what are their actions, side effects, and so on? What is the patient's probable life expectancy and general condition if treatment is given? What is the patient's probable life expectancy and general condition if treatment is not given? What are the risks and side effects of the proposed treatment?

In Mr. Dossey's case, the clinical information appeared to be unambiguous. His cancer was inoperable; it had metastasized and was now causing acute renal failure—a life-threatening condition. Because of the acute problem, Dr. Jajoura asked him if she could perform a diagnostic test, a CT scan, to determine the extent of the cancer. However, this information would not change his poor prognosis and would only assist in determining appropriate treatment for the renal failure. Mr. Dossey will certainly die in the immediate future if he does not receive treatment to relieve the blockage of the ureters—the cause of the acute renal failure. The risks of performing an operation to relieve the blockage would also have to be considered. Even if the likelihood that the treatment would relieve the immediate problem was great, the underlying condition would not change. At that point, Mr. Dossey would have to consider the risks and burdens of radiation and chemotherapy treatment options.

As much as possible, it is important to clarify the relevant clinical information in the case before moving on to a more in-depth analysis of the moral relevance of these facts.

Situational information includes data regarding the values and perspectives of the principals involved; their authority; verbal and nonverbal communication including language barriers; cultural and religious factors; setting and time constraints; and the relationships of those immediately involved in the case. In other words, even if the clinical "facts" of a case are held constant, changes in the situational or contextual factors such as the values of a key principal in the case could change the ethical focus or intensity of the ethical conflict. Of all the situational data mentioned, the most important is the identification and understanding of the value judgments involved in a case. An extensive discussion of value judgments can be found in Chapter 2.

The main players in this case are Mr. Dossey, his wife and son, Dr. Jajoura, members of the nursing staff, and, from a distance, the surgeon who first cared for Mr. Dossey and supplied the less-than-honest news about his prognosis. All the individuals involved in the case possess values about many things, including values about health, honesty, professional competence, and loyalty, to name a few.

We know that Mr. Dossey has a wife and son. Did they completely understand the seriousness of Mr. Dossey's condition? What were their positions? Did they agree with one another? What are the views of the other individuals involved in the case such as the nursing staff or Mr. Dossey's pastor? How do these views compare and contrast?

We know that responsibility for the care of Mr. Dossey rested with various members of the health care team. Each member's responsibilities are distinct, yet overlap. As part of the information-gathering step, it is important to sort out the various responsibilities, not for blame-placing purposes but for identifying moral

accountability. For example, Dr. Jajoura may not be the one who presented the less-than-accurate view of Mr. Dossey's diagnosis, but she is the one who has to break the bad news at this point if she wants to honestly present treatment options to her patient and obtain valid consent. These are only some of the facts that affect an ethical decision from all of the information provided in the case. Once the facts are outlined, one can examine them to see whether the case has the characteristics of an ethical problem.

3. Identify the Ethical Problem/Moral Diagnosis

As has been noted in the Introduction, ethics deals with a wide range of imperatives and obligations regarding human dignity and conduct. The distinct characteristics of moral evaluation, also mentioned in the Introduction, apply to this third step of the five-step model, that is, they must be ultimate, possess universality, and treat the good of everyone alike. Ethical principles are relevant sources of ethical guidance and can serve to help identify the types of ethical problems in a case. The values, rights, duties, or principles that are in conflict should be identified. The ethical principles most often involved in complex cases such as Dr. Jajoura's situation are (1) respect for patient autonomy, (2) beneficence and nonmaleficence, and (3) veracity. In this volume we will treat justice, fidelity, and avoidance of killing as possible principles as well. Separate chapters are presented in Part 2 of this book to develop each of these principles.

The principles that are in conflict in the case at a minimum are respect for autonomy, which, in this case, implies the patient's right to make an informed decision about his treatment, and veracity, nonmaleficence, and beneficence, raising the question of the obligations of the physician to be honest and to prevent harm and do good when possible. Because the patient's preferences or wishes take priority over other parties involved, his wishes should be considered first. Generally, the wishes of competent, informed patients should be respected and followed, that is, the implication of the principle of respect for autonomy. Therefore, ascertaining the patient's competency is important. Is Mr. Dossey capable of making decisions? The fact that his creatinine and BUN levels were rising quickly may have affected his central nervous system and affected his ability to make a competent decision. Though determination of competency is a legal determination, the parties involved with Mr. Dossey could have informally validated his ability to understand the information presented to him, to appreciate that the information applied to his case, to state the benefits and burdens of treatment and nontreatment options presented, and to demonstrate a logical coherence between his wishes and the predictable outcomes. For example, it would be illogical for Mr. Dossey to say, "I really want to be discharged without any treatment, but I want to do everything to prevent my death." A competent person would understand that discharge without treatment is tantamount to death.

Nonmaleficence is the principle underlying the original surgeon's decision to withhold the truth from Mr. Dossey. He wanted to avoid the psychological trauma that the bad news would bring. Nonmaleficence also motivates Dr. Jajoura's conviction that she should strive to protect Mr. Dossey from unnecessary harms.

The immediate harm from acute renal failure is of greatest concern, especially since it is a harm that can probably be corrected. The long-term harms from metastatic disease can be ameliorated but not eliminated. Assuming she was not willing, like the original surgeon, to treat Mr. Dossey without informing him of his situation, the duty to protect her patient from harm could lead Dr. Jajoura to try one more time to reach Mr. Dossey about the seriousness of his present status. Perhaps she would even consider seeking the family's support in convincing him about the treatability of the acute renal failure. At a minimum, treatment of the acute problem could buy more time for the family and the patient to grasp the poor prognosis and determine if palliative radiation or chemotherapy is worth the benefits and burdens involved or if hospice care is the right choice at this time.

Also at stake is the principle of veracity, the moral notion that one is obligated to speak truthfully, especially in situations in which one is in a role in which one cannot keep silent. This principle separates Dr. Jajoura and the original treating physician. Mr. Dossey was not adequately informed about his prognosis. Clearly, the surgeon who initially treated him was not honest about his diagnosis and prognosis. Dr. Jajoura did offer information about the prognosis, but did Mr. Dossey really hear anything after that? When Mr. Dossey fully grasped the truth, he became angry. Furthermore, the revelation about the gravity of his diagnosis and the deception might have caused him to mistrust other health care professionals including Dr. Jajoura. She believes that she is obligated to tell the truth to Mr. Dossey about his diagnosis and prognosis so that she can propose treatment options to him. She may also believe that Mr. Dossey will benefit from open discussion of his prognosis—it could avoid anxiety from not knowing his situation. In that case, the principle of beneficence would support disclosure even if Dr. Jajoura did not accept the principle of veracity.

At this point we can move to the fourth step in the solving of the problem at hand by exploring various courses of action, which requires both determining which principles are involved and what their implications are.

4. Seek a Resolution

The working phase of decision-making is, indeed, proposing more than one course of action and examining the ethical justification of various actions. Many people try to avoid this step in the decision-making process and at the same time reduce stress by settling for the first option that comes to mind or what at first appears to be the safe choice.

Some of the courses of action that are open to Dr. Jajoura are: (1) if she faces her moral choice before she has revealed his true situation, she could continue the original plan of deceiving him; (2) she could, by declaring him incompetent or simply ignoring his competence, treat him against his will to eliminate the risk of life-threatening renal failure; (3) she could let Mr. Dossey leave and call the next day to see if he has changed his mind keeping the door open to treatment of the acute renal failure; (4) she could propose hospice care for Mr. Dossey in his home, thereby honoring his wishes. The actions actually fall into the categories of directly overriding Mr. Dossey's autonomy, treating him as nonautonomous, honoring

Mr. Dossey's autonomy but still trying to change his mind, completely honoring his decision by ordering hospice services (thus confirming the decision to stop curative treatment for the acute renal failure), and offering symptom management and assistance with end-of-life care.

To determine which options are morally justifiable, one must project the probable consequences of each action and the underlying intention of the action as well as whether there are moral duties that prevail independent of the consequences. This process involves the application of the ethical principles presented earlier and the ethical theories described below. By following this process, one can reject some options immediately because they would result in harm or would conflict with another basic ethical principle.

Choosing the first option would be hard to reconcile with the principle of veracity but could be supported by more consequence-oriented ethics that stress beneficence and nonmaleficence. Two major versions of consequence-oriented ethics were presented in the Introduction: utilitarianism and Hippocratic ethics. Hippocratic ethics would focus on the principles of beneficence and nonmaleficence, but only insofar as the action affects the patient.

Utilitarianism differs from Hippocratic ethics not in focusing on the principles of beneficence and nonmaleficence, but in which consequences are relevant. It holds that we should choose the option that would bring about the greatest good for the greatest number. For example, if Dr. Jajoura were a utilitarian, she might agree with the original surgeon that Mr. Dossey would be better off if he were deceived, but she might still fear that others (including his family) would learn from this experience that doctors lie to patients. If she was worried that the long-term bad consequences for other patients—developing fear that doctors cannot be trusted—would outweigh any benefits for Mr. Dossey, she might decide against the first option.

By contrast, the Hippocratic form of consequentialism factors in only the consequences for the individual patient. Dr. Jajoura might still reject the first option if she thought Mr. Dossey himself would be harmed by the continuing deception, if, for example, she feared he would soon find out he was getting worse and faced the additional problem of not being able to talk openly with his doctor and family about his impending death. Thus, consequentialists—those who focus only on principles of beneficence and nonmaleficence—can either accept or reject the first option depending on how they assess the consequences and whose consequences they include.

Option two may involve a variation on option one—ignoring respect for autonomy. In some cultures, physicians have had the power simply to treat a patient in the way that they think is best for the patient, ignoring the patient's autonomy. If Dr. Jajoura is driven by beneficence for the patient, she might conclude that this is a viable strategy. It could solve the renal failure problem but could make Mr. Dossey upset. It would also be illegal in our society, assuming Mr. Dossey was competent to consent or refuse consent. On the other hand, if Dr. Jajoura really believed Mr. Dossey was incompetent to consent, she could pursue the course of trying to get him declared incompetent, thus acting on the principle of

beneficence, which may be the only relevant principle left for one who, lacking competence, has no possibility of autonomous decision-making. Dr. Jajoura should realize, however, that if Mr. Dossey is declared incompetent, someone will be appointed his guardian—probably his wife or son—and they may make the same choice for him that he was going to make.

Options three and four both follow a different strategy, one based on a belief that Mr. Dossey is an autonomous agent and that his autonomy must be respected. Respect for autonomy is a principle that leaves patients free to follow their own life plans even if sometimes doing so does not result in what is best for the patient. The principle of veracity also supports some version of open disclosure. Respecting autonomy and the related principle of veracity will prohibit deception in Mr. Dossey's case. Such respect, however, does not rule out reasonable attempts to persuade a patient to follow a course that the doctor believes to be best. One could leave Mr. Dossey to his own choice and still follow up at some time in the near future to see if he has changed his mind. At that time one could again offer hospice care, which would be consistent with respecting autonomy and veracity. This might also avoid some harm due to other courses and lead to giving Mr. Dossey as much benefit as possible. It is possible, however, that the conflict between such respect for autonomy and the more consequence-oriented principles of beneficence and nonmaleficence cannot be resolved. In that case Dr. Jajoura will have to decide whether she is to be guided by a consequence-oriented ethic or one that holds that in the end the duty to respect the patient's autonomy must prevail.

We have at this point identified several possible courses of action and the implications of various ethical principles for each of those courses.

5. Work with Others to Determine a Course of Action

No one makes decisions alone in a health care setting. The same is true for ethical decisions. A better decision can be reached if the people who are legitimately involved have the opportunity to discuss their perceptions, values, and concerns openly. Referring back to the first step of the decision-making model, the response to the sense that something is wrong is a subjective one that is limited by one's intuition and is informed by many factors such as culture, gender, class, race, and ethnicity, to name a few. To help broaden our limited perspectives, it is important to share views and insights with others involved in a case. Who should be part of the team or group to resolve ethical problems? In an acute-care setting, that will usually involve members of the health care team who provide direct care to a patient and family. A care conference or other form of team meeting in which goals of treatment are discussed could be the place where collaborative decisions are made and concerns aired even if those concerns are not specifically labeled as ethical ones. In a complex case such as this, Dr. Jajoura should also call on the input of the institutional ethics committee that usually has representatives from a variety of disciplines such as nursing, social services, pastoral care, and medicine. One should seek the counsel of an ethics committee when the goals of care are confused or there is a sense of conflicting duties, or when those involved would benefit

from a facilitated discussion. By soliciting different points of view and discussing concerns in a mutually respectful environment where all voices can be heard, they can reach a more comprehensive decision that is ethically justifiable.

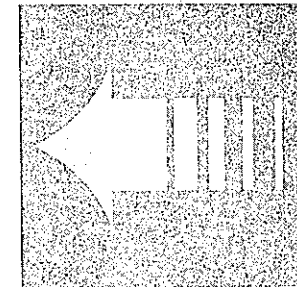
It is apparent that the duty-based principles such as respect for autonomy and veracity push us very hard to disclose Mr. Dossey's diagnosis and honor his decision if it is indeed substantially autonomous. On the other hand, the Hippocratic form of a consequence-based ethic provides the most plausible basis for overriding his decision to refuse treatment for an acute health problem that could probably be reversed. There are many cases in ethics that lead to relatively clear resolutions. At times, reasonable people can come to the same resolution but support their decision with entirely different principles or theories. Mr. Dossey's case, however, does not lead to a definitive resolution because of the facts of the case and the individuals involved. Health professionals encounter all of these types of ethical problems from the clear-cut to the vague and messy. The decision-making model is one tool to help determine justifiable options whether the case is simple or complex.

Notes

- 1 Purtilo, Ruth. *Ethical Dimensions in the Health Professions*, 3d ed. Philadelphia: W. B. Saunders, 2005; Fletcher, John C., ed. *Fletcher's Introduction to Clinical Ethics*, 2d ed. Frederick, MD: University Publishing Group, 2005; Haddad, A., and M. Kapp. *Ethical and Legal Problems in Home Health Care*. Norwalk, CT: Appleton and Lange, 1991; Rule, James T., and Robert M. Veatch. *Ethical Questions in Dentistry*, 2d ed. Chicago: Quintessence Books, 2004.
- 2 Leong, Trevor. "Chemotherapy and Radiotherapy in the Management of Gastric Cancer." *Current Opinions in Gastroenterology* 21 (2005): 673–678.
- 3 Haddad, Amy. "The Anatomy and Physiology of Ethical Decision Making in Oncology." *Journal of Psychosocial Oncology* 11 (No. 1, 1993): 69–82.
- 4 Salladay, Susan, and Amy Haddad. "Point-Counterpoint Technique in Assessing Hidden Agendas." *Dimensions of Critical Care Nursing* 5 (No. 4, 1986): 238–243.
- 5 Haddad and Kapp. *Ethical and Legal Problems in Home Health Care*, p. 13.

Chapter 2

Values in Health and Illness



Learning Objectives

1. Identify moral and nonmoral evaluations in health care practice.
2. Identify value judgments in clinical cases involving a health professional and patient.
3. Describe the criteria for an evaluation to be considered an ethical evaluation.

Other Cases Involving Values in Health and Illness

Case 10-7: Biased Counseling: Teaching about Birth Control

Case 11-2: Dwarfism: When Is a Fetus Normal?

Case 12-1: Guilt over Suicidal Thoughts

Case 12-2: Obesity: Medical Problem or Lifestyle Choice?

At first it might appear that ethical and other value problems arise infrequently in medical decision-making. Although the health professional and patient are increasingly seen as confronting such issues—in decisions about abortion, euthanasia, test-tube baby cases, and genetics, for