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Ethics consultation in practice 3: Case from Oncology
My approach: principle-based case discussion

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Clinical ethics consultation is about *ethics*…

⇒ What is an *ethical* issue?

⇒ Ethical issue:

  • *Different options* to act available (e.g. different clinical management strategies)
  • *Uncertainty* about what is the best course of action from a *moral point* of view
  • Maybe (not necessarily!): Disagreement within the team what is *ethically* the best option
  • (Mere) personal/psychological conflicts ⇒ no case for *ethics* consultation

⇒ Goal of clinical ethics consultation: *good ethical* workup of the case ⇒ What is the best course of action from a moral point of view?
Moral reasoning in clinical ethics consultation

Explicit definition of step-by-step workup of the case
⇒ clear cognitive structure of the case discussion
⇒ assures the ethical quality of the result!
⇒ Moderator/ethics consultant: responsible for cognitive structure

(1) What can we do? ⇒ Medical analysis
   (a) What are the options, i.e. management strategies?
   (b) What are the consequences of each management strategy?
      ⇒ outcomes: benefits & burdens/risks

(2) What should we do? ⇒ Ethical evaluation
   (a) What is the best option from a moral point of view?
      • Required: Normative standard for ethical evaluation
        ⇒ What are our ethical obligations?
      • Principles of biomedical ethics define our ethical obligations
        ⇒ Beneficence, nonmaleficence, respect for autonomy, justice
      • Coherentist model of justification (not quite the B&C-approach!)
      • Cognitivist & objectivist metaethical position
        (I do not ask for the subjective values of the participants in the CEC)
Step 1: Analysis ⇒ Medical workup
(a) Patient information (history, symptoms, findings, diagnosis…)
(b) Management strategies + outcome of each strategy (benefits & burdens/risks)

Step 2: Evaluation ⇒ Specification of moral obligations
(a) Beneficence/nonmaleficence ⇒ best interest perspective

Guiding question:
What is the best management strategy according to the beneficence-based obligations, i.e. from the perspective of the team?

Step 1: **Analysis** ⇒ Medical workup  
(a) Patient information (history, symptoms, findings, prognosis)  
(b) Management strategies + outcome of each strategy (benefits & burdens/risks)  

Step 2: **Evaluation** ⇒ Specification of moral obligations  
(a) Beneficence/nonmaleficence ⇒ best interest perspective  
(b) Autonomy ⇒ patient perspective  

**Guiding question:** Which management strategy does (or would) the patient prefer?

**Step 1: Analysis ⇒ Medical workup**

(a) Patient information (history, symptoms, findings, prognosis)

(b) Management strategies + outcome of each strategy (benefits & burdens/risks)

**Step 2: Evaluation ⇒ Specification of moral obligations**

(a) Beneficence/nonmaleficence ⇒ best interest perspective

(b) Autonomy ⇒ patient perspective

(c) Justice ⇒ obligations to third parties

**Guiding question:**

Which management strategy would be best for *third parties* involved in the case?

Principle-based model of clinical ethics consultation

Step 1: Analysis ⇒ Medical workup
(a) Patient information (history, symptoms, findings, prognosis)
(b) Management strategies + outcome of each strategy (benefits & burdens/risks)

Step 2: Evaluation ⇒ Specification of moral obligations
(a) Beneficence/nonmaleficence ⇒ best interest perspective
(b) Autonomy ⇒ patient perspective
(c) Justice ⇒ obligations to third parties

Step 3: Synthesis ⇒ Balancing of moral obligations

Guiding question:
Do our obligations converge or conflict?

Principle-based model of clinical ethics consultation

**Step 1: Analysis ⇒ Medical workup**
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**Step 2: Evaluation ⇒ Specification of moral obligations**
- (a) Beneficence/nonmaleficence ⇒ best interest perspective
- (b) Autonomy ⇒ patient perspective
- (c) Justice ⇒ obligations to third parties

**Step 3: Synthesis ⇒ Balancing of moral obligations**
- (a) Obligations converge ⇒ no ethical conflict
- (b) Conflicting obligations ⇒ balancing justified by good reasons

**Step 4: Critical review ⇒ Objections? Prevention?**

Participants: Members of the team who care for the patient
- Relevant medical disciplines, nurses, chaplain/pastor, psychologist, physiotherapist, speech therapist, etc.
- Bring in relevant information about patient & family
- Result is worked out with those who care for the patient ⇒ assures implementation of the result

Moderation by ethics consultant
- Primary objective: ensure cognitive structure of workup ⇒ quality of moral reasoning in the group

Usually, I do not talk to the team, the patient and the family before the case conference
- Relevant information is revealed by the participants within the case conference ⇒ careful selection of participants is highly relevant!
- Exception: Conflict with or within the family ⇒ “indication” for inclusion of relatives into case conference in second round after team discussion
- Time frame: result within 1 hour 😊 ⇒ (too?) “short bridge”
Putting the model into practice…

Simulation of ethical case discussion within the team
⇒ application of the principle-based model

Questions:

(1) Is the result of the ethical workup of the case convincing?

(2) Do we need a clearly defined cognitive structure for the workup of clinical-ethical issues within CEC?

(3) What do you think about the principle-based model of CEC?

(4) Is a pluralism of approaches regarding the cognitive structure (for the same type of cases!) inevitable, acceptable or unacceptable?
Principle-based model of clinical ethics consultation

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**Step 2: Evaluation** ⇒ Specification of moral obligations
(a) Beneficence/nonmaleficence ⇒ best interest perspective
(b) Autonomy ⇒ patient perspective
(c) Justice ⇒ obligations to third parties

**Step 3: Synthesis** ⇒ Balancing of moral obligations
(a) Obligations converge ⇒ no ethical conflict
(b) Conflicting obligations ⇒ balancing justified by good reasons

**Step 4: Critical review** ⇒ Objections? Prevention?

Slides: [www.dermedizinethiker.de](http://www.dermedizinethiker.de) (next week)