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

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„Clinical Ethics: Bridging Clinical Medicine and Ethics“

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Background

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)

Principle-based model of clinical ethics consultation

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?

Cf. McCullough LB, Ashton CM. A methodology for teaching ethics in the clinical setting: a clinical handbook for medical ethics. Theoretical Medicine 1994;15:39-52.

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

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

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(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?

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(c) Justice ⇨ obligations to third parties

Step 3: *Synthesis* ⇨ Balancing of moral obligations

Guiding question:
Do our obligations converge or conflict?

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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?

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Setting of case-discussion

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?

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Slides: www.dermedizinethiker.de (next week)