Approach to the Medical Ethics Consultation

Grace Farris, MD

KEYWORDS

• Medical ethics • Ethics consultation • Refusal of treatment • Substituted judgment

HOSPITAL MEDICINE CLINICS CHECKLIST

1. The principle approach to medical ethics grapples with the four principles of modern medical ethics: autonomy, justice, beneficence, and nonmaleficence.
2. Substituted judgment describes the process whereby a health care proxy attempts to guide care based on what a patient would have chosen.
3. Patients with capacity have the right to refuse care.
4. The use of medical ethics consultation services began in the 1970s.
5. Medical ethics consultation services usually provide guidance, but do not have authority.
6. Medical ethics consultation services are often composed of physicians, nurses, and nonmedical staff.
7. The most common reasons for medical ethics consultation requests are conflicts between medical providers and patients and their families, dilemmas surrounding end-of-life care, and medical futility.
8. At teaching hospitals, up to half of medical ethics consultations may originate with trainees.
9. In additional to medical staff, patients and their families can request ethics consultations.

KEY PRINCIPLES AND APPROACH TO MEDICAL ETHICS CONSULTATION

What are the four principles of modern medical ethics?

In their seminal book *Principles of Biomedical Ethics*, Beauchamp and Childress[1] identified the four principles of modern medical ethics as autonomy, justice, beneficence, and nonmaleficence.[1] Autonomy has been defined by Immanuel Kant as

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Hospital Medicine, Division of General Internal Medicine, Beth Israel Deaconess Medical Center, Harvard Medical School, Span 2, 330 Brookline Avenue, Boston, MA 02215, USA
E-mail address: gfarris@bidmc.harvard.edu

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complete "moral freedom" and later by John Stuart Mill as a political and social freedom.[1] Preservation of patient autonomy is a frequent reason for ethics consultation requests.[2] Patient autonomy may conflict with medical standards of care in a variety of settings: some patients' religious beliefs may forbid certain medical treatments, and when a patient refuses a treatment based on religious reasons, this can be seen as a patient exercising autonomy.

Beauchamp and Childress acknowledge that many different definitions and interpretations of justice have plagued medical ethics,[1] defining justice as "what is fair, equitable and appropriate treatment in light of what is due or owed to persons." Beauchamp and Childress go on to clarify that no single principle can address "all problems of justice." Deliberations around justice often arise with the need to allocate scarce resources, such as organ transplants. For example, is it just to provide a young person with alcoholic cirrhosis with a liver transplant? What if the transplant recipient relapses and develops alcohol-related liver disease again? Because resource allocation frequently takes place at an institutional level (a transplant committee might make the decision about whether a patient with alcohol use and liver disease merited a liver transplant), the "problems of justice" more often are the subject of ethics committees rather than individual ethics consultations.

Beneficence (a duty to protect or heal a patient) and nonmaleficence (which originates with the Latin *primum non nocere* or "first, do no harm") are considered corollaries, and often it is possible to satisfy both principles.[1] However, in the case of end-of-life palliative care, when treating a patient's pain with sedating medications may hasten death, these two principles can be at odds with one another.[1,3]

What approaches have been used in medical ethics decision making?

The most common framework used in modern medical ethics consultations is "principle-ism." Principle-based medical ethics uses the principles outlined by Beauchamp and Childress to logically arrive at an ethical judgment. Cases will often involve situations in which two competing principles are in conflict. For example, in the case of Karen Ann Quinlan, a landmark court decision about a woman in a persistent vegetative state whose parents asked her physicians to withdraw life support, autonomy and nonmaleficence were in opposition. Those arguing in favor of the removal of life support argued that this would further Quinlan's ability to be an autonomous decision maker (through her family), whereas those in favor of maintenance of life support argued that the physician's primary objective was to do no harm (nonmaleficence) and that removal of life support would cause harm (death).[4,5]

Other approaches to decision making in medical ethics include a utilitarian approach (this is less often used for clinical consultative ethics, but is used at an institutional level when determining resource allocation in the case of transplant medicine and public health campaigns such as vaccinating health care workers for influenza), and the biopsychosocial model, or narrative medicine approach, which attempts to assign primacy to patient autonomy and the patient narrative or personal story.[4,6,7]

What is casuistry and how is it used in ethics consultation?

Casuistry is a form of moral decision making that has its roots in Christian theology, and follows an established framework to generate a moral decision.[4] It has been influential in the development of the medical ethics consultation technique because it involves a case-based approach similar to what other specialty clinicians use to structure a consultation. In medical ethics casuistry, first the details of the case are