ETHICAL DECISION MAKING

1. THE ROLE OF ETHICS IN MEDICAL PRACTICE

Though this is law, ethics provides a vital role. Legal and ethical obligations must be taken into account by doctors at all times – both must be considered. Everytime a doctor makes a decision there are ethical factors to take into consideration – should a patient be treated, what priority should they be treated in etc.

The New Zealand Medical Council Code of Ethics begins by stating: “The profession of medicine has a duty to maintain and improve the health of the people and reduce the impact of disease. Its knowledge and consciousness must be directed to these ends. The medical profession has a social contract with its community.”

In return for the trust patients and the community place in doctors, ethical codes are produced to guide the profession and protect patients.

2. THE ROLE OF ETHICS IN MEDICAL REGULATION

Ethics is important for medical regulation, e.g. technology that effects us may require government restrictions. In the 1990s scientists cloned a sheep ‘Dolly’ and once this had been done there were discussion on whether we could clone humans. Governments had to decide how to regulate human cloning and all arguments were ethical at first which later led to legal restrictions. What about genetic engineering? If we can alter certain genes to change ourselves should such be regulated, e.g. genes to make us smarter.

3. THE LEGACY OF THE 1930S-40S.

Previously is a patient was sick the doctor would make their own decision on how to treat the patient without explaining what was happening or giving options. Today though the focus is on giving the patient all information needed and getting them to make their own decisions. What happened to change this? During the 20s the idea of eugenics was beginning to take forward (all traits are inheritable where genes determine who we are). People with good characteristics were encouraged to breed with each other, and those with bad traits were discouraged from breeding with each other. Forced sterilisations began with people of low intelligence in the 1920s. This was mostly done in the US, UK, Australia and to a lesser extent NZ. By the end of the 1930s with WWII we realised eugenics was no longer a good idea. The Nazi’s increased the programmes tenfold and instead killed people off who they saw with undesirable genes.

By the end of WWII medicine took a step away from eugenics and moved towards taking care of patients to stop the eugenics scenario starting again. Human rights began to take a large leap forward at this time as a result. The Universal Declaration of Human Rights was founded. Doctors moved from thinking they knew best to empowering patients to make their own decision making. There were now principles they had to take into account.

4. HOW ARE DECISIONS MADE?

There are 4 basic ethical principles a doctor must take into account:
- Respect for autonomy
- Beneficence
- Non-maleficence
- Justice.
- Dignity (recent development)

A. Respect For Autonomy

i. What is autonomy?

Autonomy is a person’s ability to make their own decisions taking into account all factors important to them. In order for it to work and for a patient to make decisions they must understand what is happening to them – they need lots of information from a doctor given in a way they can understand, as well as receiving it in an
environment that they can deal with it properly. Cultural sensitivity comes into play as well. A doctor must maximise the ability of the patient to make a decision. A doctor should not deceive a patient – they should not lie to them. There are some cases where a patient may not want information though, e.g. cancer status – in this instance the doctor can deceive the patient.

When a patient gives a decision the doctor must consider whether it was autonomous or not. There are three considerations to make from such:

Ideal desire autonomy- what society thinks we should want
This is not really an autonomous decision – simply following everyone else is not enough.

Best desire autonomy- overall desire based on values
This depends on the particular patient at the time.

Current desire autonomy- immediate inclination
What does the patient want at that immediate time?

Re MB
A woman needed to give birth by c-section or else she would have died, only she is afraid of needles and in order to do one a large injection is done. The woman says she cannot have the c-section because of this. What should the doctor do? The doctor must find out what the patient want. Should he follow the ideal desire autonomy (everyone wants to live) and give her the needle, follow the best desire autonomy (what has she said about the birth and child?) or the current desire autonomy (not get needle)?

ii. What if a person changes their mind?
Normal we would expect to follow the best desire autonomy, but is that right? What if she had changed her mind? Consider that a Jehovah’s Witness will not take blood transfusions even if it would result in their death; if they refuse one to save their life is this ethical for the doctor? If they wanted one, then following the best desire autonomy would stop their current desire autonomy – here we see conflict between the two when trying to determine which of the two we should follow.

iii. When can autonomy be limited?
Is a doctor automatically required to take into account a patient’s wishes? A doctor is not enforced to comply with a patient’s wishes.

Arguments for limiting autonomy include;
- Risk relative capacity
  Whether your autonomy can be taken into account depends on the level of risk of the operation, so the higher the risk, the clearer a patient must be thinking. If refusing something means you will die then you must be shown to have high competence. The criticism of this is that it reverts to the old paternalism method of doctors who decide for their patients the best decision.

- Limit autonomy now, to maximise autonomy later
  Should a patient be kept alive now (against wishes) to give them more choice later. In one case a woman went to a doctor and was told without surgery she would go blind. The doctor explained all this to the patient and said there was a 1% chance of getting ‘floaters’ – permanent blurry flickering patch in the eye. The woman said she did not want the surgery despite the small chance of such. The doctor got her a second opinion, and sent her to another doctor who lied to her (in agreement with the other doctor) who told her there was no chance at all of getting it. The patient was happy with this information and got the surgery which was successful. Did the doctors do the right thing by lying to her about the small chance? Did they do the right thing of limiting her autonomy to maximise it at a later point?
Lack of Resources

R (Burke) v GMC [2005] 3 FCR 169

A right to decide treatment is not the same as a right to demand treatment – can’t have whatever you want. Sometimes a treatment option is not available. To comply with autonomy, of the options a doctor gives you does not mean you can choose another. In the case a patient was able to talk and eat but was deteriorating to the point where in the near future he could no longer feed himself without artificial feeding, and that he would later not be able to communicate and eventually lose his mental capacity and die. The patient wanted his artificial food and support taken away when he lost his ability to communicate. He went to court to get this order, and the court said he could not demand this treatment. The court said he could not demand the artificial food from the beginning and demand it be shut off because he may not get the artificial food in the first place.

B. The Principle Of Beneficence

Beneficence means to do good and is the duty to take care of patients and make them better. Non-maleficence means to do no harm. If a doctor has to do harm then the idea is that they do more good than harm, e.g., surgery requires cutting a person, but the good of the surgery outweighs the bad.

C. The Principle Of Non-Maleficence

This means to do no harm and says a doctor should not harm a patient.

i. What is harm?

Harm comes from what the patient considers to be harm. If a patient has breast cancer the best way to treat it is to remove the breasts – the harm from such will differ from woman to woman.

ii. Whose benefit/harm are we talking about?

After WWII in the Nuremberg Trial this was considered a lot. In concentrations camps medical experiments were undertaken on prisoners – some had medical benefits and some did one. In one instance a prisoner was doused in cold water to get hypothermia and then experiments to treat them were undertaken. What the Nazi’s learnt though was that the current method of treating hypothermia was not the best. After the war an interesting question was raised over what we should do with such information. The medical information came from horrific experiments, so should we use it? By using it are we suggesting what the Nazi’s did was beneficial? Should we use the information, as regardless of the information it can save lives? What is the right thing to do?

What about clinical trials? If you are a cancer sufferer in a late stage where normal treatment does not work then you could use experimental drugs. Many clinical trials expect that the patients involved will not actually recover from such, and the benefit from the trial is normally for those in the future – is it right to ask these cancer sufferers to take part in the trial? Is it right to ask them to suffer more harm than good to benefit those in the future?

D. The Principle Of Justice

This covers three basic concepts:

i. Distributive justice - fair distribution of scarce resources

If there are limited resources how do we decide who should get them? If one person can pay and another cant, should the one who can pay get it faster? If a person needs a kidney, should a person be able to buy one rather than remaining on a waiting list? Should money take advantage of such? What about private healthcare – if we have money we can get better care – is this right?

ii. Respect for people’s rights – rights based justice

People should be treated equally by doctors so doctors don’t get to make decisions based on how deserving a patient is, e.g., a patient with lung cancer due to smoking should not be punished because they refuse to stop smoking. In practice this works with difficulty.

In one example; two people need a heart transplant, there is one heart only and they both could suit it. One patient is 20 and one is 65 – does age take a part in decision making? Is it fair that this factors into our decision making? Can we discriminate based on age? What if the 20 year old is morbidly obese or a heavy smoker – since he is not the healthiest of the two should he not get the heart? What factors are fair to take into account?
iii. Respect for morally acceptable laws- legal justice

Generally legal requirements must overrule personal beliefs, e.g. if the law says a doctor must act in a certain way then they must do so. This is most common with infectious diseases, e.g. certain diseases must be reported to the government as the needs of society to be protected from such outweigh the patients desire to keep their condition confidential.

There are problems with each of the four ethical considerations and we can see that they all conflict with one another in some way.

E. Dignity?
This has come up due to the UDHR which talks of a person’s dignity. What does it mean though? It is not really definable. Perhaps the other four may not give an answer for some ethical dilemma – dignity can generally give us some idea of what to consider. Dignity is about letting you be the best person you can be.

Peter Singer: the last resort of those who run out of arguments – a last resort argument if we cannot come up with anything else.

John Harris: universally attractive, also comprehensively vague.

Bagaric and Allen: used by academics and judges and legislators when rational justifications fail.

5. SCOPE
A. Who are these duties owed to?
Who does a doctor owe these ethical duties to? Primarily it is to the patient, but does the doctor have to take into account anyone else? What about the wider community? If there is an infectious disease to report then this would be the case.

B. What about unknown people?
What about unknown people in the future? Treatment may need to be refused to one person so it can be given to another in the future as an example.

One case involved a man needing dialysis while waiting for a kidney transplant. A hospital has one dialysis machine which is not in use but they refuse it to him on the grounds that he is not a good candidate for dialysis – mental break down where he keeps removing the needle and so needs to be monitored constantly. The hospital said a better candidate would not have treatment available in the future if they gave it to the man. The court said this decision was able to be made though.

C. What about future persons?
Should a doctor take into account that a woman is pregnant when talking about treatment? If a woman needs chemo to survive when pregnant should he consider the needs of the unborn child? One US case involved a pregnant woman with complications who needed to deliver by c-section to let the child live. The woman refused to have a c-section and said she did not care if it died on the grounds that she would have a scar that would affect her sex life. Can the doctor force the woman to have a c-section? Taking only the pregnant woman into account then yes, but taking the future child into account then no. In the case the woman was allowed to choose what she wanted and the unborn child’s needs were irrelevant.

D. What about family/carers?
Jonathan Herring says family looking after a patient should be taken into account when considering treatment for a patient. He discussed an example of an incontinent husband at the point where he has adult nappies. There is an operation to fix such which he refuses – Herring says if we just look at the husband then we should look no further, but what about his wife and carers? What about the harm this is causing her - should it be taken into account? Should the doctor take it into account that the wife’s life would be made easier?
Firstly a complaint must be made – there are three different groups of people who can do this; another practitioner (based on competence of them, or their health), the licensing authority themselves (heard of an issue), and lastly a consumer/patient.

**Complaint of Competence from another Practitioner of the Licensing Authority**

What if it is by the licensing authority or another practitioner? They can both make a complaint based on the practitioner’s competence. Under s34 HPCAA a practitioner may lay a complaint on another if they think they think there is potential harm to the public. There is no compulsory reporting – the practitioner may tell the licensing authority only if they want to. Previously it was compulsory in the drafting but it was removed as they assumed difficulty would arise from such. If a licensing authority wants to make a complaint based on competence and such would likely occur when they are carrying out inspections on hospitals, or perhaps when dealing with renewals of licences. Consumers can complain based on competence but this is different than we have mentioned.
Complaint based on Health of another Practitioner from a Practitioner

A practitioner can complain based on the health of another practitioner under s45. This section makes it compulsory for a complaint to be made if they feel there is a health issue suggesting another doctor cannot perform their job due to physical or mental issues. The licensing authority cannot make a complaint on this ground.

Investigation by the Licensing Authority

When a complaint is made the licensing authority looks at it and considers whether to investigate it or not. If they proceed they are required to let the subject of the complaint know what is going on – S v Medical Council [2004] – natural justice must apply. They also have a right to speak in their defence. Under the Act the form of the review depends on the authority, though generally a panel of two practitioners (same as one under investigation) and a lay person of the public. They will hear the case and the person under investigation can respond in person or in writing. The decision can be made where they can find that there is nothing, or that there is a problem.

Remedial orders can be made if it is a competency issue. An authority can require the practitioner to undergo additional training, conditions (not to practice in a specific area), sit examinations of assessments, or supervision to ensure that competency is upheld.

Under s50, if they think health is an issue the authority can suspend the licence of the practitioner until the issue can or is addressed. If the practitioner refuses examination then this is taken as a sign of guilt. If the health issue resolves itself the suspension can be uplifted and they may be able to practice again.

The authority can refer the issue to a PCC – professional conduct committee. This is where they suggest prosecution for a serious charge of incompetency. Here is will go to the committee to decide if the issue should go further to the Health Practitioners Disciplinary Tribunal.

The HCPPA Act tells us a complaint can be made by people other than the patient, e.g. friends and family – this is relevant where a patient has died in treatment or it they are a child. When investigating, if the investigator finds it is a competency issue or health issue they can send it to the licensing authority, but if it is a breach of the code they need to choose whether to investigate it or not. Natural justice applies in the second case as well, and so the practitioner must be advised if they are under investigation and they have a right to respond.
In NZ we have the central government which brings in money from tax which is then distributed to the minister, which is allocated as required. Some goes to ACC and some to other health crown entities – mostly to the Ministry of Health. NZ is divided in 21 districts and each has an administrative body - a health body, to serve for those in the district. This is done through funding within the district. An average person getting sick will be dealt with primarily by a Primary Health Organisation (PHO). A PHO is a body set up during legislative changes and to be classed as one there must be a wide range of health professionals from a wide variety – doctors, physiotherapists, alternative providers etc.

By enrolling in a PHO a customer is covered for all primary care required e.g. they can be sent by a doctor to someone else if needed. There are 81 PHOs within the 21 districts and they are funded from the government.
The funding depends on the amount of people enrolled within the PHO – funding per person enrolled. For example, if a person moves to Christchurch they must enrol in a PHO with their doctor and once this is done funding is received for that person whether they need it or not. The same amount of money is funded per person irrelevant of how many times they go to the doctor.

The best way for the PHO to make money is to have patients enrolled and not have them come in – does this model of funding create an incentive to affect the type of health care they get? Does this funding inspire good follow up care by a doctor? It appears unlikely. If a doctor is not being paid extra for a patient to come back, where is the incentive for them to come back?

The second way a PHO is funded depends on the demographic of the patients enrolled. When a PHO forms it is designated as an ‘access’ PHO or an ‘interim’ PHO. An access one gets more, and to get it you need a large amount of low income patients and high amounts of Maori and Pacific Islanders. The reason is that those who go to the doctor more are generally rich and white, and Maori and low income people go less. The reason why these groups get more funding is to encourage doctors to encourage them to see them. If a low income person doesn’t go to the doctor at first and gets sicker then the costs go up – there are more savings by treating them immediately then down the line when they get first, and as such they are encouraged through the extra funding.
RELEVANT LEGISLATION

A. New Zealand Public Health and Disability Act 2000

This Act sets up the funding model of the public health service.

Purpose

s3(1) The purpose of this Act is to provide for the public funding and provision of personal health services, public health services, and disability support services, and to establish new publicly-owned health and disability organisations, in order to pursue the following objectives:

(a) to achieve for New Zealanders—
   (i) the improvement, promotion, and protection of their health:
   (ii) the promotion of the inclusion and participation in society and independence of people with disabilities:
   (iii) the best care or support for those in need of services:

(b) to reduce health disparities by improving the health outcomes of Maori and other population groups:

(c) to provide a community voice in matters relating to personal health services, public health services, and disability support services—
   (i) by providing for elected board members of DHBs:
   (ii) by providing for board meetings and certain committee meetings to be open to the public:
   (iii) by providing for consultation on strategic planning:

(d) to facilitate access to, and the dissemination of information to deliver, appropriate, effective, and timely health services, public health services and programmes, both for the protection and the promotion of public health, and disability support services.

(2) The objectives stated in subsection (1) are to be pursued to the extent that they are reasonably achievable within the funding provided.

B. Health and Disability Services (Safety) Act 2001

This Act says any provider of health care services must be certified – this is the company/group that the doctors work at, e.g. hospital or practice. The Act ensures that a doctor’s surgery is certified before patients go there. This is done so they can be watched and made sure that compliance is occurring.

Purpose: to promote the safe provision of health and disability services to the public’ and ‘enable the establishment of consistent and reasonable standards for providing health and disability services to the public safely’ - s3

C. Health Practitioners Competency Assurance Act 2003

This Act ensures that Health practitioners are registered. It is a way of ensuring ongoing competence and fitness to practice. This covers the individual practitioners, rather than their place of work (previous Act). The Act sets out who health practitioners are, and what the health practitioners are, e.g. doctors, nurses, psychiatrists, optometrists etc. It sets up a certification scheme, so to use one of those titles you must be registered first. If the title is not listed then the person may call themselves that without being certified.

To be registered you must meet three criteria. Firstly they must meet the required training level. Secondly they must be fit for registration – there must be a high level of English, and there must be a degree of cultural sensitivity in NZ. Thirdly they must be competent – not just graduated but act as a reasonably competent person in your field. A practitioner must reregister from time to time so they can be checked on.

D. Health and Disability Commissioner Act 1994