ARE WE TRANSITIONING TO A CONSUMER MODEL OF HEALTHCARE DELIVERY? WHAT ARE THE ETHICAL IMPLICATIONS FOR CLINICIANS?

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Case 1

Mr. S is a 63 yr. old widower who has been living independently and alone in community. He has two grown children who also live in Edmonton. Mr. S is discovered collapsed in his driveway and brought to emergency by EMS. Mr. S is clearly emaciated and medically unstable. He receives full medical support and within two days in hospital is diagnosed with metastatic disease with prominent presence in his liver, brain, lungs, as well as other suspected organs. Mr. S's children are upset by the news, particularly, as they confess, they have seem little of him in past year. They claim that Mr. S was a member of religion x and would want "everything done". ICU is consulted from internal medicine and reports that Mr. S is not a candidate for admission and should be changed to a C GOC and receive palliative care.

Objectives

- Autonomy and Substituted Decision-Making

Trends

- Judicial
- Professional (Colleges)
- Academic
- Institutionally Rhetorical

context

Richard Taylor's Two Questions:

Old Question: What is the good life?

New Question: What makes right actions right?

context

Richard Taylor's Two Questions:

Old Question: What is the good life?

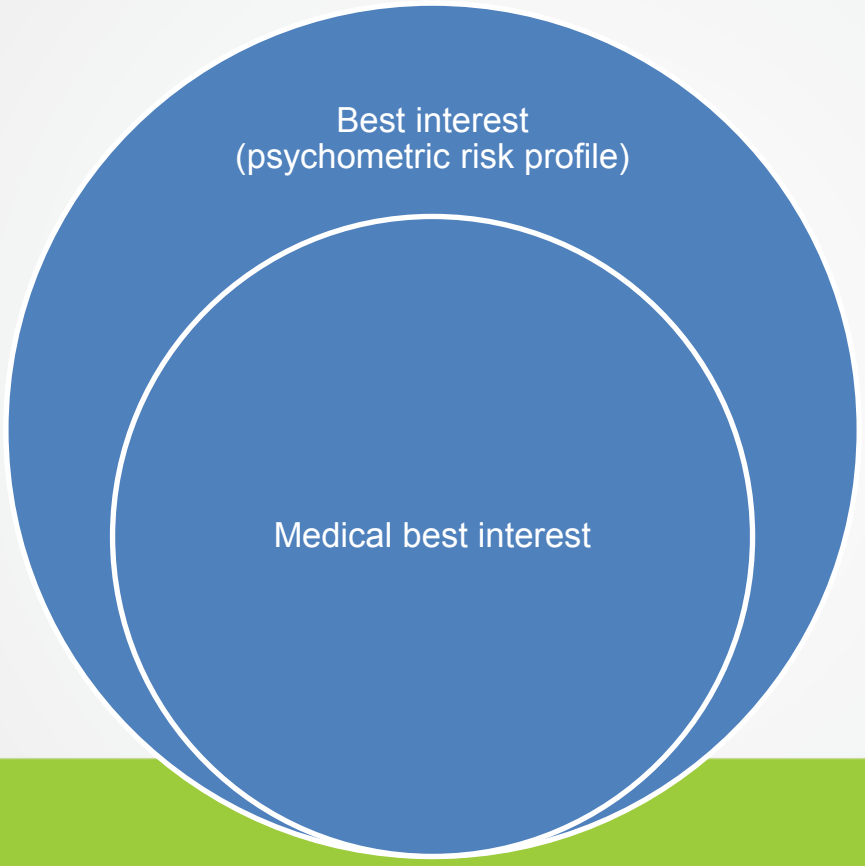
-professions

New Question: What makes right actions right?

-consumerism/materialism

context

Paternalism vs respect for patient autonomy



Shifting the paradigm of autonomy

CLINICAL ethics

The Case of Nancy B.: A Criminal Law and Social Policy Perspective

Barney Sneiderman

Introduction

Over a three month period beginning in late 1991, the Canadian media accorded front page status to the story of Nancy B., a 24-year-old patient at the Hôtel-Dieu Hospital in Quebec City who sought a court order to compel her caregivers to disconnect her life support apparatus. The case attracted nation-wide interest because it dramatically raised the question of whether a hospital had the legal right to treat a mentally competent patient against her will. Did the hospital have the right literally to force treatment down the patient's throat? That was the scenario here because Nancy B. was being kept alive by a respirator (a breathing machine attached by tube to the windpipe), whose removal she had repeatedly asked for. Although the media was quick to label it as a "right to die" case, the issue before the court was simply whether a mentally competent patient was powerless to enforce her refusal of life-prolonging treatment. In other words, her petition squarely addressed the informed consent doctrine: not the patient's right to die but the patient's right to refuse treatment.

Nancy B. was afflicted with Guillain-Barré syndrome, a neurological disease that in her case had caused total and permanent paralysis as well as weakness of the muscles required for breathing. She had been a quadriplegic since 1988 and over

Shifting the paradigm of autonomy

What I will suggest here today is that the interpretation of the value of respecting patient's autonomy is shifting at multiple levels from:

freedom ***from*** the imposition of disproportionately burdensome technology

to

freedom to demand any intervention or service regardless of the opinion of professionals as to the therapeutic benefit or disproportionately harmful nature

SCC Carter

a declaration that s. 241(b) and s. 14 of the *Criminal Code* are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

Three important points

- Made physicians solely responsible
- Described criteria in non-medical and non-legal jargon thus reducing to radical subjectivity (consumer choice)
- Described right of ‘conscientious objection’ for individual physicians.

Recent Legal Examples

Courts

Hassan Rasouli case: top court upholds life-support right

Wife of man on ventilator says ruling makes her happy for all humanity

Courts

Ontario family's legal fight to keep daughter on life support could change how death is defined across Canada

Though at least five examining physicians have declared Taquisha Deseree McKitty brain dead, her family's refusal to discontinue life support kicked off a labyrinthine legal dilemma, which they're taking to the Ontario Court of Appeal this week

Changes in Ontario

*"**A decision regarding a no-CPR order cannot be made unilaterally by the physician**. Where a physician is of the opinion that CPR should not be provided for a patient & that a no-CPR order should be written in the patient's record, the College requires physicians to discuss this with the patient and/or substitute decision-maker at the earliest and most appropriate opportunity, and to explain why CPR is not being proposed. This discussion must occur before a no-CPR order can be written.*

If the patient or substitute decision-maker disagrees and insists that CPR be provided, physicians must engage in the conflict resolution process as outlined in Section 8 of this policy which may include an application to the Consent and Capacity Board. Physicians must allow the patient or substitute decision-maker a reasonable amount of time to disagree before a no-CPR order can be written.

***While the conflict resolution process is underway, if an event requiring CPR occurs, physicians must provide CPR. In so doing, physicians must act in good faith and use their professional judgment to determine how long to continue providing CPR**."*

Voluntary Euthanasia — Implications for Organ Donation

Ian M. Ball, M.D., Robert Sibbald, M.Sc., and Robert D. Truog, M.D.

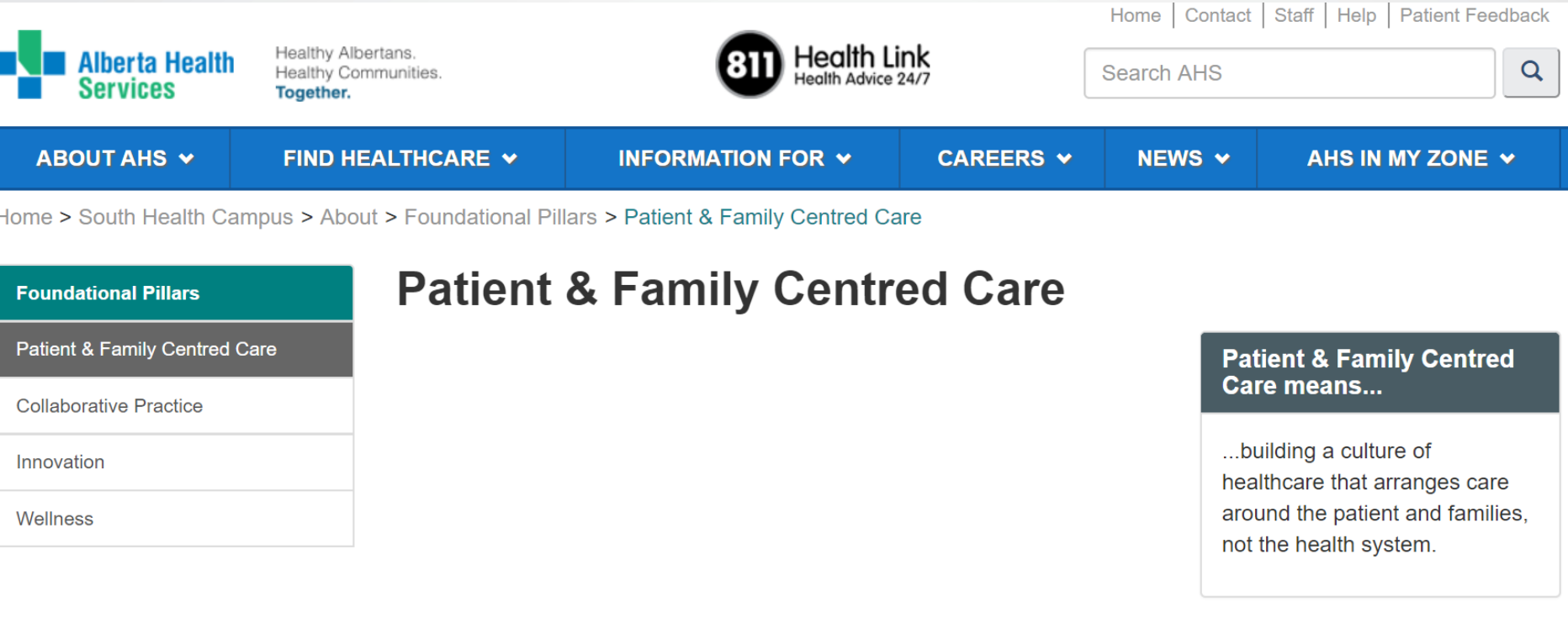
In 2015, the Supreme Court of Canada decided to decriminalize medical assistance in dying for patients who are experiencing "grievous and irremediable" suffering. The next year, the Canadian government passed legislation that permits physicians to hasten the death of a patient by means of physician-assisted suicide (in which lethal medications are prescribed by the physician and administered by the patient) or voluntary euthanasia (in which lethal medications are administered by the physician). These developments create a new pathway for organ donation — and with it, some challenges that will also be relevant for other jurisdictions where medical assistance in dying is permitted or under consideration.

In the case of physician-assisted suicide, patients typically take lethal medications at home or elsewhere outside the hospital, rendering organ donation impossible. Voluntary euthanasia, however, may take place in the hospital, enabling patients who choose this method for ending their lives to donate their organs. But voluntary euthanasia differs from traditional end-of-life care provided in the intensive care unit (ICU) in two important ways that have implications for organ donation.

First, in an ICU environment, health care teams often rely on surrogates to understand what patients would want if they were capable of making decisions. However, the majority of countries that permit voluntary euthanasia, including Canada,[1] require first-person consent. Clinicians must confirm that patients have decisional capacity and that their choices are fully informed, voluntary, and not unduly influ-

Corporate Rhetoric

CLINICAL ethics



Ethical Implications

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- Erosion of fiduciary responsibility

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- Erosion of professional integrity and quality of care
  - History of legislative limits
  - History of legislated pseudo-science

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- Erosion of fiduciary responsibility
- Erosion of professional integrity and quality of care
  - History of legislative limits
  - History of legislated pseudo-science
- Moral Distress and attrition
- Loss of trust

Thanks!

I welcome ANY questions or comments!

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