Leadership Ethics and Moral Management

Maine Primary Care Association
October 19, 2017

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Introduction to Ethical Process

MEDICAL ETHICS CASE STUDY

Ms. A

24 year old black female
Unmarried with two children
No private insurance

Background Information

- Presented in the ER complaining of headache, denied history of serious illness
- Admitted for workup of possible seizure disorder
- Condition deteriorated rapidly in the hospital
- Tested HIV positive, T-Cell count of four
- LP showed presence of cryptococcal infection
- Neurological exam indicated irrevocable and serious brain damage
- Probable PVS
- Physician wished to avoid extraordinary care including intubation
- Family indicated that all life-saving measures should be utilized
- Family refused to discuss code status

Two Standard Approaches (Theory)

Ethical Theory

NORMATIVE ETHICS

•Utilitarianism (J.S. Mill): Always act so as to bring about the greatest good (happiness) for the greatest number.

•Deontology (Immanuel Kant): Always treat people as ends in themselves, never as a means only.

•Virtue Theory (Aristotle): Always act consistently with the standards of the role you play in life.

CORE VALUES

"Principles of Medical Ethics"

Autonomy

Nonmaleficence

Beneficence

Justice

An Alternate Approach (Casuistry)

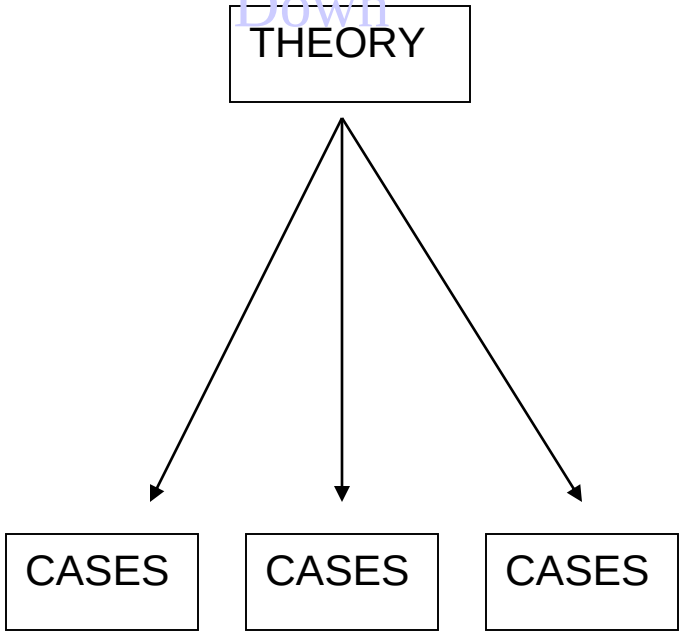
The Eye Doctor
or
Reverse Engineering

Methods of Doing Ethics

"Theory and Casuistry"

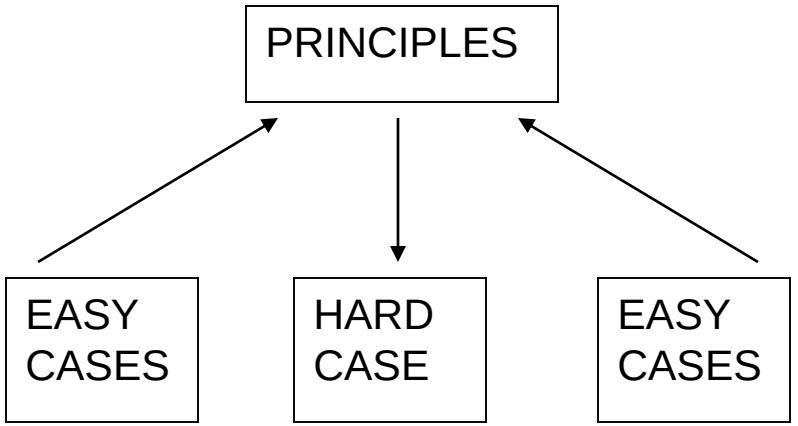
Theory

Top-Down



Casuistry

Bottom-Middle-Down



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Casuistry takes place in a three dimensional conceptual space involving multiple data points and is not restricted to two analogues.

We become wiser as we get older because our bank of experience is broader.

Think about Pong vs. a modern video game. As resolution improves, detail becomes visible.

The Structure of a Pragmatic Argument

A Procedural Approach To Ethics

The Five R's

REVIEW the situation and identify the problem/area of need

RESPOND to the issues

REDUCE the list of possible responses

RECAST the conflict

RESOLVE the dispute and clarify the confusion

The Five R's

A Procedural Approach To Ethics

1) Review the situation, identify the problem, define the area of need:

This stage requires the gathering of information. Become familiar with the present situation and identify the factors that might be relevant.

a) Are there any genuine problems here? Do I perceive the possibility of confusion or disagreement? Are any "normal" procedures being ignored? What motivates concern in this case?

b) Is this problem medical, social, legal, or moral? Do I have the resources needed to solve the problem? Who/what are my additional resources?

The Five R's

A Procedural Approach To Ethics

2) Respond to the issues:

List all possible responses to the situation. Identify all of the arguments that could be made in support of each possible response. Responses can either be an intuitive or answers that you believe to be obviously incorrect. Either way, your initial responses and arguments will be only starting points for further development, or targets for criticism.

The Five R's

A Procedural Approach To Ethics

3) Reduce the list of possible responses**:**

Eliminate excess arguments either by combining redundant views, ignoring irrelevant views, or eliminating irrational views. Even positions that appear correct should be subjected to criticism. Why would anyone respond in the ways listed in step two? Develop supporting positions and create counter-examples to all positions. Examine difficult ramifications of accepting possible views.

The Five R's

A Procedural Approach To Ethics

4) Recast the conflict**:**

Once the central arguments and options for response have been identified and considered, recast the issue in order to clarify the operative concepts. Appeal to analogues that admit to clearer intuitions in order to place the present issue in a clear conceptual framework.

The Five R's
A Procedural Approach To Ethics

5) Resolve the dispute and clarify the confusion**:**

Once the issues have been identified, and analogous cases have been considered, identify acceptable responses to the issue and develop an action plan for implementing recommendations. If possible, construct a generalizable theory that accounts for the acceptable options and explain how exceptions might be accommodated without giving up on the ethical principles involved. Once this has been accomplished, create a universalizable view that will help in other cases. Show why your final position is not unique to the case at hand, or alternatively, show how this case is in fact morally unique.

IDENTIFY THE BURDEN OF PROOF

The Structure of Ethical Argument

The Process of Moral Reasoning

The Default Assumption

The Burden of Proof

Casuistic Exploration

Application to the Current Case

Back to the Example

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Medical Ethics Case Study

"The Arguments"

1. Cost Containment (Hospital Reimbursement & Social Resources)
2. Futility of Care
3. Quality of Life
4. Family Authority
5. Physician Authority
6. Facility Standard of Care

Medical Ethics Case Study

"The Strategy"

Cost Containment:

Although this is an important ***biomedical*** ethics issue, it is not an appropriate ***clinical*** ethics issue.

Futility:

The judgment of futility is based on an evaluation of the benefit to be achieved by continued treatment, not on an objective standard. This argument can be combined with the Quality of Life argument.

Quality of Life:

Quality of life judgments here are based on divergent value judgments.

Whose value judgments prevail reduces this argument into a question of authority.

Parental Authority vs. Physician Authority:

Whose judgment should prevail in this case?

Family Authority

Parental authority over minor children is powerful, *but not absolute* :

- The burden of proof rests with those seeking to overrule parental authority.
- Parental authority does not empower a parent to be negligent in the care of a child.
- Parental authority does not empower a parent to be abusive in the care of a child.
- Parental authority does not empower a parent to demand that care providers offer sub-standard care.

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Three Responses to Conflict Between Providers and Families

1. If it can not be shown that the family's choice is abusive, negligent, or inconsistent with the standard of care, the care must be provided.
2. If it can be shown that the family's choice is inconsistent with the standard of care, but not abusive or negligent, then care can be refused but transfer must be allowed.
3. If it can be shown that the family's choice is abusive or negligent, judicial relief is appropriate.

Medical Ethics Case Study

"Examination of the Conflict"

Questions:

- Does the family have the right to demand aggressive management?
- Is the family being abusive or negligent in their request?
- Does the facility have the right to refuse to provide the requested treatment?
- Is the hospital capable of satisfying the standard of care while providing treatment?

Assumptions:

- The burden of proof initially rests with the hospital based on a background assumption of family authority.
- Family authority does not include the power to engage in negligent or malificent action, or to force an individual or facility to fall below its standard of care.

Conclusion:

- The family is within its rights to demand care provided that the physician and hospital are unable to establish negligence or abuse, and provided that the physician is not being forced to act in a way that is inconsistent with the standard of care.

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Casuistry In Action

The Ethics of Refusing Treatment

"Listen To Me Or Else…"

Ms. I was recently assigned a new physician to the practice who advised her that she needed to lose 20 pounds and quit smoking in order for him to properly manage her high blood pressure. The physician repeated the same recommendations on two subsequent office visits, but after 18 months Ms. I has neither lost weight nor quit smoking. Her physician recently called for an ethics consult to determine if he could discharge her from his practice for noncompliance.

The Ethics of Refusing Treatment

"Cocaine or Coumadin"

Mr. J is a 61-year-old individual who receives services from PACE which include the provision of Coumadin for treatment of a cardiac blood clot. Mr. J suffers from CHF, COPD, Renal insufficiency, Hypertension, Chronic Thrombosis and he is S/P CVA. Mr. J's most serious risk factor presently is his admitted continued use of crack cocaine. Mr. J lives in his own apartment, although he is currently at risk of eviction, and receives in-home ADL and medication management support from PACE. Staff has become increasingly uncomfortable with continuing to provide Mr. J with Coumadin given his ongoing use of crack cocaine which counteracts the clinical efficacy of warfarin, but ethical question has emerged regarding the withdrawal of Coumadin from an individual with a known thrombosis.

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The Ethics of Refusing Treatment

"Infection By Injection"

Ms. K is a 20-year-old recurrent patient at the local hospital who has been hospitalized on an almost monthly basis for IV antibiotic therapy of a recurring infective endocarditis. After receiving antibiotic therapy, the bacterial infection generally resolves. However, providers believe that Ms. K's IV drug abuse is the source of the recurrent infections. Ms. K refuses to stop using heroin and on her most recent hospitalization she is suspected of having introduced illicit drugs by means of her IV line. She developed a new infection in the hospital which staff believe was introduced by injection of less than sterile substances.

Core Ethical Issues

Individual Choice

Basic Assumptions

1) What is the default assumption regarding an adult individual's right to direct his/her own healthcare?

2) Where does the burden of proof rest? Does the patient have to justify control, or do those who would intervene have to justify wresting control away from the individual?

3) What would it take to satisfy the burden of proof?

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Individual Choice

The Burden of Proof

1) All other things being equal, individuals have an autonomy right to control their own care.

2) The burden of proof rests on the party that would restrict an individual's autonomy right.

3) The burden of proof can be satisfied in on the basis of only two classes of argument: prevention of harm to self (paternalism) and prevention of harm to others (distributive justice).

Paternalism

An intervention is ‘paternalistic’ whenever the justification for the restriction of an individual’s freedom is calculated to be in their own best interest.

Distributive Justice

An intervention is justice-based whenever the justification for the restriction of an individual's freedom is that it is calculated to protect a victim of the individual's action other than him/herself.

The Two Paradigms Explained: Harm To Self

Ethics in Long-Term Care

"Psychiatric Instability"

Mr. C is a resident in assisted living who has requested to return to independent living. Staff indicate that Mr. C was admitted to assisted living based on concern surrounding his documented suicidal ideation and a desire to closely monitor his medication management, even though he did not meet UAI criteria for assisted living. It is unclear how Mr. C scores on the UAI currently but his physical function has not deteriorated since admission. However, Mr. C does have a history of depression and there is some concern that we will be less able to monitor his mental health status in independent living. The primary ethical issue is based, therefore, on whether or not depression, without associated losses of physical function, creates a legitimate basis for ruling out an individual for living independently.

Requirements For Paternalism

Paternalistic interferences with clients' liberty of action are justified only when:

- The client lacks the capacity for autonomous choice regarding the relevant issue
- There is a clearly demonstrated clinical indication for the treatment or restriction under consideration
- The treatment or restriction under consideration is the least restrictive alternative that is reasonably available and capable of meeting the client's needs
- The benefits of the treatment under consideration outweigh the harms of the interference itself

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Paternalistic interventions must attempt to advance the values of the individual whose freedom is restricted.

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Diminished Capacity

Basic Assumptions

The two most important things to remember at the beginning of any interaction with a patient surrounding capacity issues are:

1) All adults should be presumed to have capacity until they are explicitly found to lack it,

2) An individual cannot be found to lack capacity simply because s/he carries a particular clinical diagnosis.

Diminished Capacity

The Definition of Capacity

In order for a patient to have diminished capacity, s/he must meet at least one of three criteria:

1) The inability to understand information about the decision that needs to be made (ARBs)

2) The inability to use the information, even if understood, to make a rational evaluation of the risks and benefits involved in the decision

3) The inability to communicate by any means

Diminished Capacity

Incapacity Determinations

There is an important difference between a clinical finding of incapacity that can be documented by the attending physician, and a legal adjudication of incompetence.

A determination that a patient has diminished capacity can apply to a particular healthcare decision, a set of healthcare decisions, or all healthcare decisions.

It is essential that a clinician making a determination that a patient has diminished capacity be able to define the scope of the finding and its basis. A note must be set forth in writing to indicate something like “This patient is unable to make decisions of type X because of deficit Y.”

Diminished Capacity

Important Concepts

- Capacity is task specific, so incapacity must be assessed relative to the particular decisions at hand.

- Patients can maintain capacity in certain decisional areas while simultaneously lacking it in others.

- The amount of capacity necessary to make any particular decision is relative to the complexity of the decision and the risks associated with the decision. Therefore, clinicians should be very careful when assessing the inability of patients to make complicated high-risk choices and to verify that the patient lacks a sufficient level of capacity to take responsibility for those choices.

The Two Paradigms Explained: Harm To Others

Ethics and Dementia

"The Silver Fox"

Mr. S is an 82-year-old gentleman who presented in his primary care physician's office requesting that his Foley Catheter be removed. When asked why he wanted the Foley removed, Mr. S replied that he "wanted to have sex". The attending believes that Mr. S could tolerate the removal of his catheter for a short period of time, and agrees that Mr. S has the right to engage in a sexual encounter if he desires to do so.

The attending asks Mr. S with whom he intends to have sex and Mr. S replies that "there are any number of women on the third floor who would be happy to oblige". The attending knows that Mr. S is correct in his assumption, but she also knows that the third floor of the nursing home where Mr. S resides is the Alzheimer's unit. Many of the women on that unit are married, but don't remember that information. Furthermore, they are women who would not have consented to a casual sexual relationship prior to onset of their illness, but they have lost many of their inhibitions secondary to their dementia.

Requirements For Justice

Justice-based interferences with clients' liberty of action are justified only when:

- The client behaves in some manner that places others at risk

and

- Those placed at risk have not provided valid consent to be placed at risk (either by choice or incapacity)

and either

- The risk of harm to others is more significant than the harm generated by restricting the client's freedom and is not protected by an identified right (deterrence)

or

- The client forfeits his/her right to liberty by transgressing a clearly defined social expectation (punishment)

Leadership Ethics and Moral Management

Leadership Ethics

"Tough Choices Part I: The Revolution"

"Lee's green jacketed troopers broke in close to the British lines, completely upset Tarleton's dragoons in a stiff little fight, and then fell back toward Guilford Courthouse with the whole aroused British force after them... The stillness was broken as North Carolinians coolly ripped out the three volleys that Greene had asked and then peeled off from the fence toward the second line... Virginians in the second line became entangled in the woods and could offer little resistance as the fight swept north toward a brick courthouse. Disaster threatened, ebbed, threatened again. Washington's dragoons checked the course of the Guards, and down from the hill came John Howard with his Delawares is and Marylanders.

"There was wild fighting, with cocked hats, bearskins, bandaged heads, and silver helmets tangled in a whirl of bayonet lunges, gunfire, and swinging musket butts. The British line began to sag dangerously. Cornwallis, seeing his own sudden peril, took the hard ... course of turning his artillery on the confused struggle, killing Briton and American with mechanical impartiality. Gradually, the two swaying masses drew apart."

- Lancaster and Plumb, The Book of the Revolution, Dell, 1975, p.317

Leadership Ethics

"Tough Choices Part II: The Pinto"

LOSSES PER DEATH			COSTS TO RECALL
Future Prod. Loses:			BENEFITS:
Direct	$132,000		Savings: 180 burn deaths, 180 serious burn injuries,
Indirect	$41,300		2,100 burned vehicles
Medical Costs:			
Hospital	$700		Unit Cost: $200,000 per death, $67,000 per injury
Other	$425		$700 per vehicle
Property Damage	$1500		
Insurance Admin.	$4,700		Total Benefit: (180 X $200K)+(180 X $67K)+
Legal Expenses	$3,000		(2,100 X $700) = $49.5 million
Employer Losses	$1,000		----------
Victim's Pain &			COSTS:
Suffering	$10,000		Sales: 11 million cars, 1.5 million light trucks
Funeral	$900		
Assets (lost			Unit Cost: $11 per vehicle
consumption)	$5,000		
Misc. costs	$200		Total Cost: 12.5 million X $11 = $137.5 million
TOTAL=========>	$200,725		

NORMATIVE ETHICS

•Utilitarianism (J.S. Mill): Always act so as to bring about the greatest good (happiness) for the greatest number.

•Deontology (Immanuel Kant): Always treat people as ends in themselves, never as a means only.

•***Virtue Theory (Aristotle): Always act consistently with the standards of the role you play in life.***

Ethics in Supervision

Ethics in Supervision

"When Can I Squeal?"

As a member of the Senior Management Team, you are aware that budgetary limitations are likely to require reductions in staffing on certain units. You have been asked to keep this information confidential, because the specific decisions as to how the cuts will be made have not yet been finalized. One of your direct supervisees is in the process of buying a new home and has expressed his excitement at finally having a stable enough job to make home ownership possible. Should you warn the employee of the upcoming cuts and recommend that he wait on buying the house until after his position is secure?

Moral Management

"Being Nice Vs. Being Ethical"

Supererogation

Moral Management

“Identify the Default Assumptions”

Background Obligations

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"The Source of Obligation"

What Is Your Role?

Moral Management

"The Source of Obligation II"

What Are Your Relationships?

Moral Management

"How Relationships Work"

Tacit Expectations

Explicit Promises

Moral Management

"What Ethical Leaders Do"

- Identify Default Obligations
- Recognize Distinct Obligations Across Individuals, Disciplines and Departments
- Prioritize Conflicting Obligations
- Support Valid Processes

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Roles and Boundaries

Information Control

"I'm Not Asking Much"

Mr. D provides services at a local residential SA program and often transports individuals in the agency van from one location to another. During one such drive, Mr. D was struck by a motorcycle after turning onto a street. Although Mr. D believes that he stopped at the corner first, and then carefully entered the intersection where he was hit by the motorcycle that was traveling too quickly, he has been charged with failure to yield. Mr. D believes that the van passengers can help in his defense, but is unsure whether or not he may submit their names to his attorney or the court so they might be called as witnesses.

Information Control Revisited

Boundaries and Dual Relationships

The previous case is not fundamentally about confidentiality and the control of information. The core ethical issue is one of boundaries and dual relationships. The nature of the relationship between the provider and the recipient determines the appropriate ethical response.

Additional Cases

Dual Relationships

"The Greatest Gift"

Facility Director A recently learned that the Nursing Director in her agency wants to have a child, although she underwent an hysterectomy several years ago. The Nursing Director's ovaries were not impacted by the surgery and she is looking for a contract parent who will carry her eggs after they are fertilized by her husband's sperm in-vitro. The Facility Director has indicated a desire to help by serving as the contract mother.

Dual Relationships

"I Can Help You Out"

Ms. L is a 19-year-old unmarried college student who has been receiving pre-natal care from a local OB. Toward the end of her pregnancy, Ms. L indicates that she really doesn't think that she can care for her baby, but she is unsure what to do. The OB is supportive and understanding. She explains to Ms. L that he and his wife have wanted to have a baby for quite some time and that they would be happy to provide a good home to Ms. L's child.

Ethics in Adolescent Psychology

"Foster Care"

A mental health counselor working at a residential center has identified two children in his care that need foster care placement. The counselor has indicated a desire to provide those services directly and has begun foster care provider training. Should these children be placed with the mental health counselor as foster children?

Dual Relationships

"A Few Quick Vignettes"

- My son's teacher is enrolled in SA out-patient and I am facilitating the group while the primary clinician is on FML…

- My best friend is trying to adopt a child without success. One of youth I am providing wraparound services to is in foster care and needs to be adopted. The youth is exactly what my best friend is seeking and the two would be an ideal match…..

- An individual with whom I am treating in ICT has found a place to live and needs furniture and house supplies. My parents just sold their mountain cabin and have a household of furniture and house supplies. I ask if they want to donate to a client and they agreed. I arrange to borrow my friend's pick up and take loads of goods from my parents' cabin to the individual's new apartment….

- An individual enrolled in group home treatment is clinically ready to be discharged to her own residence but cannot find an affordable place and there aren't any Housing Choice Vouchers. My cousin's friend is seeking a roommate. I offer to the individual in the group home to make the introduction to help her move in with my cousin's friend…..

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Basic Concepts

Dual Relationships

The Definition

Dual relationships may be defined as situations in which individuals simultaneously maintain a professional (or agency related) relationship and a conflicting outside relationship. A professional (or agency related) relationship and an outside relationship shall be considered to conflict whenever the following two conditions exist: (1) one person plays the role of provider or supervisor of services to the other person that involves access to information about or the exertion of control over the provision of services; (2) the individuals are involved in a hierarchical, dependent or influential relationship that is not part of the professional relationship.

Dual Relationships

The Dangers

Dual Relationships are dangerous because they:

- Create the opportunity for the erosion of objectivity on the part of service providers
- Create pressure on patients to act in accordance with staff wishes (loss of patient autonomy). This loss of patient freedom may be the result of intentional manipulation or unintentional influence
- Create the opportunity for secondary gain on the part of staff, and thus create real or apparent conflicts of interest
- Create situations in which the authority of care providers may be eroded
- Create opportunities for the loss of confidentiality
- Support the development of double standards (other patients lose trust, other patients' care deteriorates)

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Dual Relationships

Some Questions To Ask

1. Is the consumer voluntarily engaged in this activity?
2. Is this activity consistent with my role as a care/service provider?
3. Is this activity available equally to all the capable consumers whom I serve?
4. Do I experience secondary gain by engaging in this activity?
5. Does the facility experience secondary gain by engaging in this activity?
6. Is there significant opportunity for this activity to negatively impact on my ability to do my job?
7. Is there a reasonable chance that the consumer(s) involved in this activity may misconstrue the nature of our relationship as a result of the activity?
8. Is this activity something that I would rather other staff and consumers not know about even in general terms?
9. Is this activity a reasonable part of the consumer's treatment/service plan?
10. Have I spoken about this activity with my supervisor?

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Dual Relationships

Strategies for Avoidance

- Explain boundaries at the outset of a professional relationship
- Promptly disclose potential issues to your supervisor
- Seek staffing adjustments when friends or family seek services
- Refuse gifts when possible
- Deflect other gifts to communal acceptance
- Distinguish professional activities from personal relationships