The Ethical Limits of Individual Choice

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The Process
The Structure of Ethical Argument

The Process of Moral Reasoning

The Default Assumption

The Burden of Proof

Casuistic Exploration

Application to the Current Case

Individual Choice
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?

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).
The Two Paradigms Explained

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

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

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**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 on incompetence 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.”

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**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.
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)

The Two Paradigms Applied
Clinical Ethics Case Studies

“Don’t Let Him Drink”

Mr. H is a 79-year-old long-term care resident who suffered a stroke resulting in left side hemiparesis and difficulty swallowing. According to a modified barium swallow, Mr. H can only safely tolerate a level two diet of thickened liquids. Mr. H objects to the dietary restrictions and currently receives a level three mechanical soft diet. Nevertheless, he desperately wants access to thin liquids, especially a morning cup of coffee, and to some other contraindicated foods. A mental health evaluation was performed and although it indicates a possibility of some underlying dementia, it clearly states that Mr. H is not at imminent risk of causing harm to self or others and that he is able to understand the alternatives, risks and benefits associated with eating potentially dangerous foods. Mr. H’s children indicate a desire that the resident’s diet be restricted, but Mr. H is adamant about his desire to eat at least certain types of food and drink that are not consistent with a limited diet. This ethics consult was requested to examine the ethical implications of restricting access to food for an individual who has capacity to make his own healthcare decisions.

Ethics and Dementia

“We Want to Live Together”

The T’s are a married couple who resided in Independent Living when they were first admitted to the facility. When their need for assistance increased, the Ts then moved together into Assisted Living. Mr. T’s health has continued to deteriorate, however, and he has been transferred to Skilled Care. Mrs. T has been diagnosed with moderate to severe multi-infarct dementia. Mrs. T is capable of living in Assisted Living but has forcefully expressed a desire that she be allowed to share a room with her husband. The T’s children oppose placing their parents together, because they believe that their mother places too many demands on their father. Staff are unsure how to proceed in the face of Mrs. T’s repeated requests for a change in placement. Mr. T seems agreeable to sharing a room, but his capacity is limited.
Clinical Ethics for Non-Clinicians
“Control”

Ms. O is a patient in skilled care who very much enjoys visits from her grandson. Every time he visits, however, he ends up leaving with a check. Ms. O’s children are very upset by the imposition that their child places on their mother, but they are not able to police the situation all of the time. They have asked staff to notify them whenever the grandson attempts to visit, and to prevent the visit if they are not available.

Autonomy and Safety
“Ah, The Joy Of The Open Road”

Mr. R is a 77-year-old gentleman who carries a diagnosis of Alzheimer’s Dementia and exhibits poor safety awareness. Mr. R requires assistance in transitioning from sitting to lying positions and he recently recovered from an ankle fracture that was caused by operating his mobility scooter too close to a wall. Mr. R has been observed using his scooter in a dangerous manner, specifically by operating it on the road in traffic. Mr. R’s children, who carry his POA, want the community to restrict access to the scooter in order to protect their father from harm. Mr. R insists that he is safe, however, and demands that he be allowed to operate his mobility scooter without restriction.
**Ethics in Long-Term Care**

*“Appropriate Placement”*

Mr. B is a 92-year-old resident who was originally admitted to independent living but was recently transferred to assisted living. Mr. B has a history of hypertension, atrial flutter, macular degeneration, irritable bowel syndrome, back pain and constipation. Mr. B has difficulty with several ADLs including dressing and toileting. Mr. B has incontinence of bowel and on several occasions he has entered public areas with feces on his clothing. Mr. B’s most recent Uniform Assessment Instrument (UAI) indicates that he is appropriate for “intensive assisted living”. Mr. B wishes to return to his independent living apartment and is willing to hire a private duty sitter for the maximum eight hours per day that is allowed by facility policy, and to sign a release of liability indemnifying the facility in the event that he has a poor outcome. Staff are concerned that Mr. B does not meet criteria for independent living and have requested this consult to outline the ethical implications of allowing or restricting transfer back to Mr. B’s apartment.

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**Ethics in Long-Term Care**

*“He Smells”*

Mr. B is a 92-year-old resident who has a history of hypertension, atrial flutter, macular degeneration, irritable bowel syndrome, back pain and constipation. Mr. B has difficulty with several ADLs including dressing and toileting. Mr. B has incontinence of bowel and on several occasions he has entered public areas with feces on his clothing. Mr. B wishes to remain in his independent living apartment and is willing to hire a private duty sitter for the maximum eight hours per day that is allowed by facility policy, and to sign a release of liability indemnifying the facility in the event that he has a poor outcome. Even with these supports, Mr. B often shows up at the dining room disheveled and odorous. Other residents have complained that he needs to be restricted from the dining room at the very least and also moved to assisted living.
Ethics in Long-Term Care

“They’re Just Bizarre”

Mr. and Mrs. E currently reside in assisted living but they take their meals in the main dining hall. The Es have engaged in a variety of behaviors that indicate an inappropriate understanding of social boundaries and are disruptive. These behaviors include rearranging other residents’ plants, interrupting business meetings in conference rooms, and engaging in bizarre behavior during meals. Examples of disruptive behavior in the dining hall include Mrs. E going table-to-table to introduce people to her stuffed animal. Other residents are annoyed by the Es dining room behavior and have ask the facility to restrict their access to the main dining room.

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.
The Two Paradigms Revisited