Current Issues in Medical Ethics

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Liverpool Medical Institution
16.3.17

John Chisholm
Chair
Medical Ethics Committee
British Medical Association

Outline

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Ethical decision-making

Confidentiality

Decriminalisation of abortion

End-of-life care

Physician-assisted dying

Human rights

BMA Medical Ethics Committee

BMA Medical Ethics and Human Rights Department

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What are medical ethics?

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“The standards of professional competence and conduct which the medical profession expects of its members.”

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What are some key concepts in medical ethics?

- Self-determination or autonomy
- Honesty and integrity
- Confidentiality
- Fairness and equity
- Harms and benefits

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How do we approach ethical dilemmas?

Approaching an ethical dilemma

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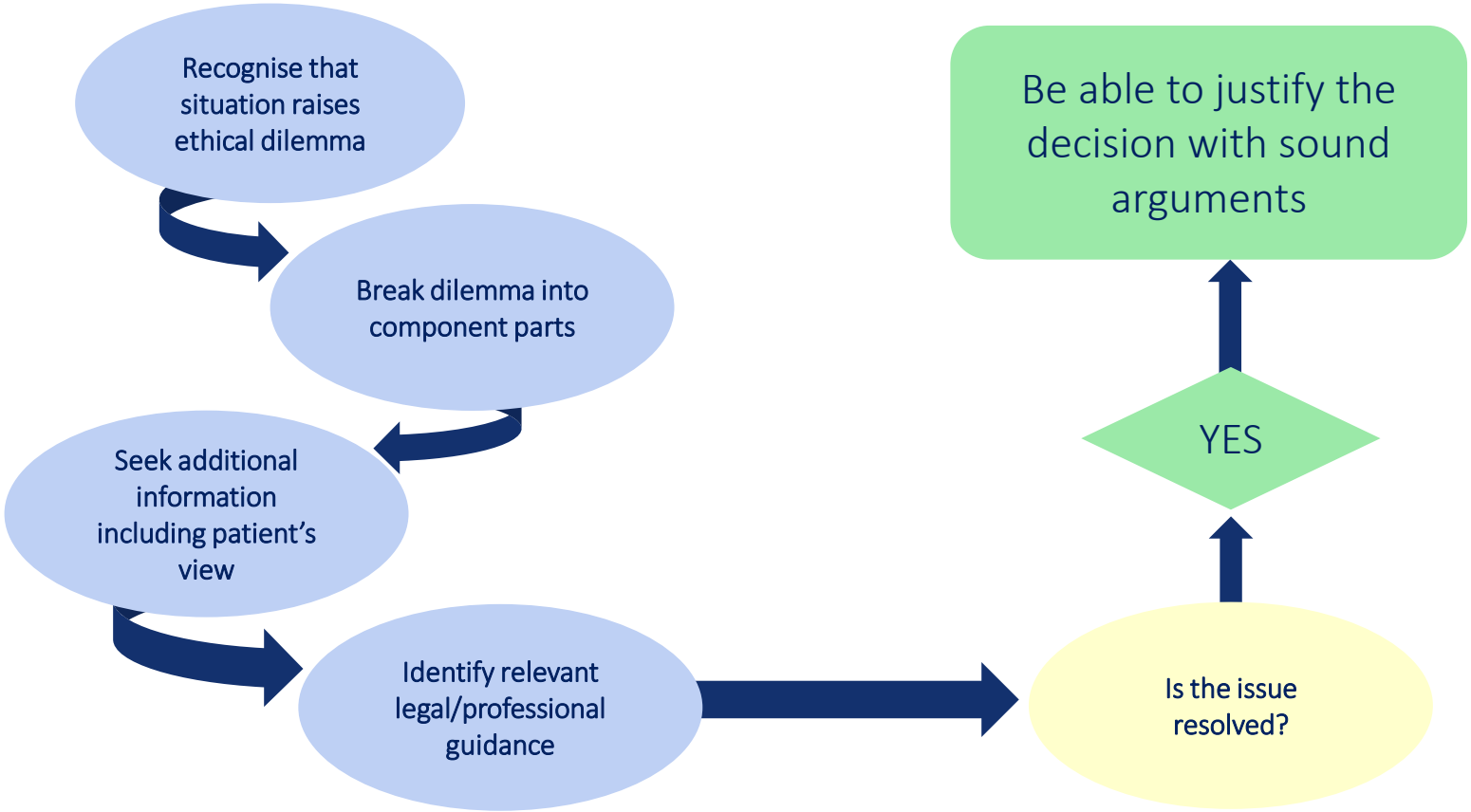

Approaching an ethical dilemma

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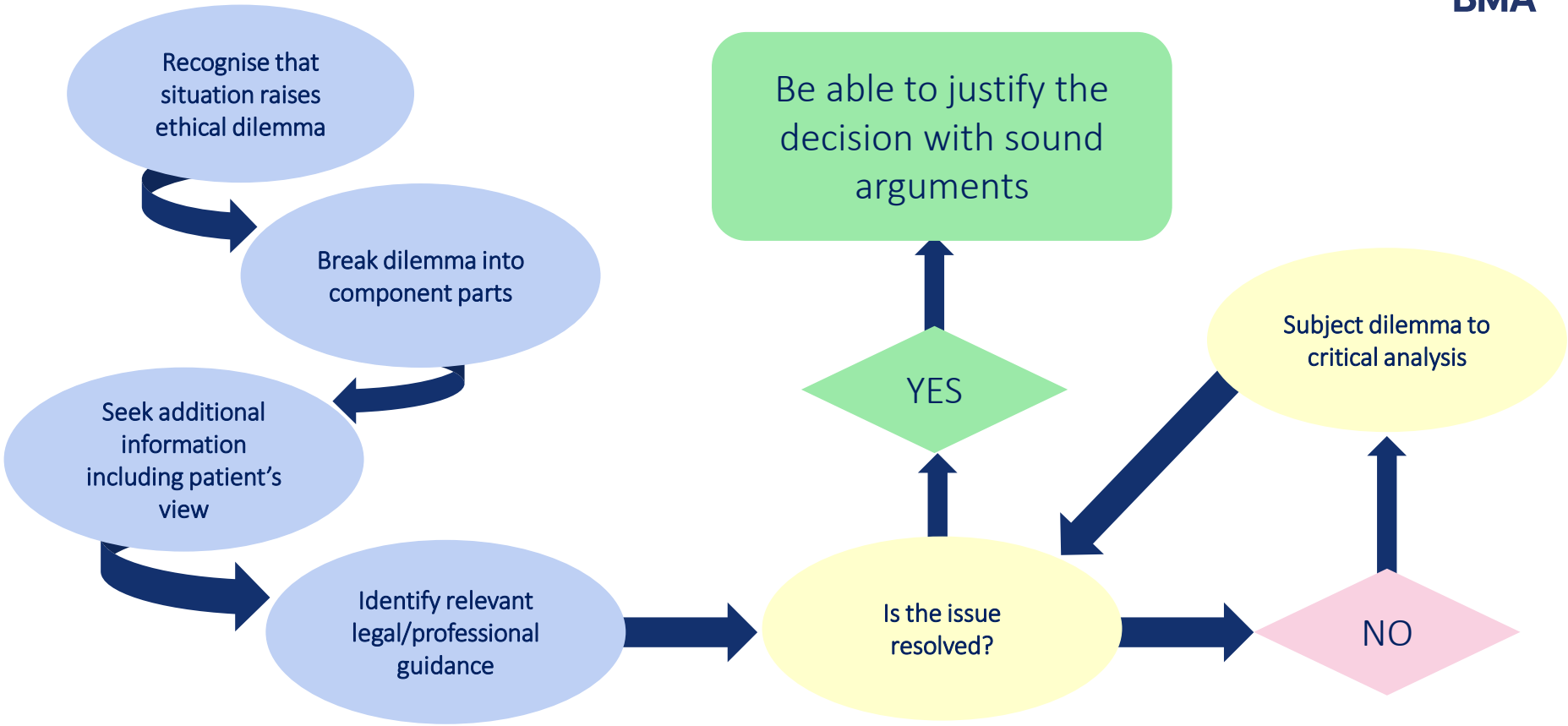

Approaching an ethical dilemma

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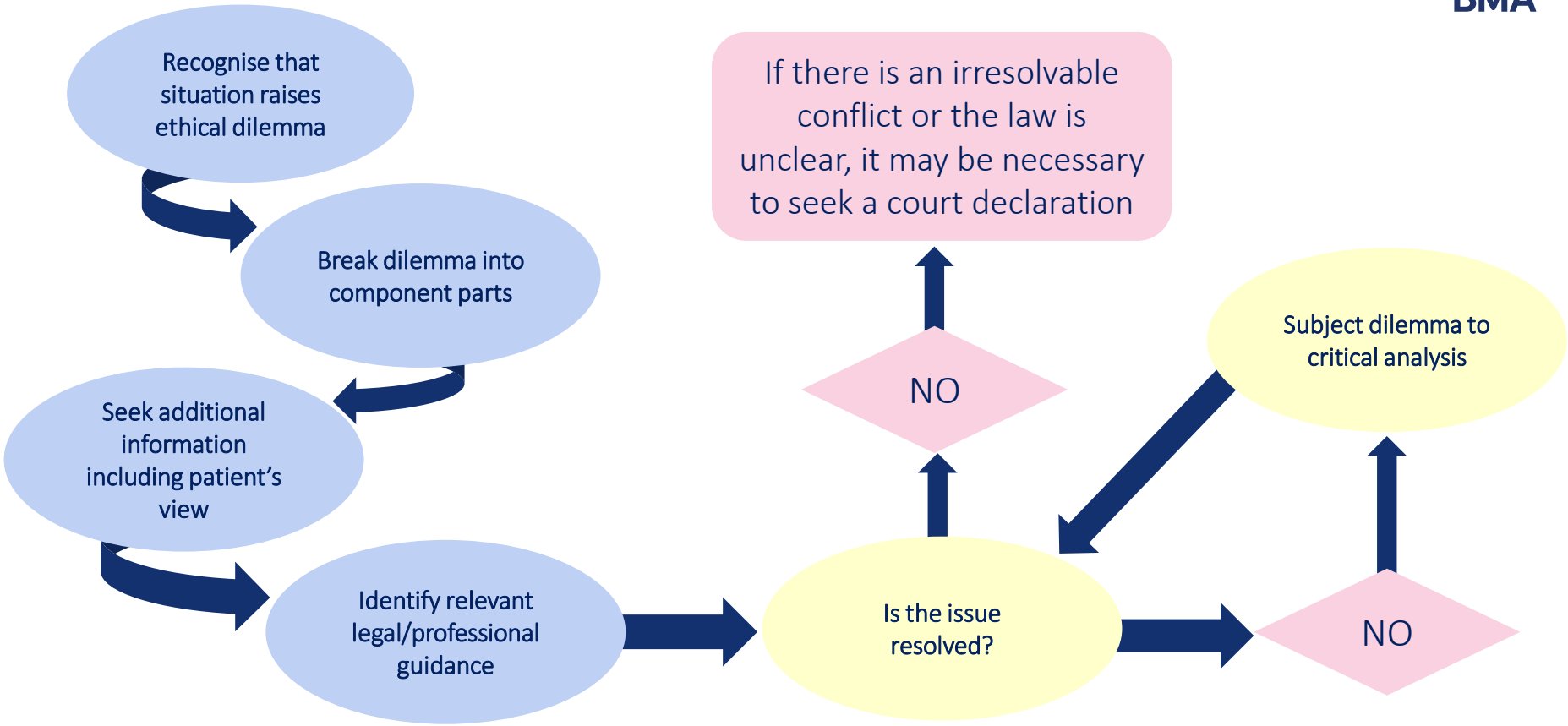

Philosophical approaches - utilitarianism

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What matters are the consequences of actions

Consequences are measured in terms of ‘happiness’ or ‘wellbeing’

The overall moral objective of any action is the ‘greatest good for the greatest number’

Philosophical approaches - deontology

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Theories of ‘rights’ or ‘duties’

Absolute and universal quality to obligations

Kantian ‘respect for persons’

Reflected in ‘human rights’

Philosophical approaches – four principles

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Autonomy

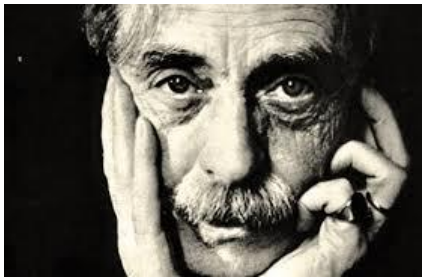
Beneficence

Non-maleficence

Justice

A form of deontology – these principles must always be respected

The blessings of ethical dilemmas



"Une difficulté est une lumière. Une difficulté insurmontable est un soleil."

Paul Valéry

Confidentiality: Type 1 opt-out

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Obligation on healthcare providers to share information with NHS Digital at request of Secretary of State or NHS England (Health and Social Care Act 2012)

Concerns about care.data

Jeremy Hunt allowed type 1 opt-out – preventing data leaving general practice

National Data Guardian now recommends single opt-out at NHS Digital level

Removal of type 1 opt-out would restrict autonomy

Effect on relationship of trust between patient and doctor

Effect on consulting behaviour: whether consultation occurs and what is disclosed

Confidentiality: NHS Digital as ‘safe’ haven

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Public relies on NHS Digital to keep information safe and confidential

NHS Digital should only release data with consent or when common law ‘public interest’ disclosure threshold is met

- to protect individuals/society from risks of serious harm
- to prevent or detect serious crime

NHS Digital using lower threshold to release information to Home Office

NHS Digital put under ‘immense pressure’ to release confidential data

Breach of second data protection principle

Confidentiality: Digital Economy Bill

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Scope of new information-sharing powers so broad they could encompass health data

Regulation-making power could include other public bodies within scope, including NHS Digital, Trusts, general practices

Government would be able to access all data held by NHS Digital

Data would be shared without consent or consideration of common law ‘public interest’ threshold

Bill overrides common law duty of confidentiality including medical confidentiality

Breach of second data protection principle

Abortion

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Induced abortion is a crime

A range of exceptions are laid out in statute and/or common law – eg Abortion Act 1967

Several criminal prosecutions

Some women have purposefully exposed themselves to risk of prosecution

Some attempts to seek prosecution of doctors authorising or carrying out abortions

Abortion cases

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Individuals who have illegally supplied of abortifacients

Women who have procured and self-administered abortifacients

Individuals who have procured abortifacients on behalf of others

Individuals who have maliciously and covertly tried to procure an abortion or administer an abortifacient

Doctors who have been challenged for their involvement in the provision of abortions they deemed to be lawful

Decriminalisation of abortion

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BMA has no policy

Medical Ethics Committee asked to develop factual discussion paper about decriminalisation

No single interpretation

- complete or total decriminalisation
- decriminalisation and selective recriminalisation
- selective decriminalisation

What role, if any, should the criminal law play in setting parameters for provision and administration of abortion?

BMA Annual Representative Meeting may make policy

Arguments for decriminalisation

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Changes in societal views

Changes in clinical practice

Autonomy

Removing unacceptable stigma

Reducing risks for doctors

Safer provision of abortion

Giving women time to make right decision for them

Preventing unsupervised abortions

Criminalising women is wrong response

Developing appropriate accountability and regulation

Arguments against decriminalisation

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Decriminalisation unnecessary – abortion law can be reformed

Moral status of fetus

Hard cases can be dealt with through prosecutorial guidance

Need for effective deterrence

Risk of unsafe abortions

Insufficient accountability

Current legislation a ‘good compromise’

More restrictive access may result from opening up debate

Discouraging use of effective contraception

Decriminalisation of abortion: Some questions

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In what, if any, circumstances should women who self-administer an abortion be subject to criminal sanctions?

How should the criminal law and the prosecution services respond to the increasing number of women who are acquiring abortifacients on line?

If there are to be criminal sanctions, should these apply to both women themselves and suppliers of the abortifacients?

In what, if any, circumstances should health professionals who participate in the provision of abortion be subject to criminal sanctions?

Should the point of viability be treated as significant in determining whether criminal sanctions should apply in some cases of abortion?

End-of-life care and physician-assisted dying project

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- Approved by BMA Council in November 2014 with the aim of developing a **comprehensive understanding** of **doctors' and patients' views** on some of the **practical and ethical issues** around end-of-life care and physician-assisted dying

- Our aims were:
    - to **inform** our future discussions on these issues
    - to hear from more of **our members**
    - to **understand the public's concerns** about end-of-life care in order to be able to contribute to the ongoing public debate

- We commissioned social research experts **TNS BMRB** to develop and conduct on our behalf a series of dialogue events around the UK.

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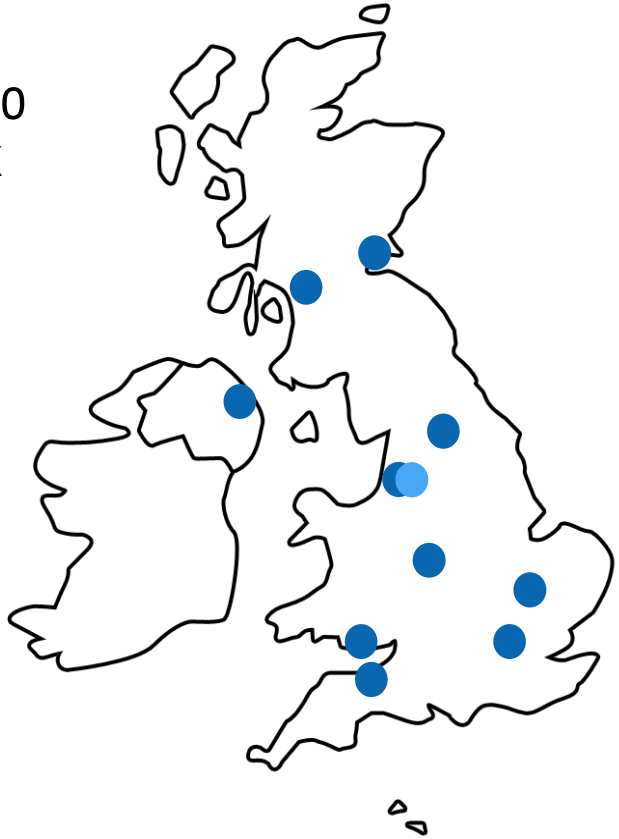
We held:

- 21 dialogue events in 10 locations across the UK

We heard from:

- 237 doctors – selected and invited at random from categories broadly representative of the whole medical profession
- 269 members of the public – recruited by TNS BMRB



We discussed:

- Doctor-patient relationships
- Hopes, fears and concerns about end-of-life care and dying
- Perceptions and experiences of end-of-life care
- Experiences of providing end-of-life care (doctors only)
- The potential impact of legalisation of physician-assisted dying on the doctor-patient relationship

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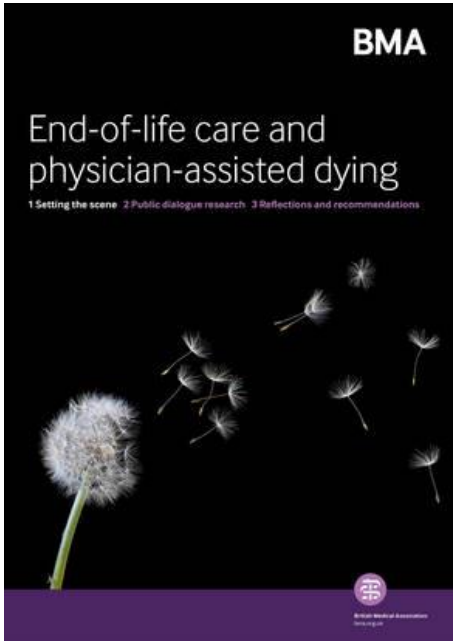

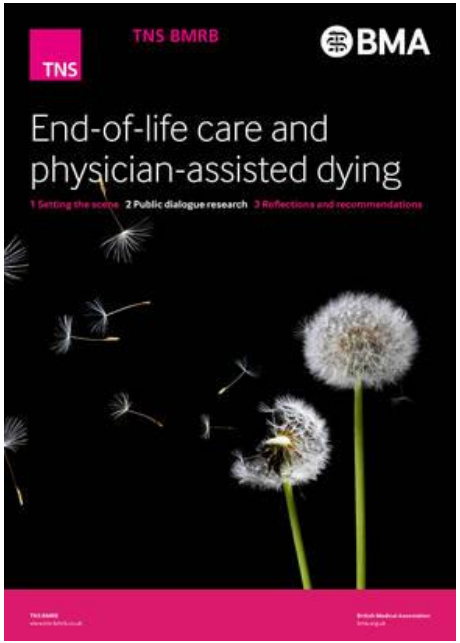

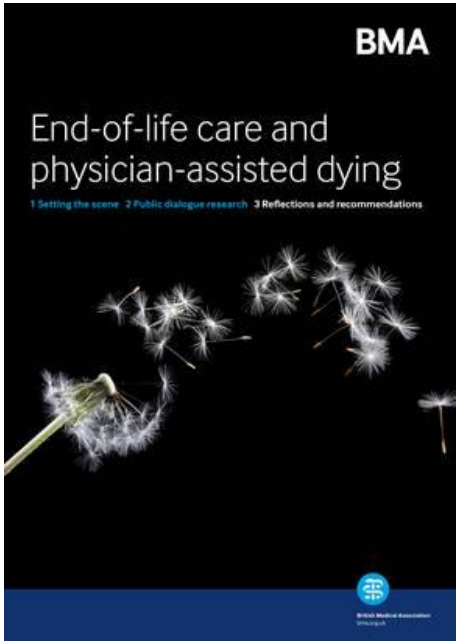

www.bma.org.uk/endoflifecare

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End-of-life care

Overarching themes

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We heard examples of excellent practice but also significant variability in the quality of service within and between geographical areas and between conditions.

Doctors expressed a desire for more education and training in caring for dying patients, and for more ongoing support to be available.

The wellbeing of family members was one of the most important considerations for members of the public, but was rarely identified as such by doctors.

What does good end-of-life care look like for the public?

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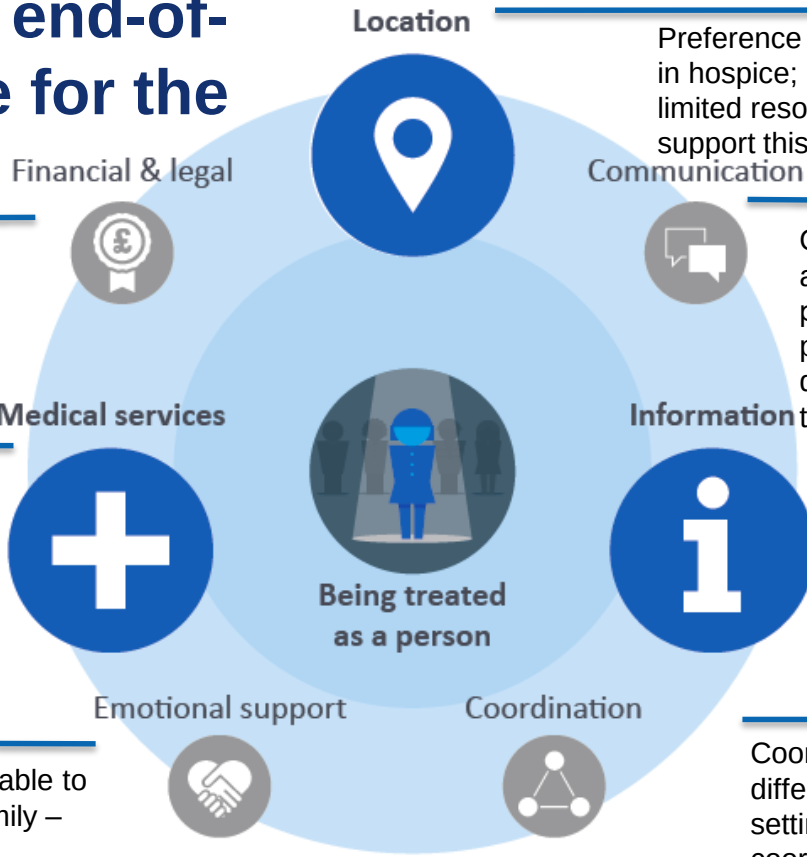

Preference for being at home or in hospice; but perception of limited resources available to support this

Information about financial and legal matters such as benefits available, allowing people to ensure affairs are in order

Open and honest, between all those involved in a patient's care and the patient and family about diagnosis, prognosis and treatment

Timely access to personalised high-quality medical care – particularly effective pain management – regardless of the care setting

Consistent and non-conflicting information provided throughout treatment – recognising that different patients will want different levels of information

Emotional support available to the patient and their family – including after death

Coordination of care between different professionals and settings, ideally with a central coordinator responsible for this

What are the challenges to providing that?

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Medical services
It is not always recognised when patients are approaching the end of life, meaning planning comes too late to organise appropriate services.

Location
Hospice was seen as the gold standard for care although it might not always be available. Quality of care was seen as particularly variable in out-of-hours services.

Communication
Many doctors expressed a lack of confidence in discussing end-of-life care and dying with patients and their families. Very few felt they had adequate training in this area.

Time
Doctors highlighted the time constraints that can prevent them from delivering the consistently high quality of care they want to provide.

Coordination
Lack of coordination was often the result of poor communication between services, particularly primary and secondary care.

Information
The public are reluctant to talk about death and dying.

What's difficult for doctors?

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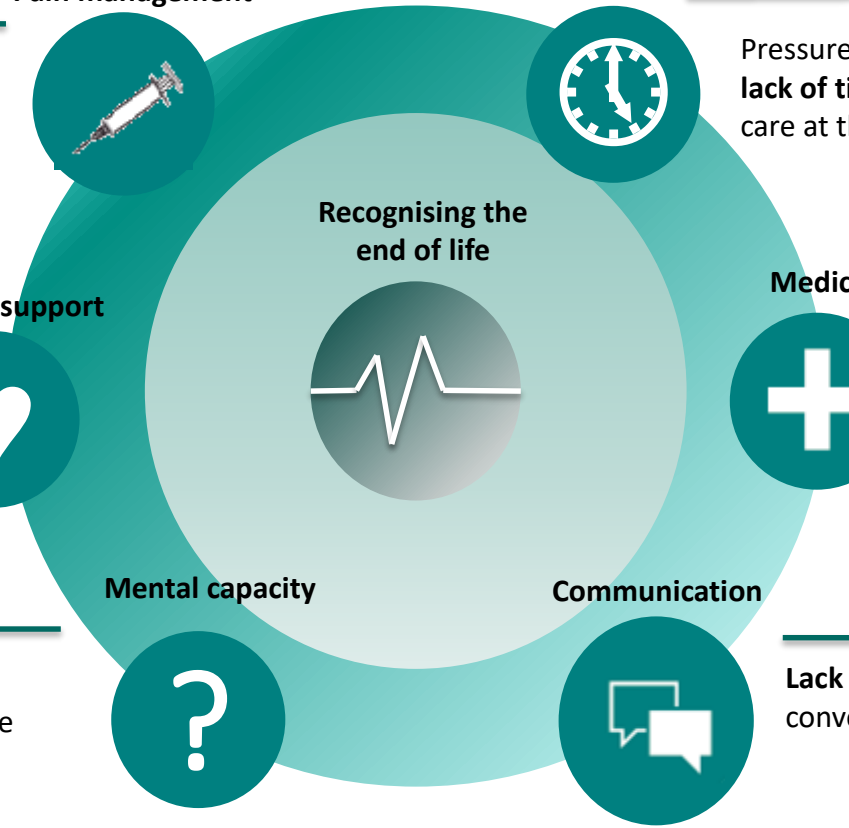

Lack of confidence in administering pain relief; **unrealistic** expectations of patients.

Pressure of **workload** on doctors; **lack of time** to ensure high-quality care at the end of life.

Caring for dying patients can be **emotionally difficult**.

Huge variability in services available; difficulties in **coordination.**

Not always **straightforward**; complexities at the end of life

Lack of confidence in having difficult conversations.

What can we learn?

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Policy-makers

- End-of-life care needs to be prioritised.
- Education, training and ongoing support for doctors are crucial.
- Doctors must be backed up by support from managers and systems.
- Wider availability of support mechanisms
- Information for patients

What can we learn?

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Doctors

- Death should not always be seen as a failure.
- Take an overall view of care.
- There is only one chance to get it right.
- Remember to think about those close to the patient.
- *Physician, heal thyself.*

Discussion points

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- To what extent do these findings resonate with your own experiences?
- What, in your view, are the biggest challenges to providing good end-of-life care?
- In seeking improvements, which issues should be prioritised?
- What can the BMA do to address these challenges and help to improve end-of-life care?

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Physician-assisted dying

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Physician-assisted dying:

An overarching term to describe physician-involvement in measures intentionally designed to terminate a patient's life. This may include knowingly and intentionally providing a person with the knowledge and/or means required to end his or her life, including counselling about lethal doses of drugs and prescribing such lethal doses or supplying the drugs. Administration of the drug may be by the individual him- or herself (physician-assisted suicide) or by the physician or another person (euthanasia).

The impact of physician-assisted dying on the doctor-patient relationship

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The public gave a largely balanced view of potential positive and negative impacts

Doctors more able to provide a good death:
- Relieve pain and suffering
- Maintain control and dignity
- Improve quality of life

Doctors more able to offer choice:
- Another service available
- Meet some patients' wishes

Improves communication and openness about patients' wishes

Increases fear of doctors/hospitals
- Particularly for the elderly, disabled, vulnerable, et al

Would negatively affect relationships if:
- Doctor refused or opted out
- Patient's family disagrees with patient or doctor

Changes the role and purpose of doctors:
- Fears about "Dr Death" and doctors "killing"
- Doctors should work to preserve life

The impact of physician-assisted dying on the doctor-patient relationship

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Doctors were generally more negative and had greater fears

More able to provide a good death
- Patients would see doctors as “on their side”

Would be seen to be able to “help” those who want it
Would be able to give patients choice

Improves communication
- Able to have more open and honest conversations about options
- Enable more discussions about end-of-life care

Increases fear and suspicion of doctors (particularly for the elderly, disabled, vulnerable) and affects what information patients share

Harms the reputation of doctors (particularly in small communities) and undermines the profession

Affects relationship if doctors refuse/disagree/opt out
Affects relationship with relatives if they disagree with wishes.

Changes the fundamental role of doctors – “playing God” – when doctors should preserve life

Impact might depend on who is making the decision – public and doctors

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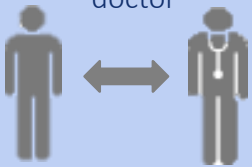
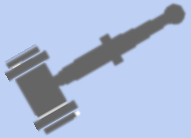
+		-
• More personal – knows your medical history, family, circumstances, trust • Has medical knowledge • Better able to assess coercion from family members	Own physician 	• Lots of responsibility and emotion for doctor: distance themselves from patients • Becomes known as “Dr Death” • Refusal or opting out could ruin relationship or future relations with family
• Balances subjectivity and objectivity • Less pressure on family doctor • Has medical knowledge • Could be a condition specialist or separate branch	Independent doctor 	• Less personal – won’t know the patient, their history or family • No time to get to know you • People may just seek another doctor if one disagrees
• Protects doctors from litigation • Protects the doctor-patient relationship • Impartial, objective, detached, legalistic • Able to assess evidence and manage disputes • Able to assess coercion	Judge 	• Bureaucratic/costly/a burden/upsetting process • Prolongs pain and process; strain on family • Impersonal • Associated with crime and punishment • Public more negative about judges than doctors

Discussion points

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- Do you think legalised physician-assisted dying would change your relationship with patients? In what way would it change?
- Do you think it would change the way doctors are perceived by the general public?
- Would the impact on the doctor-patient relationship be different depending on who made the decision on eligibility?
- If physician-assisted dying were to be legalised, how would such services be organised and legislated for?
- What would conscientious objection mean in practice?

European Convention on Human Rights

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Right to life

Prohibition of torture and inhuman or degrading treatment or punishment

Prohibition of slavery and forced labour

Right to liberty and security

Right to a fair trial

No punishment without law

Right to respect to family and private life

Freedom of thought, conscience and religion

Freedom of expression

European Convention on Human Rights

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Freedom of assembly and association

Right to marry

Prohibition of discrimination

Prohibition of abuse of rights

Limitation on use of restrictions on rights

Protection of property

Right to education

Right to free elections

Abolition of the death penalty

Rights under threat

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Proposal to abolish Human Rights Act

Proposal to withdraw from European Convention on Human Rights

Proposal to withdraw from access to European Court of Human Rights

Rights apply to all people – are universal, inalienable, indivisible, interdependent and interrelated

What rights do opponents of Human Rights Act wish to forgo?

Do they wish to take away or limit the rights of some others, rather than their own rights?

Not for State to defend some rights rather than others or distinguish between those who deserve and do not deserve protection

BMA's human rights work

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Defending and speaking out about human rights

Letter-writing campaigns in response to evidence of abuses of health-related human rights such as breaches of medical neutrality

Responding to cases where doctors are involved – eg force-feeding of hunger strikers or assessing fitness for torture or capital punishment

Campaigning when doctors are victims of human rights abuses

Participating in drafting of World Medical Association statements relevant to human rights

Producing books and reports addressing health-related human rights

BMA human rights actions: Some examples

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Medical Ethics Today

The Medical Profession and Human Rights

Medicine Betrayed

International Dual Loyalty Working Group

Istanbul Protocol

World Medical Association

International Federation of Health and Human Rights Organisations

Toolkits: armed forces, forensic physicians

Advice to members and others

Lobbying nationally and internationally on human rights

BMA Medical Ethics Committee: Topics 2015-17

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End-of-life care and physician-assisted dying

Mandatory reporting of child abuse

Testing incapacitated patients following needlestick injuries

Decisions relating to artificial nutrition and hydration for patients in permanent vegetative state and minimally conscious state

Deprivation of Liberty Safeguards

Emergency Care and Treatment Plans

Female Genital Mutilation

Competence and staff shortages

Marketisation and conflicts of interest in the NHS

Managing conflicts of interest in the NHS

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Models for generic consent for the use of data for research

Seeking consent

Confidentiality

Limits of implied consent for information-sharing

Development of a database for innovative treatments

Developments in organ donation and transplantation

Genome editing

Surrogacy

Decriminalisation of abortion

Pandemic flu

Cosmetic procedures

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Conscientious objection

Buyers' clubs

UK withdrawal from the EU: Effect on medical ethics and law

Anti-terrorism Prevent strategy

Doctors as active combatants in the armed forces

Migrant access to assisted reproduction services

Immigration detention

Solitary confinement of children and young people in custody

The Mediterranean refugee crisis, international law and migrant health

Ethical issues in humanitarian innovation in health

BMA involvement in an international conference on medical neutrality

Work of the BMA's Medical Ethics and Human Rights Department

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Delivering wide range of services and products to support doctors in their professional lives

Ethics advice service: ethical and medicolegal advice for doctors

Publishing advice and guidance: books, guidance notes, toolkits etc

Providing training to doctors, international medical graduates and medical students

Monitoring and influencing medical law

Campaigning for changes in public policy

Defending and speaking out about human rights

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How can the BMA Medical Ethics and Human Rights Department support you?

How can the BMA Medical Ethics and Human Rights Department support you?

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Ethics advice service

ethics@bma.org.uk

02073836286

Guidance

Free to BMA members via the BMA Library e-Books collection

Online resources

www.bma.org.uk/ethics

www.bma.org.uk/ethics

www.bma.org.uk/support-at-work/ethics/ethics-a-to-z

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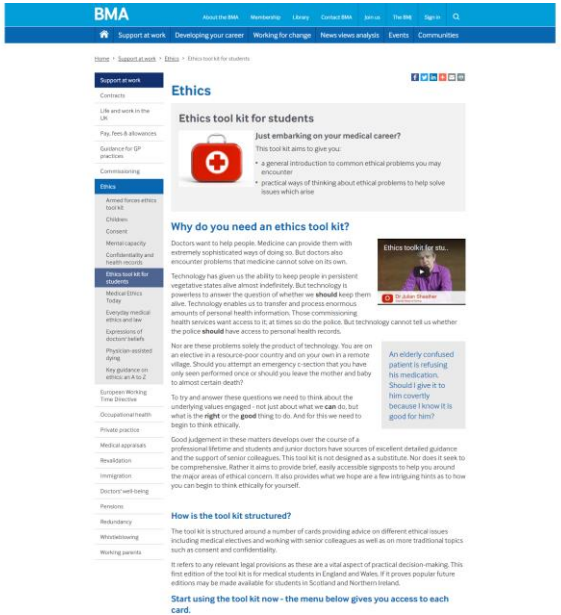

www.bma.org.uk/support-at-work/ethics/medical-students-ethics-tool-kit

Contacting the BMA Medical Ethics and Human Rights Department

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