ALMA MATER STUDIORUM
UNIVERSITÀ DI BOLOGNA

Bioethics

Silvia Zullo

Department of Legal Studies
– CIRSFID - silvia.zullo@unibo.it

Health Care Professional-Patient Relationship

-Informed consent as the basis of the doctor-patient relationship

-Ethics of paternalism

-Ethical decision making

Informed consent

-Moral basis of informed consent

-The problem with the level of information: "reasonable patient standard": doctors are expected to disclose what other patients would usually consider worth knowing who find themselves in similar situations

-Informed consent requirements

Informed consent

The provisions contained in law **n. 219/2017** are based on the fundamental principles concerning the human being rooted in the Italian Constitution, expressly mentioned in the first article of the law, and aim to protect the person's rights to life, health, dignity and self-determina-tion in every moment of the person's life, even when the individual is temporarily or no longer able to decide and express choices about health-care

The law promotes the person's autonomy, and a patient-physician relationship shifted to a patient-centred approach: the person's view, preferences and wills are valued, and the goal of the therapeutic relationship appears to be the pursuit of the patient's health, understood as the best physical, psychological and relational well-being achievable by the person taking into consideration both medical criteria and the person's individuality.

The discipline drawn up by the law to achieve such patient-physician relationship is basically composed by three elements: Informed consent (article 1), Shared care planning (article 5) and Advance directives (article 4)

Informed consent

Article 1 (Informed consent) provides for the patient's rights to be fully informed about his/her health conditions (or, on the contrary, not to be informed and to delegate health-related decisions), to give consent or dissent to medical treatments, to withhold consent to unwanted therapies, even if life-sustaining.

Article 4 (Advance directives) ensures the citizen's right to express wills about medical treatments and give directions of care in anticipation of a possible future inability to self-determination. Article 5 (Shared care planning) states that in case of a chronic and disabling disease or disease characterized by an inevitable progression with poor prognosis, patient and physician can discuss and prepare together a care plan which health providers are obliged to abide in the event the patient becomes unable to express consent or reaches a condition of incapacity.

Rules established about advance directives and shared care planning also include the person's right to nominate a trusted person with power of representation in the relationship with healthcare professionals and organizations. Article 1 also provides for the health facilities obligation to guarantee, through their own organizational modalities, the full and proper implementation of the principles of the law, ensuring the necessary information to patients and adequate training of staff on care relationship, pain therapy and palliative care.

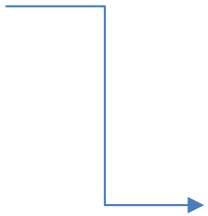
Ethics of Paternalism

Soft paternalism= A health care professional acts in a benevolent way by overriding an incompetent patient's choices.

Strong paternalism= courses of action that override a competent patient's considered self-regarding choices.

Ethics of Paternalism

Deciding for Others

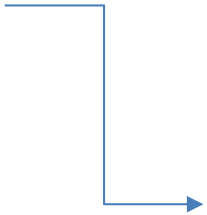


Advance Directives

(a) patients who never had legal capacity to make decisions; (b) patients who had legal capacity but lost it and left no advance directive; as well as (c) patients who created an advance directive while they had capacity and there is an argument between caregivers and family members about the interpretation of the advance directive.

Ethics of Paternalism

Deciding for Others



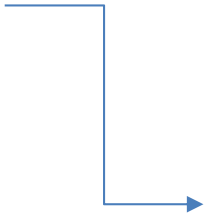
Advance Directives

are based on respect for competent patient choices.

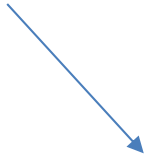
If we have a right to refuse life-sustaining treatment while we are competent, we should be able to issue ADs that address a situation where we might not have the capacity any longer to make such a choice

Ethics of Paternalism

Deciding for Others



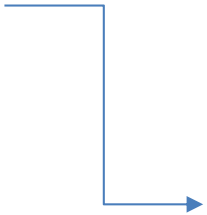
Advance Directives



Patients who are incapacitated:

it is difficult to see what objective interest could be ascribed to this patient who suffered irreversible brain damage and would have been unable to benefit from any kind of medical intervention

Ethical decision making



- Truth-telling
- Confidentiality in the doctor-patient relationship
- Conscience matter
- Duty to treat

Ethical decision making

Truth-telling:

An autonomous choice is not feasible in the absence of true information about one's state of health and one's options. True patient first person voluntary informed consent is only feasible if the patient has been informed truthfully about the nature of their condition, their treatment options, cost associated with those treatment options, and so on.

Paternalistic prerogative: the idea that the doctor's beneficence obligations toward their patients can sometimes justify telling outright lies, at least in circumstances where the doctor thinks that the patient would likely benefit from a lie

Ethical decision making

Confidentiality in the doctor-patient relationship:

It is a trust-based relationship, with the patient assuming that the doctor is a professional who will do what is in that patient's best interest.

Doctors are indeed generally expected to maintain patient confidences, but there are also clear limits. For instance, if the life or well-being of another person is threatened by past or future patient con- duct, doctors are legally obliged to breach confidentiality as a matter of law. Doctors might also be required by law to pass on confidential test results to public health authorities in order to protect the wider public's health interests

Ethical decision making

Conscience matter:

when we talk about con- science we are talking about both our conviction that we should act in accordance with our individual understanding of what morality demands of us, and of deliberately and voluntarily acting in accordance with what we consider to be morally good and right (Sulmasy 2008).

In medical ethics when there is talk about conscience, however, it is not about patient conscience, but about doctors refusing to provide particular medical services that are within their scope of professional practice and that are both perfectly legal and that eligible patients have a right to receive. Often, but not exclusively so, this affects patients seeking reproductive health services such as an abortion or sterilization, or end-of-life medical services such as aid in dying.

Ethical decision making

Conscience matter:

Doctors are *professionals*, patients visit them İn that capacity, and not as individuals with their own idiosyncratic views of the universe. Professionalism entails the profession's **right to self-regulate**, but it also comes with clear societal expectations with regard to the delivery of professional services. Societies typically endow professionals with a monopoly on the provision of particular specialized services. The denial by individual doctors to provide the range of services that they voluntarily contracted to provide could well lead to a situation where patients are una- ble to access services that they are entitled to receive (Charo 2005). This concern is not of a purely theoretical nature.

Today in many jurisdictions a compromise position on this controversial issue has been reached. Health care professionals are often not obliged to provide the service they conscientiously object to, but they are obliged to transfer the patient on to a colleague who they know will provide it, and who is in reasonable proximity so that the patient is able to receive the ser- vice they have a moral and legal claim to. The obvious problem with this compromise solution is that it is not quite a compromise from the perspec- tive of the conscientious objector. Say, if you believe that abortion is akin to murder, it is unlikely to be a satisfactory compromise that you do not have to commit the murder yourself but that you must transfer the assistance-seeking woman on to a health care professional who you know will commit the act you object to.

Ethical decision making

Duty to treat:

It is uncontroversial that health care professionals have beneficence duties toward patients, the question is how far reaching those duties are. The ethical challenge is to determine where to draw a defensible line with regard to risks that society can expect health care professionals to accept on the job. It should not come as a terrible surprise that there is no professional or regulatory consensus on this difficult subject matter.

Good arguments exist on both sides of the divide.