Structure in Ethical Reasoning

The Structure of Ethical Argument
The Process of Moral Reasoning
The Default Assumption
The Burden of Proof
Casuistic Exploration
Application to the Current Case
A Review of Some Basic Ethical Assumptions

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).
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.*

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)

Applications to Behavioral Health in Long Term Care
Withholding Treatment

To Treat or Not To Treat…

Mr. J is a 40-year-old patient with schizoaffective disorder, dementia NOS and has a history of poly-substance abuse. Mr. J became progressively more disoriented and is now being treated with Aricept. The Aricept is achieving marked results and has improved Mr. J's alertness and orientation, to the point where he is able to act on his delusions. Is it ethically better to treat Mr. J with Aricept, which increases his autonomy, or to withhold Aricept so that, although clearly less oriented, Mr. J will not engage in confrontational behavior and will experience reduced agitation?

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.

Ethics in Long-Term Care

“Refusing Mood Stabilizers”

Mr. D is a 78-year-old gentleman who recently moved into assisted living directly from his own home. Although Mr. D initially seemed to adjust well to the move, he has now been reported as bothering other residents. He is awake for most of the hours of the day and night, and often engages other residents in conversations with an aggressive and pressured speech pattern. Discussions with Mr. D about his behaviors have not resulted in any modification to his behavior, and Mr. D's children indicate that this is often how he behaves. They explain that Mr. D has an old diagnosis of Bipolar Affective Disorder, but that after a short and successful experience on Lithium, Mr. D complained that he did not like how the medications made him feel, and he refused any further attempt to manage his manic symptoms with medications. Mr. D’s behaviors appear to be worsening and complaints from other residents are increasing. Nevertheless, while Mr. D admits to having a mood disorder, he refuses all interventions.
Placement Issues
“She Will Just Drink Again”

Ms. D is a 70-year-old resident who was recently moved to the memory impairment unit when her ADL skills took a dramatic decline. After a couple of weeks in the unit, however, Ms. D improved greatly and it is appears that many of her functional challenges were secondary to an exacerbation of her ETOH abuse. The family now reports that Ms. D had a long history of alcohol abuse. The attending psychiatrist is very concerned that if Ms. D goes back to a less supervised setting, she will re-engage in heavy drinking. On this basis, he refuses to write an order to release her from the memory impairment unit.

The Ethics of Hoarding

Privacy and Pathology
“`I’m a Collector”

Ms. L and her husband have lived in Assisted Living for the past two years and during that time concerns have repeatedly been raised regarding Ms. L’s excessive hoarding behavior. Difficulties regarding hoarding became so pronounced that the Ethics Committee was asked to prepare a general policy level discussion of the issue. Subsequent to the completion of the policy work on hoarding, staff worked diligently with Ms. L and they were able to help her clean out her apartment significantly and to satisfy health and safety concerns. However, Ms. L’s hoarding behavior has continued and the progress made previously has now been reversed. Staff are concerned that the hoarding behavior creates an unsafe living environment that must be mitigated, that it is significant of a mental illness that would benefit from treatment, and that inappropriate amounts of nursing staff time are now being expended on housekeeping tasks. Since efforts to refer Ms. L to counseling and to assist in maintaining a clean apartment have failed, this ethics consult was requested to identify and examine the ethical implications further intervention.
Hoarding Disorder
A psychiatric condition that produces symptoms such as:
- excessive accumulation of possessions that congest active living areas
- persistent difficulty discarding or parting with possessions regardless of their actual value
- associated clinically-significant distress or impairment in social, occupational, or other important areas of functioning, including maintaining a safe environment


Hoarding Disorder: Diagnostic Criteria

• Prior to 2013 (publication of DSM-V), Hoarding Disorder was considered a symptom of Obsessive-Compulsive Disorder, not a separate diagnosis

• Excessive acquisition is displayed by 80-90% of individuals with Hoarding Disorder
  – Excessive buying (most common), Acquisition of free items, Stealing

• Persistent difficulty discarding or parting with possessions
  – Distress associated with discarding, Need to save the items due to perceived utility, aesthetic or sentimental value, Avoiding wastefulness and fear of losing important information are also common

• Most commonly saved items: newspapers, magazines, old clothing, bags, books, mail, paperwork
  – Often valuable items are found in piles mixed with other less valuable items

• Living areas become cluttered to the extent that their intended use is no longer possible
  – Examples: can’t cook in the kitchen or sleep in the bedroom
  – Possessions often spill beyond active living areas and can impair the use of vehicles, yards, the workplace, and other friends’/relatives’ houses
  – Access for repair work may be difficult, utilities may be disconnected or appliances broken
  – Severe cases can put individuals at risk for fire, falling, poor sanitation, and other health risks
  – Causes strain in family relationships
  – Conflict with neighbors and local authorities is common

• “Normal collecting” does not produce the clutter, distress, or impairment of hoarding disorder

• Approximately 75% of individuals with hoarding disorder have co-morbid mood or anxiety disorders
Hoarding:
An Actual Case Study and Ethics Committee Response

Privacy and Pathology
Consultative Response

1) We recommend that, as outlined in the previous policy work by the ethics committee on this matter, the facility does have a legitimate ethical duty to A) protect the safety of the environment for the subject individuals and others, B) attend to clinical issues presented by residents, and C) protect its property rights to the facilities in which residents live. On this basis, we recommend that a sufficient ethical issue does exist in this case to warrant facility response, and that a resident's claim to privacy would be insufficient to counter the organizational need to intervene.

Privacy and Pathology
Consultative Response

2) Questions were posed during our conversation about the appropriate use of Fellowship Funds for an individual whom staff believe is misspending discretionary money. After careful discussion, we generated consensus on the point that discretionary funds are meant to be spent based on the values of the individual, and that tight control beyond limitations already contained in existing policy would set a dangerous precedent for paternalistic control. Therefore, we recommend that intervention in the hoarding behavior by limiting funds to which Ms. L would be entitled were it not for her hoarding is not an ethically sound basis for restricting those funds. We recommend that Ms. L's access to Fellowship Funds should not be considered a mechanism by which hoarding could be managed.
Privacy and Pathology
Consultative Response

3) We recommend that while the psychiatric components of hoarding are becoming more well known, management of those symptoms should be referred to appropriate clinical personnel. In other words, believing that Ms. L suffers from a mental illness is not an ethical basis for forcing intervention. If staff are concerned for Ms. L’s mental health, they should make referral to psychiatric services, which they have. Unless Ms. L’s mental health issues rise to the level of imminent risk of harm to self or others secondary to a mental illness, then the existence of a mental health diagnosis does not, by itself, justify forcible intervention.

Privacy and Pathology
Consultative Response

4) On the basis of recommendations two and three, above, we recommend that while referral and assistance is appropriate, the only ethical justification for forcible intervention must be based on the documented presence of a life and/or safety risk or damage to the facility property. We also recommend, however, that there is ample evidence to support the view that Ms. L’s hoarding activity does create an unacceptable situation. Staff are convinced that a health and safety risk does exist for the Ls and other residents around them because of fire hazard and fire suppression limitations caused by the hoarding, ambulation risks for the Ls, and the inability for staff to provide appropriate housekeeping and housing unit maintenance services. Therefore, we recommend that intervention based on existing policies and standards is ethically justified.

Privacy and Pathology
Consultative Response

5) We recommend that insistence on removal of excess material in the L’s living area is ethically justified and consistent with precedent. We recognize four possible solutions to this problem: A) Ms. L ceases her current hoarding behavior and the underlying problem is thereby eliminated, B) Ms. L finds an alternate location to store the items that she continues to purchase, C) Ms. L agrees to move to a higher level of supervision, such as Healthcare if she meets admission criteria, and is no longer able to store excess items, or D) upon refusal of any of options A-C, the Ls are discharged from the facility. We recommend that the least invasive of these alternatives should be attempted and exhausted prior to moving to a more restrictive option.
Privacy and Pathology
Consultative Response

6) In order to justify any of the actions contemplated in the previous recommendation, we recommend that staff must confirm and document exactly how the hoarding creates a health or safety risk to the Ls or others, communicate clearly with the Ls what actions would constitute compliance with facility expectations, and communicate clearly with the Ls what the consequences of their failure to ameliorate the situation entails, including possible discharge.