

Health Ethics Journal Update (January-April)

A New Defense of Brain Death as the Death of the Human Organism, Andrew McGee, Dale Gardiner, Melanie Jansen, The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine, 2023;, jhac040,

<https://doi.org/10.1093/jmp/jhac040>

This paper provides a new rationale for equating brain death with the death of the human organism, in light of well-known criticisms made by Alan D Shewmon, Franklin Miller and Robert Truog and a number of other writers. We claim that these criticisms can be answered, but only if we accept that we have slightly redefined the concept of death when equating brain death with death simpliciter. Accordingly, much of the paper defends the legitimacy of redefining death against objections, before turning to the specific task of defending a new rationale for equating brain death with death as slightly redefined.

Reconsidering Capacity to Appoint a Healthcare Proxy. Appel, J. (2023). Cambridge Quarterly of Healthcare Ethics, 32(1), 69-75. doi:10.1017/S0963180122000512

Clinicians are often called upon to assess the capacity of a patient to appoint a healthcare agent. Although a consensus has emerged that the standard for such assessment should differ from that for capacity to render specific healthcare decisions, exactly what standard should be employed remains unsettled and differs by jurisdiction. The current models in use draw heavily upon analogous methods used in clinical assessment, such as the “four skills” approach. This essay proposes an alternative model that relies upon categorization and sliding scale risk assessment that can be used to determine to how much scrutiny the proxy appointment should be subjected and how much certainty of accuracy should be required in order to maximize the patient’s autonomy and ensure that her underlying wishes are met.

The End of Personhood, The American Journal of Bioethics, Jennifer Blumenthal-Barby (2023) DOI: 10.1080/15265161.2022.2160515

The concept of person-hood has been central to bioethics debates about abortion, the treatment of patients in a vegetative or minimally conscious states, as well as patients with advanced dementia. More recently, the concept has been employed to think about new questions related to human-brain organoids, artificial intelligence, uploaded minds, human-animal chimeras, and human embryos, to name a few. A common move has been to ask what these entities have in common with persons (in the normative sense), and then draw conclusions about what we do (or do not) owe them. This paper argues that at best the concept of “person-hood” is unhelpful to much of bioethics today and at worst it is harmful and pernicious. I suggest that we (bioethicists) stop using the concept of person-hood and instead ask normative questions more directly (e.g., how ought we to treat this being and why?) and use other philosophical concepts (e.g., interests, sentience, recognition respect) to help us answer them. It is time for bioethics to end talk about person-hood.

Samuel Doernberg & Robert Truog (2023) Spheres of Morality: The Ethical Codes of the Medical Profession, The American Journal of Bioethics, DOI: 10.1080/15265161.2022.2160514

The medical profession contains five “spheres of morality”: clinical care, clinical research, scientific knowledge, population health, and the market. These distinct sets of normative commitments require

increasingly occupy multiple roles in healthcare and move between them frequently, creating the possibility of conflict between the ethical obligations of their various roles. This paper examines the entire moral landscape of medicine through the lens of role morality. It develops a novel framework that helps physicians recognize how their moral commitments depend on the nature and context of the situation, clarifies ethical conflicts that physicians face, and concludes with ideas for resolving these conflicts.

Relational autonomy and the clinical relationship in dementia care. Klein, E. Theor Med Bioeth 43, 277–288 (2022). <https://doi-org.proxy.library.carleton.ca/10.1007/s11017-022-09580-5>

The author notes that the standard conception of the physician-patient relationship starts to break down when the patient has dementia. Klein takes this to be in part due to the individualistic conception of autonomy that underpins the standard conception of the physician-patient relationship. Klein suggests a reconceptualization of the physician-patient relationship that is based on a relational notion of autonomy which may fair better when it comes to patients with dementia.

Why caregivers have no autonomy-based reason to respect advance directives in Dementia Care. Lauridsen, S., Folker, A. P., & Andersen, M. M. (2023). Bioethics, 37(4), 399–405. <https://doi.org/10.1111/bioe.13142>

Advance directives (ADs) have for some time been championed by ethicists and patient associations alike as a tool that people newly diagnosed with dementia, or prior to onset, may use to ensure that their future care and treatment are organized in accordance with their interests. The idea is that autonomous people, not yet neurologically affected by dementia, can design directives for their future care that caregivers are morally obligated to respect because they have been designed by autonomous individuals. In this paper, we first criticize the idea that ADs can retain moral authority in severe dementia by arguing that it is paradoxical. Second, we consider two arguments that initially seem to refute this critique of ADs, but we eventually dismiss them. The first argument states that ADs retain moral authority in severe dementia because autonomously formed interests, for example, ADs, can only be appropriately discarded by autonomous persons. This we term the historical autonomy argument. We dismiss it by demonstrating how we, in analog cases, are not obligated to continue to respect autonomously formed interests even though they have been discarded under nonappropriate conditions. The second argument is that ADs can be justified by what we term external interests. While we agree that people with severe dementia plausible can be said to have external interests, we show that ADs cannot express such interests and hence cannot be justified by them. We conclude that none of the discussed arguments support the use of ADs and because of this, the idea of ADs should be reassigned.

Patient autonomy and withholding information. Rees, M. (2023). Bioethics, 37(3), 256–264. <https://doi.org/10.1111/bioe.13130>

Disclosure in clinical practice is aimed at promoting patient autonomy, usually culminating in patient choice (e.g., to consent to an operation or not, or between different medications). In medical ethics, there is an implicit background assumption that knowing more about (X) automatically translates to greater, or more genuine, autonomy with respect to one's choices involving (X). I challenge this assumption by arguing that in rare cases, withholding information can promote a patient's autonomy (understood as the capacity for rational choice in alignment with one's values and goals).

Ethical Challenges in Chronic Pain. Prim Care. Reeves K, Jones N. 2022 Sep;49(3):497-506. doi: 10.1016/j.pop.2022.01.002. Epub 2022 Aug 27. PMID: 36153089.

Health care providers are ethically obligated to provide effective management for patients suffering from chronic pain. Many patients have not had access to such management, and current bioethical principles are not sufficient to create the roadmap needed on how to improve current standard of care. Principles described in the emerging field of urban bioethics greatly enhance the toolbox available to providers regarding chronic pain management. Redefining the principles of autonomy, beneficence/nonmaleficence, and justice to agency, social justice, and solidarity is essential to having the framework needed to provide more ethical, equitable care

The Unexamined Benefits of the Expansive Legalization of Medical Assistance-in-Dying. Riley, S., Sarbey, B. Bioethical Inquiry 19, 655–665 (2022).

<https://doi.org/10.1007/s11673-022-10211-w>

If you slide far enough down the slippery slope envisioned by opponents of medical assistance-in-dying (MAiD), you eventually land in a ghastly society with industrialized euthanasia, rampant suicide, and devalued life. But what if the slippery slope leads us somewhere better? This paper explores the benefits of eliminating nearly all MAiD prohibitions and regulations. We anticipate three positive effects for public health: 1. Expanded access to those currently not qualified from MAiD by removing ineffective access criteria; 2. Harm reduction by making MAiD safer and by rerouting suicidal patients into alternate care; and 3. Improvements to the health system through lowered healthcare costs and increased patient activation in end-of-life care. Safeguards and prohibitions deny those who wish to die the ability to do so to prevent the potential danger of a few being subjected to an undesired early death.

Autonomy to a fault: The confluence of organ donation, euthanasia, and the dead donor rule. Rubin, J. (2023). Bioethics, 37(4), 374–378.

<https://doi.org/10.1111/bioe.13138>

Five countries now permit organ donation after euthanasia, on the basis of respecting donor autonomy. Some now openly consider performing euthanasia itself via organ extraction to better preserve organ viability, albeit in violation of the dead donor rule. Proponents argue that respect for patient autonomy requires this option; the dead donor rule is inapplicable since it fulfills donors' wishes. Other ethical arguments, not addressed herein, explore issues including dying at home, impact on clinicians, and societal faith in donation enterprise, but these concerns are not insurmountable. This paper instead solely critiques proponents' oversimplified understanding of autonomy with an autonomy-based argument against any linkage of organ donation and euthanasia, regardless of its timing. Respect for patient autonomy does not unilaterally require fulfilling patients' every wish. Moreover, the very possibility of organ donation with euthanasia limits donor autonomy qualitatively and quantitatively substantially more than by offering it. In fact, organ donation after euthanasia violates the purpose of the dead donor rule, even if not its technicalities.

Conspiracy theories and clinical decision-making. Stout, N. (2023). Bioethics.

<https://doi.org/10.1111/bioe.13146>

When a patient's treatment decisions are the product of delusion, this is often taken as a paradigmatic case of undermined decisional capacity. That is to say, when a patient refuses treatment on the basis of beliefs that in no way reflect reality, clinicians and ethicists tend to agree that their refusal is not valid. During the COVID-19 pandemic, however, we have witnessed many patients refuse potentially life-

interventions not based on delusion but on conspiracy beliefs. Importantly, many of the beliefs espoused by conspiracy theorists resemble delusions in a number of relevant ways. For instance, conspiracy beliefs often posit states of affairs that could not possibly exist in the world, they are recalcitrant in the face of disconfirming evidence, and they tend to put the believer in a state of paranoia. Given these similarities, how should we think about conspiracy theorists' capacity for making clinical decisions? In this paper, I attempt to answer this question by first offering an account of just what makes some set of beliefs count as a conspiracy theory. Second, I attempt to disambiguate conspiracy beliefs from delusions by exploring important conceptual and psychological features of both. Finally, I apply standard criteria for assessing a patient's decision-making capacity to instances of conspiracy beliefs and argue that, although the picture is muddy, there may be cases in which conspiracy beliefs undermine capacity. I end by exploring the implications that this might have for surrogate decision-making and addressing potential objections.

Assessing the impact of patient-involvement healthcare strategies on patients, providers, and the healthcare system: A systematic review, Patient Education and Counseling, Thomas Miller, Markus Reihlen, Volume 110, 2023, 107652, ISSN 0738-3991, <https://doi.org/10.1016/j.pec.2023.107652>.

A systematic review of academic literature on patient involvement in healthcare in order to identify risks and benefits as well as highlight effective implementation strategies. The authors concluded that patient involvement can improve healthcare quality and health literacy, however, this requires policy-maker interventions.

Choosing death in unjust conditions: hope, autonomy and harm reduction, Wiebe K, Mullin, A Journal of Medical Ethics Published Online First: 26 April 2023. doi: 10.1136/jme-2022-108871

In this essay, we consider questions arising from cases in which people request medical assistance in dying (MAiD) in unjust social circumstances. We develop our argument by asking two questions. First, can decisions made in the context of unjust social circumstance be meaningfully autonomous? We understand 'unjust social circumstances' to be circumstances in which people do not have meaningful access to the range of options to which they are entitled and 'autonomy' as self-governance in the service of personally meaningful goals, values and commitments. People in these circumstances would choose otherwise, were conditions more just. We consider and reject arguments that the autonomy of people choosing death in the context of injustice is necessarily reduced, either by restricting their options for self-determination, through their internalisation of oppressive attitudes or by undermining their hope to the point that they despair.

Second, should MAiD be available to people in such circumstances, even when a sound argument can be made that the agents in question are autonomous? In response, we use a harm reduction approach, arguing that even though such decisions are tragic, MAiD should be available. Our argument engages with relational theories of autonomy as well as recent criticism raised against them and is intended to be general in application, although it emerges in response to the Canadian legal regimen around MAiD, with a focus on recent changes in Canada's eligibility criteria to qualify for MAiD.