PERSON CENTRED HEALTHCARE ETHICS 2,956 wds

Doctors and nurses have codes of ethics which serve as a guide in their professional work because they are persons and moral agents. Human beings are persons precisely because they are have a nature that is rational. Unlike Professor Peter Singer and other philosophers, the Christian tradition holds that unborn children and newborn infants are persons because they are endowed with a nature that is rational from conception on account of their spiritual souls. Human nature, then, includes rationality. However, persons are moral agents once the reach the age of reason.

Ethics is about doing the right thing -- doing good and avoiding evil. The notion of good is primitive, underived, and pivotal for ethics. It is *relational* in meaning: good signifies *good for persons*—ourselves and others. Some deeds are judged to be g*ood and* generate an *obligation, a must* for persons. They make absolute demands on our free will to be true to ourselves and others as persons, e.g, visiting a sick parent. [1] Other actions are judged to be no good, bad for ourselves and others, e.g. being cruel to a child. Reflecting on our nature and our relationships with others, reason is able to discern that some kinds of deeds are good for us and that others conflict with what is good for us as persons, i.e. are bad. *Good* then is correlative to persons – ourselves and others.

Relevance of the concept of the human person

Ethics and its specific obligations to ourselves and to others presuppose an implicit concept of the human person which underpins it and of which they are an expression. [2] We readily recognise the fundamental category distinction between *being* and *having*. We are aware that each one of us is a unique subject of existence, not an object. We resent being treated like an object. Through our conscious activities, feelings and encounters, the self is revealed as a personal and relational subject of these experiences. All that constitutes us is part of our human nature and shares in our personal dignity: reason, free will, the body with all its organs, sexuality, sensations, feelings and limbs. Their purpose and significance are to be interpreted from a personalist, and not simply a biological, perspective. We are *one* with our human nature: a wedge cannot be driven between it and the person.

I will mention two seminal personalist philosophers, Paul Tounier, a Swiss doctor and Frenchman Emmanuel Mounier and show how their view of the person helps us gain some ethical insights into persons and their inter-personal relations.[3] For these philosophers, an object, say a plate, *is* whereas a person *exists*, i.e. stands out. Still, for Mounier, the personal mode of existence has to be acquired and fostered.[4]

Tournier suggests that the person is internal, silent and hidden whereas the *personage* or

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[1] Ford, N., *The Prenatal Person. Ethics from Conception to Birth*, Oxford: Blackwell Publishing, 2002, see 17-19.

[2] Ford, *The Prenatal Person*, see 9.

[3] Much of the inspiration for this section is inspired by the works of the following personalist philosophers: Paul Tournier, a medical practitioner turned philosopher, *The Meaning of Persons*, London: SCM Press, 1957, 1974, the whole book, but especially Part One 'The Personage' and Emmanuel Mounier, *Personalism*, Notre Dame/London: Notre Dame Press, 1952, the whole book.

[4] Mounier, E. *Personalism*, Notre Dame/London: Notre Dame Press, 1952, see p. xix.

mask people use in their representative roles is visible.[5] Think of the roles of actors, their *personage*, -- say Sean Connery in a *James Bond* movie or the characters in "Yes, Minister". A professional *personage* is needed by healthcare staff and it offers some protection for the person in the world of things and the world of persons. We should move in the right one at the right time. As Tounier says: "Our life is subject to an inexorable law of unity. Either we move in the world of things, phenomena, *personage*s, and God Himself is just an abstract idea; or else we enter the world of persons; God becomes personal; we meet persons everywhere, in the intimacy of the home as well as in those great impersonal machines we call hospitals." [6]

Mounier reminds us that "The fundamental nature of the person … lies not in separation but in communication."[7] Communication with others is fullness of personal being: isolation from others leads to alienation. He adds "One might almost say that I have no existence, save in so far as I exist for others, and that to be is, in the final analysis, to love."[8] This is a high ideal that not all manage to achieve at work.

Implications of being a person for health care ethics

I must say from the start that CHA's own *Code of Ethical Standards* is excellent and provides an ethical answer to practically every health ethical problem that may arise. This *Code* needs to be known almost as well as each Catholic healthcare institution's statement of mission and values. The *Code's* first basic principle *Respect for persons within a culture of life* rightly states "Our care for people who are sick, aged or disabled is founded on love and respect for the inherent dignity of every human being."[9] Healthcare staff members should also follow their respective professional codes of ethics and professional conduct and the Australian Commission on Safety and Quality in Health Care submission on performance benchmarks.[10]

Patients and residents

Before all else, patients are human persons who do not exist in the abstract without a name, family ties, a personality, a national culture and some religious faith, or other personal beliefs. Touch one of these factors and you touch the person. Healthcare professionals need to recall that patients and residents are persons, not clients or customers. They may be vulnerable, but are ever endowed with personal dignity in need of medical treatment, nursing care and inter-personal interaction. Personal contacts outside of the nursing role or *personage*, however, should never be to the detriment of one's professional duties.

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[5] Tournier, P. *The Meaning of Persons*, London: SCM Press, 1957, 1974, see 88.

[6] Ibid. 190.

[7] Mounier, 17.

[8] Ibid. 20.

[9] *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, Canberra: Catholic Health Australia, 2001, 2.

[10] www.safetyandquality.gov.au/

Australian Commission on Safety and Quality in Health Care: Submission to the National Health and Hospitals Reform Commission on the *Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements*. June 2008.

Continuity of nursing staff is important: less reliance on agency nurses would promote the practice of each hospital's own ethos of care. With medical specialisation increasing, there is a danger of the focus shifting from the patient to a diseased organ: the patient as a whole person is always to be treated. In order to ensure greater practical respect for patients/residents as persons advertisements for staff need to include reference to person centred criteria for the guidance of selection panels.

Sympathetic provision is to be made for patients special needs. Patrick McArdle and Anne Tuohy offer incisive insights: "To focus on the humanity of the person in need prevents us from de-personalising those in our care. … It is, in fact, the challenge to respond personally and relationally towards those in our care. … When we fail to respond to them with compassion we not only diminish their humanity, but also our own." [11] Elizabeth Hepburn adds: "The frail elderly show … signs of wasting when no social interaction is available to them."[12] Pastoral care practitioners are invaluable in healthcare institutions to make and maintain personal contacts with patients and residents, especially if nurses are under pressure.

Some patients and residents need to be read carefully by nurses and carers to avoid mistaking their confident *personage* as the true person. Experienced staff can soon break through their *personage* to encounter the person and find out how they feel. Once made, personal contact is precious and appreciated by patients and residents alike. Saying '*how are you today?*' with a smile can put patients at ease. Attending to their 'basic nursing care needs'also gives them welcome reassurance.

Out of respect due to persons, private patient information should be kept strictly confidential and disclosed only on a need to know basis to members of the treating team, including information on a patient's HIV/AIDS status. A surgeon who during surgery finds out that a woman has previously had an abortion should not disclose this information if it is not relevant for her current medical treatment. Secretarial and administrative staff are also bound by patient confidentiality obligations. Patients' right to privacy when meeting with pastoral care practitioners/chaplains should be respected as far as practical.

Patients should be listened to and the nurse, as patient advocate, should facilitate any form of patient feed-back, be it positive or a complaint. Patients should be compassionately supported according to need in this exercise: no patient should be made to feel embarrassed if something negative is mentioned. Hospital administrators need to ensure that there is a transparent complaints policy for patients and that all relevant evidence is scrutinised by an independent person. Appropriate and prompt action should be taken as required. Even if there is no substance to a complaint, the matter should be handled promptly and delicately to the satisfaction of the patient concerned.

Medical practitioners

[11] McArdle, Patrick and Anne Tuohy, On Being Pastoral, Canberra: Catholic Health Australia, 2007, 8. 10, 14.

[12] Elizabeth Hepburn, *Catholic Care of the Ageing*, Canberra: Catholic Health Australia: 2005, 15.

Patients should be allowed to be accompanied by their next of kin or another support person in doctors' rooms.. Doctors and other health professionals should still speak directly to competent patients when communicating information about their diagnosis or prognosis rather than to their support person in order to show respect for patients as persons. They need to communicate to patients their expert medical opinions in plain language, including the likelihood of a terminal condition. Patients need to feel free to ask questions and to be given the time needed to receive answers. They should be informed of the relevant risks, the likelihood of a cure from any of the treatment options and the pain or discomfort that may accompany treatment compared to no treatment at all. It is important that information about surgery be understood by patients to enable them to give informed consent before the day of surgery. Patient Preadmission Clinics run by trained nurses provide excellent preparation for surgery. Patients may morally and legally refuse medical treatment if they find it too burdensome. But treatment in emergencies, normal nursing care and palliation of uncomfortable symptoms should always be given.

Clinicians should respect human life: there should be no condoning of euthanasia for competent or incompetent patients, even for those who are permanently unconscious, from newborns to the terminally ill. Euthanasia has been defined by Pope John Paul II as "an action or omission which of itself *and* by intention causes death, with the purpose of eliminating all suffering."[13] Likewise *direct* abortion is unethical. In the name of patients' personal dignity and autonomy it is imperative that express wishes of patients be sought and implemented as far as practicable. As the case requires, '*Not-for CPR Orders*' ought to be discussed in good time with relevant patients so that their wishes may be known and acted upon. These decisions should be made by patients while they are still competent and not left, as competence fades, to persons with an enduring power of attorney (medical) or next of kin. .

Pope John Paul II taught that there are ethical limits to the duty to undergo medical treatment. A patient may decide "to forego so-called 'aggressive medical treatment, in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are disproportionate to any expected results or because they impose an excessive burden on the patient and his family. ... It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement. To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia. It is rather the acceptance of the human condition in the face of death."[14] There is no ethical need to continue medically assisted nutrition and hydration if becomes physically or otherwise too burdensome for patients.

Pope Benedict XVI even states that "to eliminate death or to postpone it more or less indefinitely would place the earth and humanity in an impossible situation, and even for the individual would bring no benefit … ultimately we want only one thing – 'the blessed life', the life which is simply life, simply 'happiness'." [15] It is unethical to give medical treatment to patients if it only serves to prolong a painful dying process. Healthcare professionals should not act against their professional judgement to

[13.] Pope John Paul II, *The Gospel of Life*, Homebush: St Paul's, 1995, N 65.

[14.] *Ibid*. N. 65.

[15] Pope Benedict XVI, *On Christian Hope*, 2007, n. 11.

accommodate the misguided wishes of relatives who want treatment to continue to keep them alive. Timely consideration needs to be given to the transfer of patients to palliative care instead of active medical treatment. Doctors, however, may continue active treatment for terminal patients when this is required by a patient's religious beliefs.

The wishes of persons to donate their organs after their death to others in need of transplants is ethical and an act of charity. Relatives should respect the wishes of their deceased loved ones in much the same way as they accept their last will. However, sometimes, out of respect for the deceased person's corpse, relatives object for cultural reasons. In practice health professionals will be bound by any relevant state laws supporting relatives in such cases.

Another related ethical issue is the legitimacy of accepting brain death criteria. A person with a functioning brain is still alive even if life is supported by an artificial heart. A live heart beat is not of the essence for life. Brain death criteria require absolute knowledge of the basis of cerebral failure for brain death to be certified. A patient in a severe coma who is still breathing spontaneously or has any brain stem reflexes preserved is not brain dead. Simple clinical evaluations carried out at the bedside are reliable in determining cessation of cerebral blood flow and the resulting state of brain death. Ultimately death of the person is cerebral death related either to direct brain injury or cardiac arrest. Pope John Pauil II recently spoke in support of accepting the ethical validity of brain death criteria:

> "It can be said that the criterion adopted in more recent times for ascertaining the fact of death, namely the *complete* and *irreversible* cessation of all brain activity, if rigorously applied, does not seem to conflict with the essential elements of a sound anthropology. Therefore a health-worker professionally responsible for ascertaining death can use these criteria in each individual case as the basis for arriving at that degree of assurance in ethical judgement which moral teaching describes as "moral certainty". This moral certainty is considered the necessary and sufficient basis for an ethically correct course of action. Only where such certainty exists, and where informed consent has already been given by the donor or the donor's legitimate representatives, is it morally right to initiate the technical procedures required for the removal of organs for transplant". [16]

This statement does not mean that the criteria for brain death should not be refined in the light of advancing medical knowledge. Recourse to patients' or their legal agents' informed consent does not ethically suffice in the absence of certified brain death.

Nurses and carers

Nurses and carers should acquire an adequate work/life balance and also be given reasonably spaced shifts to ensure they begin their work well and rested. Out of a sense of solidarity they have a responsibility to keep an eye out for each other, show mutual courtesy, care and support, especially when it is known that a colleague is enduring

[16] Pope John Paul II, *Address to 18th International Congress of the Transplant Society*, Rome, 2000, Para. 5.

personal or family hardships. If some nurses or carers are hesitant about an ethical issue, they should feel free to mention it to a trusted colleague or nurse unit manager who should offer a helpful sympathetic ear, especially in the case of new nurses. Simple misunderstandings can arise when staffing is multicultural and they can be easily sorted out where goodwill prevails. Nurse unit managers and directors of nursing can be quite helpful whenever a sense of security, support and fairness is threatened.

At times nurses or carers share personal or private information about themselves or their families. This information should be treated as strictly confidential, unless patients' wellbeing is put at risk, say by a nurse who may be adversely affected by an illegal drug. It is worth noting that mutual acceptance is fostered by communicating in staff rooms in English, unless all present understand another national language.

The respect due to the dignity of patients in nursing homes requires that they be appropriately clothed if it is necessary to leave them for a while in a corridor. In multicultural settings, care needs to be taken to avoid any perception that a policy of equality for all is neglected. Mounier says: "Freedom is not the being of the person but the mode and manner in which the person is everything that it is and the more fully because it is freely so"[17] This applies to all: nurses and carers need to remember that patients and residents miss the personal freedoms they enjoyed in their homes. Still, reasonable limits of movement may be required of patients, say, for doctors' visits, etc.

Administrators and managers

Patients and healthcare professionals need to be affirmed, appreciated and supported. Catholic health care "extends the idea of care and wholeness to be the responsibility of the whole community."[18] Administrators have a responsibility to create and maintain an environment where staff members are able to deliver, in addition to the necessary medical treatment, the required *person centred healthcare.* Staff need in-service sessions on CHA's ethics *Code*. Patient care at the bedside in an ethical way will be undermined unless there is a culture of healthcare ethics throughout the whole healthcare institution. Where institutional practices endorse healthcare professionals as persons, the likelihood of achieving the goal of person centred healthcare ethics is enhanced. Hepburn put it well: "The whole purpose of the hospital is to offer healing and support and this will be done most effectively in an atmosphere of mutual appreciation, in which those delivering the care also feel cared for."[19]

A desire to increase efficiency and *patient throughput*, could lead to fewer staff, overwork and a lessening of attention for patients as persons. A balance has to be struck between financial viability, efficiency and keeping alive the goal of person centred healthcare ethics. It is important that staff morale be maintained for Catholic healthcare institutions to achieve their mission and values. I feel confident good will and sincerity prevail in Catholic healthcare facilities in Australia and that person centred healthcare ethics is well under way.

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[17] Ibid. 64

[18] McArdle and Tuohy, *On Being Pastoral*, 35.

[19] Hepburn, E, Being *a Catholic Hospital*, Canberra, 2004, 21.