Brookhaven Hospital
Tulsa, Oklahoma

Programs
- Behavioral Health
- Chemical Dependency
- Eating Disorders
- Neurological Rehabilitation Institute

Autonomy, Capacity and Beneficence:
Ethical Considerations In a Disabled Population

Ron Broughton, M.Ed., LPC, CRST
Chief Clinical Officer
Brookhaven Hospital
Tulsa, Oklahoma

Disclosure Statement

My only disclosure is that I am an employee of Brookhaven Hospital in Tulsa, Oklahoma. The content of this presentation is designed to promote quality improvements in healthcare and not advocate for any particular provider or entity. In addition, every effort has been made for the information to be well balanced, evidence-based and unbiased.

Goals
1. Understand pros/cons of autonomy
2. Know scenarios & ethical guidelines of capacity assessment
3. Question and weigh ethical benefits of treatment decisions
4. Know how to review treatment decisions from an ethical perspective
5. Challenge our thinking processes

Bio Ethics

Autonomy \(\rightarrow\) Beneficence

Justice

How are we doing?

Brain Injury

Treatment Since 1970
The 1970's
- Medical Advances
- Glasgow Coma Scale
- "Modern Era"
- "Era of Enlightenment"

The Early 1980's
- Brain Injury Rehab Becomes Sub Specialty
- Centers Grow From 10 to 500+
- "Era of Proliferation"

The Early 1980's
- Dr. Mitch Rosenthal & The National Head Injury Foundation
- Becomes the BIAA
- Provide Support, Education, & Advocacy for Access & Funding

The Early 1980's
- American Congress of Rehabilitation Medicine
- Dr. Sheldon Berrol Head Injury Special Interest Group
- Advance Standards of Care, Uniform Definitions, Education & Training

The Early 1980's
- "The Consumer Era"

1986-1989
- Public Questions
- The Theory Base?
- Interventions?
- Efficacy?
1986-1989

The Response
CARF & Standards of Care
National Institute on Disability Research
5 Model Systems of Care

“The Era of Refinement”

1986-1989

The 1990’s

Proliferation of Facilities
10-500+

The 1990’s

Few Treatment Guidelines

The 1990’s

Minimal Ethical Standards

The 1990’s

Abuse

Scrubtny
The 1990's
National Head Injury Foundation
Develops Basic Guidelines for
Ethical Practice

The 1990’s
“The Era of Accountability”

The 21st Century
Where Has the Evolution in Brain
Injury Rehabilitation Lead Us?
The “Era of Consolidation”

The Factors
Healthcare Reform
Insurance Company Mergers
HMO’s
Decreased LOS

Who Are the Stakeholders?
Insurance Companies
Taxpayers
Consumer
Treating Professional
Families

What Are Their Questions?
Is the Treatment Efficient?
Is the Treatment Efficacious?
Is the Treatment and Service Satisfactory?
Treatment Efficacy

Time To Revisit Some 1996 Treatment Myths

Proposed by Dr. Mitch Rosenthal

Myth #1
Treatment should continue for years?

Myth #2
Most expensive produces the best outcomes?

Myth #3
Most interventions are grounded in research?

Myth #4
Need to be delivered by high-skilled professionals?

Myth #5
Sub-acute delivers equivalent outcomes, as comprehensive rehabilitation?
A Short Look at One Reality
Johnson & Lewis 1991

$106,000
1991

$250,000
2010

Treatment did not generate a return to work.

"May be no more effective than support care."

The Challenge
Banja states, "To the extent that a delivery system becomes an end in itself and loses sight of the needs of those persons it is intended to serve, that service delivery system runs a danger of creating a false need or advocating treatment or therapies simply because they are available, irrespective of whether the patient actually needs them."

What Are We Really Doing?
Some Questions to Ask Ourselves

How do we ensure autonomy during treatment?

What Are We Really Doing?
Some Questions to Ask Ourselves

Do we assess capacity throughout treatment?
What Are We * Really* Doing?
Some Questions to Ask Ourselves

What evidence is there that our treatment benefits the consumer?

What Are We * Really* Doing?
Some Questions to Ask Ourselves

Do we examine ethical issues related to treatment decisions?

What Are We * Really* Doing?
Some Questions to Ask Ourselves

During treatment are we attune to the ultimate outcome?

What Are We * Really* Doing?
Some Questions to Ask Ourselves

How do we view or ensure consumer satisfaction?

What Are We * Really* Doing?
Some Questions to Ask Ourselves

How are we holding ourselves accountable?

Autonomy & Ethics
Principilism: The Foundation of Biomedical & Behavioral Research

The quality or state of being self-governing: self-directing freedom.
Autonomy & Ethics

U.S. Supreme Court. "No right is held more sacred, or is more carefully guarded, by common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference from others, unless by clear and unquestionable authority of law."

Autonomy & Ethics

Autonomy and Ethics

Example
- Consumer enrolled in services
- We encourage participation
- Assume consumer will benefit
- Assume they don’t know what’s best
- Consumer refuses intervention
- We interpret refusal as evidence of need for treatment

Beneficence

- Doing or producing good
- Macciochi’s definition “the promotion of health as defined in part by the patient’s own values.”
- Basic tenets of principlism—a system of ethics
  - Autonomy—free will or agency
  - Beneficence—to do good
  - Nonmaleficence—not to harm, and
  - Justice—social distribution of benefits & burdens

Beneficence

Doing good or producing good
**Beneficence**

The promotion of health as defined in part by the patient's own values.

---

**Pitfalls of Beneficence**

- Beneficence vs. Respect for Autonomy
- Beneficence Assumed vs. Compliance
- Autonomous Person vs. Autonomous Choice
- Holy Grail = Safety
- Clinical Predictions: What If They are Wrong?

---

**More Challenges**

1. Are we allowing consumer to express autonomy?
2. Is our treatment based in best practices?
3. If not, are we offering best-practices alternatives?
4. Are we blaming the consumer?
5. Is our assumption i.e., they need treatment, self-serving?
6. What about our value judgments?
7. How do we determine who knows best?

---

**Capacity**

Defined as the faculty or potential for treating, experiencing or appreciating.

1. Informed consent
2. Situational vs. Psychometric
3. Provider assumptions from observations
4. Fluid as rehab progress

---

**Example 1**

John: six weeks post TBI and possibly needs surgery. Doctor and wife talk while John is listening and without involving John, they agree to the surgery. Three months later John appears improved and elects to stop his medication. Doctor agrees.

Autonomy, capacity and beneficence addressed.
Example 2
Tommy, who is not his own guardian, is on post-acute unit and has attended cognitive group for three months. He decides he no longer needs to attend. Staff attempt to persuade him to no avail. Staff implement a plan where he loses points needed to attend the community outing.

Autonomy, capacity and beneficence in question.

Tommy and Ethical Considerations
Questions
1. Is it ethical to generate consequences?
2. Is there a universal code of ethics?
3. Who ensures ethical practice in treatment?
4. Is there a need for ethical rounds?
5. What would ethical rounds look like?

Ethical Rounds
1. Complete a functional analysis including safety and risk.
2. Consider the consumer’s autonomy and capacity.
3. Evaluate the pros & cons of possible decisions.
4. Assist consumer with reconsideration of decision.
5. If over riding consumer, ensure all team view points are heard & consider alternatives.
6. Do individual self-reflection for bias.

Example 3
Elaine is 18 yo who suffered TBI 1 ½ years ago. She is verbally abusive, continues to drink and lacks respect for others or self. Elaine is placed in a personal care home. Once there, she defies rules, is disrespectful to staff and makes minimal progress.

Autonomy, Beneficence & Disruptive Behavior
1. How do we grant autonomy with disruptive behavior?
2. Is it reasonable to think in terms of capacity?
3. How do we strive for beneficence?
4. Is it clinically or morally acceptable to discharge her?
5. Should she be forced into another program although likely it will be unsuccessful?

Risk Assessment
1. What objective measures of risk should be in place before consumer is disallowed from engaging in an activity?
2. What level of confidence must we have to prohibit a consumer from engaging in a potentially problematic activity?
3. What about risk to others?
Tepper & Elwork Model
1. Establish parameters of consumer’s processing ability.
2. Evaluate capacity to understand information related to decisions.
3. Evaluate capacity to arrive at and communicate a treatment decision.
4. Identify barriers to effective decision making.
5. Remove the barriers.
7. Create longitudinal record of consumer’s competency status.

Family Involvement
Positive Aspects of Family Involvement
1. Support treatment team.
2. Assist with transition skills.
3. Represent consumer when needed.
4. Speak to their hope & expectations of outcomes.

Family & Conflicts of Interest
Who will guard the guardians?
1. When there is emotional turmoil?
2. Lack of sufficient information?
3. Resentment of incompetent consumer?
4. Weak or non-existent bond?
5. Conflicting financial interests?
6. Inability to separate interests e.g., financial and emotional burden or moral differences?
7. Professional’s conflict of interests?

Research
The New Paradigm
"The old paradigm which was reductive to medical condition has presented disability as the result of a deficit in an individual that precludes him/her from performing functions and activities...The new paradigm is integrative and holistic and focuses on the whole person functioning in an environmental context."
U.S. Department of Education, 2000
Research & Outcomes

Our Values That Affect Research and Outcomes

1. Attitudes
2. Sentiments
3. Interests
4. Preferences
5. Subjective view of worth

Research Designs Should Address

2. Details of treatment methods.
3. Standardized and other accepted outcome measures (e.g., ecological perspective).
4. Use of control group when possible.
5. Use of multiple sites.
6. Exclusion of consumers with premorbid history of CD or psychiatric issues.

Research, Treatment & Challenges

1. Which functional domains chosen for treatment are most important for a good outcome?
2. How do we decide which criteria to use in determining whether an outcome is acceptable i.e., value justifies the cost?
3. With what frequency should the desired outcome occur to justify allocating the treatment?
4. Given the outcome will be beneficial, at what point is it deemed financially excessive?

Participatory Action Model (PAR)

Benefits

1. Reinforces autonomy and beneficence.
2. Tate & Pledger state, “Research and the knowledge and products generated from research bear little importance if they do not involve and benefit or have meaning for consumers.”
3. Allows consumers to be partners rather than participants.
4. Allows consumer to experience empowerment, mastery and social acceptance.

Example of Success

Examined impact of person centered information on consumer satisfaction. Spent 29 days in intensive care before admission to TBI unit.

Results

1. Consumers given personal information exhibited greater effort in physical therapy.
2. Made more improvements in functional independence.
3. Were more satisfied with the rehabilitative treatment.
4. Concluded cognitively impaired individuals can benefit from treatment designed to enhance their sense of control and personal involvement.
5. Medical model vs. Socioecological model of research.

Summary

1. Have talked about autonomy
2. Looked at capacity and considerations in assessing
3. Proposed questions related to beneficence
4. Considered family involvement
5. Examined research, outcomes and potential bias
6. Pushed ourselves to think.
Questions?

Thank You!

Suggested Readings


Suggested Readings


Suggested Readings


Suggested Readings

- Photos and back grounds are from http://www.freedigitalphotos.net/