CONCEPTUAL APPROACHES TO SAFETY; AUTONOMY OF RISK-TAKING AND MODELS OF HARM REDUCTION

PRESENTED BY ALEXIS CHETTIAR, RN, MSN, ACNP-BC, PH.D.
AGENDA

- Conceptual models of Safety and Risk
- Safety versus Harm Reduction
- Autonomy and self-determination
- Competence and capacity
- Roles and responsibilities of the IDT
- Ethical dilemmas and the IDT
- Case studies
- Resources for supporting IDTs through challenging cases
CONCEPTUAL MODELS OF SAFETY AND RISK
DEFINING SAFETY

- Binary
  - Safe versus unsafe
DEFINING RISK LEVEL

- Graduated Level of safety
  - Risk continuum
ASSESSMENT OF SAFETY AND RISK

- **Source of threats to safety**
  - Intrinsic factors
  - Extrinsic factors
  - Mutable
  - Immutable
SAFETY VERSUS HARM REDUCTION
PRACTICING RISK REDUCTION

Risk reduction; also known as harm reduction

Well-established approach in substance use disorder

Assess intrinsic and extrinsic factors that impact safety and risk
SORTING RISK FACTORS

• Intervene to reduce mutable risks
• Reduce cumulative level of risk
  • move the needle on the risk continuum

Quantify and classify risk

Mutable intrinsic factors

Immutable factors

Mutable extrinsic factors
IDT Interventions; Moving the Needle on the Risk Continuum

Deconditioning
Orthostatic hypotension
Non-adaptive home environment
Lack of caregiver support

Improved conditioning
Stable BP
Grab bars, toilet riser
Increased home care hours
HARM REDUCTION

through IDT interventions

Reduce risk to improve safety
AUTONOMY AND SELF-DETERMINATION
PATIENT SELF DETERMINATION ACT

- Federal law
- Legal framework for patient right to self-determination related to healthcare
- The PSDA does not create new rights for patients but reaffirms the common-law right of self-determination as guaranteed by the Fourteenth Amendment.
- The purpose of this act to ensure that a patient's right to self-determination in health care decisions be communicated and protected
- PSDA obligates healthcare providers and health system to ascertain preferences for care and deliver care according to expressed preferences
AUTONOMY OF RISK-TAKING

PARTICIPANT-CENTERED CARE

CONFERS APPROPRIATE STATUS FOR ADULT DECISION-MAKERS
ASSESSING DECISION-MAKING CAPACITY
CORE PRINCIPLES

Autonomy
• self-directing freedom; especially moral independence

Beneficence
• the quality or state of doing or producing good
FRAMEWORK FOR ASSESSING AUTONOMY AND BENEFICENCE

MEDICAL INDICATIONS
The Principles of Beneficence and Nonmaleficence
1. What is the patient's medical problem? Is the problem acute?
2. What are the goals of treatment?
3. In what circumstances are medical treatments not indicated?
4. What are the probabilities of success of various treatment options?
5. In sum, how can this patient be benefitted by medical and nursing care, and how can harm be avoided?

PATIENT PREFERENCES
The Principle of Respect for Autonomy
1. Has the patient been informed of benefits and risks, understood this information, and given consent?
2. Is the patient mentally capable and legally competent, and is there evidence of incapacity?
3. If mentally capable, what preferences about treatment is the patient stating?
4. If incapacitated, has the patient expressed prior preferences?
5. Who is the appropriate surrogate to make decisions for the incapacitated patient?
6. Is the patient unwilling or unable to cooperate with medical treatment? If so, why?

QUALITY OF LIFE
The Principles of Beneficence, Nonmaleficence, and Respect for Autonomy
1. What are the prospects, with or without treatment, for a return to normal life, and what physical, mental, and social deficits might the patient experience even if treatment succeeds?
2. On what grounds can anyone judge that some quality of life would be undesirable for a patient who cannot make or express such a judgment?
3. Are there biases that might prejudice the provider's evaluation of the patient's quality of life?
4. What ethical issues arise concerning improving or enhancing a patient's quality of life?
5. Do quality-of-life assessments raise any questions regarding changes in treatment plans, such as forgoing life-sustaining treatment?
6. What are plans and rationale to forgo life-sustaining treatment?
7. What is the legal and ethical status of suicide?

CONTEXTUAL FEATURES
The Principles of Justice and Fairness
1. Are there professional, interprofessional, or business interests that might create conflicts of interest in the clinical treatment of patients?
2. Are there parties other than clinicians and patients, such as family members, who have an interest in clinical decisions?
3. What are the limits imposed on patient confidentiality by the legitimate interests of third parties?
4. Are there financial factors that create conflicts of interest in clinical decisions?
5. Are there problems of allocation of scarce health resources that might affect clinical decisions?
6. Are there religious issues that might affect clinical decisions?
7. What are the legal issues that might affect clinical decisions?
8. Are there considerations of clinical research and education that might affect clinical decisions?
9. Are there issues of public health and safety that affect clinical decisions?
10. Are there conflicts of interest within institutions or organizations (e.g., hospitals) that may affect clinical decisions and patient welfare?
COMPETENCE VERSUS CAPACITY

- **Capacity and competence**
  - Often are used interchangeably

- **Capacity**
  - Refers to the ability to perform a specific task
  - Determined clinically

- **Competence**
  - The legally defined standard for performing a specific task such as making a will.
  - Legally determined
ASSESSING CAPABILITY

- Fundamental to the ethical principle of respect for autonomy
- Key component of informed consent to medical treatment
- Determining whether an individual has adequate capacity to make decisions is an inherent aspect of all clinician-patient interactions.
- The main determinant of capacity is cognition
  - Impaired cognition may be
    - Transient
    - Chronic
    - Degenerative
    - Relapsing and remitting in nature
- Determining whether a patient has adequate capacity is central to striking the proper balance between respecting patient autonomy and acting in a patient’s best interest (beneficence).
- Critical for PACE teams to incorporate an assessment of capacity into clinical judgments about the ability of patients to choose their treatment.
ROLES AND RESPONSIBILITIES OF THE IDT IN MANAGING SAFETY AND RISK
LEGAL AND PROFESSIONAL OBLIGATIONS OF THE IDT

Legal liability

Under what circumstances could licensure be at risk
- PACE personnel or program
- Participant competence/capacity
- Role of advance care planning

Separating personal values from professional judgement

Particularly challenging (and important!) in PACE
ETHICAL DILEMMAS AND THE IDT
SOURCES OF ETHICAL CONFLICT

**Personal**
- Moral, religious or values differences between participant and care team

**Professional**
- Difference between opinion of care team and preference of participant

**Practice**
- Different decision-making priorities and methods can result in ethical conflict
What are the ethical obligations of members of the interdisciplinary team in patient care?

Ethically, every member of the team has separate obligations, or duties, toward patients, which are based on the provider’s profession, scope of practice and individual skills. **Team members also have ethical obligations to treat each other in a respectful and professional manner.**

Relationships between professionals on the interdisciplinary team are by their nature unequal ones. Different knowledge and experience in specific issues both ethically and legally imparts unequal responsibility and authority to those care providers with the most knowledge and experience to handle them. But also because of differences in training and experience, each member of the team brings different strengths. **Team members need to work together in order to best utilize the expertise and insights of each member.**
IDT INTERACTIONS WHEN FACING ETHICAL DILEMMAS

- **What is meant by "respectful" exchange of views?**
- Precisely because of the inequality of authority and responsibility in inter-professional, inter-physician, and student-teacher relationships, obligations of mutual respect are particularly important on the multidisciplinary team.

- **Disagreements between professionals are common and expected**, because of different knowledge, experience, values, and perspectives of the various team members. While disagreements might be settled in a number of ways, mutual respectful behavior is a mandatory feature of professionalism. Thus, while it is not only possible, but expected, that members of the patient care team will disagree at times, **it is never acceptable for disagreements to be verbalized in an unprofessional manner.**

- Respectful behavior begins with both listening to and considering the input of other professionals. **Ask yourself whether your perception of whether you are respected depends more upon whether the other party agrees with you, or whether, despite disagreeing, they listened and acknowledged your point of view.**

- Respect is demonstrated through language, gestures, and actions. **Disagreement can and should be voiced without detrimental statements about other members of the team, and without gestures or words that impart disdain.** Both actions and language should impart the message: "I acknowledge and respect your perspective in this matter, but for the following reasons. I disagree with your conclusions, and believe I should do something else..."
CASE STUDIES
RESOURCES FOR SUPPORTING IDTS THROUGH CHALLENGING CASES

Bioethicist
Published materials;
https://depts.washington.edu/bhdept/ethics-medicine/bioethics-resources

Online resources
https://depts.washington.edu/bhdept/ethics-medicine

Up to Date, reference guides on:
- Assessing competence
- Medical decision-making in the presence of impaired competence
- Medical ethics
- Advance care planning