

Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care

This joint statement was developed cooperatively and approved by the Boards of Directors of the Canadian Healthcare Association, the Canadian Medical Association, the Canadian Nurses Association and the Catholic Health Association of Canada.

Preamble

The needs, values and preferences of the person receiving care should be the primary consideration in the provision of quality health care. Ideally, health care decisions will reflect agreement between the person receiving care and all others involved in his or her care. However, uncertainty and diverse viewpoints sometimes can give rise to disagreement about the goals of care or the means of achieving those goals. Limited health care resources and the constraints of existing organizational policies may also make it difficult to satisfy the person's needs, values and preferences.

The issues addressed in this statement are both complex and controversial. They are ethical issues in that they involve value preferences and arise where people of good will are uncertain of or disagree about the right thing to do when someone's life, health or well-being is threatened by disease or illness. Because everyone's needs, values and preferences are different, and because disagreements can arise from many sources, policies for preventing and resolving conflicts should be flexible enough to accommodate a wide range of situations.

Disagreements about health care decisions can arise between or among any of the following: the person receiving care, proxies,¹ family members, care providers and administrators of health care authorities, facilities or agencies. This joint statement deals primarily with conflicts between the person receiving care, or his or her proxy, and care providers. It offers guidance for the development of policies for preventing and resolving ethical conflicts about the appropriateness of initiating, continuing, withholding or withdrawing care or treatment. It outlines the

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basic principles to be taken into account in the development of such policies as well as the steps that should be followed in resolving conflicts. The sponsors of this statement encourage health care authorities, facilities and agencies to develop policies to deal with these and other types of conflict, for example, those that sometimes arise among care providers.

Principles of the Therapeutic Relationship²

Good therapeutic relationships are centered on the needs and informed choices of the person receiving care. Such relationships are based on respect and mutual giving and receiving. Observance of the following principles will promote good therapeutic relationships and help to prevent conflicts about the goals and means of care.

The needs, values and preferences of the person receiving care should be the primary consideration in the provision of quality health care.

2. A good therapeutic relationship is founded on mutual trust and respect between providers and recipients of care. When care providers lose this sense of mutuality, they become mere experts and the human quality in the relationship is lost. When persons receiving care lose this sense of mutuality, they experience a perceived or real loss of control and increased vulnerability. Because persons receiving care are often weakened by their illness and may feel powerless in the health care environment, the primary responsibility for creating a trusting and respectful relationship rests with the care providers.
3. Sensitivity to and understanding of the personal needs and preferences of persons receiving care, their family members and significant others is the cornerstone of a good therapeutic relationship. These needs and preferences are diverse and can be influenced by a range of factors including cultural, religious and socioeconomic backgrounds.
4. Open communication, within the confines of privacy and confidentiality, is also required. All those involved in decision-making should be encouraged to express their points of view, and these views should be respectfully considered. Care providers should ensure that they understand the needs, values and preferences of the person receiving care. To avoid misunderstanding or confusion, they should make their communications direct, clear and consistent. They should verify that the person receiving care understands the information being conveyed: silence should not be assumed to indicate agreement. The person receiving care should be provided with the necessary support, time and opportunity to participate fully in discussions regarding care.
5. The competent person³ must be involved in decisions regarding his or her care.
6. The primary goal of care is to provide benefit to the person receiving care. The competent person has the right to determine what constitutes benefit in the given situation, whether with respect to physical, psychological, spiritual, social or other considerations.
7. Informed decision-making requires that the person receiving care or his or her proxy be given all information and support necessary for assessing the available options for care, including the potential benefits and risks of the proposed course of action and of the alternatives, including palliative care.
8. The competent person has the right to refuse, or withdraw consent to, any care or treatment, including life-saving or life-sustaining treatment.
9. Although parents or guardians are normally the primary decision-makers for their minor children, children should be involved in the decision-making process to the extent that their capacity allows, in accordance with provincial or territorial legislation.
10. When the person receiving care is incompetent, that is, lacking in adequate decision-making capacity with respect to care and treatment, every effort must be made to ensure that health care decisions are consistent with his or her known preferences. These

preferences may be found in an advance directive or may have been communicated orally. In jurisdictions where the issue of decision-making concerning care and medical treatment for incompetent persons is specifically addressed in law, the requirements of that legislation should be met.

1. When an incompetent person's preferences are not known and there is no family member or proxy to represent the person, decisions must be based on an attempt to ascertain the person's best interests, taking into account:
 - (a) the person's diagnosis, prognosis and treatment options,
 - (b) the person's known needs and values,
 - (c) information received from those who are significant in the person's life and who could help in determining his or her best interests, and
 - (d) aspects of the person's culture, religion or spirituality that could influence care and treatment decisions.
12. When conflicts arise despite efforts to prevent them, they should be resolved as informally as possible, moving to more formal procedures only when informal measures have been unsuccessful.
3. In cases of disagreement or conflict, the opinions of all those directly involved should be given respectful consideration.
4. Disagreements among health care providers about the goals of care and treatment or the means of achieving those goals should be clarified and resolved by the members of the health care team so as not to compromise their relationship with the person receiving care. Disagreements between health care providers and administrators with regard to the allocation of resources should be resolved within the facility or agency and not be debated in the presence of the person receiving care. Health care authorities, facilities and agencies should develop conflict resolution policies for dealing with such issues and monitor their use.
15. When the needs, values and preferences of the

person receiving care cannot be met, he or she should be clearly and frankly informed of the reasons for this, including any factors related to resource limitations.

16. Health care providers should not be expected or required to participate in procedures that are contrary to their professional judgement⁴ or personal moral values or that are contrary to the values or mission of their facility or agency.⁵ Health care providers should declare in advance their inability to participate in procedures that are contrary to their professional or moral values. Health care providers should not be subject to discrimination or reprisal for acting on their beliefs. The exercise of this provision should never put the person receiving care at risk of harm or abandonment.
17. Health care providers have a responsibility to advocate together with those for whom they are caring in order that these persons will have access to appropriate treatment.

II. Guidelines for the Resolution of Ethical Conflicts

Health care organizations should have a conflict resolution process in place to address problems that arise despite efforts to prevent them. There may be need for variations in the process to accommodate the needs of different settings (e.g., emergency departments, intensive care units, palliative care services, home or community care, etc.).

The conflict resolution policy of a health care authority, facility or agency should incorporate the following elements, the sequence of which may vary depending on the situation. The policy should designate the person responsible for implementing each element. That person should work closely with the person receiving care or his or her proxy. Anyone involved in the conflict may initiate the resolution process.

Clarify the need for an immediate decision versus the consequences of delaying a decision. If, in an emergency situation, there is

insufficient time to fully implement the process, it should be implemented as soon as possible.

2. Gather together those directly involved in the conflict; in addition to the person receiving care and/or his or her proxy, this might include various health care providers, family members, administrators, etc.
3. If necessary, choose a person not party to the conflict to facilitate discussions. It is imperative that this person be acceptable to all those involved and have the skills to facilitate open discussion and decision-making.
4. Identify and agree on the points of agreement and disagreement. While ensuring confidentiality, share among those involved all relevant medical and personal information, interpretations of the relevant facts, institutional or agency policies, professional norms and laws.
5. Establish the roles and responsibilities of each participant in the conflict.
6. Offer the person receiving care, or his or her proxy, access to institutional, agency or community resources for support in the conflict resolution process, e.g., a patient representative, chaplain or other resource person.
7. Determine if the group needs outside advice or consultation, e.g., a second opinion, use of an ethics committee or consultant or other resource.
8. Identify and explore all options and determine a time line for resolving the conflict. Ensure that all participants have the opportunity to express their views; the lack of expressed disagreement does not necessarily mean that decision-making is proceeding with the support or consent of all involved.
9. If, after reasonable effort, agreement or compromise cannot be reached through dialogue, accept the decision of the person with the right or responsibility for making the decision. If it is unclear or disputed who has the right or responsibility to make the decision, seek mediation, arbitration or adjudication.
10. If the person receiving care or his or her

proxy is dissatisfied with the decision, and another care provider, facility or agency is prepared to accommodate the person's needs and preferences, provide the opportunity for transfer.

11. If a health care provider cannot support the decision that prevails as a matter of professional judgement or personal morality, allow him or her to withdraw without reprisal from participation in carrying out the decision, after ensuring that the person receiving care is not at risk of harm or abandonment.
12. Once the process is completed; review and evaluate: (a) the process, (b) the decision reached, and (c) implementation of the decision. The conclusions of the evaluation should be recorded and shared for purposes of education and policy development.

III. Policy Development

Health care authorities, facilities and agencies are encouraged to make use of an interdisciplinary committee to develop two conflict resolution policies: one for conflicts among health care providers (including administrators) and the other for conflicts between care providers and persons receiving care. Membership on the committee should include care providers, consumers and administrators, with access to legal and ethics consultation. The committee should also develop a program for policy implementation.

The successful implementation of the policy will require an organizational culture that encourages and supports the principles of the therapeutic relationship as outlined in this joint statement. The implementation program should include the education of all those who will be affected by the policy with regard to both the principles of the therapeutic relationship and the details of the conflict resolution policy. It should also include measures to ensure that persons receiving care and their families or proxy decision-makers have access to the policy and its use. The policy should be reviewed regularly and revised when necessary in light of relevant clinical, ethical and legal developments.

Because policies and guidelines cannot cover all possible situations, appropriate consultation mechanisms should be available to address specific issues promptly as they arise.

Notes

The term ‘proxy’ is used broadly in this joint statement to identify those people who are entitled to make a care and treatment decision for an incompetent person (in some provinces or territories, the definition of proxy is provided in legislation). This decision should be based on the decision the person would have made for himself or herself, to the best of the proxy’s (substitute decision maker’s) knowledge; or if this is unknown, the decision should be made in the person’s best interest.

2. The term ‘therapeutic relationship’ is used broadly in this document to include all professional interactions between care providers, individually or as a team, and recipients of care.
3. Competence can be difficult to assess because it is not always a constant state. A person may be competent to make decisions regarding some aspects of life but not others; as well, competence can be intermittent: a person may be lucid and oriented at certain times of the day and not at others. The legal definition and assessment of competence are governed by the provinces or territories. Health care providers should be aware of existing laws relevant to the assessment and documentation of incompetence (e.g., capacity to consent and age-of-consent legislation).
4. Professional judgement will take into account the standard of care that a facility or agency is committed to provide.
5. On this matter, cf. Guiding Principle 6 of the *Joint Statement on Resuscitative Interventions (Update 1995)*, developed by the Canadian Healthcare Association, the Canadian Medical Association, the Canadian Nurses Association and the Catholic Health Association of Canada, “There is no

obligation to offer a person futile or nonbeneficial treatment. Futile and nonbeneficial treatments are controversial concepts when applied to CPR (cardiopulmonary resuscitation). Policymakers should determine how these concepts should be interpreted in the policy on resuscitation, in light of the facility’s mission, the values of the community it serves, and ethical and legal developments. For the purposes of this joint document and in the context of resuscitation, “futile” and “nonbeneficial” are understood as follows. In some situations a physician can determine that a treatment is “medically” futile or nonbeneficial because it offers no reasonable hope of recovery or improvement or because the person is permanently unable to experience any benefit. In other cases the utility and benefit of a treatment can only be determined with reference to the person’s subjective judgement about his or her overall well-being. As a general rule a person should be involved in determining futility in his or her case. In exceptional circumstances such discussions may not be in the person’s best interests. If the person is incompetent the principles for decision making for incompetent people should be applied.”