DEPARTMENT: Medical Services Division		**POLICY NUMBER:** DPOTMH-MPP-BIOETHICS-P002-(01)	
TITLE/DESCRIPTION: **ETHICS CONSULTATION**			
EFFECTIVE DATE: July 15, 2024	**REVISION DUE:** July 14, 2027	**REPLACES NUMBER:** DPOTMH-C-102-P02	**NO. OF PAGES:** 1 of 7
APPLIES TO: All Physicians, Nurses, Psychiatrists, Psychologist, Social Workers, Medical Technologists, Pharmacist, Patient Representative and other Healthcare Professionals		**POLICY TYPE:** Multi Disciplinary	

PURPOSE:

1. This policy will serve as a guide in recognizing complex ethical concerns that often arise in the health care environment, whether in the care of individual patients or in matters affecting patient care in general.
2. To clarify ethical issues and values, facilitating discussion, and providing expertise and educational resources, ethics consultants promote respect for the values, needs, and interests of all participants, especially when there is disagreement or uncertainty about treatment decisions.

DEFINITIONS:

Palliative Care- Total active care of patients whose disease is not responsive to curative treatment to achieve the best quality of life until they die. It includes the control of pain and other symptoms, psychological, social and spiritual support for the patient and the family.

Euthanasia or Mercy killing - is the deliberate and painless acceleration of death of a person usually suffering from an incurable and distressing disease. This is not sanctioned in our hospital and not legally approved in the Philippines.

Dysthanasia - is the attempt to extend the life of a person who is dying by the use of extraordinary mean like volume respirators, repeated cardiac stimulation or repeated or continuous dialysis, continuous administrations of drugs to sustain blood pressure. These measures are usually done in emergency cases until the attending physician has fully evaluated the patient's condition and makes decisions to continue or discontinue these treatment after a thorough discussion with the family.

RESPONSIBILITY:

All Physicians, Nurses, Psychiatrists, Psychologist, Social Workers, Medical Technologists, Pharmacist, Patient Representative and other Healthcare Professionals

POLICY:

REASONS FOR MEDICAL ETHICS CONSULTATION

1. This is usually requested when problems arise, when there is uncertainty or conflict, when no intervention is clearly preferable.
2. When there are conflicts about the value of an intervention or when communication breaks down.
3. When there are questions of moral, legal or economic justifications.
4. When it is simply unclear on whom to ask for advise.

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5. Most of the issues are concerning End of life care, allowing natural death, prolonged illness, palliative care but may also involve newborn care especially in severely premature babies, those with congenital anomalies and maternal fetal conflicts.

GUIDELINES FOR ETHICS CONSULTATION

1. Any patient or legal guardian should be able to initiate an ethics consultation.
2. The patient or parent or legal guardian should be able to refuse to participate in an ethics consultation.
3. The refusal of a patient or parent or guardian to permit an ethics review should not obstruct the ability of an ethics committee to provide consultation services to physicians, nurses and other concerned staff.
4. Any physician, nurse or other healthcare worker patient care should be able to request an ethics consultation without fear of reprisal.
5. The process of consultation should be open to all persons involved in the care of the patient yet conducted in a manner that respects patient and family confidentiality.
6. Anonymous request for consultation should not be accepted in the absence of unidentifiable person who is willing to talk about the issue being raised.
7. The Primary Care Physician should be invited to participate in the consultation to support existing physician-family relationship.
8. A formal letter is usually written by the person requesting ethics consultation addressed to the Medical Director outlining the reason for the consult which is then presented to the BioEthics Committee (BEC).
9. Usually about 2 members of the BEC will evaluate the case and go over management and guided by Clinical Practice Guidelines to make an assessment. The members should also discuss problems, expectations, wishes with the patient or his relatives/representatives. The case is presented to the committee after which recommendations are made and presented to the attending physician.
10. The recommendations from the BioEthics Committee are only advisory in nature with all parties to a disagreement taking full responsibility for their actions.
11. All consideration should be documented in the committee records and in most cases a brief but complete summary should be included in the Patient's Medical Records.

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MEMBER OF ETHICS COMMITTEE

1. Doctors Chairperson of different Departments or Training Officer.
2. Nursing Supervisor or her representative.
3. Clinical Psychologist/Psychiatrist.
4. Social Worker
5. Religious Leader
6. Corporate Communications Manager
7. Corporate Lawyer

*Advisory members may also be invited to contribute to the solution of a specific problem.

STEPS OF IMPLEMENTATION

The Four Topics Method developed by Dr. Albert Jonsen et al is a practical approach to analyze and resolve ethical problems and make recommendations and is now used universally to aid in decisions for these often very complex problems. (CLINICAL ETHICS-9th Edition, 2020)

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FOUR TOPICS OF METHOD

The Four Topics Chart

Medical Indications	**Preferences of Patients**
The Principles of Beneficence and Non maleficence 1. What is the patient's medical problem? Is the problem acute? Chronic? Critical? Reversible? Emergent? Terminal? 2. What are the goals of treatment? 3. In what circumstances are medical treatment not indicated? 4. What are the probabilities of success of various treatment option? 5. In sum, how can this patient be benefited by medical and nursing care, how can harm be avoided?	The principle of Respect for Autonomy 1. Has the patient been informed of the benefits and risks of diagnostic and treatment recommendations, understood this information, and given consent? 2. Is the patient mentally capable and legally competent or 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 an incapacitated patient? What standards should govern the surrogate's decisions? 6. Is the patient unwilling or unable to cooperate with medical treatment? If so, why?
Quality of Life	**Contextual Features**
The Principles of Beneficence and Non maleficence 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?	The Principles of Justice and Fairness 1. Are there professional, interprofessional, or business interests that might create conflicts of interest in the clinical treatment patients? 2. Are there parties other than clinician and patient, such as family members, who have

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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 if 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 assessment raise any questions that might contribute to a change of treatment plan, such as forgoing life-sustaining treatment?
6. Are there plans to provide pain relief and provide comfort after a decision has been made to forgo life-sustaining interventions?
7. Is medically assisted dying ethically or legally permissible?
8. What is the legal and ethical status of suicide?

a legitimate interests 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 resources that affect clinical decisions?
6. Are there religious factors that might influence clinical decisions?
7. What are the legal issues that might affect clinical decisions?
8. Are there considerations of clinical research and medical education that affect clinical decision?
9. Are there considerations of public health and safety that influence clinical decisions?
10. Does institutional affiliation create conflicts of interest that might influence clinical decisions?

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PROCEDURE (SOP): N/A
WORK INSTRUCTION: N/A
WORK FLOW: N/A
FORMS: N/A
EQUIPMENT: N/A
REFERENCES: N/A

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DR. PABLO O. TORRE MEMORIAL HOSPITAL

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APPROVAL:				
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