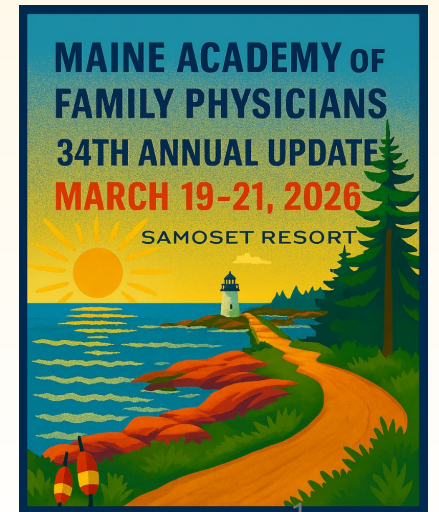


# Medical Ethical Decision-Making in the Primary Care Setting

Navigating Autonomy, Beneficence, & Moral  
Distress in Everyday Clinical Practice

Jims D. Jean-Jacques, DO, FACC, FHFSFA  
Chair Ethics Committee

Director Heart Failure - Chief of Medicine  
St. Joseph Cardiology - St Joseph Healthcare



# Why This Topic Matters

- Primary Care is where most ethical dilemmas first appear.
  - Pts refusing life-saving care.
  - Family conflict about treatment.
  - Non-adherence.
  - Confidentiality dilemmas.
  - Limited time & resources
  - Medical error disclosure
- **Key Message:**
  - Ethical dilemmas are rarely theoretical
  - They occur in exam rooms every day.

# Session Objectives

1. Identify & Apply Ethical Principles in Clinical Decisions
2. Analyze Common Ethical Dilemmas in Primary Care
3. Communicate Ethically Sensitive information w/  
Cultural Awareness
4. Use Practical Decision Tools in Real Clinical Scenarios

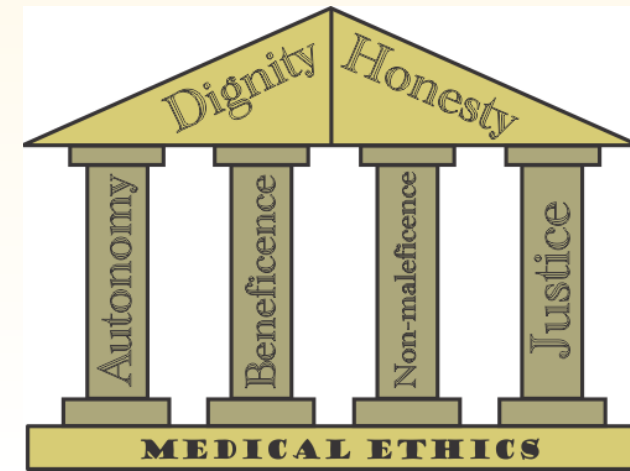
# Ethical Foundations

## Autonomy

- Respecting pt's decision-making & self-determination.
- Pt's right to make informed decisions about their own healthcare.
  - Based values, beliefs, & preferences.
- Respecting pt as a moral agent capable of directing their own life.

- **Key Components:**

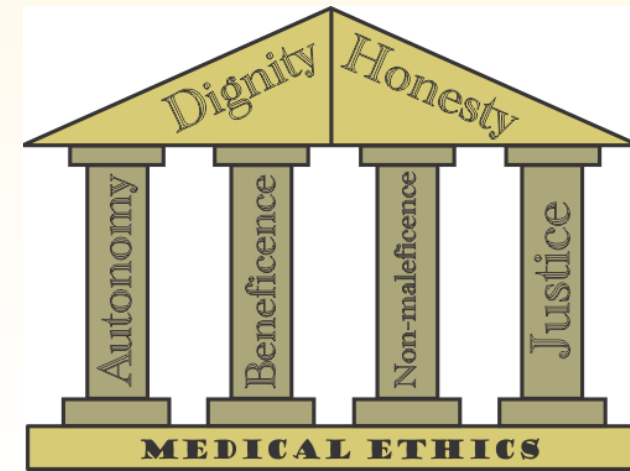
- Informed Consent
- Decision-Making Capacity
- Respect for refusal of treatment
- Shared Decision-Making



# Ethical Foundations

## Autonomy

- **Important Clarification**
  - Autonomy is not absolute.
- Limitations occur when:
  - Lacks decision-making capacity
  - Poses harm to others
  - Public health risks are involved



# Ethical Foundations

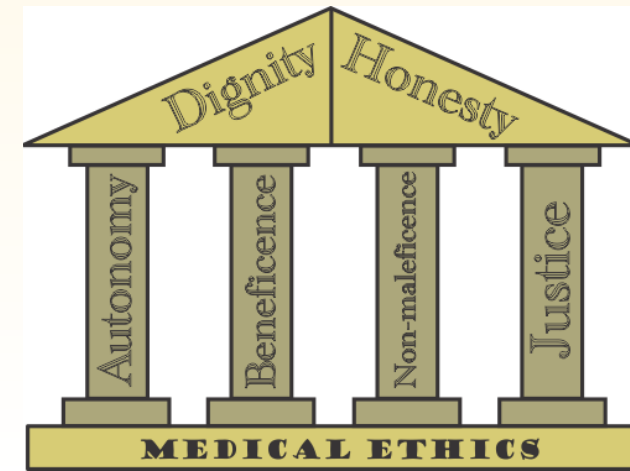
## Autonomy

- **Case Scenario**

- Pt w/ severe 3V CAD (s/p stents) refuses GDMT despite clear evidence of benefit.
- Provider believe treatment is strongly indicated (class I, beneficence)
  - but ethically must respect the pt's informed decision (autonomy).

- **Autonomy** frequently conflicts w/ **beneficence**.

- Vaccine refusal
- Non-adherence to GDMT
- Refusal of cancer screening
- Refusal of life-saving treatment



# Ethical Foundations

## Beneficence

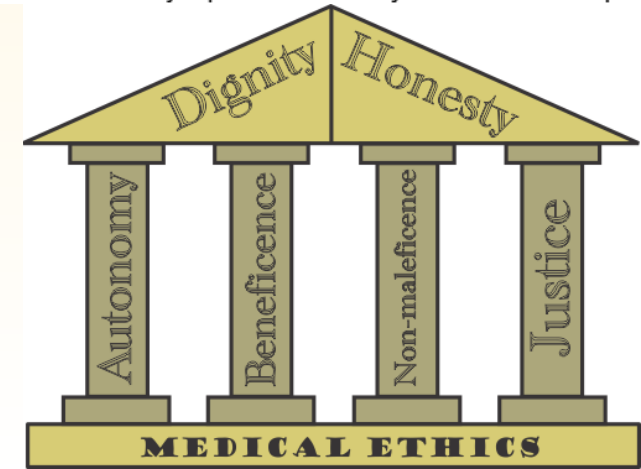
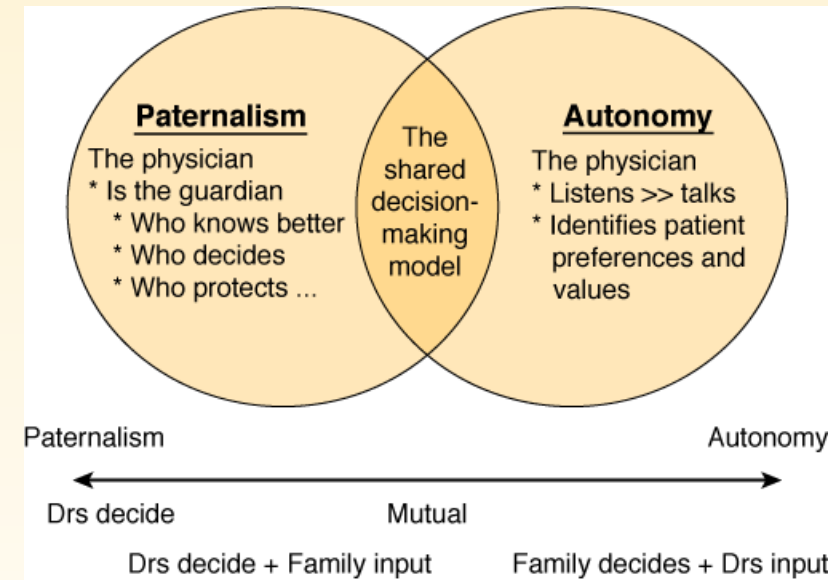
- Acting in pt's best interest.
  - Obligation to act for benefit & promote welfare.
  - Traditional moral commitment to heal & help.
- **Key elements**
  - Prevent & Remove Harm
  - Promote Good
  - Balance Risks & Benefits.



# Ethical Foundations

## Beneficence

- **Practice through:**
  - Preventive medicine
  - Vaccination
  - Chronic disease management
  - Early diagnosis
  - Lifestyle counseling
- However:
  - Must always be balanced with autonomy.
- **Historically:**
  - Paternalism (“doctor knows best”) vs Shared Decision-Making.



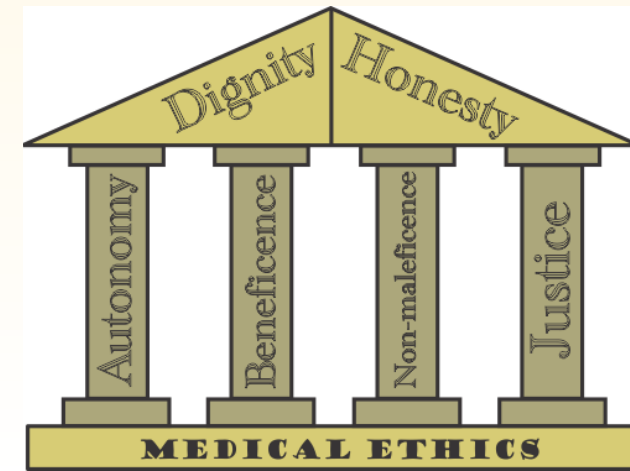
# Ethical Foundations

## Non-Maleficence - “First, Do No Harm”

- “*Primum non nocere*”
  - While beneficence encourages doing good
- Non-maleficence requires avoiding harm (*class III*).

### • Clinical Application

- Avoiding unnecessary tests
- Avoiding overtreatment
- Preventing medication side effects
- Avoiding futile or burdensome interventions



# Ethical Foundations

## Non-Maleficence - “First, Do No Harm”

- **Example**

- Frail elderly pt w/ limited life expectancy may not benefit from aggressive cancer screening.
- Ordering tests that lead to invasive procedures may violate non-maleficence.

- Non-maleficence also applies to:

- Polypharmacy
- Overdiagnosis
- Overtesting
- Procedural risk

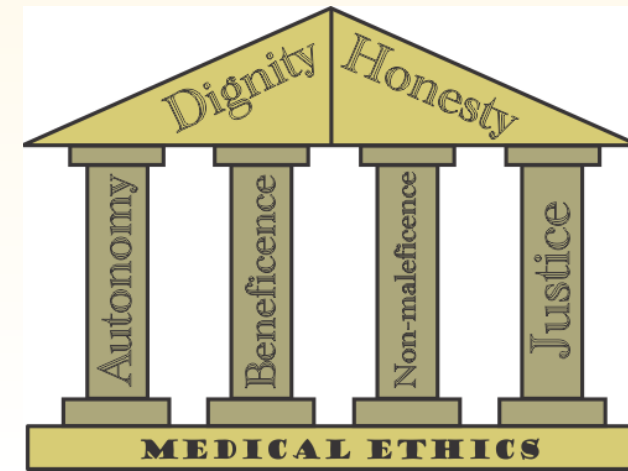
- **Must constantly balance benefit vs harm.**



# Ethical Foundations

## Justice - Fairness

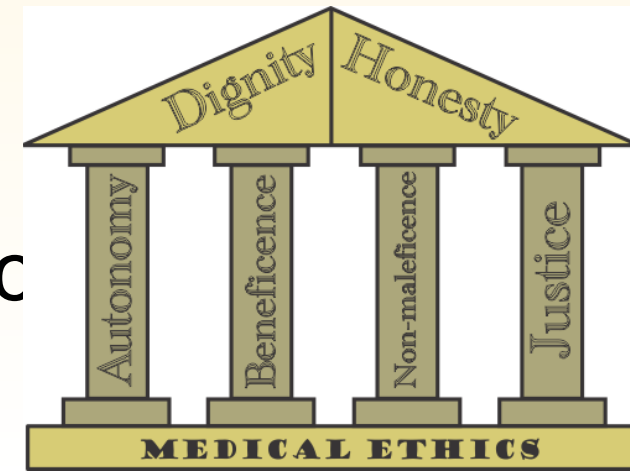
- Fair & Equitable distribution of healthcare resources.
- Addresses questions such as:
  - Who receives limited resources?
  - How should care be allocated fairly?
  - Healthcare disparities?



# Ethical Foundations

## Justice - Fairness

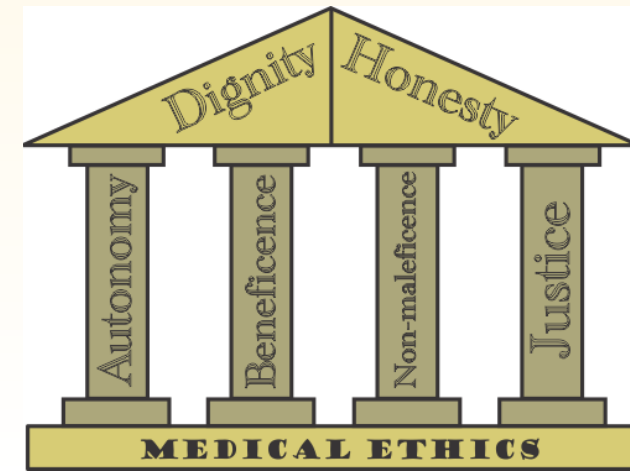
- Primary Care Justice Challenges
- Healthcare systemic justice dilemmas:
  - Rural access limitations
  - Insurance restrictions
  - Medication cost barriers
  - Limited mental health resources
- Primary providers must advocate for equitable care
  - working w/n imperfect systems.



# Ethical Foundations

## Justice - Fairness

- **Examples in Clinical Practice**
  - Justice applies when deciding:
    - Referral prioritization
    - Allocation of limited specialist access
    - Distribution of vaccines during shortages
    - Insurance-driven treatment limitations



# Ethical Foundations

## Additional Ethical Duties

- **Veracity**

- Truth telling

- **Fidelity**

- Maintaining trust

- **Confidentiality**

- Protecting privacy

- **Informed consent**

- Meaningful understanding

- **Utility**

- Maximizing benefit for populations
  - Balancing individual & population ethics.

# Why Ethical Dilemmas Occur

When principles conflict.

- ***Autonomy vs Beneficence:***
  - Pt refuses recommended treatment
- ***Beneficence vs Non-maleficence:***
  - Treatment may help but carries significant risk

# Why Ethical Dilemmas Occur

**When principles conflict.**

- ***Justice vs Beneficence:***
  - Expensive treatment with limited benefit
- ***Autonomy vs Justice:***
  - Individual preference vs fair resource allocation.

# Practical Ethical Decision Tool

## 5-Step Model

- “What do I do in the room right now?”
- Useful approach:
  - Move from ethical confusion → structured reasoning.
    1. **Clarify** (*What are the medical facts?*)
    2. **Assess** (*Does pt have decision-making capacity?*)
    3. **Identify** (*Which ethical principles are in conflict?*)
    4. **Explore** (*What are pt’s values and goals?*)
    5. Can **shared decision-making** resolve the conflict?
- **Consider Ethics Consultation**

# Case-1

## Family Demanding Non-Beneficial Treatment

- 84yo pt w/ advanced dementia, recurrent aspiration pneumonia, & severe frailty.
- Family insists “*Do everything possible, she’s a fighter.*”
- CPR survival extremely unlikely, invasive care may increase suffering
- What should to do?

# Case-1

- **Ethical Conflict**
  - Autonomy:
    - whose autonomy? (pt vs. family)
  - Beneficence:
    - avoid non-beneficial treatment
  - Non-maleficence:
    - avoid causing suffering
  - Justice:
    - use of medical resources
- **Key concept:**
  - Medical futility vs family expectations

# Case-1

- **Communication Approach with Effective phrasing:**
  - Instead of:
    - *“CPR would be futile.”*
  - Try:
    - *“Our goal is to provide care that helps rather than harms. In her condition, CPR would likely cause suffering without meaningful recovery.”*
- **Key communication elements:**
  - Empathy
  - Shared goals
  - Values clarification

# Case-2

## The Non-Adherent Pt

- 52yo w/ uncontrolled T2DM/HTN w/ repeatedly misses appointments & does not take meds (last A1c of 11.5% & recent BP 175/95).
- Provider frustration.
  - “At what point do we dismiss this pt from the practice?”

# Case-2

- **Ethical Issues**
  - Autonomy
    - Pt's right to choose
  - Beneficence
    - Provider obligation to help
  - Justice
    - Resource utilization
  - Social determinants of health may include:
    - Transportation barriers
    - Food insecurity
    - Health literacy
    - Unstable housing
- **Ethical question:**
  - Is this noncompliance or structural barriers?

# Non-compliance (Non-adherence)

Complex, variety of factors

• *rather than simple disobedience.*

➤ Cost & Financial Constraints

➤ Misunderstanding & Low Health Literacy

➤ Fear of Side Effects

# **Non-compliance (Non-adherence)**

- Lack of Symptoms (Asymptomatic Condition)
- Complex or Excessive Treatment Plans
- Psychological & Denial
- Forgetfulness

# Non-compliance (Non-adherence)

- Mistrust in Healthcare System
- Cultural & Religious Beliefs
- Substance Abuse
- Logistical Barriers

# Non-compliance (or non-adherence)

- Key Factors for Addressing Non-Adherence:
  - Improve Patient-Provider Communication:
    - Building trust & ensuring understanding.
  - Simplify Treatment Regimens:
    - Reducing complexity of dosage schedules.
  - Identify Social Determinants:
    - Help reduce disparities in adherence.

# Case-3

## Abusive Pt in Clinic

- Pt repeatedly yells at staff & threatens providers.
- Staff feel unsafe.
- Ethical conflict:
  - Provider duty to care vs staff safety.

# Case-3

## Ethical Response

- **Professional obligations:**
  - Maintaining pt care
  - Protecting healthcare workers
  
- **Ethically appropriate steps:**
  - Set clear boundaries
  - Behavioral contracts
  - Safety protocols
  - Possible termination of relationship
    - w/ proper transition.

# Moral Distress

- **Define:**

- *Knowing the ethically appropriate action but being unable to carry it out because of institutional, legal, or social constraints.*

- **Common Drivers:**

- time pressure
- insurance limitations
- family conflict
- unrealistic pt expectations
- fear of litigation
- resource scarcity
- administrative demands

# Moral Distress

- Provider Well-Being
- Common signs:
  - Emotional exhaustion
  - Frustration w/ system constraints
  - Moral residue after difficult cases

# Strategies to Manage Moral Distress

- **Individual strategies:**
  - Peer discussion
  - Reflective practice
  - Ethics consultation
  
- **Institutional strategies:**
  - Ethics committees
  - Interdisciplinary case review
  - Psychological support programs

# Key Insights

- Primary care providers:
  - Function as frontline medical ethicists.
- Must simultaneously navigate:
  - Clinical evidence
  - Pt values
  - Social determinants of health
  - System constraints
- Ethics is therefore not theoretical philosophy
  - But a daily clinical skill.

**Thank  
You**



# Q&A

