

# Ethics in LTC: Overview and Case Studies



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*I am grateful to live, work and play as an uninvited white settler on the unceded traditional territory of the K'omoks First Nation, the traditional keepers of this land (colonially known as the Comox Valley)*

# Disclaimer and a request

- Candid conversations – seeking to create a safe space for ethics discussion
- If you don't feel comfortable speaking up here, feel free to reach out
- Bringing ethics to those caring for and working with our patients...
- ...making ethics accessible, nimble and approachable



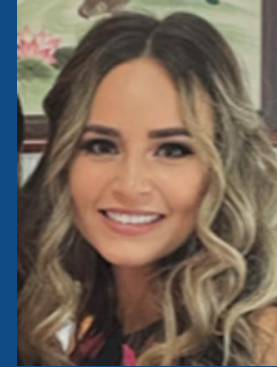
# This evening

- ✓ The 'who, what, when, where, how, and why' of Ethics at Island Health
- ✓ Two case studies offered last fall from this audience
- ✓ Questions and open discussion
- ✓ Ethics team contact information

# Island Health Ethics – Who?



Dr. Jill Boerstler, MPA, MA,  
DBioethics, HEC-C  
Ethicist and Ethics Manager  
Adjunct Professor at UBC



Jill McQuary  
Quality Coordinator,  
Accreditation & Ethics



Dr. Jeff Kerrie, BSc, MSc (Bioethics), MD, FRCPC  
Medical Director: Quality, Safety, & Ethics;  
General Internal Medicine; Clinical Ethicist;  
Clinical Assistant Professor at UBC

# What we do

Ethics is about making the best possible decision in a complicated, value-laden situation

- Unpack and explore the points of conflict/tension
- Clarify the reasons supporting or justifying a decision

We are invited to pause in our delivery of healthcare and think intentionally about a case

- What is the right or best thing to do in this situation (maybe it's the “least worst” option)
- **Can we explain and defend why we made this choice?**

# What we do

- Ethicists create a “moral space” for people to set aside their titles and power differential and think through cases or tough issues
  - Ideally a safe space where the care team can candidly share thoughts, concerns, ideas
- Identify and talk through the “ick factor”
  - Discomfort, a gut feeling, tensions
  - Sharing space with people in untenable situations



# When, Where, and Why?

- We pick apart the “knot”
- Sometimes people need help finding the words to explain what they’re feeling or experiencing
- Accreditation Canada requires an ethics function
- Anyone within Island Health can reach out to us for confidential assistance





# Ethical Resolution Process

- We listen to the facts and narratives from those involved and affected
- Unpack values in tension/ick factor
- Uncover the ethical question(s)
- Parse the ethical issues, thinking through and weighing values, ethical principles, and considerations
- Offer recommendations





# Case 1: Redemptive Suffering

- A patient in LTC who was suffering pain from a terminal illness
- He also had dementia and was unable to make medical decisions for himself
- He had a large family with multiple children, and two of them were formally designated as his representatives.
- They belonged, as did he, to a religion which did not support the use of medications to relieve suffering. They declined to allow the use of medications for pain (e.g. opioids).

# Case 1: Redemptive Suffering

- They did not want the patient to be cloudy, and it became obvious to [the physician] that they felt the patient was meant to feel the pain of suffering.
- This was very hard for physicians and staff to accept and witness
- His family came and went and were not unloving, so the physician did not feel they could ethically over-rule his medical representatives.
- This physician was not his regular doctor and the patient went back to their MRP so ending of the case is unknown.

# Ethical Resolution Process

- What facts do we know?
- What are the values or principles in tension?
- What is the ethical question(s)?
- Is it ethically permissible for the patient's family to decide he lives out his terminal illness in (preventable) pain/suffering?
- How do we weigh key values/principles at stake (deeply held religious beliefs and pain/symptom relief)?
- What recommendations emerge?



# Case Continuations...

- What if it was determined the representatives were not making decisions in accord with the patient's wishes or best interest (i.e., an advance directive was located?)
- What about therapeutic deception?
- What if this was in the ICU and the patient (or representatives) demanded “do everything” treatment to increase redemptive suffering?

# Case 2: Harm Reduction in LTC

- What about harm reduction in the elderly / LTC, specifically approaching individuals who are potentially lacking in capacity but continue to do high risk activities such as use alcohol or other substances?



# Case 2: Harm Reduction in LTC

- How to approach reducing the harms in these patients (iMAP, prescribed safer supply of substances, providing pipes, needles etc...) when they are unable to provide consent themselves?
- Perhaps these patients don't have family or friends but also do not understanding the risks of their current SUD.



# Ethical Resolution Process:

- What is the ethical question(s)?
- Is it ethically permissible to support LTC populations with harm reduction?
- What values, principles, and approaches are in tension or conflict?
- How should we proceed?



# “When patients choose to live at-risk”

- Be effective
- Be least intrusive
- Not cause greater harm than it seeks to prevent
- Be non-discriminatory
- Be fair

See Young and Everett, “When patients choose to live at risk: What is an ethical approach to intervention?”, <https://bcmj.org/articles/when-patients-choose-live-risk-what-ethical-approach-intervention>

# Case Continuations

- Would like to extend this question to sexual health.
- Increasing numbers of consults about patients engaging in “at risk” sexual health behavior; do the same ethical arguments hold?
- What if patients have dementia and do not recall or cannot consent?
- What do you do in these cases?

# Other Cases to Discuss?



# How to Contact Us



Island Health Ethics offers a free, confidential consultation service for **anyone** in Island Health

Ethics Voicemail: 1-866-995-3199

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