Mrs. Dalloway Essay, Research Paper

Principles of Ethics: Which ethical model is truly ethical?

Wayne Dyer said, “Live one day at a time emphasizing ethics rather than rules.” This quote rings true across all fields of profession, especially rehabilitation. Why must we follow a code of ethics and not just a list of rules? Ethics are a set of standards by which an individual or a particular group decides to regulate its behavior to distinguish between what is legitimate or acceptable in pursuit of their aims and what is not. As a professional it is important to follow ethics, to consider what is right and what is the correct behavior in a given situation. When merely following rules one does not necessarily consider these things. What is ethical must be a rule but a rule may not be ethical. A code of ethics are needed in the field of rehabilitation so we do not confuse “rights” with “right” and that we don’t let what we think of as our “rights” lead us to hurt others.

There are five principles that are the core of ethics. Beneficence applies to promoting the welfare of clients; nonmaleficence is to prevent harm to clients; autonomy is to respect clients’ freedom to make their own decisions; fidelity applies to keeping promises or commitments that are stated or implied; justice is treating clients fairly. Since the priority given each is determined by the situation, no principle always takes precedence over another. Rehabilitation counselors need to know these five principles in order to help them choose which ethical model to use in their client relationship. These ethical models are the paternalistic model, contractual model, educational model, and deliberative model.

The paternalistic model casts the provider in the role of decision maker. The paternalistic approach is reflected in the Hippocratic Oath where one swears to “benefit” the sick and “keep them from harm” but there is nothing in the oath about respecting their rights. Providers, such as physicians, have many good reasons to make judgments about which treatments, among the wide array of possible interventions, are most likely to benefit patients. Physicians have expert knowledge of medicine, and increasingly this knowledge includes scientific rather than anecdotal judgments pertaining to the effectiveness of treatments. However, the physician’s expertise does not automatically include knowledge of which aspects of health and illness are most significant for the particular patient. Evidence has accrued that physicians do not know their patients values, making them poor proxy decision makers for patients. As with most medical codes of ethics developed over the years, it articulates standards physicians should be guided by and virtues they should have and exercise. For instance, physicians are enjoined to “promote their patient’s well-being” but nothing is said about a patients right to define their own well-being” or participate in decisions affecting it. There are also implicit patient physician stereotypes in the paternalistic model. Patients are dependent individuals medically clueless and emotionally distraught, obliged to trust the doctor’s judgment and follow “doctor’s orders” while doctors are considered wise, benevolent, objective, and skillful. The clear and predominant ethical principles guiding this model are beneficence and nonmaleficence.

The contractual model is based on the notion of increased patient autonomy and participation through the use of informed consent. Informed consent is legally and morally accepted because competent adults ought not to be subjected to medical interventions without their informed and voluntary consent. Courts have ruled: “Physicians have a duty to satisfy the informational needs of the patient.” The patient may question treatment plans and question that the care provided is that which was agreed upon by the patient. This gives the client the ability and the option to refuse treatment. There are limitations to this model. There are difficulties affecting the application of the requirements. Who is competent to give consent? How much information do patients have to be given? When is consent voluntary and not influenced by a third party? Multiple providers who are involved in carious aspects of treatment also limit the model. There are limitations on the providers’ ability to describe every outcome, and whether patients can make informed choices early in the rehabilitation when they cannot understand the risks and benefits of choices.

The educational model starts off by emphasizing beneficence and nonmaleficence but then gradually reaches its goal of restoring long-term autonomy. In the early stages of rehabilitation, the provider assumes the greater responsibility in the decision making due to either a sudden illness or injury making it difficult for the patient to make informed decisions. As therapy progresses and the patient becomes more educated and informed and becomes a participating partner in the treatment. This model however emphasizes unidirectional education. The context of this model may serve to support patients adapting to our environment rather than mutual accommodation.

The discourse theory of deliberative democracy is core to the deliberative model. The theory posits that decisions made among a polity of free and equal citizens, regarding issues of collective concern, and in the common interest, are fair and binding. Decision-making processes must include all who are affected by an issue and legitimate outcomes must represent “an impartial standpoint said to be equally in the interests of all.” Thus, the deliberative democratic theory offers principles of equality among and inclusion of all individuals affected by a decision. Through the deliberative process in rehabilitation, the client, through reflection, choice, and discussion, comes to join the community and through their participation realize that they are members or a community bounded together by a common interest. Clients who participate in the community achieve autonomy and self worth. The environment and community is no longer seen as this is “yours” or this is “mine”. The deliberative model redefines the environment as one that is owned mutually by the provider and patient. One of the most important characteristics in the deliberative model is that it calls for the provider to expand and enhance their empathetic understanding of the patient. This empathetic attunement requires that the parties be able, and willing, to express and receive emotional messages.

Since ethics are vital for a rehabilitation counselor to due his/her duty, they must make sure that the ethical model they choose for their clients meet all five principles of ethics. Counselors can easily hinder a clients’ autonomy without even realizing it. In the paternalistic approach, the counselor can be blinded by their will to do no harm and to promote the welfare of their clients but may end up hindering their clients’ freedom and trust. In the contractual model where the sole guiding principle is autonomy, we have to question whether clients are really autonomous or are they merely being coerced and sold on accepting a certain treatment. The educational model encompasses beneficence, nonmaleficence, and eventually autonomy, but it is still lacking fidelity and justice. Since the guiding principle in the deliberative model is empathy, it is the one true model that incorporates all five of the principles of ethics. It emphasizes equality and justice and because of that fidelity is held up. And because empathy is guiding the counselor, there is beneficence, nonmaleficence, and the respect for the client as an autonomous person. Rehabilitation counselors need to think about what is ethical when deciding which approach to use on their clients and not be influenced by their own belief systems. If counselors follow what is ethical then they should be able to choose an ethical model in their client relationship that will benefit both the client and counselor.

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