

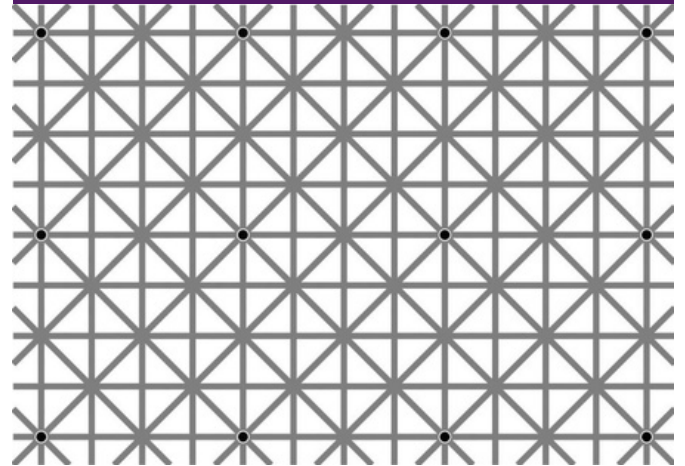


Person Centered Duty and Decision (3)

The first blog in this series highlighted how decisions about duty rest on legal considerations of “foreseeable risk”, and ethical deliberations about informed consent, beneficence, non-maleficence, and fairness. This blog links these dual considerations by exploring the links between beneficence, non-maleficence, and risk. In doing so it addresses the question of how the Care Aims framework supports practitioners to measure and weigh-up likely harm, risk, and potential benefit?

Like the illusion below, the answer to questions about risk, harm and benefits to health depends on where you focus. Broadly speaking there are two perspectives on healthcare. These are that of the observer and the person being observed. Traditionally, communications in healthcare have come from the observer’s perspective with practitioners telling communities about their rates of various diseases or telling individuals about the diseases or levels of risk factors they have. From this standpoint, good and harmful outcomes are typically framed in biomedical terms (e.g. more or less disease or impairment).

Where are the black dots?¹



The Mayo Clinic Center for Innovation looked at “health” from the perspective of the observed citizen. Interestingly they found that community members tended to express “health” related goals in social, not biological terms. In an editorial for the Mayo Clinic Proceedings, Thomas Kottke (MD) notes that “Health” for members of the community is not defined as the medical community defines it, that is, as the absence or presence of disease, a risk score, or a score of comorbidity. Instead, community members defined “health” as the ability to meet one’s social obligations. Like, being “well” means having a high quality of life.”²

The findings of the Mayo clinic support the way decisions about duty are made using the Care Aims Framework. If we stick with the perspective of the observed citizen - beneficence, non-maleficence, and risk are seen in terms of actual or foreseeable impact on social functioning, wellbeing, and quality of life. This is the perspective adopted by the Care Aims Intended Outcomes Framework.

Similarly, if duty relates to “foreseeable” risk of harm, and harm is experienced by community members as impact on wellbeing and life-plans, we can’t assess risk until we understand what matters to the identified person in terms of their wellbeing needs and plans.

As a final point, the highly personalised nature of life-plans and wellbeing means that a risk for one person may not be for another. Put another way, decisions about duty are highly personalised. It is this focus on individual wellbeing needs that places person-centredness at the core of the Care Aims Framework. It is perhaps significant then that the Mayo Clinic researchers also found that in relation to healthcare, citizens said that they “want to be known as a whole person by someone with whom they can hold a conversation”.

The next blog takes a more in depth look at research into the factors that contribute to wellbeing.

References

1 Ninio, J. & Stevens, K.A., (2000). Perception.

2 Kottke, T.E. (2011). Mayo Clinic Proceedings. 86(10): 930-932. (Doi:10.4065/mcp.2011.0444).