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Editors' Forum

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This edition of *Health Ethics Today* contains three very different papers illustrating the wide variety of health issues involved in health ethics study. The topics include the 'old chestnut' of consent but with new ideas relating to children developed by Kathleen Oberle & Stan F. Whitsett. Sandra MacPhail describes the newer subject of moral distress & moral residue among health care professionals. Colin Soskolne describes how a subject such as air quality can have important ethical aspects for individual and group health.

Both the public and health care providers tend to identify ethics with immediate issues involved in individual patient care, often related to end-of-life or quality-of-life. This narrow focus is a problem because it promotes limited ethical awareness of many other situations of moral concern, leading to the misconception that "if its not a life and death issue we don't need ethical analysis". Indeed, the recent publicity given to the Schiavo case in the USA, where Governor Bush of Florida enabled legislation to be rushed through to allow the reinsertion of gastrostomy feeding tube into a persistent vegetative state patient, illustrates this problem. Such cases feed the misconception that these dramatic life saving conflicts are what health ethics is all about. In reality, it is in the day-to-day care of individuals and groups of patients, that most health ethics practice gets carried out.

The papers in this edition of *Health Ethics Today* illustrate the variety of our clinical practice and the relevance of ethics across this great spectrum.

Oberle & Whitsett ask us to consider if our practice of obtaining consent on behalf of children serves their best interests in all cases. They question the ethical basis of consent for young children especially when we consider the concepts of assent and dissent as children get older. Is the consent process undertaken to 'get the job done' with both parents and health care providers feeling satisfied, or are we truly interested in the wishes and interests of the older morally aware child?

MacPhail takes us into an area of discomfort for all health care providers who are involved in clinical practice. We have all stood idly by in situations where another person (patient, family member, staff member) was treated in an unacceptable manner by other health care providers. This continues to occur in all areas of health care delivery with accumulation of moral stress among care providers. It is usually a result of a hierarchical system of decision-making imposing a poor standard of care on individuals who

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Revisiting Consent for Treatment in Pediatrics

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Background

Over the past two decades there has been growing concern about paternalism in traditional models of decision making in health care. This is reflected in the increasing emphasis on autonomy as an ethical principle and the evolution of informed consent as the basic instrument for safeguarding autonomy. By definition, informed consent is “to give approval or permission”, and requires not only that the individual be provided with the necessary information, but that he/she understands what is proposed (Committee on Bioethics, 1995). In practice this becomes a problem when there is a question about the patient’s cognitive abilities and whether he or she can truly understand. Nowhere is this of greater concern than in pediatrics. The purpose of this paper is to begin exploration of two particular issues surrounding consent for treatment in pediatrics, children’s assent and parental permission, and to invite health care providers to consider the moral legitimacy of current practice related to those issues. Our argument is based on practice observations and reflection, and is offered mainly to stimulate thought.

Consent and Assent

The bioethical principle of autonomy holds that individuals have the right to control what happens to them, and that health care providers must seek consent, or at the minimum, assent, for treatment. Although most dictionaries list assent as a synonym for consent, and vice versa, in practice it is generally considered that assent requires a lower level of understanding than does consent. That is, assent is taken to mean agreement with, or acquiescence to, what is proposed, without necessarily having full

understanding. It is assumed (of course, sometimes incorrectly) that individuals have developed capacity for full understanding by a certain legal age, and children are not considered to have the capacity to give consent until that age is reached.¹ If the child is under legal age, parental or surrogate consent is required. This in itself is problematic because, as the Committee on Bioethics of the American Academy of Pediatrics indicated, one consents only for oneself. That is, “Only patients who have appropriate decisional capacity and legal empowerment can give their informed consent ... parents or other surrogates provide “informed permission” with the assent of the child *whenever appropriate* [final emphasis added].”(Committee on Bioethics, 1995; p. 314). Thus, one could argue that informed consent for pediatric treatment is never possible at all—in the strictest sense, children not of legal age cannot consent, nor can their parents/guardians consent *for* them.² Nonetheless, practitioners proceed as if consent were given when parental permission is granted. That is, in practice parents are asked for permission, which is used as the “equivalent” of consent.

Problems with Consent, Assent and Dissent

The above seems fairly straightforward on first glance—assent is sought when appropriate; parental permission is required. On closer examination, however, it becomes murky, and something of an ethics minefield. First, what would appear to be in question is when it becomes appropriate (or inappropriate) to seek assent. Certainly if one is only required to seek assent *when appropriate*, there must be some fairly obvious sense of when it would *not* be appropriate. However, that assumption is rife with difficulties, as

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are not allowed to question its basis. As MacPhail points out, this practice carries a high price on patients, on individual health care providers and on the ethical standards of the health care organization.

Soskolne draws attention to the World Health Organization standards on indoor air quality and argues

that these standards must be supported as a public health issue with broad implications in health, ethics, and law. While this paper is beyond the usual scope of health ethics discussion in hospitals it is very relevant to the quality of health of both staff and patients. ■

there is no clear definition of “appropriate” in this instance.

By appearances, the issue seems to rest on whether or not a child has sufficient cognitive capacity to provide assent. However, we question whether this really is, or ought to be, the main concern. We suggest that the primary consideration ought to be whether health care providers (HCP) seeking assent have the intent to accept *dissent or refusal*. That is, if HCP are prepared to honour the child’s right to agree to treatment, are they likewise willing to honour his/her right to refuse? The Committee on Bioethics suggests that “No one should solicit a patient’s views without intending to weight them seriously. In situations in which the patient will have to receive medical care despite his or her objection, the patient should be told that fact and should not be deceived” (Committee on Bioethics, 1995; p. 316). This would seem to suggest that “when appropriate” is defined by whether or not HCP are prepared to honour dissent. In other words, we suggest that it is inappropriate to ask the child if he or she agrees with what you want to do if you intend to proceed regardless of the response.

The problem with that argument is that circumstances under which a child has the right to refuse treatment have not been well defined. It seems to be common practice to ask older children for their assent, even if we intend to proceed without their agreement. Certainly the morality of that practice could be questioned. It can be argued that to enter into such a discussion with a child may breach the ethical principle of fidelity. If assent is requested but dissent is not permitted, then requesting assent could be construed as a seductive act in which the actual intent is to persuade, not give control. Trying to persuade a child to give permission, knowing that permission is not required, is essentially dishonest. If, as has been suggested by numerous authors, the ethical foundation of health care practice is the covenantal relationship between the caregiver and the patient, and trust is the core of that covenant, then asking the child for assent without the possibility of dissent is a betrayal of trust and a breach of the covenant. In this sense it is ethically unsound.

We suggest, then, that seeking assent may be morally problematic if there is no intent to honour dissent, and that in practice a stronger moral position would be simply to inform the child that the treatment/procedure will proceed, and that what we are seeking is cooperation (the absence of which will not prevent us from undertaking the procedure). In other words, in order to demonstrate proper respect for children we need to inform them to the limits of their capabilities to understand, but we should not pretend that we will accept their refusal. The fact that many practitioners would be uncomfortable with such an honest approach suggests that the practice of seeking assent (without possibility of dissent) serves more to give practitioners a sense of comfort than to give patients autonomy, or to act beneficently.

Parental Permission and the Right to Refuse

A second issue is that of parental permission (or consent). Here common wisdom has it that parental decisions are the final authority. However if we look closely we see this, too, is not as clear-cut as one might hope. Again, the problems seem to revolve around our willingness to accept dissent. If one is prepared to honour parents’ consent for treatment, one must also be prepared to honour their dissent or refusal of treatment. Clearly there are situations in which parental authority and wishes are set aside. Take for example the most obvious case—that of the parents who are Jehovah’s Witnesses and refuse permission for blood transfusions for a child with leukemia. Here the parents’ dissent may be overridden by the court, which in certain cases will apprehend the child in order to permit treatment.

Conditions for Dissent

Under what circumstances, then, do we honour the right of the child and/or parents to dissent? We postulate that two factors, the degree of certainty about the outcome, and the degree of seriousness of the outcome, determine to a large extent how willing health care providers are to turn decision making over to someone else such as a minor or parent.

If this is correct, our analysis suggests that it might look something like the diagram below: if we, as caregivers, don't think the outcome is very serious, and we aren't certain what is the best way to proceed, we allow parents and even younger children to make the decision. If the outcome is not very serious and we are quite certain what will happen, we will allow parents and older children to have the final say. The dilemma becomes more challenging when the outcome is very serious. If we are fairly certain about what the outcome will be, we want much more control over decision making (as in the Jehovah's Witness example, above). Thus, if we believe treatment should proceed, we might take action to override a parent's dissent. Note, however, that when outcomes are uncertain, the decision is more comfortably left to parents. In these situations health care providers often, ostensibly in the interests of supporting autonomy, indicate a reluctance to make treatment suggestions. The problem in part is that there may be disagreement as to what is in the best interests of the child, and it is assumed that the parents are in the best position to understand the child's best interests. This may not be unreasonable, but certainly should be brought to light and examined. One could question whether, rather than supporting autonomy, such practice is in fact a form of abandonment of parents at their most vulnerable. Using autonomy to justify failure to support parents may be morally questionable.

In conclusion, it is our contention that we as health care providers need to revisit practices around seeking consent and assent for treatment in pediatrics. We need to reflect on whether our intent is to be supportive and respect autonomy, or merely to make ourselves feel better. If we delude ourselves and our patients/families about our intent while claiming that we have done the best we can to "get consent", we may be acting more in our own best interests. If we do not intend to honour dissent, either from the parent or the child, then we need to think carefully about the purpose being served. ■

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- 1 Note that the legal age for consent varies across provinces. In Alberta there is no legal age of consent as such; the age of majority, which is 18 years, is assumed to be the age of consent. The difficulty in defining an age of consent is related to uncertainty about when adolescence ends and adulthood begins, as developmental capacities of individuals differ widely (Canadian Pediatric Society).
- 2 A child before legal age who is considered a mature minor by definition is no longer a child, and is permitted to give his or her own consent.

		DEGREE OF CERTAINTY ABOUT OUTCOMES	
		LOW	HIGH
DEGREE OF SERIOUSNESS	HIGH	High seriousness Low certainty [Parents]	High seriousness High certainty [Health care providers]
	LOW	Low seriousness Low certainty [Parents and younger children]	Low seriousness High certainty [Parents and older children]

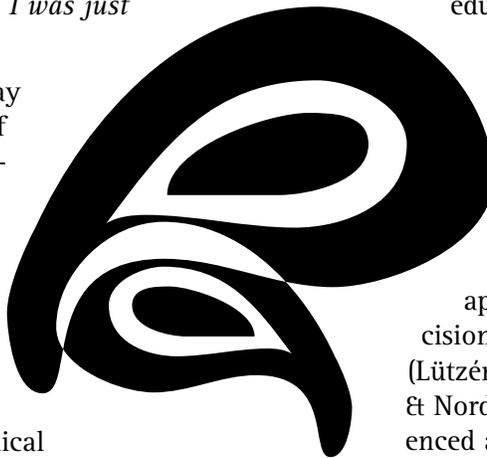
Recognizing Moral Distress and Moral Residue in Practice

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The student orientation began with a tour of the facility where we were to spend the following month-long practicum. I remember watching in disbelief as the staff took the thin sheet from an elderly, mentally ill patient and placed her on a waist-high, cold, hard morgue slab in the middle of a large tiled room and commenced spraying her with a showerhead hanging from the ceiling—no towel was used to soften the slab or to cover her shivering nakedness. Just outside in the hallway, many more elderly, clad only in sheets, were tied in wheelchairs waiting their turn. I saw no gentle touch, I heard no words of reassurance or comfort from the staff; the only noise I remember hearing was unintelligible hooting and babble. The shower room did not have a door—which is how I and my fellow nursing students were able to witness the scene. I was not assigned to the particular unit where this bathing was happening. I felt powerless to do anything about the situation; I was just a student.

Ethical behaviour is “not the display of one’s moral rectitude in times of crisis ... but the day-to-day expression of one’s commitment to other persons and the ways in which human beings relate to one another in their daily interactions” (Levine, 1977, p.846). Levine is reminding us as health care providers (HCPs) that while ethical dilemmas occur, in practice ethical issues or problems occur far more often, and while they may not be as dramatic as deciding whether a patient should receive a transplant or not, they are important. The issues Levine refers to occur in our everyday interactions with others—both patients and colleagues. When health care providers say, “I don’t have ethical issues in my practice because I don’t work in critical care” or “There are no ethical issues on the unit today, just clinical ones,” it is more likely that the ethical issues inherent in everyday practice have not been recognized.



Recognizing the Ethical in Everyday Situations

The personal experience at the opening of this article occurred when I was a student nurse being oriented to a large mental health institution. The image of the woman on the morgue slab has stuck with me for 30 years. In interpreting the scene, terms such as poor clinical care, staffing shortages, and efficiency might be used; we might not talk about the scene in explicitly ethical terms (Robertson, 1996). We may not talk about lack of engagement, inhumane treatment, lack of dignity, powerlessness, fear, dehumanization, lack of respect, mutuality, or lack of commitment to relationship as ethical. We may not recognize the ethical dimension inherent in disrespecting the elderly woman given the current emphasis on the ethical principles and dramatic dilemmas in ethics education rather than on the ethical context of the clinical practice environment (Corely, 2002).

Ethical awareness or moral sensitivity in practice is the ability to recognize an ethical conflict, understand the patient’s situation as being vulnerable and appreciate the ethical outcomes of decisions made on behalf of the individual (Lützn, 1993, cited in Lützn, Johansson, & Nordström, 2000). Although I experienced a visceral reaction to the woman being bathed on a morgue slab, it was not until much later that I was able to put ethical words to my reaction. Some argue that one is either sensitive or not—others say that moral growth, while not automatic, is only possible through moral stimulation and struggle (Romanell, 1977). For many, raising ethical awareness does not occur without sharing experiences from practice in which both dialogue and reflection are required (MacPhail, 2001). Hearing another practitioner’s view of the ethical issue can be instructive and enlightening. Since we come into health care situations with different sets of values and beliefs, we may see different ethical problems in the same situation. But what is the connection

between notions of everyday ethics, moral sensitivity and moral distress?

Moral Distress and Moral Residue

As early as 1984, Andrew Jameton categorized ethical problems in a way that they appear to be on a continuum from *moral uncertainty*, through *moral dilemmas* to *moral distress*. In keeping with my conviction that ethical issues in practice are common, *moral issues* might be added to Jameton's continuum between uncertainty and dilemma, with *moral residue* (first used by Webster in 1995) following moral distress. *Moral uncertainty* is ambiguity about how moral rules or principles apply, or about the nature of the ethical problem itself (Jameton, 1984). Often the precursor to a moral situation, moral uncertainty is described as a feeling of unease about a situation because pertinent information is lacking (Fry, 1992). *Moral issues* are those issues in clinical practice where there is uncertainty about the morally right thing to do or where the obligations and duties of the HCP are unclear (Aroskar, 1989; MacPhail, 1996). *Moral dilemmas* are conflicts of ethical principles that suggest different courses of action. *Moral distress* arises in a situation where one knows the right thing to do but is prevented from doing so by external constraints. Jameton (1984) further described moral distress as the negative feelings experienced when a person makes a moral decision but does not follow through with moral behaviour supporting the decision. The amount of moral distress is influenced by the degree of individual responsibility for an action or event (Wilkinson, 1987/88). The negative feelings associated with moral distress include anger, frustration, guilt (Wilkinson, 1987/88), resentment, sorrow (Rodney, 1988), powerlessness, shame, disappointment, and anxiety (Corley, 2002) and possibly depression (Hamric, 2000). However, HCPs will not all experience moral distress from the same situation as those who are more attuned to the moral dimensions of patient care experience more moral distress (Hamric, 2000). Moral residue is what we bring with us from previous bad experiences when in the face of moral



distress we have been morally compromised (Webster, 1995; Webster & Baylis, 2000). By this compromise, our deeply held beliefs and values are threatened or betrayed, resulting in psychological pain.

These compromises are powerful and long lasting (just as the image of the woman on the morgue slab has stuck with me for 30 years), hence the term residue.

Consequences of Moral Distress and Residue

The consequences of moral distress are apparent at the personal, professional and organizational levels (Corley, 2002). In addition to the negative feelings previously noted, experiencing moral distress can result in loss of the ability to care for and be engaged with patients (Benner, 1991; Corley, 2002) and can lead to moral blunting or a muted conscience (Russell & MacPhail, 2003). The consequences of moral distress are negative both for the HCP and for patient care. Wilkinson (1987/88) found that nurses' feelings of distress commonly led to avoiding patients, while others have suggested that moral distress is a critical factor in nurses' decision to leave practice (Corley, 2002; Erlen & Frost, 1991; Hamric, 2000; Millette, 1994; Mitchell, 2001). In turn, nurses leaving the profession has profound implications for the quality of patient care and staff retention. Work place absenteeism, increased mistakes due to moral distress-induced fatigue, staff turnover resulting in loss of senior staff, are all causes for serious concern (Corley, 2002).

What of my Student Experience in Light of Moral Distress and the Evident Moral Residue?

Although the experience of moral distress can have many negative impacts, it can also be the source of powerful insights and learning (Corley, 2002; Webster & Baylis, 2000). While I am disappointed and regret that I did nothing (I did not question the bathing practice aloud), I don't want to forget that image, because it helps me focus on recognizing the needs of the patient. Touch, voice, listening and responding to patients as persons can add dignity and humanity to a less-than-perfect clinical situation.

Conclusion

Health care providers face ethical issues daily, by virtue of their relational work with patients and colleagues (Levine, 1977). Moral distress and residue are now being recognized as common sequelae resulting from the inability to provide the care that patients and their families need (Corely, 2002; Webster & Baylis, 2000). The Canadian Nurses Association considers moral distress and residue such significant concepts that they are included in the most recent Code of Ethics for Registered Nurses (2002, p. 6). Clearly, moral distress is a frequent obstacle to ethical practice (Hamric, 2000). The challenge is to engage in thoughtfully creating ways to reduce and deal with moral distress. Such strategies include continuing ethics education and creating opportunities for interdisciplinary dialogue. An interdisciplinary forum for discussion of ethical experiences would promote ethical awareness, assist in defusing moral



distress, and encourage gains in moral insight and learning. Choosing not to address moral distress effectively results in major consequences for HCPs, for patient care, and organizationally. ■

Acknowledgement

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Integrating principles derived from human rights, bioethics, and sustainable development for healthy public policy on indoor air

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Indoor air quality is an important determinant of population health and well-being. Because people in modern societies spend most of their time in indoor spaces, such as at home, work, school and in vehicles, the World Health Organization (WHO), in 1999–2000, addressed the issue of healthy indoor air from both the public education and policy perspectives. (Mølhave et al, 2000) Aside from promoting the essential findings from this WHO initiative for application worldwide, I aim to demonstrate the utility of integrating human rights and ethics to advance public health policy. While the examples provided here relate to indoor air quality, it is the strategy of combining principles derived from human rights, bioethics and sustainable development that is encouraged for extension to other health concerns amenable to health policy intervention.

Context

Exposure to hazardous airborne agents, present in many indoor spaces, can cause adverse health effects such as respiratory disease, allergy, and irritation of the respiratory tract. Improperly or poorly ventilated combustion appliances pose a real risk of acute poisoning by carbon monoxide. Indoor exposure to radon and environmental tobacco smoke increases the risk of lung cancer. Many chemicals encountered indoors cause adverse sensory effects, giving rise to a sense of discomfort and other symptoms. (Maroni et al, 1995)

The control of indoor air quality is often inadequate in spite of its significant role in determining health. Tensions and conflicts often arise between individuals suffering from indoor air pollution and those whose actions negatively influence indoor air quality. Most exposure to indoor air occurs in private homes, where intervention by public regulation has often been considered a violation of personal freedom. Furthermore, commercial interests have often delayed the implementation of indoor air pollution

controls in spite of scientific evidence of the harmful impacts of such pollution on health. (Boschi, 1999)

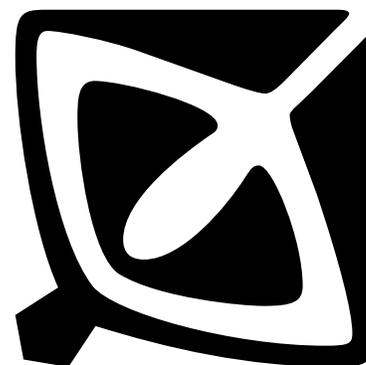
The motivation for the Working Group arose from the Agenda 21 targets adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998. Target 10 relates to “a healthy and safe physical environment”. It states: “By the year 2015, people in the Region should live in a safer physical environment, with exposures to contaminants hazardous to health at levels not exceeding internationally agreed standards.” Target 13 relates to “settings for health”. It states: “By the year 2015, people in the Region should have greater opportunities to live in healthy physical and social environments at home, at school, at the workplace and in the local community.”

These targets, and the seriousness with which they are taken in Europe, warrant consideration in other Regions of the world. Indeed, I submit, it is the duty of those in public health to work towards these goals in protecting the public health interest over any other interest, worldwide.

The WHO document on the right to healthy indoor air has a dual purpose:

- to inform those who have an influence on public health about this right and of their obligations related to this right; and
- to empower the general public by making people familiar with this right.

This WHO initiative thus facilitates those actions needed for the provision of clean air at



home, work, school, and in vehicles, in light of the negative impacts of poor air quality in these indoor environments on health. Many sources of indoor air pollution are beyond the control of the individual (i.e., they are involuntary), and thus require policy interventions for their control if public health is to be protected. It also provides an approach for addressing other health concerns.

The Process:

A careful examination by the Working Group of all 30 articles comprising the Universal Declaration of Human Rights revealed two articles bearing directly on the right to a healthy environment (Universal Declaration of Human Rights, 1948):

Article 25:

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services ...

Article 29:

(1) Everyone has duties to the community in which alone the free and full development of his personality is possible.

(2) In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

Aside from the two human rights articles identified above, each principle below was constructed by the Working Group because of its direct applicability to the issue of ensuring healthy indoor air. The principles derive not only from the four key bioethics principles articulated by Beauchamp and Childress (2001) as the “Georgetown paradigm”, but also from key articles/principles related to the fields of human rights and sustainable development, as well as from law. The framework that they provide is one that can facilitate policy interventions to promote healthy indoor air.

Principles:

Principle 1

Under the human rights article of the right to health, everyone has the right to breathe healthy indoor air.

Principle 2

Under the bioethics principle of respect for autonomy (“self-determination”), everyone has the right to adequate information about potentially harmful exposures, and to be provided with effective means for controlling at least part of their indoor exposure.

Principle 3

Under the bioethics principle of non-maleficence (“doing no harm”), no agent at a concentration that exposes any occupant to an unnecessary health risk should be introduced into indoor air.

Principle 4

Under the bioethics principle of the beneficence (“doing good”), all individuals, groups and organizations associated with a building, whether private, public, or governmental, bear responsibility to advocate or work for acceptable air quality for the occupants.

Principle 5

Under the bioethics principle of social justice, the socioeconomic status of occupants should have no bearing on their access to healthy indoor air, but health status may determine special needs for some groups.

Principle 6

Under the legal principle of accountability, all relevant organizations should establish explicit criteria for evaluating and assessing air quality in buildings and its impact on the health of the population and on the environment.

Principle 7

Under the precautionary principle as articulated at The Earth Summit in 1992, where there is a risk of harmful indoor air exposure, the presence of uncertainty shall not be used as a reason for postponing cost-effective measures to prevent such exposure.

Principle 8

Under the legal “polluter pays” principle, the polluter is accountable for any harm to health and/or welfare resulting from unhealthy indoor air exposure(s). In addition, the polluter is responsible for mitigation and remediation.

Principle 9

Under the principle of sustainability as conceived at The Earth Summit in 1992, health and environmental concerns cannot be separated, and the provision of healthy indoor air should not compromise global or local ecological integrity, or the rights of future generations.

In deciding on one line of ethical action over another, invoking principles provides a framework for analysis. In so doing, the justification for one’s decision to act in one way as opposed to another can be made transparent by presenting an accounting for the underlying rationale that led to the selected action.

Making Ethical Choices About Indoor Air Among Several Options:

Applying Beauchamp and Childress’ four bioethics’ principles in an ethical analysis, any one of the four principles could be in apparent conflict or tension with the remaining three. For example, the desire to protect personal privacy out of respect for autonomy may take second place to protecting the public interest of doing no harm. Thus, where an individual poses a threat by her/his actions to the public health, as would be the case of a person with a communicable disease who refuses to abide by quarantine measures, it may become necessary to expose her/him to protect the greater public welfare. Providing the rationale for why one action was taken over another, the justification for allowing one principle to take precedence over another is made apparent. The articulation of the rationale for invoking any one principle over another establishes transparency in conducting an ethical analysis.

In the context of indoor air quality, consider a building designed such that people are exposed involuntarily to hazardous airborne agents. The nine principles identified above are invoked as a framework for knowing what the most appropriate ethical policy action might be for eliminating the hazard, under

the assumption that people have the right to healthy indoor air. We could argue that legislation is needed either:

- to eliminate the exposure at the source, or
- to impose on the owner of the building (be it a workplace, or a residence attached to other residences as in an apartment building with adjoining walls, floors or ceilings), that appropriate technologies be installed to prevent the hazardous airborne agents (e.g., tobacco smoke) from migrating to the breathing zone of others.

In this example, the various principles have to be considered in an equation that weighs the rights due to the perpetrator (e.g., the factory owner or smoker) against those due to the victim (e.g., the worker or neighbouring resident). Let us consider the principle of non-maleficence (doing no harm). We weigh this principle against the harm caused by imposing on the freedom of the person responsible for the production and/or migration of hazardous air and the harm that the hazardous substance causes to others. Public health dictates that one excess case of any preventable disease or premature death carries more weight than the freedom of an individual (to continue to cause such harm), especially in the presence of technologically and/or practical alternatives. For those who smoke, they could do so outdoors with relatively minor inconvenience, where harm to cohabitants or co-workers could be avoided.

Thus, invoking the framework of all nine principles, first the four principles of respect for autonomy, non-maleficence, beneficence, and justice would all favour an intervention to prevent involuntary exposure. In the absence of action to protect potential victims, those responsible could be called to account for not having exercised caution, especially in the presence of known airborne hazards. If legislation were in place, the perpetrator would be encouraged to comply in the face of disincentives under the polluter pays principle.

Additionally, our chosen action must take into account the longer-term impacts on the broader environment consequent to any intervention to remedy the more immediate local problem. Thus, we would refrain from installing air conditioning if ozone-depleting chemicals are increased, enhancing the risk of increased ultraviolet radiation onto Earth. In

this circumstance, we would opt rather to eliminate exposure at the source, thus inconveniencing the few for the benefit of the many.

For a fuller explication of how the above principles are applied to concern for healthy indoor air, the reader is referred to the full WHO Report (Mølhave et al, 2000) as evidenced in Mølhave et al (2001, 2002) and promotes awareness among *Health Ethics Today* readers. The strategy used is encouraged for application in relation to other health concerns. ■

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Letter to the editor

After reading the article on “the social construct of health and medicine”, (Health Ethics Today, Vol.13 No1, 2003) I was reminded of a fellow who came to my office several years ago requesting that I complete his Disability Tax Credit form. He seemed to take it as a personal affront when I asked him for the details (such as diagnosis and impairment) needed to complete the form. He put it quite simply that he “has no legs” and he did not consider himself “disabled”. However distasteful to him, he would have to acknowledge his “disability” in order to continue receiving this tax benefit. I do not think that a diagnosis of “non-mainstream body composition” would have been acceptable to the government payer in this case.

I am not as optimistic about the prediction that “the time where we fix people only to fit the norm will be over soon and we will be able to increase the ability of beings beyond the existing norms”. Beyond the individual, there are governments, insurance companies, and local health bureaucracies who can impact how well these abilities can be attained. Currently

and in the foreseeable future, the individual will have to accept being fitted to the norm or the “abnorm” if he or she wishes to utilize the benefits of these paying agencies.

The semantics of the “new’ health care are everywhere: clients vs. patients, medical model vs. wellness model, stakeholders and payers. We have totally lost sight of the individual, and to my mind, the patient. Bureaucracies are, almost by definition, normative practices. Bureaucratic thinking and behaviour must change before true attention to the individual can be achieved.

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