Ethical Theory and Ethical Analysis Tools in Humanitarian Healthcare Aid

Veronique Fraser
Biomedical Ethics Unit
McGill University, Montreal
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Abstract

It is increasingly recognized that because humanitarian healthcare workers are trusted to provide support and assistance to vulnerable groups and populations, they have a fiduciary responsibility rendering it important for them to be explicit and thoughtful about how and why they make ethical choices. This thesis explores the ethics of humanitarian healthcare aid and examines how health care professionals can best engage with these issues, from the realm of ideal ethical theory, to the realm of applied ethical analysis tools. It begins with a brief introduction outlining important elements in the history, ideology and ethics of humanitarian healthcare aid. The second chapter provides an overview of how ethical theory, notably: deontology, consequentialism and virtue ethics, underlies and informs humanitarian healthcare aid responses. I argue that familiarity with ethical theory improves moral clarity and enhances ethical deliberation. The realm of ideal ethical theory is at times abstract and so ethical analysis tools have been developed to assist clinicians in day-to-day ethical deliberation. Many argue that ethical analysis tools facilitate more comprehensive and systematic deliberation of ethical issues arising in a variety of healthcare contexts. However, the strengths and limitations of these tools have received little scrutiny or empirical investigation. Chapter three, provides an analysis of the strengths and limitations of analysis tools, and proposes questions for further research and development in four key areas: for what purpose is the tool developed, who is it designed for, when should tools be used, and what is the structure of the tool? I argue that responding to these questions is a requisite step if ethics analysis tools are to continue to be developed and published. Chapter four unites themes from Chapters two and three by presenting a research study investigating the usefulness of a humanitarian healthcare ethical analysis tool (HHEAT) designed to assist humanitarians in the field. Participants in this study were unanimous that the HHEAT helped ensure comprehensive and more organized ethical deliberation, and expressed a preference for a shorter, more concise tool. This study is notable in presenting one of the few attempts to empirically investigate the usefulness of an ethics analysis tool. Based on participant feedback, the HHEAT was shortened and an accompanying handbook was developed. In Chapter five, I conclude that ethical theory and applied analysis tools present mutually reinforcing approaches to ethical deliberation. When used in tandem, each has the potential to enhance ethical deliberation, analysis and justification, which are essential to humanitarian healthcare practice.

Résumé

On reconnaît de plus en plus que les travailleurs humanitaires, auxquels on fait confiance pour fournir soutien et assistance aux populations et groupes vulnérables, ont une responsabilité fiduciaire et qu'il est important pour eux d'être explicites et réfléchis sur le comment et le pourquoi lorsqu'ils font des choix éthiques. Cette thèse explore l'éthique de l'aide humanitaire et examine quelle est la meilleure façon de traiter de ces questions à partir du domaine de la théorie éthique idéale et du domaine de l'éthique appliquée et des outils d'analyse éthique. La thèse débute avec une brève introduction exposant des éléments importants dans l'histoire, l'idéologie et l'éthique de l'aide humanitaire. Le deuxième chapitre donne un aperçu sur la façon dont la théorie éthique, notamment, la déontologie, le conséquentialisme et l'éthique de la vertu, sous-tend et façonne les réponses humanitaires. Je soutiens qu'une connaissance de la théorie éthique améliore la clarté morale et la délibération éthique. Toutefois, le domaine de la théorie éthique idéale est parfois abstrait et des outils d'analyse éthique ont été développés pour aider les cliniciens dans la délibération éthique quotidienne. Beaucoup soutiennent que les outils d'analyse éthique facilitent une délibération plus complète et plus systématique des problèmes éthiques qui se posent dans une variété de contextes de soins. Cependant, la force et les limites de ces outils n'ont pas été examinées ou validées empiriquement. Dans le chapitre 3, une analyse des points forts et des limites des outils de l'analyse est présentée et des questions pour de futurs projets de recherche sont proposées dans quatre domaines clés: Dans quel but l'outil est-il développé? A qui est-il destiné? Quand ces outils devraient-ils être utilisés? Et quelle est la structure de l'outil? Je soutiens que la réponse à ces questions est une étape indispensable si l'on veut continuer à développer et à publier des outils d'analyse éthique. Le chapitre 4 fait le lien entre les thèmes des chapitres 2 et 3 en présentant le développement et le raffinement d'un outil d'analyse éthique humanitaire (HHEAT) conçu pour aider les travailleurs humanitaires sur le terrain. De façon unanime, les participants à cette étude ont trouvé que le HHEAT a été utile pour assurer une délibération éthique complète et mieux organisée. Ils ont exprimés une préférence pour un outil plus court, plus concis. Cette étude est remarquable car elle représente une des rares tentatives d'investigation sur l'utilité d'un outil d'analyse éthique. En réponse aux commentaires des participants, le HHEAT a été abrégé et un manuel d'accompagnement développé. Dans le chapitre 5, je conclus que l'éthique théorique et les outils d'éthique appliquée présentent des approches qui se renforcent mutuellement dans la délibération éthique. Utilisées en tandem, ces approches ont le potentiel d'améliorer la délibération éthique, l'analyse et la justification qui sont essentiels à la pratique des soins humanitaires.

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I am very grateful to my supervisor Dr. Matthew Hunt whose support, patience and insightful comments and feedback made this thesis possible. I would also like to thank Lisa Schwartz and Sonya de Laat (along with Matt) for giving me the opportunity to join the HHEAT project and introducing me to the exciting and challenging world of humanitarian health care ethics in such a supportive, collaborative and encouraging way. I am also thankful to my fellow students and colleagues at the Global Health Lab for providing me with helpful suggestions on drafts of chapters three and four. My gratitude to Jane Chambers Evans and Dr. Eugene Bereza for taking me under their respective wings and introducing me to the world of clinical ethics consulting and for prompting thought and reflection on ethical analysis tools in clinical contexts.

Preface and Contribution of Authors:

Chapters one, two, three and five of this thesis are the sole work of the author. Chapter four, The Development of a Humanitarian Healthcare Ethical Analysis Tool, arose out of the prior qualitative work of Dr. Hunt and Dr. Schwartz, and is part of a larger Canadian Institute of Health Research (CIHR) knowledge translation grant on Humanitarian Healthcare Ethics. I joined this project as a research assistant in the fall semester of 2011. The Humanitarian Healthcare Ethical Analysis Tool (HHEAT) was originally conceived by Hunt and refined in collaboration with Schwartz and de Laat. The study design and methodology for the testing of the model is the work of Hunt, Schwartz and de Laat. I was responsible for organizing participant recruitment (McGill), facilitating the case analysis discussions in collaboration with Hunt (McGill), and data analysis and thematic coding (in collaboration with de Laat). The writing of the fourth chapter of this thesis is entirely my own work; Hunt, Schwartz and de Laat provided helpful feedback and comments. I presented this work at two conferences: the Humanitarian Healthcare Ethics Forum in Hamilton, ON (November, 2012) and at the Canadian Bioethics Society in Banff, AB (May, 2013). Dr. Schwartz presented the HHEAT at the World Association of Disaster and Emergency Medicine conference (May, 2013). A modified version of this paper will be submitted to *PreHospital and Disaster Medicine* with the following authorship: Fraser, V., Hunt, M. Schwartz, L., de Laat, S. Permission to use this version of the article in my thesis has been granted by all co-authors.

Chapter 1: Introduction

Consider the following story:

It is a summer day and you are enjoying a solitary picnic beside a river. You are just finishing lunch when you hear splashing and shouting. You look up to see someone struggling and drowning in the current, just upstream from where you are sitting. Without hesitation, you jump into the water to rescue the drowning woman. You bring her to shore, begin cardiopulmonary resuscitation (CPR) and are thrilled when you feel a weak but steady pulse return. She opens her eyes and there is a brief and ineffable moment of recognition before the quiet is broken by more shouting and splashing. Someone else is drowning in the river, a man this time. You do what you should have done initially and call for help before jumping back in the river. The scenario has a déjà-vu quality to it; you are back on shore doing chest compressions, exhausted but fervently doing your best so that this man too may live. You are relieved to hear a voice by your side asking "What is going on?" and "How can we help?" Two people nearby heard your cries and have come to assist. You ask one of them to take over compressions, and barely have time to catch your breath when suddenly, unbelievably, there is more splashing and you look up to see two more people being carried away downstream.

This time you have someone beside you as you swim out to save the two drowning men. You arrive back on shore exhausted. You need a moment to rest, but can already hear the now unmistakable sound of more people drowning as they are carried downriver. You take a moment to talk with the man and woman who have arrived to assist. You say to each other: "Why is everyone drowning?"; "How long will this last?"; "Where are all these drowning

people coming from?" although none of you have any certain answers. The woman says: "Something must be happening upstream. Maybe there was an accident. Maybe there was a flash flood. Maybe there is an evil villain throwing people in the water. I will go see, we need to stop what is happening upriver." But, you point out, "If you go upriver, we will have less manpower here, and more people will end up drowning." She replies "More people will be saved in the long term" before disappearing on the path running upriver. You do not discuss how to keep in touch and for a long time you have no means of communicating with the woman upriver. You assume she is doing her best to stop whatever is causing people to fall into the river and be swept away by the current. Meanwhile you, and a growing group of volunteers, keep diving in, rescuing as many people as you can.

This allegory is a useful means of illustrating certain fundamental elements in the development of the history, ideology and ethics of humanitarian healthcare aid. Humanitarianism is a broad concept and at the most general level encompasses a fundamental desire to save lives and relieve unnecessary suffering. The humanitarian motivation to reduce suffering is well captured in the words of John Bowker: "There is nothing theoretical or abstract about it. To talk of suffering is to talk not of an academic problem, but of the sheer bloody agonies of existence, of which all men are aware and most have direct experience." (Bowker, 1970, p.2) The World Health Organization (WHO) defines a humanitarian as: "A person who seeks to promote human welfare" (WHO, 2008) and in his book *Empire of Humanity: A history of humanitarianism* Michael Barnett concludes that: "Humanitarianism is not one of a kind but rather has a diversity of meanings, principles and practices; all humanitarians share a desire to relieve unnecessary suffering, but agreement ends there." (Barnett, 2011, p. 221)

For the purpose of my thesis, I will assume that emergency relief work, downstream approaches, and long-term development work, upstream approaches, are part of the humanitarian project.[1] This assumption is a controversial one. Many would contest this categorization, viewing development work as separate and distinct from humanitarian action. Following Barnett (2010), and Barnett and Weiss (2008), I will nonetheless argue for the inclusion of development assistance within humanitarianism. Although they may differ in approach, both share fundamental moral values, notably, an overarching belief in the inherent dignity and equality of humanity, and a common goal, the alleviation of pain and suffering, and therefore both arguably deserve inclusion in broad discussions of humanitarian healthcare aid.

A subset of humanitarianism, humanitarian healthcare aid seeks to provide medical services and care to those whose well being may be threatened by war, natural or man-made disasters, or extreme poverty. Today, a downstream approach to humanitarian health care aid might include a targeted vaccination campaign during an outbreak of infectious disease, or a refugee camp that provides health services and sanctuary to groups fleeing war or disaster. Upstream approaches are typified by projects aimed at improving the structural conditions that endanger populations and include such diverse missions as the promotion of democracy and human rights, peace-building activities, and initiatives supporting the

[1] The WHO defines humanitarian relief as operations which "primarily aims to 'save lives, alleviate suffering and maintain human dignity during and in the aftermath of man-made crises and natural disasters", while humanitarian development encompasses "operations that have long term objectives, extending beyond two years, and presume conditions of security and a functioning administration pursuing national objectives and strategies in partnership with external actors." (WHO, 2008)

Millennium Development Goals (MDGs), amongst others.[2] While downstream and upstream approaches were initially approached separately and historically characterized by a considerable lack of coordination and communication (still not uncommon today) there is increasing recognition that the two are symbiotic, interrelated and equally necessary to humanitarian healthcare work. (Barnett, 2011)

Humanitarian actors are diverse and include nongovernmental organizations (NGOs), sometimes referred to as INGOs if they work internationally, individuals (some people start what are loosely termed "My Own Personal NGO" or MONGOs in which they provide care and services as they see fit, without a formal organizational structure),[3] multilateral organizations such as the WHO, the United Nations (U.N.), and the International Committee of the Red Cross (ICRC), and private companies (most notoriously, this group includes private military and security companies providing support in conflict zones.)[4]

Upstream and downstream approaches parallel historical developments in the provision of humanitarian aid. The humanitarian desire to reduce suffering has roots in ideals of religious charity and in assisting the poor and vulnerable in day-to-day survival. (Barnett, 2011) At a most basic level, this commitment is somewhat analogous to rescuing people drowning in a river. Beginning in the late 18th and early 19th century there was a shift in ideology, as relief work began to be perceived as insufficient to respond to the "sheer bloody agonies of existence" which required greater attention to the causal factors contributing to suffering.

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[2] Though these examples may seem far removed from the traditional sphere of healthcare, proponents argue that they are necessary for health and well being. Health is contingent on a peaceful society and the observation of basic human rights (democracy and peace-building); improving the health of women and girls requires ensuring gender equality and empowering women (MDG 3).

[3] See Polman, 2010.

[4] See Barnett, 2011.

While the essence of humanitarianism, saving lives at risk, remained a fundamental imperative, it took on a broader focus throughout the 20th and into the 21st century as health and well being became increasingly recognized as inextricably linked to the social determinants of health. (Stein, 2008) In short, downstream efforts came to be viewed as insufficient in themselves and required an upstream commitment to changing the root causes and structures that either contributed to, or exacerbated, the acuity of the situation downstream.[5] As the woman in the allegory points out, performing CPR is inadequate if people keep drowning, someone needs to stop them from falling into the river.

It is worth emphasizing here that this thesis will focus exclusively on the ethical issues that arise in humanitarianism rather than explore the conditions that create the climate of global injustice that prompts humanitarian action in the first place. While recognition of the socio-economic and political factors that contribute to global health inequalities is of the utmost importance, such a discussion is multifaceted – including historical, political, and socio-economic considerations – controversial, and has been done in depth elsewhere.[6] A thoughtful engagement with the myriad factors that contribute to the root causes of upstream health inequity would require engagement with various political philosophies: colonialism, neo-colonialism, neo-liberalism, cosmopolitanism and social justice, and processes: the cold war, globalization, free trade, and resource privatization, amongst others. I will therefore assume that the reader has some familiarity with the background conditions

[5] The upstream approach to humanitarian aid aims to both create and sustain the conditions required for human health and flourishing. People should neither begin by falling into the river, nor be forced back into situations where such a situation is inevitable. Hugo Slim writes of this shifting approach: "Surely one cannot cure a wounded man only to send him back into battle or heal a small child only to discharge her back into a malarial area with no health education and primary health care system? If one sees and knows the deeper causes of a person's sickness, one is duty-bound to address it. Not to do so is morally irresponsible. It is this ethical logic that made more relief NGOs become development NGOs." (Quoted in Barnett, 2011, p.25.)

[6] For instance see: Barnett (2011); Daniels (2008); Dwyer (2005); Sacks (2005); Kim (2000); Sen (1999).

contributing to the modern globalized world in which humanitarian action occurs and concern myself primarily with the ethical issues situated within this context. This is not meant to discount the importance of these elements, but rather to recognize that delineating the socio-economic policies and politics contributing to say, the resource scarcity which prompts ethical questions in humanitarianism, is outside the scope of this thesis.

The shifting emphasis on upstream and downstream approaches to humanitarian aid is reflected in ethical commitments. From its inception up to present day initiatives, virtue ethics has occupied a predominant role in humanitarianism. Humanitarians are expected to display virtues such as, benevolence, selflessness, courage and compassion, generally held to embody the ethos of humanitarianism. (Barnett and Weiss, 2008; Alkire and Chen, 2004) While the language of virtue ethics has been used to articulate the types of people humanitarians should be, the ethics of deontology and consequentialism have been employed to guide humanitarian action. Early humanitarian healthcare aid - categorized by downstream approaches to ensuring health and well being – was primarily deontological, emphasizing duty based imperatives to respond to human need, vulnerability and suffering. (Barnett, 2011) However, as it became increasingly recognized that humanitarian healthcare aid projects can do as much harm as good, (Anderson, 1999) and humanitarian efforts shifted to include greater emphasis on public health and upstream projects addressing the root causes of suffering, consequentialist ethics- with a focus on outcomes and ensuring the greatest good for the greatest number- have become increasingly predominant. (Hopgood, 2008; Stein, 2008)

Given this background, it is perhaps unsurprising that humanitarianism is often confronted by a number of tensions in which constructs operate in opposition to one another. (Barnett, 2011) For instance: deontology and conseqentialist theory, as well as upstream and downstream approaches to aid, will at times conflict with one another; each representing a particular notion of what constitutes the right or good response to a particular issue or problem. When needs are abundant and resources are scarce, underlying tensions, whether implicit or explicit, may give rise to certain types of questions, and the responses to these questions dictate the type of care and assistance provided. These questions have been raised by different people; humanitarians, academics, journalists, politicians and activists amongst others, and include: Is humanitarian action justified only if it does more good than harm; if it does no more than a minimum of amount of harm (regardless of total good); or if it does no harm? (Terry, 2002) Should humanitarian aid always be neutral, or are there instances when advocacy is more important than access and impartiality? (IFRC, 2003) When should the needs of the few override greater benefit to the many? Put simply, should we respond to the individual need of the men and women drowning in front of us, or turn our backs on their suffering, head upstream and try to rectify the conditions causing people to drown? Or has the time arrived to stop these types of rescue efforts altogether as some would suggest, and search for a third, perhaps better, option? These questions are not new to humanitarianism, but run through its history like a current, resurfacing in distinct ways at different times and affect the allocation and provision of aid.

Motivations for this Thesis

In writing this thesis I am interested in describing some of the fundamental tensions and addressing core questions currently being asked of humanitarian healthcare aid. I am also concerned with exploring the ways in which an understanding of ethical theory and applied ethics might inform responses and approaches to some of these questions. While there are many plausible reasons to engage in this type of enquiry, my fundamental reason for doing so comes from a deeply held belief that the commitment to respond to the suffering of another is fundamentally ethical: it has to do with how we feel we *ought* to act, and as such deserves close scrutiny. Because humanitarians are trusted to provide support and assistance to vulnerable groups and populations, they necessarily assume a fiduciary duty which makes it all the more important for careful contemplation of the types of questions posed above. Humanitarians, and healthcare workers more broadly, must be accountable and responsible for the types of ethical choices they make. The aim of ethical enquiry here may not be to claim that there is a single right answer to an ethical issue, but rather to enrich discussion of what makes something right or wrong and enhance justification of the course of action taken.

My motivation to write this thesis also has roots in my personal experience. As part of my Master's in nursing, I did a specialization in global health which included conducting a research project and clinical placement in Njombe, a rural village in the highlands of Tanzania. Over the course of these four months I had the privilege of working at a small hospital which provided basic medical, surgical and trauma care and ran one of the largest HIV/AIDS clinics in the area. Before this, I worked for eight months as a youth intern for

the Canadian International Development Agency (CIDA) at a women and children's shelter in Cochabamba, Bolivia. It was in Cochabamba, sitting up late one night drinking tea with colleagues, when a nun told me a slightly different version of the river allegory, relating it to her 30 years experience working and living alongside street youth and abused women.[7] I am indebted to her, as to many of the individuals I met during these experiences, who taught me about the art of dedication, courage, perseverance, and care in settings which were at times rife with inequity, suffering and hardship.

It was these experiences that led me to specialize in emergency and trauma nursing, with the goal of becoming a humanitarian aid worker. However, as I contemplated a future as a humanitarian nurse, I found myself haunted by some uncertainties and questions which had emerged from my earlier trips overseas: questions which were largely inchoate and rudimentary versions of those posed above: how are the benefits and burdens of development programs distributed? Am I doing more harm than good? I wanted to begin to understand for myself the ethics of humanitarianism; whether humanitarian healthcare aid is good, bad or somewhere in between, and how healthcare aid workers might learn to approach and respond to the moral issues they encounter. This thesis arises out of these motivations and is divided into three main chapters.

Chapter Summaries

In Chapter two, *Ethical Theory and Humanitarian Healthcare Aid,* I provide an overview of the historical development of humanitarian healthcare work and highlight ideological and ethical

[7] It came to my attention after completing this thesis that Andrew Jameton (1984), quoting a nurse, describes a similar river allegory to illustrate themes in distributive justice.

tensions that arise in humanitarianism. I explore some of the important ethical questions being asked of humanitarianism from within the three dominant ethical frameworks that have historically guided aid work: deontology, consequentialism and virtue ethics. These ethical theories provide alternate lenses from which to view and approach the various ethical problems and dilemmas arising in modern humanitarian healthcare practice.

I argue that familiarity with ethical theory allows for the development of moral clarity and improves ethical analysis. Understanding why, how, and in what way ethical theories were developed can lead to a more thorough and critical understanding of the most significant values, principles, norms and beliefs at stake in particular ethical decisions. In addition, it gives us the language and rationale to articulate why we might believe something to be right or wrong, and provides us with knowledge of the strengths and limitations confronting a given stance. As such, engagement with ethical theory challenges us to confront our assumptions and think critically about complex moral matters. Greater moral clarity and ethical analysis are essential to moral judgement, which is an important component in justifying how, when and where humanitarian healthcare aid should occur. I conclude by describing the ways in which Reflective Equilibrium, a methodology developed by John Rawls' and later modified by Norm Daniels, might prove useful for negotiating competing moral claims and reconciling differences in ethical theory.

In Chapter three, *Mapping the Moral Landscape: From Ethical Theory to Ethical Analysis Tools,* I move from the broader conceptual grounds of ethical theory to the more pragmatic development and application of these theories. With its emphasis on ideal justification and thought experiments, ethical theory at times will be unhelpful for resolving discrete ethical

dilemmas in healthcare, which benefit from more practical decision making procedures. Over the past twenty years, there has been a variety of ethical analysis resources developed to assist clinicians in making moral decisions relevant to their practice setting, whether this be at the bedside of a tertiary hospital, in primary or community healthcare contexts, or in humanitarian aid.

Ethical analysis tools are developed to offer practical guidance to aid clinicians in making complex ethical decisions, and thus represent an important resource, which potentially facilitates more comprehensive and systematic decision making. However, the strength and limitations of ethical analysis tools have received little scrutiny in the literature and even less empirical research has been conducted to evaluate the benefits and limitations of these tools in practice. This is troubling given the increasing tendency to publish analysis tools, without any systematic analysis of whether these tools enhance ethical deliberation. This chapter provides an overview of ethical analysis tools and a critical analysis of their respective strength and limitations. It proposes four avenues of enquiry for further research into their development and refinement.

Chapter four, *The Development of a Humanitarian Healthcare Ethics Analysis Tool,* unites themes from chapters two and three by providing the results of a research project investigating the usefulness of a Humanitarian Healthcare Ethics Analysis Tool (HHEAT) first described by Hunt (2011) and later refined by Hunt, Schwartz, DeLaat, Redwood-Campbell and Fraser. This ethical analysis tool grew out of three qualitative research studies exploring the ethical issues faced by humanitarian workers in the field. (Schwartz et al., 2010; Hunt, 2009; Hunt, 2008) As described in chapter two, there is considerable discussion of ethics in humanitarian

health care practice and policy on a macro level. However, discussion of the micro level issues facing humanitarians have only recently begun to receive greater attention (Sheather and Shah, 2011; Schwartz et al. 2010; Sinding et al. 2010; Hunt, 2009; Hunt, 2008), and very few applied resources are available for humanitarian workers seeking ethical guidance. Hunt and Schwartz sought to address this gap by developing and testing the HHEAT as an action oriented resource to support humanitarian practitioners in ethical decision making.

This chapter presents the results of a qualitative study evaluating the usefulness of the HHEAT for ethical deliberation. We conducted a series of six small case analysis sessions with a total of sixteen humanitarian healthcare workers to evaluate and refine the HHEAT. Participant feedback resulted in a simplified and shortened version of the tool and prompted the development of an accompanying handbook on humanitarian ethics. More broadly, the study generated insights into the ethical deliberation processes of humanitarians and validated some of the perceived strengths and limitations of ethical analysis tools discussed in chapter three.

In summary, this thesis covers two central and overlapping themes. Firstly, it is an exploration of the ethics of humanitarian aid which highlights some of the macro level ethical issues and tensions facing humanitarianism, as well as the more specific micro level ethical dilemmas confronted by humanitarians in the field. Secondly, it is an attempt to understand various ways to ethically engage with these dilemmas, from the realm of ideal ethical theory to the applied realm of ethical analysis tools. On one level, it stems from the personal motivation to identify and respond to some of the key ethical concerns arising in humanitarianism. On another level, this thesis contributes to the dialogue surrounding

humanitarian healthcare aid ethics by critically looking at different ethical approaches, from ideal theory to ethical analysis tools, and offering an overview of the development of an ethical analysis tool designed to assist humanitarian aid workers in the field.

I argue that ethical theory and applied analysis tools should be used in tandem, as both represent distinctive yet mutually reinforcing approaches to ethical deliberation. Ethical theory enriches understanding of the strengths and limitations of various moral responses, and not only pushes new engagement with familiar questions, but challenges us to raise new questions and enhances critical thinking. Applied analysis tools, when used judiciously, can help practitioners work through complex decisions in a more structured and comprehensive manner. Results from our study of the HHEAT support these claims, finding that while humanitarian aid workers valued the usefulness of the HHEAT, they would also benefit from greater ethics training in general.

A Caveat Before Beginning…

Before beginning, a brief note on the use of allegories is in order. I began this thesis with the river story because it neatly illustrates complex ideas in a simple and tangible way. And yet, telling a simple story necessarily risks over-simplification and so some words of caution are necessary. It is worth addressing Slim's (2010) critique that over-emphasizing the distinction between upstream and downstream approaches risks contributing to a false and unhelpful dualism in humanitarianism. Slim stresses that there are many areas of commonality between these two approaches: both are committed to saving lives at risk, neither one is exclusively short or long term, and both are to some extent political (Slim, 2010). In addition, while

downstream approaches may be superficially classified as deontological and upstream approaches as more consequentialist in nature, such a demarcation is artificial and by no means hard and fast. While a useful device for representing some of the underlying ethical tensions at work in humanitarian healthcare aid, the moral philosophies underpinning humanitarianism are not mutually exclusive, nor does one philosophy directly parallel one approach more closely than another. Indeed, no single principle or moral philosophy may be sufficient to respond to, or resolve, the ethical issues arising in humanitarianism. (Hunt, 2011)

While acknowledging these limitations, I believe the allegory is nonetheless helpful, and the story itself provides a response. When looking at a river it is impossible to point out a clear boundary between where upstream currents end and downstream ones begin- currents eddy and mix. While ethical theories and humanitarian approaches to aid can be reified as occurring downstream or upstream for explanatory purposes, it is equally true that currents are dynamic and in a state of constant flux. They intermingle, push up against one another, flow into one another, and are part of the same river. Analysis of the intricacies of where currents begin, end and meet, is outside the scope of this thesis.

Chapter 2: Ethical Theory and Humanitarian Healthcare Aid

The river allegory presented in the first chapter provides a context for a discussion of ethical theory and humanitarian healthcare aid by highlighting three fundamental features of humanitarianism. Firstly, it reveals the ways in which historical and ideological approaches to the provision of aid can be classified as downstream or upstream. The scope and nature of aid efforts will be shaped and defined by ideological commitments; whether this be an upstream commitment prioritizing the social determinants and public health, or a downstream approach aimed at more acute humanitarian relief operations. Secondly, the river allegory illustrates the ways in which responding to a humanitarian crisis is not only ideological or pragmatic-i.e., choosing which strategy is likely to be most effective- but demonstrates the ways in which these choices embody ethical and moral commitments.

For instance, early humanitarians generally adopted a downstream approach to aid which characterized human life as sacred (religious) or dignified (secular) and championed deontological ethics, human rights arguments and principlist justifications in pursuit of their aims. Subsequent movement towards development aid and ensuring best possible outcomes has prompted greater emphasis on consequentialist ethics. (Hopgood, 2008; Stein, 2008). Deciding whether it is right or good to sacrifice one life at the cost of others, and vice versa, is a fundamental problem in moral philosophy which has surfaced in various ways throughout the history of humanitarianism. Finally, the river allegory encapsulates the way in which humanitarian healthcare aid is practiced in what has been described as a less-than-ideal, or "second best" world. (Terry, 2002) For instance, with enough resources at the riverside, the dilemma presented in the allegory would be a false one. Rescue teams would simply be dispatched downstream and upstream and have sufficient time as well as human

and material resources to conduct and coordinate their operations. And yet, humanitarian contexts are often characterized by resource scarcity; the decision of how to best allocate resources is often inescapable and tough choices need to be made. (De Waal, 2010)

Taken together, these three features (historical/ideological precedent and approaches, ethical and moral commitments, and resource scarcity) provide a helpful background for understanding what are alternatively described as the tough choices, ethical questions/dilemmas, and moral tensions arising in humanitarianism. In *Empire of Humanity: A History of Humanitarianism* Michel Barnett argues that humanitarian action gives rise to several ethical tensions in which opposing constructs come up against one another. These tensions include elements such as care and control, altruism and self-interest, domination and emancipation, deontology and consequentialism, intentions and outcomes, possibility and disillusionment, testimony and exploitation, universalism and individualism. For example, humanitarianism is fundamentally about caring for the poor and vulnerable, and yet, as Foucault has observed, turning humanity into an object of care may also inevitably become an opportunity for the exercise of control. (Foucault, 1984) Humanitarianism healthcare aid has been critiqued for embodying paternalism; critics argue that in caring for others, humanitarianism often adopts a "we know best" attitude, diminishes responsibility and agency in those it purports to help, and promotes western hegemony and neo-liberal policy in the guise of care and social change. (Barnett, 2011) These tensions are often voiced as questions: for instance, when should we let a great good to a small number of people override a more moderate good to a larger number of people (consequentialism and deontology)? Are publicity photos that objectify an individual or group for the sake of raising awareness ever justified (testimony and exploitation)? How should one rank or

balance the fundamental humanitarian principles (intentions and outcomes)? How does one reconcile individual patient centred bioethics with different worldviews and belief systems (individualism and collectivism)?

In this chapter I am not interested in providing a detailed account of the types of micro and macro level ethical dilemmas facing humanitarianism, which has been done in depth elsewhere. (Schwartz et al., 2012; Barnett and Weiss, 2008; Hunt, 2011; Sheather and Shah, 2011; De Waal, 2010; Hunt, 2008; Terry, 2002) Nor am I interested in championing any one ethical approach over another. Instead, I will explore the ways ethical theory, notably, deontology, consequentialism and virtue ethics, operate in relation to humanitarian healthcare work. While these three frameworks are not the only moral philosophies pertinent to a discussion of humanitarian ethics, theories of distributive justice, ethics of care and cosmopolitanism being notable omissions, they nonetheless represent the more dominant ethical discourses at work throughout the history of humanitarianism. (Barnett, 2011) The aim of this approach is to provide a general overview of the ways in which philosophy can shape and inform approaches to humanitarian aid work. Different philosophical frameworks will have different understandings of what makes something good or right, and even whether there exists such a thing as the good or right in the first place. Gaining an understanding of the ways different philosophical traditions respond to these considerations has important ramifications for the types of answers to the questions posed above. More broadly, a better understanding of ethical theory has two important implications for discussion of humanitarian healthcare aid.

Firstly, a detailed discussion of how ethical frameworks operate in humanitarian healthcare aid can improve moral clarity. Alkire and Chen, (2004) argue that moral clarity -an understanding of the moral basis for action - is essential because it can influence the scope and nature of global health action, as well as inform advocacy surrounding this action.[8] Different approaches to moral philosophy raise distinct considerations about how, why and in what ways, humanitarianism should be practiced. Thus, a call for moral clarity is useful in generating a broad understanding of the more critical ethical concerns and considerations in humanitarianism today.

Secondly, a better understanding of ethical frameworks may improve ethical analysis. Knowledge of ethical theory can help facilitate articulation and communication of important moral claims, values, principles and normative orientations, thereby clarifying tacit assumptions and facilitating richer ethical discussion. Humanitarian action is not a theoretical endeavour but a practical engagement that demands ethical decision making on a variety of different levels. Given contexts of resource scarcity, high acuity and cultural difference, humanitarians often encounter moral dilemmas and experience moral distress in the field. (Schwartz et al. 2010; Hunt, 2008) Ethical decision-making tools are increasingly being developed as a resource to help healthcare professionals in a variety of contexts deliberate about ethical dilemmas. (Hunt and Ells, 2013) However, these tools generally require that

[8] Horton (2004) also notes that moral philosophy is not the only important element to consider when contemplating humanitarianism and that other factors, such as knowledge and institutional interests, play an important role. In a similar vein, Hugo Slim distinguishes between idealism and realism in humanitarian ethics and action, arguing in part that moral ideals may be shaped by or subject to the reality of what is achievable in practice. (Slim, 2005) Craig Calhoun describes "hard-headed pragmatists" who are concerned neither with "the complex ethics of human progress nor the more primal ethics of charity but with the calculations of how best to save the maximal number of lives with the greatest efficiency, or how best to restore "order" to the disorderly scenes of humanitarian emergencies." (Calhoun, 2008, p.74) While more pragmatic considerations are important for ethics in humanitarian action, this chapter will be limited to discussion of ethical theory.

users reflect upon ethical theory, and it is therefore plausible to suggest that facilitating greater understanding of ethical theory is an important precondition for their effective use.

This chapter will begin by describing how deontology, consequentialism and virtue ethics, frame approaches to humanitarianism (Section I). In section II, I will provide a case study drawing on Fiona Terry's account of ethical decision making by humanitarian organizations in Rwandan refugee camps to more clearly illustrate how ethical theory informs humanitarian practice. While sections I and II will emphasize the strengths, limitations and differences between theories, I will conclude by examining Rawl's theory of reflective equilibrium (RE), as a potentially useful methodology for reconciling and negotiating competing moral claims. By providing a strategy for addressing divergent ethical approaches with pragmatic and empirical concerns, RE may prove fruitful in ensuring more comprehensive and nuanced ethical analysis and judgement, and contribute to the broader aim of enhancing moral clarity and ethical analysis in humanitarian aid work.

I) Ethical theories and humanitarian healthcare aid

Deontology

Deontological theories of ethics focus on duties, characterized by principles regarding specific kinds of acts, as a basis for moral conduct. The parable of the Good Samaritan offered in the New Testament, in which a Samaritan acts to help a man lying beaten and half dead, typifies this duty based commitment to help a stranger in need. (Slim, 2011) As humanitarianism evolved, the question of to whom we owe duties became a focus of enquiry. (Barnett and Weiss, 2008) The 18th and 19th century movement to help strangers in a

foreign land was justified by appeals to a shared humanity and began to move away from ideas of religious charity and benevolence, to a more secular appeal to Enlightenment ideals of reason and scientific progress. (Barnett, 2011) Modern humanitarianism came to find moral justification in Kantian based imperatives in which actions are: (1) intrinsically good regardless of consequence, and (2) required as a by-product of humanity. (Barnett, 2011) I will argue that the principles that serve as the foundations for humanitarian action and the rhetoric surrounding human rights thus have their basis in a Kantian conception of duty.

The paradigmatic philosopher of the Enlightenment, Emmanuel Kant, believed that through the use of reason people can act morally without outside assistance, notably, without religious interference or guidance. Kant argued that the only thing of fundamental moral worth is the Good Will (Kant, 1993). The Good Will depends upon an individual choosing to do something because it is a moral duty and that duty is dictated solely by reason. According to Kant, reason finds expression in an overarching principle of morality termed the Categorical Imperative (Kant, 1993; Watkins, 2000). A categorical imperative holds unconditionally for everyone and in every situation and does not depend on conditions, intentions, or 'if' statements. One of Kant's most famous formulation of the categorical imperative is the Principle of Ends which specifies that as rational beings, we must treat people as ends (entities with intrinsic moral worth) and never simply as a means (entities with instrumental value). A second important formulation of the categorical imperative is the Principle of Universal Law, in which one must act only in accordance with a maxim that can at the same time be willed to be a universal law or principle. (Kant, 1993) Kant believed individuals are autonomous moral agents, capable of free will and rational choice, and rather than be subject to external moral authority, must exercise their own moral reason alone.

(Burnor and Raley, 2011) It is this ability to act rationally and according to the Good Will that means that humans are intrinsically valuable and must never be treated as a means to an end. Human autonomy, the culmination of human sensibility, understanding and reason, is the ultimate value and goal of mankind and a precondition for human freedom.

Humanitarians often implicitly articulate this Kantian conception of duty-based imperatives, in which actions are intrinsically good regardless of their consequences. Humanitarian workers who chose to help an individual patient in spite of organizational directives stipulating they refuse to provide unsustainable treatments (Schwartz et al. 2010, p.49) arguably embodied a Kantian sense of duty. Médecins Sans Frontières (MSF) workers who refuse to participate in any way in local practices of female genital cutting (Sheather and Shah, 2011, p.163-4) adopt a deontological response favouring the inherent dignity of human beings over a more consequentialist approach weighing the risks and benefits of harm reduction. These examples are illustrative of Kantian deontology, in which ethical action is defined by the act, according to the moral law, regardless of the potential consequences of that action. Within this vision of morality, humanity deserves respect as an end in itself and we are duty bound to help others. Professional guidelines and codes of ethics, one of the main ethical resources available to healthcare professionals practicing in humanitarian healthcare contexts, are also deontological in nature, consisting of duty based statements in which professionals are provided with a set of universal maxims stipulating right conduct.

It is widely recognized that certain fundamental principles define the ethos and morality of humanitarianism. (Barnett and Weiss, 2008) While the International Red Cross and Red Crescent Societies (ICRC) first articulated seven principles, only four of these: humanity,

impartiality, neutrality and independence (Pictet, 1985) are generally accepted as fundamental to humanitarian action today. The importance of these principles to humanitarianism is widely recognized (Barnett, 2011; Barnett and Weiss, 2008) and evidenced by their increasing use by non-governmental organization (NGO) mission statements and charters over the past 30 years. (Weiss, 1999) While principlism represents a moral framework distinct from deontology,[9] I have chosen to include it here because enlightenment ideals and the Kantian emphasis on the inherent dignity of autonomous persons and morally right action defined by rationality and universality, arguably finds expression in the core principles of humanitarianism.

Of the four fundamental principles, humanity and impartiality most clearly encapsulate both the Kantian notion of the principle of ends and the principle of universal law by stipulating that each individual has intrinsic moral worth, and by articulating a vision that holds these principles as universally binding. The principle of humanity entails a duty to prevent and alleviate suffering and protect life and health. Impartiality stipulates that each individual is equally deserving of aid and protection, which should be given solely on the basis of need, regardless of place, politics, or ideology. Neutrality requires that aid be apolitical, and humanitarians must refrain from taking sides in political, religious, or ideological controversies. Independence stipulates that humanitarians must always act autonomously, in accordance with reason and with the other fundamental principles. (ICRC, 1996). At their core, these principles capture the moral essence of humanitarianism, help create a shared

[9] Priniciplism is considered mid-level theory; fitting somewhere between theoretical and applied ethics. Kantian deontology, classical utilitarianism, and Aristotelian virtue ethics exemplify "high" moral theory, or theoretical ethics, more concerned with meta-ethical questions than on providing specific action guidance. Deontologists, consequentialists, and virtue ethicists may use principles in different ways.

humanitarian identity, (Hilhorst and Schmiemann, 2003) and reflect a Kantian orientation towards rational autonomy, intrinsic moral worth, and universality.

Finally, the language of human rights is often employed as a moral justification for humanitarianism. Rights based approaches to health share a deontological commitment to "things which are owed to man because of the very fact that he is a man." (Maritain and Anson, 1944, p.37) It is a truism to state that there are no duties without rights, and no rights without corresponding duties. That is, the duty to act according to the universal law in correspondence with reason, testifies to a corresponding right. Because rights are ends in themselves, they demand obligatory behavior from states, groups and individuals (Horton, 2004). The duty which springs from a right can be "perfect" sanctified by the rule of law[10], or "imperfect", a non enforceable duty or obligation. (Horton, 2004)

Importantly for humanitarian healthcare aid, most human rights law assumes some minimum standard of health that all people should be able to realise for human dignity. For instance, the preamble to the WHO constitution (1946) states: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" and Article 25 of the United Nations Declaration of Human Rights (1948) stipulates: "Everyone has the right to a standard of living adequate for the health and well-being of himself and his or her family…"[11] Thus, some commentators argue that all humanitarian

[10] A detailed discussion of human rights law is beyond the scope of this paper. However, it is worth noting the general point that although international humanitarian law and human rights law are an important part of the contemporary moral discourse, failure to apply and enforce these laws internationally and locally means that humanitarian agencies often make moral decisions without legal recourse (Slim, 1997).

[11] The UN further specified this right in Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) which guarantees the "right of everyone to the enjoyment of the highest attainable standard of health." In 2000, the UN issued General Comment 14 on the "Right to Health" which expands on earlier iterations and elaborates core obligations of states and NGOs in meeting health needs.

action can be seen as a response to the right to a minimum standard of health for individuals affected by war or disaster. (Horton, 2004) In the 2003 World Disasters Report- Ethics in Aid, the IFRC makes a deontonlogical commitment to humanitarian aid explicit, employing the language of right action and the universalism of human rights: "…it is right to help anyone in grave danger. This deeply-held value is found in every culture and faith, as well as in the political ideology of human rights. The ideas of the 'right to life' and an essential 'human dignity' common to all people are framed in international humanitarian law (IHL), human rights conventions and the principles espoused by humanitarian organizations." (IFRC, 2003, Chapter 1 Summary)

In short, a deontological approach to humanitarian morality has roots in the Kantian philosophy of right action done according to right reason. Actions which are right are always intrinsically so, regardless of the consequences they produce. Modern notions of the rational autonomous individual as synonymous with human freedom and dignity also has a basis in Kant and finds alternate modes of expression in humanitarian principles, duty based codes of ethics, and in human rights discourse.

Challenges and Limitations

Deontology viewed through a Kantian lens generates some notable challenges, only three of which will be addressed here. Firstly, because duties are absolute, there is no clear ground for resolution when they come into conflict with one another. For example, Sheather and Shah (2011) describe an ethical dilemma encountered by MSF workers who must decide whether to disclose HIV/AIDS positive status to individuals in contexts where antiretroviral therapy

remains unavailable. The dilemma, between the duty to tell the truth versus a duty of non-maleficence (considering the harms which may result in a community in which HIV/AIDS stigma is high and disclosure may cause more harm than good) occurs between two absolute duties. Kant provides very little guidance on how to resolve this conflict, and this also remains a common criticism levelled against principlism. Secondly, the Kantian emphasis on right action done according to right reason does not allow for consideration of the consequences that may result from an action. Kant justified this by arguing that while an individual can account for action based on reason alone, future events are unpredictable, unknowable and therefore uncontrollable. (Burnor and Raley, 2011) Thus, deontological morality requires that each individual do the right thing, regardless of what might take place. Finally, Kantian deontology does not account for the moral motivation behind right action, an action is simply right if it is done according to right reason. This may conflict with the broader ethos of humanitarianism, which is assumed to embody motivations aligned with the virtues of altruism, self-sacrifice, generosity, respectfulness, and compassion. (Alkire and Chen, 2004)

The ethical theory of principlism discussed earlier is equally subject to certain limitations. For instance, lack of specification as to how to balance or rank principles which come into conflict with one another[12], specify a general principle in a discrete circumstance[13], or negotiate situations in which principles have the potential to become counterproductive.[14]

[12] For example, the IFRC questions whether human rights abuses should be exposed at the risk of sacrificing access to those in greatest need: a balancing of the principle of solidarity versus the principle of humanity (IFRC, 2003, p.7)

[13] Does the principle of humanity and the duty to prevent and alleviate suffering apply only to those with present needs, or should it take into account future need as well? How do we meet the needs of all fairly when we can't meet them all?

[14] Barnett and Weiss (2008) questions whether the principle of neutrality is viable or relevant in the face of genocide or crimes against humanity.

(Barnett and Weiss, 2008) These challenges echo some of the difficulty of specifying and balancing duties in deontology and make principlist approaches at times challenging to adopt in practice. As will be explored in the next chapter, ethical dilemmas are often articulated as a situation in which two principles conflict- leading to considerable uncertainty in decision makers about what course of action to take.

Consequentialism

In contrast to the deontological emphasis on duties and rights, consequentialism focuses primarily on consequences and outcomes. For a consequentialist, the morally right course of action is evaluated based on the consequences that action produces. Consequences are measured in terms of utility, and utility is that which makes a consequence desirable. (Burnor and Raley, 2011) There is broad philosophical debate as to whether health can be a form of utility (intrinsically valuable) or whether it is a necessary condition to generate utility (instrumentally valuable).[15] Definitions of utility are crucial to generating different versions of consequentialism.

Utilitarianism, a major branch of consequentialist philosophy, originated in the late 18th and 19th centuries and represented a deliberate attempt to make moral theory more scientific and quantifiable. It was developed in part with the goal of reforming Britain's criminal justice system and embodies a commitment to impartiality; ignoring class distinctions and appealing to the universality of humanity. (Burnor and Raley, 2011) Classical utilitarianism drew on the tradition of empiricism and observation to argue that utility was both measurable and

[15] For instance, some may override the utility of health for other goods such as individual liberty, freedom, or equity (Schwartz et al., 2012)

predictable. Early utilitarians believed careful observation and objective analysis allow us to predict which effect will follow from a cause and as a result, right action becomes an objective and quantifiable fact representing that which will generate the most utility in a given situation. This claim to objectivity and simplicity is one of the major appeals to utilitarianism as a moral philosophy. It necessarily assumes that that there is always one right response to any moral question.

Jeremy Bentham, a founder of utilitarianism, identified a number of elements which need to be considered when evaluating the utility of an action: scope, number of individuals implicated; duration, period of time in which an effect lasts; intensity, the degree of strength of force of an experience; and probability, the likelihood that an effect takes place. (Burnor and Raley, 2011) While there are several different forms of utilitarianism, including classical, act and rule[16], amongst others, in general utilitarianism holds that acts bring about effects; effects can be measured in terms of overall utility or disutility; and one can base moral decisions on the choice which will yield the greatest overall utility (or least overall disutility). As opposed to deontology in which an end cannot be justified by any given means, utilitarianism in which *overall utility* is of paramount concern, allows for the means to justify the ends in specific circumstances. For instance, WHO and MSF directives instructing that tuberculosis (TB) treatment not be offered in settings where a full treatment course is not guaranteed, in order to prevent the development of drug-resistant TB, (Schwartz et al., 2012) is an example of a utilitarian approach in which the greater good (decreasing the disutility of

[16] Classical utilitarianism held pleasure to be the only intrinsic good and defined utility in reference to maximizing pleasure. Twentieth century utilitarians, including act and rule, moved away from this formulation, defining utility in various different ways. Act utilitarianism focuses on the utility of individual acts or situations. Rule utilitarianism gives rise to general rules and principles which govern practices and tries to respond to some of the criticisms levelled against act utilitarianism by describing what actions are morally right regardless of the specifics of the situation. (Burnor and Raley, 2011)

drug-resistant TB) is accorded more value than the minimum right to health a deontologist would argue should be accorded to patients with tuberculosis.

Like deontology, utilitarianism has always been part of modern humanitarian morality, especially in triage and resource allocation decisions in which needs vastly exceed available resources. (Stein, 2008) For instance, even in downstream approaches to aid, calculations based on outcomes and risk:benefit analysis have played an important role in prioritization and selection of patients and populations. (Hunt, 2011) However, Barnett and Snyder (2008) argue that it is only in the past decade that a utilitarian emphasis on outcomes has come to supersede the more traditional deontological discourse of rights and needs in humanitarian aid. Stein (2008) describes the radical change this ideological shift has on humanitarianism as follows: "This is no longer humanitarian assistance as a need, much less as a right, but assistance when and where it is effective." (Stein, 2008, p. 134) Barnett and Snyder (2008) argue that the move towards consequentialism stems from 2 primary sources: (1) increasing recognition that humanitarian action, despite noble and best intentions, has produced negative results, and (2) a growing movement within humanitarianism recognizing the importance of upstream approaches to aid which are more in keeping with a general commitment to overall utility.[17]

The recognition that humanitarian action can produce negative outcomes has been the subject of considerable debate and scrutiny. Critics contend that humanitarian aid has fuelled conflict by supporting repressive governments and militarizing refugee camps, as well as

[17] Barnett and Synder (2008) note that the shift to consequentialism also arose in part due to mounting pressure on the part of donors and relief agencies for proof that aid was efficient and effective. This emerged in the context of the proliferation of aid agencies in the 1990s and concern for evaluating which organizations were most successful at relieving suffering.

enabling states to appear to be engaged in a crisis without actually being forced to act in a constructive way. (Barnett and Snyder 2008; Terry, 2002) Aid has also been charged with distorting the local economy by subverting local economic activity, producing new kinds of dependencies, and reinforcing existing political and economic inequalities. (Barnett and Snyder, 2008) Although these consequences are not new to humanitarianism,[18] the scope of the growing discourse and unease surrounding humanitarian action that arose in the 1990s is largely unprecedented. (Barnett, 2011) The sum of much of this analysis was that humanitarian aid must attend to and anticipate consequences of action/inaction, and first and foremost do no harm. In keeping with this, the moral language of humanitarianism began to shift from needs, duties and rights to monitoring the consequences and outcomes of humanitarian work with the aim of minimizing disutility. (Stein, 2008) Many large humanitarian NGOs have started to look more rigorously at standards and quality assurance protocols, and recent codes and charters, including the Sphere Project, have emerged as a means of improving accountability and efficiency. (Barnett, 2011)

Challenges and Limitations

One of the most important challenges facing utilitarianism is the "calculation problem". (Burnor and Raley, 2011) The calculation problem centres on the fact that the outcome of an action- including scope, duration, intensity and probability- may be difficult to predict; this is especially pertinent in humanitarian healthcare aid contexts where the situation can change rapidly and is often characterized by considerable uncertainty. Measurement and assessment

[18]For example, two important early humanitarians, Henri Dunant and Florence Nightingale, discussed whether aid could cause harm by absolving states of the responsibility to care for wounded soldiers. Nightingale believed providing aid in this manner would do more harm than good and refused to participate in Dunant's cause, which later developed into the ICRC. (Polman, 2010)

tools for evaluating humanitarian action have not been adequately developed, (Stein, 2008) in part because the extreme contexts in which humanitarianism occurs may render it difficult to develop and deploy measurement tools. (Barnett and Snyder, 2008) On a more general level, some resist the idea of outcomes as a discrete variable that can be separated and identified.[19]

Evaluation of outcomes also often depends on deeper theoretical values and commitments, which require specification, and render calculations less self evident. For instance, is the utility of saving 100 lives worth the disutility of prolonging a conflict by a month? (Barnett and Weiss, 2008) An analogous concern and widely held criticism against utility calculations is that they fail to recognize distributional concerns and principles of distributive justice. For instance, do we spend resource on people who are in need today, or on people who are at risk of being in need tomorrow? Lastly, Stein (2008) cautions that too great an emphasis on evaluating outcomes and accountability represents "a strategy for humanitarian containment, not humanitarian action." (Stein, 2008, p. 138) She argues that humanitarianism must balance attentiveness to accountability and outcomes with risk-taking, innovation, experimentation and openness to learning.

A second pressing problem for utilitarianism is the "moral permissiveness problem." Consequentialism does not always yield answers that agree with our moral intuitions. In fact, utilitarianism may permit actions that violate our sense of morality. Schwartz et al. (2012) recount how humanitarian healthcare workers may feel deep moral distress when they are confronted with instances in which they are asked to override the duty they feel they owe to

[19] Humanitarian projects are part of larger programs which are, in turn, part of more comprehensive and interconnected systems. When viewed from this perspective, it becomes difficult to determine how to evaluate cause and effect with respect to discrete moments in time. (Stein, 2008)

an individual patient in favor of benefiting the aggregate good of the community.[20] The latitude within consequentialism for sacrificing the rights of the few for the goods of the many presents one of the most intuitive (and Kant would argue rational) reasons to object to consequentialism, and may be why deontological considerations of the needs and rights of individuals continues to trump utility calculations for healthcare workers in the field. (Stein, 2008)

Virtue ethics:

Virtue based ethics represents a marked departure from deontology and consequentialism. While the former is concerned with right action and the latter with right outcome, virtue ethics places emphasis on individual moral character. Humanitarians have historically been associated with a vocation in which the quality of inner character is exemplified by virtuous conduct. The connection between humanitarianism and virtue is so closely and intuitively associated by many, that some authors even describe the two somewhat synonymously: "In a humanitarian approach, people respond to human suffering and realise human fulfilment by acting in a virtuous manner based on compassion, empathy or altruism." (Alkire and Chen, 2004, p. 1070)

The WHO (2008) defines a humanitarian as a "person who seeks to promote human welfare" and then proceeds to list an extensive array of humanitarian virtues: "Humane, benevolent, beneficent, kind, good, considerate, compassionate, sympathetic, merciful, lenient, gentle, magnanimous, public-spirited, unselfish, philanthropic, altruistic…" (the list

[20] Utilitarians respond to this is a variety of ways- notably, rule utilitarianism tries to overcome this limitation by generating rules which maximize utility while honouring moral commitments –i.e, do not lie, cheat or kill.

goes on.) Hugo Slim argues, somewhat tongue in cheek, that it is the following practical virtues that define a good humanitarian: "reasonable expectations; compassion; fine judgement, and a little bit of cunning." (Slim, 2005) In short, the language of virtue tells us not what kind of things we should do, but what kind of people we should be. Virtue ethicists would argue that the kind of people we should be is central to the humanitarian project, for the more people are virtuous, the happier life they and those they seek to help will lead.

First pondered by Plato and the Stoics, virtue ethics was later developed by Aristotle in *Nicomachean Ethics*. For Aristotle, the aim of ethics was practical; virtue was a state of character that arose from the habitual disposition to act well. (Pellegrino and Thomasa, 1993) Virtues are character traits that make a person good and enable her to do good work. One can think of a virtue as occupying the middle of a triad; as one moves further from the center one moves in the direction of vice. (Durant, 1961) For example, courage if taken to an extreme can become recklessness and if left underdeveloped may become cowardice. According to Aristotle, virtue lies in finding the middle way, or in the discovery of a golden mean: "Some vices miss what is right because they are deficient, others because they are excessive, in feelings or in actions, whereas virtue finds and chooses what is intermediate." (Aristotle, NE, 1107a, 16) Virtues are intrinsically good and are to be developed and cultivated for their own sake.

The discovery and application of the golden mean is guided by phronesis. Phronesis is considered a form of practical wisdom and depends upon the application of moral reason guided by past experiences. Behaving virtuously thus means more than acting in accordance with certain core humanitarian virtues, it depends on the development of phronesis as the

learned ability to act virtuously: right action done for the right reasons, with the right feelings and producing the right outcome. The narrow description of virtue ethics in humanitarianism that limits itself to listing cardinal virtues and emphasizing the importance of moral character (Barnett 2011; Barnett and Weiss, 2008) thus misses the most important contribution of Aristotelian ethics, the development of phronesis.[21]

Aristotle compared phronesis to a learned skill, and modern philosophers have increasingly explored how similarities to skill acquisition might help us better understand the concept. In *Intelligent Virtue* Julia Annas suggests that the exercise of phronesis shares three features common to skilled behavior: (1) it is habitual, (2) it is dependent on moral motivation and judgement, and (3) it is articulate. A closer examination of these three categories will provide insight into both the nature of phronesis and the relevance of virtue ethics to humanitarianism.

Firstly, for Aristotle, phronesis is a *habitual disposition*, it depends upon the ability to act consistently in a manner which brings about the good. To understand why habituation is central to phronesis it is helpful to examine the distinction between habit and routine. Annas argues that a central feature of routine is that reactions to a given situation are always the same and behavior can be predicted. With habituation, the action and outcome can still be counted on reliably, but in contrast to routine, habituation responds creatively and correctly to the changing and specific elements of a scenario. Aristotle writes:

> "It… seems to be characteristic of the more courageous person to be unafraid and unruffled in sudden alarms rather than to be so in those that are foreseen; it

[21] Promoting the development of phronesis has been advanced as a way in which humanitarian workers might learn to respond ethically in complex scenarios. (Hunt, Schwartz and Fraser, 2013) See also Hugo Slim (2005) for a discussion of phronesis in humanitarianism.

> comes from his state of character (hexis), because less from preparation. Foreseen actions can be rationally chosen on the basis of calculation and reason, but unforeseen ones only in virtue of one's state of character." (Aristotle, NE, 1117a)

Humanitarians working in contexts of disaster, war or extreme poverty encounter new scenarios and ethical dilemmas with which they are often unfamiliar. (Schwatrz et al. 2012; Hunt, 2011). Phronesis entails that humanitarian healthcare workers be able not only to adapt to new and different contexts, but be are able to respond appropriately to the emerging and distinctive features encountered in novel situations.

Secondly, phronesis requires excellence in moral *motivation and judgement*. Motivation and judgement are two of the key features which distinguish virtue ethics from deontological and consequentialist philosophies, and deserve closer scrutiny. For the virtue ethicist, motivation is what enables us to act well, and this is important because as the virtue ethicist argues, we value being treated *well* as opposed to simply being treated *rightly*. (Annas, 2011) Let us return to the allegory, where you are confronted by people drowning in a river. Suppose you are familiar with the principle of humanity and have a strong grasp of the categorical imperative and your duty to help a drowning stranger. Suppose you are also a strong swimmer and a well-trained first responder, able to rescue the drowning in a timely and effective manner. You are motivated primarily by the expectation that by performing these feats of rescue you will be lauded as a hero; moreover, your are fairly certain that one of the drowning people might provide you with a financial reward. While we could not in this case fault you for not having acted rightly (you are providing efficient and much needed rescue efforts consistent with humanitarian principles) we would be correct to question whether or not you have acted well. We value humanitarian action partly because we believe it embodies the virtues of compassion, empathy, beneficence and kindness. When evaluating actions, we don't just

consider the outcomes an action produces, but consider for what reasons and in what manner the action was carried out. For Aristotle, the motivation behind an action is intrinsically valuable, because it is the motivation combined with the outcome that leads to the common recognition of an action being done well.[22]

Moral motivation is also instrumentally valuable, because it lends itself to habituation; it enables us to be counted on to act reliably in the future. (Annas, 2011) It is difficult to say whether we could depend on you to continue to act in a humanitarian capacity if your primary motivation changes. If it becomes readily apparent that you will be offered neither financial reward, nor recognition, we might reasonably feel unable to count on you to continue to save lives (or to do so in the future). As Barnett (2011) and Hopgood (2008) point out, if all we care about is right action, then it should make no difference to us whether aid is distributed by MSF, WalMart, or the military. And yet this distinction does seem significant, not only because an aid organization may be technically more proficient in providing humanitarian care, but because we expect humanitarian organizations to act in accordance with humanitarian virtues and to: "…show up when needs are great, not only when there are profits to be made or power to be grabbed." (Barnett, p. 2011, 235.) Phonesis thus requires correct moral motivation, because moral motivation is essential to both the intrinsic moral worth of the act and necessary to ensure that morally worthy action can be reliably counted upon. Virtue ethics provides an account of acting well which is missing from duty based imperatives, principle based accounts, and risk:benefit calculations.

[22] Kant denied the relevance of motivation for moral action. The only motivation relevant to Kantian deontology is the Good Will, in which action is done out of moral duty and not because of anything else, whether this be pleasure, knowledge or satisfaction. (Burnor and Raley, 2011)

Moral judgement is also essential to morally worthy action. Jan Egeland, former UN Undersecretary General for Humanitarian Affairs and Emergency Relief Coordinator (2003-2006) is quoted in the New York Times: "You aren't allowed to be amateurish if you are in the game of saving lies… The one human right that the poor and the vulnerable should have at the very least is to be protected from incompetence." (Hoge, 2004) Good motivation absent proper judgement can result in a number of harms; they can raise unmet expectations, prove ineffective, impose undue burdens on local health facilities, and/or be inappropriate.[23] (Suchdev, et al 2007) This type of misalignment between motivation and judgement has led to an emerging consensus within humanitarianism that it is no longer sufficient to be good, that one must do good. (Barnett, 2011) Although this historical shift in humanitarian morality is often described with respect to the shifting emphasis from deontic to consequentialist ethics described earlier, the proper alignment of intention and outcomes is central to the ancient definition of phronesis and the exercise of virtue- which is by definition the union of being and doing.

Phronesis in humanitarian healthcare aid depends upon the ability to weigh all possible outcomes and evaluate them with respect to that which best serves the goal and embodies the ideals of the humanitarian project. In this sense, virtue ethics is less prescriptive than utilitarianism. Emphasis on consequences takes the form of practical judgement, guided by personal knowledge and experience, to achieve the union of intentions and outcomes. Thus, while a deontologist would continue to stand at the river in order to save the people in front of her from drowning, and a consequentialist would run up river to try to save as many

[23] Examples of motivation misaligning with judgement in humanitarianism are ubiquitous and range from the absurd- sending Somalian famine victims laxatives, electric blankets and slimming cures- to the tragic- surgeons on short term missions amputating limbs without considering proper postoperative care, leaving patients susceptible to haemorrhage, sepsis and death. (Polman, 2010)

people as possible, a virtue ethicist would make a situation specific decision, based upon individual judgement, past experience and properly aligned with the fundamental goals of humanitarianism.

Finally, phronesis is like a skill in that it can be taught and is *articulate.*[24] (Annas, 2011) Generally speaking, children learn to differentiate right from wrong partly by accepting the explanations of their parents. Accepting the testimony of a mentor or teacher is an essential starting point for the student, who, with active engagement, experience and practice will eventually come to a similar level of expertise.[25] Hugo Slim discusses the value of moral role models in humanitarianism and suggests that in humanitarian aid, "insiders", or virtuous people who are part of the community in which aid is being delivered might best serve as role models. Aid workers can learn important lessons from the suffering, conduct, convictions, understanding and hopes of the very people it seeks to help.[26] (Slim, 1997) It is a general accepted critique that humanitarianism fails to take into account the perspectives and agency of the individuals and populations it seeks to help (Barnett, 2011). While by no means providing a sufficient response to this critique, by privileging mentorship and moral

[24] By definition, articulacy means the ability to express ideas or thoughts fluently and coherently, or to pronounce something clearly and distinctly. Annas uses the concept of articulacy to suggest that part of behaving virtuously involves the ability to clearly and coherently explain and justify the reasons behind an ethical choice. In Aristotelian virtue ethics, justification of ethical decision making, of why an action is considered right or wrong, can be taught and learned, and therefore behaving rightly requires this ability to explain ethical choices.

[25] Pellegrino offers some practical examples of how phronesis can be taught to medical students: the use of clinical instructors as role models, promoting self-reflective practice, offering courses in medical ethics and the humanities, and introducing students to virtuous figures that can serve as historical role models. (Pellegrino, 2002)

[26] It is important to note that while phronesis may begin with deference to a mentor, this is only a starting point. As the learner matures and develops, she must gain understanding which is available only through experience. The development of virtue is a matter of habituation in which an agent needs to understand for themselves what is required and cannot rely solely on the testimony of others. It is through repeated experience and with practice that we come to understand how to prioritize between different obligations and how to behave well in new and unfamiliar situations. While phroenesis can be taught, it is also experiential and heuristic and what is essential is not mimicry of role models, but a more profound understanding of what it means for *me* to behave and act rightly which is developed from an ongoing engagement with the world. (Annas, 2011)

teaching above western rules and codes of conduct, virtue ethics has the potential to engage with local values and belief systems slightly more than principlist or human rights accounts. (Hunt, 2011; Widdows, 2007)

Challenges and Limitations

Virtue is tautological: the virtuous person does what is good, and the good is what the virtuous person does. Critics argue that this circular argumentation provides little in the way of substantive guidance on moral matters. This is especially true at macro or system level decision making. An ethical theory, which is fundamentally aimed at the level of personal character, will necessarily fall short of dealing with more meta-level concerns. One response to this is to argue that virtue ethics alone may be insufficient as a comprehensive theory and may require supplementation with principles and rules.[27] Another significant challenge confronting virtue ethics is the problem of attainability. (Slote, 1987) Achieving the union of right action, done for the right reason, with the right reason and producing the right outcome, is critiqued by many as setting an impossible moral standard. To set the bar this high means that no one qualifies as being truly virtuous. This is especially relevant in light of the fact that one is supposed to learn how to act virtuously based on past experience, but part of phronesis means responding to new scenarios correctly. This might be especially difficult in humanitarian contexts, where the moral dilemmas encountered will often be novel, challenging and complex. Absent the wisdom of past experience, how can the novice humanitarian be expected to respond virtuously? Deontology and consequentialism are more practical moral philosophies in the sense that by asking us either to "do the right thing" or

[27] See Hursthouse (1999) who provides a supplementary account of virtue in which she develops a series of V-rules to guide conduct.

"evaluate the right outcome", they don't expect us to become a person it might be impossible for us to be. (Burnor and Raley, 2011)

II) A case study

The following example is indicative of some of the tension that arises in humanitarianism between deontology and consequentialism, intentions and outcomes. It also encapsulates one of the more fundamental and frequently asked questions of humanitarianism: should humanitarian aid be provided unconditionally? In *Condemned to Repeat: A Paradox of Humanitarian Action,* Fiona Terry, then acting head of MSF France, describes the situation facing humanitarian organizations operating refugee camps in Zaire during the Rwandan genocide. During this period, it became increasingly apparent that the camps were being used by "refugee warriors" as tactical places for safe settlement, gathering strength and support for armed militias to re-enter Rwanda, potentially prolonging the conflict and resulting in many more wounded, displaced and dead. Several humanitarian aid agencies began to worry that by providing aid they were becoming complicit in strengthening a regime responsible for genocide. The central question Terry and others asked themselves was: "Can we, in the name of moral principles, cease to aid a population in need?" (Terry, 2002, p.2) Terry provides a nuanced analysis of this tragic decision and a compelling argument for the ways in which it has been a recurring dilemma in modern humanitarianism (Bosnia, Kosovo, South Sudan, and Cambodia being other notable instances in which humanitarian refugee camps have been subject to the criticism that they have done more harm than good by inadvertently prolonging conflict and strengthening genocidal regimes.) While the example is complex and worthy of the more detailed analysis it has received

elsewhere, it also clearly highlights the ways in which different ethical theories underlie and shape moral responses in some very simple and straightforward ways.

The response put forward by the majority of non-governmental organizations (NGOs), with the exceptions of MSF France and the International Refugee Committee (IRC), was fundamentally deontological. Humanitarians believed they owed a duty, grounded in their shared humanity, to the individuals living in the camps. Humanitarians who advocated staying in the camps argued that the action was right regardless of the greater potential harm it might produce, and that to abandon the refugees to their individual fates was tantamount to treating them as a means to an end.[28] Those who stayed in the camps argued for the right to a minimum standard of health and protection for all, in accordance with the principles of humanity, impartiality and neutrality. The inherent dignity of humanity meant that sacrificing the individual lives of those dependent on the camps for safety, security and survival was untenable.

This stands in contrast to the consequentialist response offered by MSF France and the IRC, who argued that the provision of aid, from security to economic resources, implicated aid actors in all outcomes- meaning that MSF was a participant in the greater harm that was occurring. (Terry, 2002) Because MSF was unable to halt the harmful practices occurring within the camps they operated, and because disutility overwhelmed the short-term good being accrued by people in the camps, MSF France honored a consequentialist commitment to leave the camps. MSF France and the IRC adopted a classically utilitarian approach: options for action were identified; overall utility was generated for each course of action

[28] For instance, it was argued that it was both morally (and legally) unacceptable to achieve a punishment (sanctions against the refugee warriors) by withdrawing basic human rights.

(subtracting disutility from overall utility) by considering such factors as scope, duration, intensity and probability, and the option representing the greatest overall utility was adopted. For those who chose to leave the camps, doing the right thing meant anticipating and evaluating outcomes in an effort to minimize harm (disutility) and promote the greatest good for the most people.

This case also demonstrates the difficulty of applying virtue ethics to macro level decision making. A virtue ethicist might argue that those in decision making positions in this case should display the virtues of thoughtfulness, compassion, courage, and intelligence, and use wisdom gained from past experience to help inform decision making. While this theory proves informative about the elements that should go into the deliberation process, it is less instructive than deontology or consequentialism, on what the end product of decision making might be and why.

III) Conclusion

Since its inception, humanitarianism has encountered numerous tensions and been confronted with difficult ethical questions. While questions may be reformulated in different ways and with different emphasis, given their significance they are likely to persist. In the pursuit of saving lives and reducing human suffering, humanitarian healthcare aid must balance between prioritizing between the worst off and maximizing harm reduction, (Rubenstein, 2008), evaluate between present need and future needs, and balance the needs of the many and the needs of the (comparatively) few. It must decide whether right action is ethical regardless of the consequences which result, or whether the ethical act is contingent on the outcomes it produces. In essence, it must decide whether it is right to keep diving

into the river or whether it is better to turn its back on the splashing and shouting and head upstream.

While responses might differ for different humanitarian organizations, and may vary depending on the specific contexts and situations faced by an organization,[29] it nonetheless begs a response, and this response has important ethical implications. And yet, the question remains: how does recognizing the complexities of ethical questions and the incommensurability of ethical theory here presented move the discussion of humanitarian healthcare aid forward? Do the differences between ethical theories and endless discussions of upstream and downstream approaches risk casting us adrift?

There is increasing recognition that perhaps there is no one "right" response to these complex ethical questions. Humanitarianism is enacted in a 'second-best world', characterized by complex questions, tough choices, ethical tensions and dilemmas. The philosophy of pure ethical theory may never completely fit with the messy realities of this less than ideal world. What ethical theory is able to do is provide us with a set of lenses through which we can come to conceptualize problems differently (Sherwin, 1999). A richer understanding of ethical frameworks brings out important values and considerations, which come into clearer focus when looking at a problem through the particular lens of an ethical theory. It suggests why we might view human autonomy, individual need and human rights as paramount; or why consequence and outcomes matter when trying to ensure greatest

[29] For example, MSF Holland states that it will: "aim to reach those most abused and/or most in need in any given context- over attempts to have the greatest impact for the greatest number"; while a CARE paper on food aid stipulates that "CARE is committed to maximizing efficiency and impact." (Rubenstein, 2008) Even when deontological commitments are valued they are not absolute, and may be subject to more pragmatic constraints. Rubenstein notes that in spite of its declaration to respond to need, MSF-Holland draws the line at providing costly medical treatments such as dialysis, chemotherapy or cardiac surgeries. In contrast, Partners in Health (PIH), an NGO founded by Paul Farmer, spent $20,000 to try to save one Haitian child (Kidder, 2004).

utility; or why moral motivation and character might prove essential to virtuous conduct. This type of understanding facilitates and enriches deliberation and communication of moral values, norms and principles, clarifies tacit assumptions, and ultimately lends itself to greater moral clarity and richer ethical analysis. Recognition of the limitations of a theory also prompts important questions that may bring new concerns to the forefront, and pushes ethical engagement in new directions. In short, understanding ethical theory enables us to think critically and enriches moral judgement, two components which are central to the "essential art of humanitarian judgement" (IFRC, 2003, p.7), which ultimately shapes how, why and in what way humanitarian healthcare aid is practiced.

Although this essay has focused on the differences between ethical theories, it is worth noting that efforts are being made to reconcile these philosophical differences in constructive ways. Reflective Equilibrium (RE), first described by John Rawls and later modified by Norman Daniels, is one such approach. RE has been advanced as a methodology for reconciling moral theory, intuitions, and principles in a non-reductionist way. This approach blurs the boundaries between practical ethics and ideal ethical theory, and has been taken up by bioethicists as a means of problem solving. (Arras, 2007). RE asks us to make room for all beliefs that might contribute to a richer synthesis of ethical problems. The basic premise of RE is that a moral belief is only justified to the extent that it is coherent with a wide set of other relevant beliefs. We feel justified in a belief when we have a maximum amount of confidence in it, and weighing and testing one set of beliefs against others generates this confidence. Arras (2007) describes the process as follows:

> "Considered judgments, principles, and background theoretical considerations incorporate as many moral and empirical beliefs as possible, and allow us to test each of these elements or strata against all of the others. Crucially, as mentioned before, no single element or stratum of this dynamic mix of beliefs is considered

> to be foundational or immune to criticism. We shuttle back and forth from judgements, to principles, to theories, and back again- always adjusting, pruning and seeking coherence among the widest possible set of relevant beliefs." (Arras, 2007 p.52.)

Thus, by balancing and moving in dialectical fashion between ethical theory, intuitions, principles and relevant empirical background, we come to a harmony or equilibrium, which may be the best chance we have at uniting practical moral reasoning and ideal ethical judgement.

In the context of humanitarian health care aid, RE would require that we contemplate moral theory, including deontology, consequentialism and virtues ethics, weigh the strengths and limitations of each approach, contrast and compare with humanitarian principles and the relevant empirical background knowledge (of social, historical, psychological, political, conditions etc.) to come to a more fully justified decision. Because the questions asked of modern humanitarianism are by no means small and the answers complex, a rigorous process of ethical reflection and justification is the very least we should expect and RE might provide one possible method of doing so.

While RE has valuable implications for evaluating ethical theory and facilitating moral judgement on complex humanitarian problems, it has also been critiqued for being somewhat idealized and impractical. (Arras, 2007) Arras argues that a distinction should be made between the more or less ideal method of moral justification represented by RE and a more "rough and ready" decision making procedure that might be helpful in guiding our thinking in practical ethics. Ethical analysis tools present one such resource aimed at guiding decision makers in deliberating on ethical problems. As such, the next chapter will engage in a closer examination of the strengths and limits of these tools for ethical decision making.

Chapter 3: Mapping the Moral Landscape: From Ethical Theory to Ethical Analysis Tools

In the classic children's story *Alice in Wonderland*, Alice meets the Cheshire cat at a fork in the road. Alice, uncertain about which direction to go, asks the cat for guidance:

> "Would you tell me, please, which way I ought to walk from here?"
> "That depends a good deal on where you want to get to," said the cat.
> "I don't much care where," said Alice.
> "Then it doesn't matter which way you walk," said the Cat. (Carroll, 1954 pp. 62-63)

Alice's decision to pick one road over another is rendered easy by her indifference; she is obligated to no one and has no immediate objective, as such, her decision whether left to chance or deliberation, is of little importance. Decisions are rarely this easy or arbitrary because more often than not we do care about the decisions we make and where they will lead us. Normative decisions pertaining to standards of right and wrong are relevant in all spheres of life. For instance, in the health care professions some argue that, broadly speaking, the clinician is not only a skilled technician; knowledgeable in medicine or nursing, but above all a moral agent. (Pellegrino 2002; Benner, 1984) Edmund Pellegrino has written that when people join the healthcare professions they engage in an act of "profession"- of promise and dedication to an ideal. Upon graduation, most clinicians will swear an oath to place their specialized knowledge at the service of the sick. This public pledge is made manifest in the daily encounters between clinician and patient; each time a clinician asks a patient " What can I do for you?", she is committing herself to two things: to have the skill and knowledge to help the patient and to use this knowledge and skill in the best interests of the patient (Pellegrino, 2002). Unlike Alice, clinicians, including those who participate in humanitarian action, are committed to contemplating and choosing the good, or right, road

from the outset – one that reduces pain, promotes health and well-being, eases suffering and provides healing.

If one accepts the premise that clinicians are moral agents then it follows that ethical decision making is an important part of clinical care. Ethical decisions may take the form of dilemmas – the weighing of two bad options (Slim, 1997) – for example, decisions of triage priority in humanitarian healthcare aid (de Waal, 2010). Ethical decisions may also be subtle and quotidian, sometimes involving unconscious or intuitive choice – such as how much time to devote to a particular patient, or what acting beneficently means for this particular patient, in this particular context.[30] (Oberle and Raffin-Bouchal, 2009; Benner, 1984) Decisions made well, in which intentions and outcomes meet and the best interests of the patient are served, can result in feelings of satisfaction, of having "done the right thing", which is one of the ultimate rewards in professions devoted to caring for others. (Slim, 1997) Conversely, decisions yielding poor outcomes, or decisions in which clinicians feel they know the right thing to do, but are unable to enact it, can lead to feelings of moral distress and have negative impacts on patients and professionals alike. (Austin, Bergum and Golderg, 2003; Sundin-Huard and Fahy, 1999) In humanitarian contexts where needs are high and resources scarce, encountering ethical dilemmas and experiencing moral distress is frequently reported by humanitarian healthcare workers. (Schwartz et al. 2010; Sinding et al,, 2010)

[30] While it may seem apparently contradictory to include unconscious or intuitive choice in a discussion of deliberative decision making, virtue ethicist and others have argued that moral decision making is experiential and proceeds from accepting moral testimony, to reasoned and conscious deliberation, to unconscious choice (For a detailed analysis see Annas, 2012; Benner, 1984) In this sense, even choices which appear intuitive or reflexive may involve complex deliberation and are deserving of greater scrutiny.

Ethical guidance for clinicians takes a variety of forms. Moral theory, applied ethics, health care legislation, codes of ethics, institutional guidelines and mentorship, are all integral to bioethics. In the past twenty years, a variety of applied resources have been developed to assist clinicians in ethical analysis and deliberation. In contrast to ethical theory, which engages in nuanced analysis of philosophical problems, ethical tools are first and foremost pragmatic instruments, aimed at providing clinicians with step-by-step guidance for approaching ethics dilemmas. These tools (sometimes referred to as frameworks, models, or guidelines) share a common purpose: the facilitation of systematic, comprehensive and reasoned ethical deliberation. (Hunt and Ells, 2013; Oberle and Raffin-Bouchal, 2009; Cottone and Claus, 2000) Tools are generally comprised of a series of steps or questions that prompt decision makers to consider important elements in ethical deliberation (for examples of some analysis tools see Appendix A). Health care curricula increasingly incorporate such tools as a means of supporting and teaching ethical deliberation.

If ethical decision making is akin to navigating a complex moral landscape, then these tools may be likened to a map; indicating potential paths, highlighting relevant elements of the topography and ultimately providing a sense of direction. In spite of the proliferation of ethical analysis tools, and the increasing attention they are being given within health care curricula, there has been little critical examination in the literature of the relevance and value of using these tools in healthcare practice.

The broadly held assumption that these tools have the potential to improve ethical deliberation deserves greater scrutiny. The relevance and value ascribed to tools by practitioners has implications for patients and professionals alike, whether in humanitarian

healthcare delivery or in more stable and higher-resourced western systems. Tools may be used to work through cases in which high-stakes decisions are made and have the potential to impact patient care. This application may be of special significance in critical care settings or when determining allocation of scarce resources. In addition, tools which support better decision making may also provide a valuable resource for reducing moral distress in clinicians, often cited as a reason for attrition from the healthcare professions. (Elpern and Kleinpell, 2005; Austin, Bergum and Golderg, 2003) MSF has reported that 50% of aid workers do not do more than one mission, and it is possible that the moral distress experienced by humanitarian healthcare workers may be an important contributor to attrition from humanitarian work. (Schwartz et al. 2010) Some have argued that the development of analysis tools will enable humanitarian aid workers to better prepare for and process the ethical dilemmas they are likely to encounter in the field. (Dwyer, 2003; Hunt 2009)

In this chapter, I will begin by providing an overview of the type and scope of ethical tools available to date (part I). I focus on tools that have been designed for a variety of clinical settings; for although not specifically designed for humanitarian healthcare contexts, such tools may be adopted by healthcare workers for resolving ethical issues in whatever contexts they see fit. Special consideration will be given to the applicability of these tools in humanitarian healthcare. I will then examine in greater detail a representative sample of ethical analysis tools, noting relevant similarities and differences between them (part II.) In part III, I will describe some of the strengths and limitations of these tools more generally. The discussion surrounding the strengths and limitations of analysis tools has included a

series of interesting assumptions, claims, and counterclaims which have yet to be rigorously investigated in the bioethics literature.

An analysis tool is meant to be an applied resource- a practical instrument- and like any other tool, should be evaluated and measured with respect to its ability to achieve the aim for which it was designed. To this end, a set of questions is proposed which arises from the discussion of strengths and limitations of such tools and might be used to guide empirical research on the value and validity of these tools for ethical deliberation in health care (Section III). I will argue that although subject to limitations, when used judiciously, ethical decision making tools can provide useful guidance to clinicians. However, empirical research on the value, use and benefits of these tools for ethical deliberation is required.[31] It is generally considered imprudent to use a tool that has not been empirically tested or validated. Given the potential relevance of these tools and the continued proliferation of publication of these tools in the academic literature, such investigation and enquiry seems a requisite and timely step.

31 One potential reason for the lack of research on these tools is that research into the value and validity of tools face certain notable challenges with respect to study design and implementation. It is a complex undertaking to evaluate what constitutes a "better" ethical decision or decision-making process. Furthermore, ethical deliberation in the clinical world is confidential and it may be difficult to evaluate real-world decision making in detail. However, the disciplines of moral psychology and business ethics have been conducting empirical research on similar types of questions for many years and may offer some important insights into study design. (Appiah, 2008; Casebeer and Churchland, 2003; Loe, Ferrell and Mansfield, 2000) Moreover, empirical research in bioethics has grown over recent years and is becoming an increasingly accepted component of the bioethics literature (Borry, Schotsmans and Dierickx, 2006). Therefore, research into the value and validity of ethical analysis tools may present notable though not insurmountable challenges, and is arguably both timely and feasible.

I) Overview of ethical models, frameworks, guidelines and tools

The terminology surrounding ethical decision making tools varies considerably with resources alternatively described as frameworks, models, tools or guidelines. While models are broad in scope and seek to explain or delineate core elements of a phenomenon, frameworks are more attuned to specific contexts and provide a structured approach to evaluating relevant considerations and principles that are applicable within that context. (Oberle and Raffin-Bouchal, 2009) Guidelines generally encompass an ordered set of processes or principles that can determine a course of action; they may be more tailored and action oriented than a framework or model. Part of the semantic confusion surrounding these terms is illustrated by Schaffer, Cameron and Tatley (2000) who in spite of naming their resource "Value, be, do: *Guidelines* for resolving ethical conflict" consistently refer to their tool as a decision making *model*. Tools in the context of this paper will refer to any resource that supports ethical decision making processes and include frameworks, models and guidelines. Regardless of terminological nuance, these tools share a common goal: to provide step-by-step guidance in ethical analysis and deliberation.

Ethical analysis tools have increased markedly in the past thirty years and represent a variety of disciplines and theoretical perspectives. Some tools are broad in scope - for example, clinical decision making models applicable in a range of clinical contexts and scenarios (Storch, 2012; Keatings and Smith, 2010; McDonald, 2009; Gracia, 2003) - or models addressing macro level resource allocation, or public health decisions. (Thompson et al., 2006) Other tools are tailored to specific clinical contexts or professions; for example, models developed specifically for rehabilitation care (Hunt and Ells, 2013), community

health workers (Community Ethics Network, 2008), speech language pathologists (Kenny, Lincoln and Balandin, 2007), and nurses. (Schaffer, Cameron and Tatley, 2000) The moral philosophy underlying resources also demonstrates considerable variation: models employ principlism (Storch, 2012; Keatings and Smith, 2010; McDonald, 2009; Chambers-Evans, 2000); feminism (DeRenzo and Strauss, 1997); relational ethics (Oberle and Raffin-Bouchal, 2009); virtue ethics (Schaffer, Cameron and Tatley, 2000); ethics of care (Davis, 1997); constructivism (Cottone, 2001); casuistry (Jonsen, Siegler and Winslade, 2002) and transcultural decision making, (Garcia et al., 2003) amongst others.

Tools may be more or less explicit in how they use moral theory and account for their theoretical foundations. (Hunt and Ells, 2013) Ethical analysis tools are also developed quite differently. Some originate from empirical work and/or engage in a formal process of research and enquiry for further refinement. (Gracia et al. 2009; Gracia et al. 2008; Thompson et al., 2006; Schaffer, Cameron and Tatley, 2000) Generally however, empirical investigation of ethics analysis tools is the exception rather than the rule, and most tools are developed using moral theory, at times coupled with practical experience. (Centre for Clinical Ethics, 2012; Storch et al., 2012; Keatings and Smith, 2010; Oberle and Raffin-Bouchal, 2009; McDonald, 2009; Community Ethics Network; Garcia et al., 2003; Cottone, 2001; Chambers-Evans, 2000; DeRenzo and Strauss, 1997; Hills, Glaser and Harden, 1997)

II) Ethical analysis tools: Principlism, Relational ethics, Feminism, and Virtue

Before attending to differences, it is worth noting that there is considerable overlap and similarity between tools. The espoused goals of tools share certain fundamental characteristics; they are designed with the aim of supporting and structuring deliberation and

promoting comprehensive, rational and systematic decision making processes. By and large, tools offer a step by step procedure to achieve the following objectives: break down a decision into its component parts, identify and examine these parts in an orderly and systematic fashion, generate different possible courses of action, contemplate the magnitude and probability of consequences which might follow from choosing one course of action over another, and ensure that decision makers follow up and reflect upon the results of the decision taken. (Gutheil et al., 1991) This stepwise approach is especially common amongst analysis tools designed for clinical contexts, which are generally principlist in orientation and tend to follow a similar structure.

It is beyond the scope of this paper to provide a comprehensive or systematic review of all decision-making tools. Without being exhaustive, the following overview provides a purposive sample that is illustrative of some of the important conceptual, contextual and procedural elements that underpin ethical analysis tools, and highlights some of the diversity and range of tools available to date. For conceptual ease and clarity, tools are subdivided into categories representing the more common moral theories and approaches in bioethics today: principlism, relational ethics, feminist ethics, and virtue ethics.

Principle based ethics

Many decision-making models employ a principle-based account in which balancing and ranking established moral principles provides clarification on the salient values at stake in a given problem. Some models use principles exclusively, (Storch, Rodney and Starzomski, 2012; Keatings and Smith, 2010; McDonald, 2009; Community Ethics Network, 2008;

Thompson et al., 2005; Chambers-Evans 2000; Campbell et al., 1990) while others do so in conjunction with other forms of moral philosophy or religious values. (Catholic Health Association of Canada 2012; Garcia et al., 2003; Cameron, 2000) Several models directed at clinical decision making follow a similar format – generally a series of 2-6 steps – and require the specification, ranking and balancing of familiar bioethical principles: autonomy; non-maleficence, justice, beneficence, veracity and fidelity. (Storch, Rodney and Starzomski, 2012; Keatings and Smith, 2010; McDonald, 2009; Chambers-Evans 2000) Some models specify a list of principles or values deemed especially relevant to a particular context. For example, a model designed to assist ethical deliberation in pandemic planning emphasizes equity, liberty, privacy, proportionality, stewardship and solidarity, amongst others, (Thompson et al. 2006) while a model designed for community health workers identifies principles of advocacy, safety, confidentiality, empowerment and access. (Community Ethics Network, 2008)

Given that most clinicians are familiar with principles of medical ethics (Beauchamp and Childress, 2012), principle-based tools have the immediate benefit of being easily understood and accessible to practitioners. As noted in chapter 2, principlism provides a useful vocabulary for clarifying relevant values and provides a series of benchmarks for evaluating potential action. The step-wise algorithms of many of these models are linear, simple and easy to follow; potentially facilitating a decision making process that is straightforward and logical. Models specifying sets of principles tailored to specific contexts may highlight important concerns and values otherwise overlooked, potentially ensuring a more comprehensive and judicious decision making process. (Community Ethics Network, 2008; Thompson 2006) Principle based tools also often combine deontic codes of right conduct

(ethical guidelines, professional ethics codes) with consequentialist orientations of risk:benefit analysis and outcomes, in an effort to provide action guidance.

Limitations to principle-based tools are somewhat analogous to the critiques of principlism outlined in chapter 2. These tools lack specific guidance for the balancing and ranking of principles/values which is often the source of moral tension in the first place; they lack attention to moral motivation and character which some regard as essential to the genesis of moral action and outcomes; (Armstrong 2006; Pelegrino 2002) and there may be insufficient attention paid to the contextual and relational features of a scenario. (Oberle and Raffin-Bouchal, 2009; DeRenzo and Strauss, 1997) Most principlist tools require the identification of a specific problem, which may unintentionally narrow conceptualization of the moral landscape by emphasizing ethical dilemmas over the more systemic ethical issues arising in daily practice. An example might better illustrate this point. A qualitative study by Sinding et al. (2010) describes how working in under-resourced humanitarian contexts can lead to healthcare workers becoming accustomed to maximizing resources and deciding on triage priority on a daily basis, even if this means turning away or refusing to treat sick patients. In the words of one participant: "You're playing God because you have to at some point because there are too many, there's just too many sick cases and sick kids that you can't look after them all…" (Sinding et al., 2010, p.150)

Being unable to provide care that is in the best interest of a patient, or group of patients, is a common feature of humanitarian healthcare and a source of moral distress for healthcare workers. Insofar as this problem is systemic, it raises moral questions that are inadequately

captured by principlism[32], which tends to characterize ethical dilemmas in terms of competing principles. In these cases, there is no acute dilemma, because resource scarcity may be a chronic problem, and principlism fails to capture the complexity of systemic moral issues. A final limitation of principle-based tools is that many are remarkably similar in content and structure, raising questions of redundancy between tools and the value and integrity of publishing one tool that is near identical to another.

Relational Ethics

The "Framework for Ethical Decision Making in Nursing" (Oberle and Raffin-Bouchal, 2009) draws on relational ethics. It emphasizes concepts of moral sensitivity and embodiment and focuses on factors which impact supportive, nurturing and caring relationships. The framework also draws on feminist ethics; it accentuates sensitivity to hierarchical structures and power dynamics in health care institutions and the effects of these dynamics on individual relationships. The framework is very detailed, consisting of five steps and over thirty questions that aim to guide clinicians in contemplating the relational features at work in a given scenario. The framework also draws attention to ethical codes and legislative components as relevant features of ethical decision making.

This framework is notable for emphasizing applicability outside the scope of traditionally defined ethical conflicts or problems, to encompass the daily occurrences that can give rise to feelings of moral distress among clinicians. Unlike tools that require identification of a

[32] This is especially true in situations which have become so quotidian and normalized that they become perceived as inevitable.

problem, this framework begins by asking clinicians to assess the ethics of "the situation," and refrains from using the words conflict, problem, or dilemma throughout. Whether this framework succeeds in extending the perception of moral decision making to encompass more "everyday" ethical issues remains undetermined as the model has yet to be validated empirically. The emphasis on relational and contextual elements in this framework may support analysis of concerns which remain overlooked in principle based accounts and be useful for analyzing some of the ethical issues arising in humanitarian aid work.

Humanitarian aid occurs in contexts where social inequalities, exploitive commercial industries, colonial histories, and violence between social groups or between nations, operate on a variety of different levels and have the potential to impact individual and collective relationships. (Barnett, 2011; Schwartz et al. 2010) Humanitarian workers often report feeling moral distress and ethical tension when confronted with scenarios emerging from asymmetrical relationships, such as issues surrounding: gender inequality; (Schwartz et al. 2010) and inequitable differences in the treatment of national and expatriate staff with regards to the division of labour, remuneration and security. (Fassin, 2012; Schwartz et al. 2010) A relational tool that emphasizes attentiveness to levels of participation, perspectives of different stakeholders, and power dynamics, may help generate a clearer understanding of the contextual and relational features underpinning an ethical decision. Conversely, the length and detail of the framework may make it time consuming and daunting for busy healthcare workers and may be impractical for use in the field. The emphasis on the interpersonal, embodied and contextual may make this type of approach less suitable to certain contexts, such as decisions pertaining to resource allocation and/or public health decisions.

Feminist Ethics[33]

The "Feminist Model for Clinical Ethics Consultations" (DeRenzo and Strauss, 1997) shares many similarities with the relational ethics model of Oberle and Raffin-Bouchal, (2009), the latter perhaps developed with the former in mind. DeRenzo and Strauss (1997) reject "traditional" ethical analysis in which moral conflict is seen as the moment of departure and resolution is achieved through the specification and ranking/balancing of values and principles. Instead, the authors sought to design a model that is able to account for "housekeeping problems," or ethical problems that are non-critical, more systemic in nature and often overlooked (similar to what Oberle and Raffin-Bouchal describe as "everyday" ethical problems and illustrated by the earlier nursing example.) Although they discuss the nature and scope of ethical problems in their introduction to the feminist model, like Oberle and Raffin-Bouchal (2009), the tool itself rejects identifying the ethical problem in favor of identifying "the salient features" of a scenario. Emphasis in this model is on context and narrative, with recognition of power dynamics at play and special attention to vulnerable individuals or "previously unheard voices."

The model is also attentive to institutional ethical issues such as interdisciplinary team dynamics and organizational culture. As noted in Chapter two, a common critique of ethical responses in humanitarianism is that it fails to meaningfully engage with the ethical perspectives of national and local staff. A strength of feminist (and relational) analysis tools is this potential ability to bring to the foreground voices which might otherwise be

[33] For another example of a feminist models see Hills, Glaser and Harden (1997)

"unheard" or marginalized. The model comes in two versions: a five-page version, and a short version consisting of three steps and fifteen questions.

The strengths and limitations of the feminist model are similar to the relational model. The use of the model may be limited to clinical encounters and not as easily translated to questions of resource allocation, distributive justice, or macro or systemic level concerns. Providing two versions is an interesting feature of this model- the short version may be more accessible to clinicians working through dilemmas in applied contexts, while the longer version is available for more in depth analysis or teaching purposes.

Virtue ethics[34]

Schaffer, Cameron and Tatley (2000) developed "Value, Be, Do: Guidelines for Resolving Ethical Conflict" based on empirical research on ethical decision making in HIV/AIDS patients and the elderly. The authors found that in making ethical decisions, participants in these studies tended to use an approach that more closely resembled virtue ethics than principlism. "Value, Be, Do" combines virtue ethics, principlism and ethics of care to provide a "more comprehensive theory of ethics." (Cameron, Schaffer and Park, 2001, p.343) Compared to other tools, the guidelines offered by Cameron are short, consisting of three questions: What should I value? Who should I be? and What Should I do? Schaffer, Cameron and Tatley (2000) write that responding to the third question depends on developing a resolution consistent with responses given to the first two questions with a view to promoting right action and good outcomes. Value, Be, Do is one of the more

[34] For other virtue based models see: Jordan and Meera (1995) and Freeman. (2000)

distinct tools in that it is much simpler and shorter than others, and it is one of the few models to be agent, rather than act centred. It privileges the virtue ethicist's focus on motivation and character as essential components to moral action. All three questions require self-reflection, each highlighting the self, or the "I" that is the moral decision maker. Cameron, Schaffer and Park (2001) suggest that the Value, Be, Do model might be especially useful for clinicians who dislike the constraints of principlism and the binding rules of deontology.

The strengths of the model may also be the source of some of its limitations: it is overly broad and does not provide any tangible guidance; for example, there are no specific questions to deliberate and there is no reference made to resources such as codes of ethics, legislation, policies and/or guidelines. The emphasis on the "I" may unintentionally silence the moral voices of others who deserve to be heard or implicated in the decision making process. In contrast to most other tools, there is no question relating to adequate follow up of the decision taken. Following up on decisions is widely recognized as an important and requisite step if we are to learn from ethical analysis, and is included as a final step in most analysis tools. This omission is somewhat striking in a virtue ethics model, insofar as the meeting of intentions and outcomes is central to the definition of Aristotelian virtue as described in chapter two. Central to virtue ethics is the concept of phronesis, which is developed and learned from past experience.[35] It is plausible to assume that learning from decisions requires knowledge of outcomes. Finally, Cameron (2000) suggests that the Value, Be, Do guidelines apply equally to individual, community and systems level decision making.

[35] This also raises a paradox: for an Aristotelian, phronesis, (virtue) is a skill that is developed through experience and practice. It requires habituation. While suitable for a child, a tool would not need to be used by a virtuous agent. In fact, use of a tool would necessarily be the mark of a beginner, and not indicative of virtuous wisdom. This tension will be explored later in the paper.

The usefulness of these guidelines on a systems level is questionable as one of the central limitations of virtue and care ethics is the difficulty that arises when trying to apply them outside the context of immediate relationships. (Burnor and Raley, 2011)

III) Benefits and Limitations of ethical analysis tools

The usefulness of a tool is arguably commensurate to its ability to achieve the outcome for which it was designed. The benefits and limitations of ethical analysis tools will be examined by answering four questions which I believe are fundamental to assessing the usefulness of any tool: (1) What is the purpose of this tool? (2) When should the tool be used? (3) Who should use the tool? and (4) What is the structure of the tool (does form fit function)? As aforementioned, there is very little empirical evidence available to ground the discussion surrounding these questions. Each section therefore concludes with research questions that have yet to be answered, and which might provide valuable insight and discussion into the value and validity of ethical analysis tools in healthcare.

(1) What is the purpose of this tool?

General consensus in the literature is that ethical analysis tools are developed to support and structure ethical deliberation by facilitating a more comprehensive, rational and systematic decision-making process. Some authors suggest that ethical analysis tools facilitate the "best" possible ethical decisions because they clarify ethical values, build logic and rationality into what can be an intuitive process, and elucidate more specific iterations about probability and magnitude of benefits and burdens. (Cottone and Claus, 2000) A study by Garcia et al. (2009) found that rehabilitation professionals trained in using a multicultural ethical analysis tool made better ethical decisions with the tool, as judged by a panel of ethics "experts",

than when presented with similar cases for analysis without the tool. Others are more conservative, asserting that while analysis tools do not necessarily result in better decisions, they may improve the process of ethical deliberation. Garcia (2003) argues that it is through the process of deliberation, in which individuals must account for their reasons and beliefs, and listen to those of others, that moral agency is enacted. As such, deliberation enriches moral perspectives and assists in the formation of more prudent decisions. In other words, ethical analysis tools lead to better deliberation, not necessarily better decisions. Thompson et al (2006) emphasize that decision-making tools are intended to inform decisions rather than replace them and conclude that while "ethical processes do not guarantee ethical outcomes…" (Thompson et al. 2006, pp. 4) they can nonetheless play an important role in ensuring just deliberative processes. Aside from the study by Garcia et al. (2009) there has been almost no empirical research on how tools impact decision-making processes in healthcare contexts. Whether tools have the potential to improve process (better deliberation) or product (better decisions), or a combination of both, would be an important avenue for future research and enquiry.

While not their primary purpose, ethical analysis tools can also promote accountability and transparency in ethical decision making and thereby enhance legitimacy (Hunt and Ells, 2013; Thompson, 2006). This may be especially important in humanitarian aid contexts, where staff turnover often occurs at a rapid pace. Analysis tools may contribute to documentation of decisions and thereby enhance institutional memory. For instance, the use of ethical analysis tools can produce a written record of events and thought processes, rendering the decision making process more explicit and accessible. The step-by-step approach of most ethical analysis tools may lend clarity and structure to the documentation

of complex decisions. DeRenzo and Strauss note that tools are also developed to avoid some common mistakes which occur in their absence, notably: "accepting erroneous assumptions, acting out of one's own moral biases and putting personal need first." (DeRenzo and Strauss, 1997, pp.243)

In sum, analysis tools are developed to ensure more systematic, comprehensive and rational deliberation of ethical dilemmas and possibly generate better moral decisions. They may improve procedural as well as substantive elements of decision making by facilitating transparency and accountability through documentation. Tools can also help safeguard against personal biases and mistaken assumptions. Given the lack of empirical data, it remains to be determined to what degree ethical analysis tools achieve the outcomes for which they are designed. Two notable concerns that may be made with respect to the function of ethical analysis tools will be discussed here.

The American psychologist Abraham Maslow famously said: "When all you have is a hammer, everything looks like a nail." (Maslow, 1966, p.15) From this statement we might derive the following 2 inferences: (1) the exclusive use of a single tool can lead to it being applied indiscriminately and/or inappropriately, and (2) the use of a single instrument can lead to confirmation bias in which the answer is dictated by the questions posed, calling into question the assumption that tools have the *de facto* benefit of promoting unbiased deliberation. Though not insurmountable, these concerns are relevant, largely ignored, and deserve greater attention. The first is more easily dealt with. Many authors recognize that ethical analysis tools are not meant to be used in isolation. (Hunt and Ells, 2013; Garcia 2003; Cameron, Schaffer and Park, 2001) They are an aid, a "tool", in what should be a

comprehensive process with many features, including though not limited to, prior ethics teaching, casuistry and cased-based analysis, consultations with peers, ethicists and ethics committees, team meetings, moral reflection, and familiarity with moral philosophy, ethical guidelines and healthcare legislation. (Hunt and Ells, 2013)

That ethical analysis tools are but one component that compliments but does not supersede or replace other ethical processes is a fundamental insight. Tools are perhaps only effective to the extent that they are taught and recognized as such by practitioners and educators. The stethoscope in the hands of a clinician who has poor knowledge of clinical disease and cardiac murmurs, who lacks experience in detecting and reacting to a cardiac bruit, is little more than an instrument for detecting sound. The same applies to ethical analysis tools. Without knowledge of moral theory, law and codes of ethics, absent attention to the wisdom that comes from experience, and proper development of moral sensitivity, motivation and judgement, an ethical analysis tool will necessarily be of limited use and unlikely to substantively improve deliberation, regardless of the purpose for which it was developed. This point may be especially salient if ethical analysis tools are to be developed for humanitarian healthcare aid, in which formal preparation and training of staff in ethics has historically received little priority (Schwartz et al. 2010).

The second point begs the following question: do ethical analysis tools have the potential to distort or bias decision-making procedures? This is a significant consideration given that one of the perceived strengths of these tools is that they help safeguard against individual and/or institutional bias (DeRenzo and Strauss, 1997). The theoretical foundations or orientations of a tool are not always explicit (Hunt and Ells, 2013). A good indicator of this can be found in

the titles of tools, the majority of which specify the context of application, without reference to the moral theory employed. Practitioners may therefore mistakenly assume that the model they are using is value-free and objective, when in fact the moral theory underpinning tools has a variety of important implications. As indicated in section II of this chapter, the moral theory grounding a tool will have implications for what is included and excluded from discussion. Theoretical orientation can change the way in which the salient elements of a problem are indentified; alter the weight or value given to different options; promote or limit the interpretation of who should be involved in the decision making process; and ultimately change the outcomes of the decision taken. (Derenzo and Strauss, 1997)

For example, principlist tools tend to ignore context and power dynamics; relational and feminist ethics privilege context and relationships over moral character and motivation; virtue ethics frameworks may minimize professional standards and principles. All of these have implications for the ways in which deliberation occurs and recommendations are chosen. At the very least, judicious use of a tool requires understanding of how and with what intentions it has been developed if it is to avoid indiscriminate and inappropriate use. This may depend on appropriate training and education in analysis tools and ethics generally.

Avenues for research: For what purpose was the tool developed?
1.) Do ethical analysis tools facilitate better ethical decisions? 2.) How does the use of an ethical analysis tool impact deliberation? 3.) What understanding do clinicians have of the relationship between ethical theory and ethical analysis tools?

(2) When should the tool be used?

Although analysis tools are most often associated with deliberation on individual ethical dilemmas, they may be useful in a variety of ways. For instance, decision making in healthcare is often multidisciplinary and team based. The use of ethical analysis tools may provide a useful focus for collaborative decision making, especially when there is the potential for conflict between team members, or when people are emotionally invested in an issue. By providing a systematic and rational approach to deliberation, analysis tools may focus discussion when multiple voices need to be heard and when emotions are running high. Tools may also be important for retrospective debriefing of particularly difficult cases or scenarios. (Hunt and Ells, 2013) Retrospective review of cases may be especially pertinent when moral issues reoccur or when the outcome of a process or decision was unsatisfactory (Hunt and Ells, 2013). Models can ensure that relevant gaps in analysis between intentions and outcomes are scrutinized in a manner that is rational, objective and ideally ensures that mistakes and omissions are not repeated and future outcomes are improved. This process may be a valuable means of addressing feelings of moral distress or uncertainty.

Tools may also be a valuable resource for teaching ethics and approaching case based discussion and analysis in the classroom or in the pre-departure training sessions offered to humanitarians. Ethics may be an unfamiliar and daunting subject to many students in the healthcare professions, and tools a useful means of teaching students how to break down a complex case into component parts and consider salient ethical elements by responding to a specific set of questions. Tools may also present an alternative method of introducing and

familiarizing students to some of the more common ethical issues they might encounter in their practice.

Given their capacity to enhance accountability and transparency, ethical analysis tools may also be especially helpful in times of crisis, or when decisions have particularly grave consequences. This is true of both micro and macro level decision making. For example, in a qualitative study of ethical issues encountered by humanitarian workers, a physician described how the only ventilator in a field hospital generated over "100 ethical discussions" (Schwartz et al., 2010, p.47). Important decisions surrounding end-of-life and goals of care, for instance- to which patient to assign a ventilator- might benefit from an analysis tool that improves documentation of the rationale behind the decision and helps ensure accountability in the decision making process. This is equally true of resource allocation decisions made at a macro level. Lessons learned from the SARS outbreak in Toronto indicate that organizations that did not have decision making processes in place emphasizing ethical values and accountability faced low morale and distrust from patients and staff, and that stakeholders and the public were more likely to accept difficult decision during a pandemic if the decision making process is perceived to have ethical legitimacy (Thompson et al. 2005) Public health decision making models emphasizing procedural and substantive elements may also be useful in humanitarian contexts which often require a public health approach to population health. (Schwartz et al. 2012) Finally feminist and relational ethical analysis tools (Oberle and Raffin-Bouchal 2009; DeRenzo and Strauss, 1997) emphasize ethical issues that are systemic and often overlooked in traditional bioethics. These tools have the potential to extend ethical discussion beyond the bedside and may be used to address organizational and management

issues arising in health care institutions as described earlier. (Oberle and Raffin-Bouchal 2009; DeRenzo and Strauss, 1997)

There is little empirical evidence examining when and in what contexts ethical analysis tools are actually used by practitioners; or what makes one analysis tool more suited to one context than another. For instance, are ethical analysis tools more suitable for chronic or systemic issues, in which there is greater time for deliberation, than in acute or emergency scenarios? How does a practitioner choose which analysis tool is best suited to a given context? For instance, would a street nurse encountering an ethical dilemma surrounding a homeless client and access to care, be better off using a feminist model (attentive to vulnerable patient populations) or a community health care analysis model (attentive to the principles of community nursing)? Would choice of tool impact deliberation in a meaningful way? A study by Garcia et al., (2008) asked 50 rehabilitation counsellors to compare the use of a multicultural analysis tool to a rational analysis tool. The study found that while participants ranked both tools highly, there was no appreciable difference in user satisfaction between the tools, even though researchers hypothesized that the multicultural tool would be more valuable to counsellors in the highly multicultural research setting. Given the large number of ethical analysis tools already available, and the tendency to publish analysis tools designed for specific contexts, more research examining the relevance of tools for specific contexts is required.

Directions for research: When should the tool be used?
1.) When are ethical analysis tools used by clinicians? What benefits/impediments do clinicians associate with using an ethical analysis tool in a given context? 2.) Is there such a thing as a "better" analysis tool for a given context? 3.) How do different analysis tools compare in facilitating analysis for a given context?

(3) Who should use the tool?

There is surprisingly little discussion in the literature of who ethical analysis tools are intended to be used by. Most tools, by virtue of the language they employ (referring to the patient/family as the object of discussion), and their method of dissemination (scholarly publications and classroom teaching sessions), seem intended for use by clinicians exclusively. Whether or not, in an era of patient centred care, these tools could be designed for use by patients/families, or for use by clinicians and patients/families jointly, may be an area for future development and enquiry. A separate issue arises as to whether tools are developed for novices or experts[36], or both. The following questions can be asked: Is use of these tools limited to ethics classrooms? If not, who is using these tools in health care contexts? A virtue ethicist might argue that while a suitable aid for beginners, analysis tools have no place in ethical deliberation for more experienced practitioners. The virtue ethicist would claim that deliberating correctly about ethical matters requires phronesis.

As described in chapter two, phronesis is like a skill and can only be gained through experience and practice; it entails the ability to unite right reason, right feeling, right action and right outcome (Annas, 2011). Moral development is a process that begins by accepting the testimony of others, to reasoned and conscious deliberation, and culminates in practical wisdom. The empirical work of Patricia Benner has attempted to illustrate the ways in which deliberation differs in nursing novices and nursing experts; with the former more inclined to use aids and systematic thinking than the latter, whom she argues exemplify phronesis.

[36] Whether there is such a thing as an ethics "expert" is contentious. For the purpose of this paper, I will assume that someone with considerable professional experience in ethics- such as a clinical ethicist or chair of an ethics committee- can reasonably be expected to have some degree of knowledge, skill and thus expertise in ethics.

What is important here is not whether or not we agree with virtue ethics, but whether it is plausible to suggest that the use of a tool is to some degree the mark of a beginner, and that we value something more complex when it comes to ethical engagement. For instance, if we do not expect a skilled emergency physician to consult an algorithm on basic cardiac life support when leading resuscitative efforts, then why should we expect an ethics consultant to use an ethical analysis tool? Of a true ethics expert we might expect more sophisticated and creative ethical analysis that draws on moral motivation, sensitivity and judgement arising from experience. Conversely, the use of an ethical analysis tool by ethics "experts" may standardize the decision making process, lending it an aura of objectivity and thereby increase legitimacy.

Tools generally do not discuss the audience for whom they were designed, other than to specify a cadre of health care professionals. And yet, these considerations hold implications for how we conceptualize the scope and use of these tools. For instance, should they become obsolete as ethical reasoning and processes become more sophisticated? Are they intrinsically valuable to all decision making and decision makers, or just instrumentally so? If they are more relevant for beginners, what does this tell us about how they should be taught and to whom? Are tools more useful for individual or collective decision making? For instance, by providing a potentially more organized and comprehensive approach to discussion, ethical analysis tools may be especially useful in deliberations involving several people with different perspectives and priorities. This may be especially pertinent for humanitarian contexts in which deliberation is often team based and decision makers are from different countries, with distinct values and beliefs systems. Exploring how ethical

analysis tools structure ethical deliberation in humanitarian contexts would be an important area for future investigation.

Another key concern reflects the process of consulting and validating analysis tools with stakeholders and practitioners. Thompson et al. (2006) suggest that endorsement of ethical analysis tools by hospital administrators, vetting of the tool by key stakeholders, and a decision review process, are key elements for the successful adoption of an ethics tools into an institutional setting. This "buy in" from key actors could be the difference between a tool that looks good in theory and yet remains unused. Notably, very few ethical analysis tools engage in this process.

Directions for research: Who should use the tool?
1.) Who is using ethical analysis tools outside of the classroom? 2.) How do ethics "experts" and practitioners differ in their perceptions on the value and quality of ethical analysis tools? 3.) Are tools more useful for individual or collective decision making? 4.) Who validates the usefulness and quality of an ethical analysis tool?

(4) What is the structure of the tool (does form fit function)?

As discussed in Sections I and II, there is no standardization of the structure and format of ethical analysis tools. They can be as succinct as three questions (Schaffer, Cameron and Tatley, 2000) or include a detailed list of over thirty questions. (Keatings and Smith 2009; Oberle and Raffin-Bouchal 2009) While most employ a linear, step by step approach to analysis, some favor a structure intended to facilitate a more iterative and less hierarchical approach to deliberation. (Jonsen, Siegler & Winslade, 2002; Cotonne, 2001) This variety in structure is indicative of another challenge facing analysis tools: the need to balance

generalizability and specificity. (Hunt and Ells, 2013) Insofar as their strength lies in guiding comprehensive deliberation, tools are only as good as the step by step deliberation they help facilitate. On the one hand, models may be overly broad and appeal to many philosophical traditions, thereby providing little in the way of specific moral guidance. For example, in an addendum to the first iteration of the "Value, be, Do" guidelines, Cameron, Schaffer and Park (2001) write that the nurse should also strive to balance the "subjective perspective of ethical caring" with the "impersonal, objective stance of principlism." With three simple questions, and little else in the way of guidance, the tool asks the practitioner to balance four major branches of ethical theory- deontology, consequentialism, virtue and care ethics- a philosophic problem for the ages.

On the other hand, tools with multiple steps or questions, may lend themselves to an exhaustive and overly detailed analysis that runs the risk of losing sight of the forest for the trees. Models designed by Keatings and Smith (2010) and Oberle and Raffin-Bouchal (2009), contain over 30 questions and require a considerable amount of time to work through. Given the time constraints and pressures facing healthcare professionals, these models may be most useful in classrooms, for team meetings, or for use by ethics committees or consultants. While this is not in itself a reason to eschew the value of an ethical tool - there are valid arguments for ensuring that ethical deliberation is thorough, comprehensive and detail oriented – it does suggest that the procedural elements of a tool, including length, scope and level of detail, might impact the process and outcomes of ethical deliberation in important ways. Perhaps one of the most crucial points to be made about decision-making models is that they are not "recipes" (Thompson et al., 2006) and they need not be followed rigidly. Some argue that using tools effectively may require a non-linear approach and the

discerning user may want to spend more time on certain steps, skip over subsections or questions which may not be relevant to a particular case, revisit questions as new information becomes available and approach the overall analysis in an iterative manner. (Hunt and Ells, 2013) Appropriate training in ethics and the use of tools may be crucial to ensuring their effective use in ethical deliberation.

Avenues for research: What is the structure of the tool (does form fit function)?
1.) What level of detail do clinicians value in an ethical analysis tool? 2.) Does (and to what extent, should) context and intended user impact the length of the tool? 3.) How should ethical analysis tools be made available to practitioners?

Conclusion

Moral decision making can have profound impact on the quality of health care and on the lives of patients and clinicians alike. Some studies indicate that an inability to make or enact moral decisions can lead to feelings of guilt and frustration among clinicians. For example, it has been reported that one of the most common coping behaviours for distressed nurses is avoidance of patients or situations involving conflict and the denial of responsibility for resolving that conflict, which can have serious consequences for patients (Raines, 2000) Ethical decision making tools are a valuable resource, offering pragmatic and step by step guidance to healthcare professionals who find themselves at an ethical cross-roads. However, these tools are not without limitations. While a map is essential to any journey, it may be less helpful if it is difficult to read, if it lacks important details, and if it does not explicitly account for its (moral) orientation. Without training in moral theory, knowledge of ethical codes, laws and guidelines, and absent moral sensitivity and awareness, the use of a

tool will be like the Cheshire cat handing a map to Alice lost in Wonderland; it means nothing if she does not know where she is, understand how to read maps, or care where she is going. Research exploring whether and how tools are used, if they improve or strengthen moral deliberation and outcomes, and which types of models are most useful, is essential if we are to move in a well-reasoned and thoughtful direction.

Chapter 4: The Development of a Humanitarian Healthcare Ethical Analysis Tool

Humanitarian healthcare work is often practiced in contexts where the provision of healthcare is complicated by heightened material and human resource scarcity, political and social instability, and rapidly changing needs of the population. In Chapter two, we saw how these features can combine to create a variety of ethical tensions in which different approaches, values and priorities operate in opposition to one another. This discussion focussed primarily on macro level concerns and highlighted some of the broad ethical issues at stake in humanitarian healthcare practice. (Barnett, 2011) However, macro and micro level concerns do not exist independently of one another. (Burnor and Raley, 2011) Systemic level decisions impact care decisions made by healthcare workers on the ground, and contribute to the types of ethical issues encountered in the field. Conversely, micro level decision making by individuals can shape and influence policy decisions and inform guidelines.

While macro and micro level ethical issues present themselves in distinct ways, they often revolve around the same ethical concern- in this sense they are two sides of the same coin. For example, consider ethical issues surrounding the equitable treatment of expatriate and national/local humanitarian healthcare workers. On a macro level, organizational directives and policies have been critiqued for providing greater security considerations to expats than to local staff in complex humanitarian emergencies. (Fassin, 2011) On a micro level, healthcare workers often describe feeling moral unease with the differential treatment they receive relative to the locals they work alongside, whether it be higher pay or superior accommodations. (Schwartz et al. 2010) At both levels, issues of equity and justice come into question as the humanitarian ideal of universal human dignity and worth paradoxically

confronts policies and scenarios that embody a "hierarchy of humanity"- in which the worth of expats is ostensibly treated as superior to that of the local. (Fassin, 2011)

The micro-level ethical issues being faced by healthcare workers have recently begun to receive greater attention. A series of qualitative studies has explored the moral experience of humanitarian workers and identified the common types of ethical dilemmas that arise in the field. (Sheather and Shah, 2011; Schwartz et al. 2010; Sinding et al. 2010; Hunt, 2009; Hunt, 2008) A study by Schwartz et al. (2010) identified four key sources of ethical challenges in humanitarian healthcare aid. Firstly, challenges related to resource scarcity and the need to allocate them. For instance, one participant in this study described a situation in which healthcare workers needed to decide which of the many patients in distress would benefit from the single ventilator available at a field hospital. (Schwartz et al, 2010) Secondly, challenges emerged form historical, social, political and commercial structures, such as the inequitable provision of security, or remuneration, to healthcare staff as described above. Thirdly, challenges arose from aid agency policies and agendas; for example, participants described how disease-specific vertical projects (such as, providing directly observed tuberculosis (DOT) treatment) may not allow for the provision of care for other important health needs of a population (for instance, malnutrition). This narrow focus caused concern and moral unease surrounding the provision of appropriate healthcare, especially when patients who did not fit the project mandate needed to be turned away or refused care or treatment. Lastly, challenges emerged from norms around professional roles and interactions. Participants described scenarios in which they needed to decide whether or not to practice at the limits of, or exceed, scope of professional practice. (Hunt, Schwartz and Fraser, 2013)

The ethical issues described by humanitarian workers in these studies parallel some of the broader tensions described in chapter two. The moral unease surrounding vertical programs parallels the tension between upstream and downstream approaches, as treatment and care is targeted exclusively at a single pathology. To treat with DOT is to save an individual from a particular disease; however, chronic malnutrition and poor housing may be part of the upstream factors precipitating and worsening the tuberculosis. Healthcare workers working with this downstream approach often feel they are not doing enough to address upstream causal factors. Interestingly, they are able to rationalize the decision, for instance, one participant stated: "I understand the reasons for not doing it…", (Schwatrz et al. 2010, p.49) and yet healthcare workers nonetheless reported feeling distress when confronted with the reality of the situation.

Ethical questions surrounding the equitable treatment of expat and national staff, and whether or not to exceed scope of competency to treat a patient when a more appropriately skilled health professional is not available, are manifestations of tension between deontological and consequentialist approaches; they represent the struggle of how to balance imperatives directed at respecting universal human rights and dignity and rules of right conduct, with risk:benefit ratios aimed at generating the greater good. Proximity to the situation and relationships with patients affected by decisions can make decision making extremely challenging for practitioners. While many ethical issues encountered by healthcare workers are resolved on a daily basis; others can lead to moral distress and uncertainty, which sometimes lingers long after the situation has ended. (Hunt, 2009)

As described in chapter two, a variety of ethical approaches are available to support humanitarian workers in ethical reflection. These include moral theory, international and professional codes of ethics (ICN, 2012; WMA 2006a), international guidelines (IFRC, 1994; The Sphere Project 2004; WMA 2006b), and humanitarian principles, amongst others. Although ethical theory informs understanding about what constitutes the good or the right and offers insight into the strengths and limitations of adopting one approach over another, and principles and codes of ethics act as important benchmarks to right conduct, they offer little in the way of specific action guidance. While reflective equilibrium presents a methodology for balancing ethical theory with empirical evidence, it has also been critiqued for being abstract and difficult to implement. (Arras, 2007) Moreover, ethical decisions in humanitarian healthcare contexts may need to be made quickly, especially in high acuity relief scenarios, and without familiar ethical supports (such as consulting an ethicist or ethics committee). Crucially, few healthcare workers receive training, preparation or resources for managing ethical challenges in ways that can help them cope with moral distress and provide ethically sound care and services to those they aim to assist. (Hunt, Schwartz and Elit, 2012)

Ethical analysis tools, as shown in chapter three, offer a different approach to deliberation and decision making which may be especially useful in humanitarian contexts. These tools provide a pragmatic means of providing assistance to clinicians faced with complex moral dilemmas; they are designed with the purpose of fostering systematic and comprehensive analysis of ethical dilemmas and generating recommendations. As I argued in chapter three, when used judiciously, ethical tools can be helpful in a variety of ways. They help identify and clarify underlying values, promote comprehensive analysis and generate suggestions leading to well considered, ethically defensible judgement and actions, (Oberle and Raffin-

Bouchal, 2012; Cotonne and Claus, 2000) and may contribute to increased transparency and accountability in decision making. Given these considerations, a Humanitarian Healthcare Ethical Analysis Tool (HHEAT) was developed by Hunt and Schwartz to provide humanitarian workers with a readily accessible, action-oriented resource to guide ethical decision-making in the field.[37]

In this chapter, I will present and discuss the findings of a research study conducted to evaluate the usefulness of the HHEAT for the analysis of ethical issues arising in humanitarian aid work. The study was designed to respond to the following research question: How do humanitarian healthcare workers perceive the usefulness of the HHEAT in guiding ethical deliberation? Our aim in posing this question was twofold: it sought to address both (a) the substantive content and (b) the structural format of the tool. With respect to (a) content, we were interested in identifying which aspects of the tool participants thought were helpful in facilitating ethical deliberation, and whether elements were missing or required improvement. We also sought to evaluate how participants' perceptions of the utility of the tool related to claims in the literature that ethical analysis tools help clarify values, increase transparency and accountability, and improve comprehensiveness in decision making. We examined (b) the structural format of the tool, by encouraging participant feedback on the length, format and wording of the tool. We hypothesized that a tool that is easy to use and accessible to practitioners would facilitate its uptake among humanitarian aid workers in the field.

[37] Development of the HHEAT is part of a larger knowledge translation project on humanitarian health care ethics aiming to provide humanitarian workers with access to various resources to facilitate their ability to evaluate and address ethical dilemmas experienced in their professional roles.

Six case analysis sessions were held in which participants with experience in humanitarian aid settings were asked to discuss ethical cases with or without the HHEAT. Following the case analysis, participants completed a questionnaire documenting both their impressions of the tool and the decision making process undertaken by their case analysis group. This study is one of the first to explore how practitioners perceive the usefulness of an ethical analysis tool.[38]As such, this study responds to some of the questions and concerns identified in chapter three. Study results also enabled refinement and restructuring of the HHEAT to better meet the needs of humanitarian workers in the field. This chapter will begin with a brief description of the origins of the HHEAT (section I), and then discuss study methods, results, discussion, limitations and conclusion (sections II-VI).

I) Origins of the HHEAT

As noted in chapter three, a multitude of ethical analysis tools exist to guide ethical healthcare practice, however, analysis tools available to date fail to respond to some of the ethical concerns which may be most prevalent in humanitarian work. Resource scarcity, widespread inequalities, insecurity, instability, steep imbalances of power, organizational policies and the shifting of professional roles and norms contribute to the moral landscape of the humanitarian aid sector. (Hunt, 2011) The inspiration for the HHEAT came from three empirical studies that described in detail the ethical issues encountered by humanitarian healthcare workers in the field. (Hunt, 2008 and 2009; Schwartz et al., 2010) The ethical challenges encountered by healthcare workers was used to inform the content of the tool, and key themes which might require greater deliberation and discussion were generated: (a)

[38] For other empirical studies exploring perceptions of the value and validity of ethical analysis models among healthcare practitioners see: Garcia et al. 2009 & 2008; Cameron, Schaffer and Park, 2001.

participation, perspectives and power, (b) community, project and policies, and (c) resources, clinical features and obstacles. The HHEAT prompts decision makers to contemplate information relevant to these key themes with the goal of facilitating ethical discussion which is comprehensive and responsive to the distinctive types of dilemmas and moral issues arising in humanitarian contexts. The HHEAT is not grounded in a specific ethical framework but rather tries to embrace a pluralistic methodology that addresses the multiple perspectives relevant to a given ethical issue in a stepwise and systematic fashion.

The preliminary version of the HHEAT consisted of 8 cue-card sized cards, covering 9 major themes, 15 subthemes, and 48 questions – with an average of 6-7 questions per card (see Appendix B). Four out of the eight cards were devoted to facilitating deliberation on the three key themes in humanitarian healthcare aid. A preliminary version of the tool was published in the journal *Disasters* and presented at several workshops. (Hunt, 2011) Feedback from these forums was used to refine the tool. The HHEAT was then presented to six reviewers with expertise in decision making models and clinical ethics, public health ethics, humanitarian medicine, and humanitarian nursing, who provided feedback on the structure and content of the tool. As noted in chapter three, vetting of the tool by key stakeholders may increase the likelihood that important considerations are not overlooked and enhances legitimacy. Moreover, early stakeholder engagement may be necessary for future uptake of the tool. (Thompson et al, 2006) The tool was revised based on these comments, and this version was then distributed to study participants. A worksheet outlining the main categories and questions of the model was developed to accompany the HHEAT.

II) Methods

Study Design

A series of case analysis sessions was conducted to explore perceptions of the usefulness of the tool among humanitarian workers. These case analysis sessions were inspired by focus group methods (Litosseliti, 2003; Morgan, 1997) and oriented by an interpretivist paradigm (Denzin and Lincoln, 1998). Data sources in this project included: (1) observation of small groups of humanitarian workers as they discussed an ethical case study, and (2) questionnaires filled out by small group participants at the completion of the case study. The goal of the case analysis group discussion was to understand how the groups given the HHEAT used the tool when engaging in ethical deliberation. Case analysis sessions are well suited for responding to open-ended questions and facilitate an interaction in which participants discuss information and concerns they identify to be important and relevant (Litosseliti, 2003). Given these features, case analysis sessions were identified as a useful approach for conducting an initial evaluation of the usefulness of the tool for ethical case analysis.

The use of small groups for case analysis is also representative of the multidisciplinary, team based discussions in which many decisions are made in the field. Participants were selected to reflect individuals that typically make up a humanitarian healthcare team in order to enable researchers to observe the process by which decisions are made, the types of questions participants may ask each other in order to arrive at a decision, as well as the priorities, values and principles identified by participants. The interaction, because of its open-ended nature, occurs in the participant's own language and vocabulary, further contributing to the development of a final model that will include terms and processes that

are accessible and familiar to humanitarian healthcare workers. This is important to evaluating and ensuring the usefulness of the tool with respect to final format and structure.

Sampling and recruitment

The population of interest for this study was licensed healthcare professionals with experience in global health settings, especially in contexts of disaster, conflict or extreme poverty, and individuals with experience as team coordinators or project leaders. Recruitment was initiated through investigator contacts and through university-based global health interest groups and programs. Once a pool of potential participants was established, recruitment occurred primarily through snowball sampling. Participants were contacted by email with an invitation including detailed information about the project and a consent form. Participants who met eligibility criteria and agreed to participate were then asked to confirm their availability for a case analysis group.

A total of 16 individuals participated in the case analysis sessions: 7 physicians, 4 nurses, 2 physiotherapists and 3 coordinators (e.g. logistician, project-coordinator and head of mission). Collectively, participants had worked with 17 non-governmental organizations (NGOs) with an average field experience of 3.4 years spanning a range of 5 months to 11 years. This sample is broadly representative of multidisciplinary humanitarian healthcare teams.

Case analysis groups

A total of six case analysis sessions were held. Groups were constructed with the multidisciplinary nature of humanitarian field teams in mind (for instance, one case analysis group of three participants comprised a logistician, physician, and registered nurse) and ranged in size from two to four participants, reflecting some of the diversity in the size of teams making decisions in the field. Prior to arriving for the small groups, participants were emailed a copy of the HHEAT and encouraged to familiarize themselves with it. Before beginning the discussion, these groups were also given a two page worksheet in which the main thematic categories and questions of the model were highlighted. Participants were encouraged to use the worksheet to take notes during the case discussion.

In total, six case-analysis sessions were held in which participants were asked to deliberate on ethical cases. (Appendix C) In keeping with the primary purpose of the study (ascertaining the usefulness of the HHEAT for humanitarian practitioners) five groups were given the HHEAT and asked to use it in their deliberation. One group did not receive the HHEAT and was used as a point of comparison. Participants in this group were given the HHEAT only after the group discussion and asked for their perceptions of the tool; including whether or not they felt it would have impacted the group's discussion or final decision related to the resolution of the case. Having one group engaged in case analysis without the HHEAT was designed to better gauge the overall utility of the HHEAT in the deliberation process, and to help identify any significant difference in ethical deliberation in the absence of an analysis tool.

The two cases used for ethical deliberation in the case-analysis sessions were developed based on actual events in humanitarian work and reviewed for verisimilitude by the panel of experts who reviewed the HHEAT. One case related to a humanitarian relief project and the other to humanitarian development work. The use of two different scenarios allowed for comparison on whether different types of situations impacted the use and evaluations of the HHEAT. A facilitator and note-taker were present for all sessions and each session was audio-recorded. Groups were asked to examine the case study from the perspective of a field-based humanitarian team required to make a time-sensitive decision. Each group was given 30 minutes to discuss the case study, at the end of which they were asked to present their decision as to how they would respond to the situation described in the case narrative, and articulate their reasoning for the course of action selected.

Questionnaires

Following small group discussions, participants were asked to fill out a questionnaire describing their experience with the case discussion. Two questionnaires consisting of demographic and open ended questions were developed, one for the five groups using the HHEAT, the other for the group without the HHEAT. (Appendix D) Both questionnaires included questions related to (1) demographic information and field experience, (2) impressions of group discussion and deliberation, and (3) perceptions of the usefulness of the HHEAT.

Data analysis

Descriptive and thematic analyses were conducted of the small group audio-recordings, questionnaires, and observational field notes. These data sources were analyzed using constant comparison techniques with the goal of identifying patterns and linkages between different data sources (Thorne, 2000).

Audio recordings of case analysis sessions were carefully reviewed and detailed observational notes were taken during the sessions and completed following each group discussion. In addition, selected sections of the audio recordings were transcribed verbatim in order to facilitate the analytic process. Summaries of individual groups were then generated based on transcripts and observational notes. These summaries noted the main discussion points, areas of dissent and consensus, and a general impression of the groups' discussion and conclusions, including observations on the decision-making process and how participants engaged with the HHEAT. Questionnaire responses were copied into a separate document. All individual participant responses from within a case discussion group were then compiled into a single document for ease of comparison of opinions within the group, and between groups. Two pairs of investigators (MH and NF, and SD and LS) did the provisional analysis separately. Results were subsequently compared and discussed until consensus was achieved on the main patterns and linkages within the data. Two authors (NF and SD) conducted a second stage of analysis in which preliminary themes were explored in greater depth. As part of this stage, areas of the tool that required improvement, alterations, additions or removal were identified.

Triangulation of multiple data sources was used to enhance the rigor of the analysis– including observational field notes, audio-recordings of small group discussion sessions, and questionnaires. (Creswell, 2003) Group discussions can be used to qualify or elaborate upon attitudes and statements made in questionnaires and provide a deeper and enriched understanding of a topic. (Bloor et al, 2001) Comparing areas of convergence and divergence between participant perspectives of utility (questionnaires), researcher observations of how the tool was used (field notes), and dialogue and discussion surrounding ethical deliberation in real time (audio-recordings), enabled the examination of the research question from multiple perspectives. This process of triangulation facilitated the identification of consistencies and inconsistencies in determinations of the utility of the HHEAT in ethical deliberation. For instance, questionnaires reporting that the HHEAT provided structure to ethical decision making were reinforced by field notes documenting participants checking the analysis tool, taking notes, and proceeding in a careful and systematic fashion, and audio-recordings of dialogue surrounding ethical analysis with the use of the HHEAT.

Ethics

Ethics approval for this study was obtained form the McGill University Faculty of Medicine Institutional Review Board (IRB) and the McMaster/Hamilton Health Science Research Ethics Board (REB). All participants read and signed an informed consent form. (Appendix E)

III) Results

Four principal themes relating to the usefulness of the HHEAT were derived through data analysis. These key themes were informed by a mixed inductive-deductive approach in which the primary research question: "How do humanitarian healthcare workers perceive the usefulness of the HHEAT in guiding ethical deliberation?" informed the ways in which data was organized. The four themes include: (1) benefits, (2) challenges and limits, (3) ethical context and expertise, and (4) promoting use and applicability. Where relevant, verbatim quotes are included to illustrate aspects of the analysis.

1.) Benefits: "It keeps everyone on the same page"

One of the primary benefits of using the HHEAT identified by participants was that it brought to light issues and concerns which otherwise might have remained overlooked, thereby ensuring a more comprehensive decision making process:

> "Make sure we don't forget any important information." (FG1 Questionnaire)
> "Think more of different resources, people, consequences. More comprehensive approach." (FG6 Questionnaire)

All participants reported being satisfied or very satisfied with the decision made, including the comparison group. Interestingly, the group deliberating without the HHEAT was unanimous in responding that they did not think that using the tool would substantively change their decision or decision making process. However, individual comments contradicted this somewhat and are suggestive of some of the ways in which the HHEAT, by facilitating attention to detail and raising novel questions, might contribute to a more comprehensive process:

> "I am not sure that the outcome would have been any different. I think we touched on several of these topics but with the model our discussion may have been more fleshed out/detailed. The process certainly would have been more organized." (FG3 Questionnaire)

There was broad agreement amongst participants that using the HHEAT provided structure to the decision making process; for example, some felt the tool contributed to a more organized discussion:

> "Provided structure and prevented jumping to conclusions/decisions." (FG2 Questionnaire)

Some participants noted that using the HHEAT clarified beliefs and assumptions by rendering them more explicit and transparent:

> "Yeah, I mean at the individual level you can have various interpretations of what a value is; what humanity means; or what autonomy means; so if you have core principles it is a good start, but this kind of model allows you to make clearer your thinking and your understanding of these issues…I am very happy to know about this model." (FG2 Recording)

Finally, participants reported that using the HHEAT might help ensure a more rational, less emotional decision-making process. One participant stated that this might be particularly important given the potential for interpersonal issues and team dynamics to affect decisions:

> "It allows a group of individuals with potentially differing opinions to focus on the issue in a constructive way instead of emotionally." (FG2 Questionnaire)

In sum, benefits of using the HHEAT such as fostering deliberation that is comprehensive, organized, transparent, explicit, and rational, supports the potential usefulness of a tool to assist humanitarian workers making complex moral decisions. The majority of participants agreed that they would use the HHEAT in the future. As one participant out it:

> "A framework to guide difficult decision making is potentially useful. It keeps everyone on the same page." (FG1 Questionnaire)

2.) Challenges and limits: "I don't know if the big guy with the beard and the cigarette would use it"

Participants commented on limitations on the current formulation of the tool and offered recommendations for improvement. Most notably, participants felt the tool may not be suited to all organizational cultures as it was time consuming as well as (overly) detailed and somewhat difficult to follow. Some participants also suggested that the name of the tool, specifically the use of the word "ethics", might limit its usage.

Participants suggested that the tool might not be applicable to all organizations, which differ with respect to organizational culture, values and priorities. One participant felt that the tool may not be readily adopted or applied by all humanitarian workers:

> "I don't know if people on the ground will sit down and use it… I don't know if the big guy with the beard and the cigarette would use it… it might be useful to use in a training workshop or when you are in a stressful situation and need to calm down… but I don't know if it would be useful with people I work with often. It is a lot of text… I don't know." (FG3 Recording)

The majority of participants felt that the HHEAT was too long, would take too much time to work through and therefore be difficult to use, especially in situations requiring quick, on the spot decision making:

> "Too many things for our allocated time… In this particular case we would have had max. 10-15 minutes to make a decision." (FG1 Questionnaire)
> "In 'real' life, I don't know if people would consider to go through 8 cards." (FG3 Questionnaire)

In conjunction with the perception that having a tool consisting of 8 cards was time consuming, many participants suggested that the tool was dense, complex and difficult to follow. This was reflected both in specific comments and in suggestions for improvement, many of which recommended simplifying the tool:

> "Needs to be very simple- with minimal writing on the actual cards so it's easy to use." (FG6 Questionnaire)

> "Simplify it for on the spot decisions. Produce a small work flow chart of questions. Half a page maximum." (FG3 Questionnaire)

Finally, participants reflected on whether the name "Humanitarian Healthcare Ethical Analysis Tool" might limit the adoption and use of the tool by clinicians who might be more inclined to view the situation pragmatically:

> "I have a feeling that the word ethics narrows the possible use of this model. And maybe some people would consider that they are not facing an ethical issue. But still they would. Or maybe it would be needed to use the model even though it is not an ethical issue at first."(FG2 Recording)

One participant noted that it would be interesting to see whether variations in understanding of the word "ethics" lead to "false positives" and greater use of the tool. Another noted that humanitarian workers may be intimidated by the use of the word "ethical", and be less likely to use the tool as a result.

3.) Ethical content and expertise: "What are the ethical issues?"

A separate but related theme to limits and challenges was discussion surrounding ethics more broadly. Because contradictory and competing statements rendered it unclear whether participants found engagement with ethics to be, strictly speaking, a true limitation, we present it separately. Participants struggled with the ethical dimensions of the tool in a variety of ways. Some participants found it difficult to identify what constituted an ethical issue. For example, a group spent some time at the beginning of the discussion debating whether the central problem in the scenario was "ethical" or "pragmatic", before concluding by describing the scenario and their decision as "quasi ethical." (FG2 Recording) Some participants were explicit about their uncertainty in identifying ethical issues:

> "I don't know if people know what an ethical issues and values are or how to identify them." (FG 5 Recording)

> "What are we supposed to be saying in answer to that question? What are the ethical issues?" (FG 1 Recording)

The majority of participants were equally uncertain when it came to discussing ethical values, norms and principles. For instance, groups struggled with the HHEAT Card 6, which asks participants to "Review the ethical issue and explore ethical resources" including norms, values and principles. Groups required prompting by the facilitator to clearly identify moral values and principles and seemed uncertain about what was being asked of them. For example, when asked to identify moral principles and values most at stake in the case, a participant responded: "You mean like saving lives?" (FG1 Recording) In another group participants discussed ethical themes such as: colonialism, power differentials, hegemony of western medicine and obligation to stakeholders, but struggled when asked to frame these in terms of ethical argumentation and use the language of principles and values.

Two participants categorized the unfamiliarity with ethical language somewhat negatively; suggesting that this emphasis was unnecessary and the tool could be improved by omitting such analysis altogether:

> "Hard to differentiate between ethical issues, values, principle – unhelpful – to know." (FG5 Questionnaire)

A couple of participants linked the uncertainty surrounding using ethical concepts to a lack of ethics education:

> "This is where my academia lets me down a little in terms of being able to identify ethical values" (FG6 Recording)

Some participants also discussed what they felt were the most important ethical issues arising in humanitarian healthcare work. While most felt that the ethical themes brought up in the case studies resonated with their experiences, some participants noted that the ethical concerns that preoccupied them most related to broader questions regarding to the value of humanitarian aid itself:

> "Is this project even accomplishing what you set out to accomplish? Sometimes (the) team seems so cut off from the reality on the ground… Disconnected from the reality of the people." (FG1 Recording)

> "…The big question is this helping anyone? The last job I did with…. was a terrible project. I quit, it is the only time I have ever quit anything. No one in that organization would even address this kind of question. Tough to go there." (FG1 Recording)

Some of the specific ethical concerns raised by participants included: long term impacts of aid organizations and questions of sustainability, misalignment of project goals with population needs, and differences in remuneration between foreign and national staff, amongst others.

4.) Promoting use and applicability: "Helpful in pre-departure training"

Many participants brought up the importance of prior training in the HHEAT as integral to ensuring use in the field. Most cited pre-departure training sessions, typically a series of short training sessions offered by humanitarian organizations before sending clinicians overseas, as an ideal venue for this training:

> "Very helpful in pre-departure training for all health professionals…" (FG6 Questionnaire)

Some noted that including the HHEAT in pre-departure training would raise awareness about the types of ethical scenarios that may arise in the field:

> "Good tool to use in pre-departure training to at least be aware of the situations, to think about." (FG6 Questionnaire)

Others felt that given the length and detail of the tool coupled with time constraints and pressures facing clinicians making decisions in the field, clinicians with prior familiarity and training in the HHEAT would be more likely to use it:

> "I would think that it would be useful to have a training including this tool, this model. Because when you are in the field, you don't, especially in humanitarian contexts, you don't take time to read this kind of documents. Sometimes you can, sometimes you don't, and you are pressed by the time, pressed by people. So I think as a pre training it would be very useful and having it as a, as something physically available, like cards, would be an additional thing to do, I mean to provide after the training…." (FG2 Recording)

In addition to introducing the HHEAT in pre-departure training, participants specified other contexts and forums for which they felt the tool might be applicable. One participant felt that using the tool for retrospective debriefing would be especially valuable in cases where decisions are difficult, controversial or emotionally charged:

> "In my case, there was no ethics training at all. And then, there were some cases when I was left out of decisions… it might have helped to have something to go back to. Because it makes it hard to work with people again. Even as a follow up kind of thing, regardless of whether you have had training before, maybe as a debrief." (FG3 Recording)

Another participant echoed that using the HHEAT as a debriefing tool might prove a valuable learning experience:

> "Can kind of look back and say what we would do differently as a team." (FG1 Recording)

Others suggested that the HHEAT might be more relevant in long-term aid scenarios or development projects, and/or discussions surrounding the ethics of opening and closing projects:

> "For on the spot decision making I am not sure how helpful it will be. When looking at opening or closing projects, might be more helpful. I am looking more for an aide memoire. When I read it the thing that keeps popping up is ethics, ethics, ethics, and this makes me think long term… In my personal opinion, you need to think of these things before you get on the ground." (FG3 Questionnaire)

Finally, 14 of 16 participants reported that the most useful format for the HHEAT was to have it available online and 9 of 16 identified wallet cards as a valuable format. Three

participants suggested having the HHEAT available as a paper handout, and one suggested generating an online App.

IV) Discussion

The study generated information on perceptions of the usefulness of the HHEAT for resolving ethical issues in humanitarian contexts, as well as opinions on ethics and ethical dilemmas in general among humanitarian health care workers. Study results reinforced some of the perceived strengths and limitations of ethical analysis tools discussed in chapter three and provided insight into the format and structure of the HHEAT, prompting further revision and refinement to create a tool more in line with the needs of humanitarian aid workers.

Consensus in the literature is that ethical analysis tools improve ethical deliberation by facilitating systematic and comprehensive analysis of moral problems (Hunt and Ells, 2013; Oberle and Raffin-Bouchal 2009; Cottone and Claus, 2000). As discussed in chapter three, proponents argue that tools help: identify and clarify morally relevant factors and values; conduct risk benefit analysis with due consideration of magnitude and probability; generate multiple recommendations; provide orderly and systematic analysis; and encourage decision makers to follow up and reflect upon decisions taken (Gutheil et al, 1991). It is ostensibly these qualities, amongst others, which make ethical analysis tools useful to practitioners. The benefits and utility of the HHEAT described by participants align with these perceived strengths and provide some tentative responses to two of the questions posed in chapter three: Do ethical analysis tools facilitate better ethical decisions? and How does the use of an ethical analysis tool impact deliberation?

The majority of participants agreed that the HHEAT fostered ethical deliberation by prompting a more comprehensive approach to decision making, enabling identification of concerns which might otherwise have been overlooked, including identification and discussion of different resources, stakeholders, and consequences. Deliberation using the tool was also helpful in making value assumptions and beliefs more explicit, which participants suggested added clarity and transparency to the discussion. One participant noted that the tool was useful because it prevented those making decisions from jumping to conclusions. This lends support to the claim made by Derenzo and Strauss (2009) that tools can act as a potential safeguard against acting on mistaken assumptions and operating according to personal bias. Some participants also felt that using the tool promoted a more rational, less emotional, approach to the decision making process, thereby facilitating deliberation between individuals with different points of view.

Although participants thought the HHEAT facilitated systematic and comprehensive decisions making by improving clarity about ethical issues, identifying important concerns, and safeguarding against mistaken assumptions and personal bias, this is not meant to imply that the HHEAT fosters a more objective, or value-neutral process of ethical-decision making. As noted in Chapter three, the very design of an ethical-analysis tool, including the moral theory that underlies it and the questions or steps it highlights, will have important implications for the ethical deliberation which ensues. A tool may safeguard against personal bias only to substitute a theoretical orientation in its place (which if left unacknowledged may act as a sort of bias in its own right: a preference for or against something.) Like many other tools, the current iteration of the HHEAT is not explicit in accounting for its

theoretical foundations, which may erroneously lead users to conclude that it is a-theoretical or value-neutral. Further development of the HHEAT will include efforts to increase transparency and accountability surrounding the theoretical foundation of the tool. The authors of the HHEAT are in the process of constructing a more detailed account of the theoretical framework underpinning the tool, which will be made available in the HHEAT handbook. Training session on how to use the tool might also benefit from discussion of the HHEAT's origins and theoretical underpinnings.

Participant feedback also provided an interesting response to questions of *when* analysis tools might be most useful to clinicians, and what benefits/impediments are associated with using ethical analysis tools in given contexts. Some participants felt that given the ability of the HHEAT to foster comprehensive deliberation and clarify values and beliefs, the tool might be especially useful in retrospective debriefing sessions. Participants suggested that retrospective debriefing using the HHEAT might prove beneficial in humanitarian contexts characterized by high rates of expatriate staff turnover. Rapid staff turnover can lead to a tendency to "reinvent the wheel"(Hunt, 2011) and might generate inconsistency in approaches to particular problems. By 'getting everyone on the same page', and potentially providing a written record of arguments supporting a decision, retrospective team based review of significant moral decisions may improve organizational memory and project continuity.

Many participants also thought the HHEAT would be useful in pre-departure training sessions. Participants believed that training on the HHEAT would raise awareness about the types of ethical dilemmas often encountered in humanitarian contexts and this would lend

itself to better preparation. Participants also felt that pre-departure training would ensure greater uptake of the tool in the field. Training in the tool might be essential when considering its utility. We observed that use of the HHEAT without proper orientation and training could result in misinterpretations. For instance, participants expressed reservations about having to use the tool "literally" by following each individual step and addressing every question in a sequential fashion. In practice, many groups treated the tool as a type of checklist, at times jumping from one category to another, returning to a step they had skipped, and itemizing the elements they had covered. This is consistent with descriptions of the use of these tools; Thompson et al (2006) note that tools are not meant to be used as "recipes", and they need not be followed rigidly. Proper training in the use of ethical decision making tools may be required to facilitate this sort of approach, especially if a reservation towards using them is that they require a strict and dogmatic approach to discussion. There is some evidence to suggest that training in ethical analysis tools also improves decision making capacity. Garcia et al. (2009) found that training in the use of a multicultural model enabled rehabilitation counsellors to resolve ethical dilemmas more effectively.

To our knowledge, this study is one of the first to address what practitioners value with respect to length and detail of a particular ethical analysis tool. This information is helpful when considering the format and structure of the HHEAT, and presents an answer to a question posed in chapter three: What level of detail do clinicians value in an ethical analysis tool? Participants in our study were near unanimous in their preference for a simplified version of the HHEAT. The tool was perceived as being too long for deliberation in emergency situations and that it was dense and difficult to follow. Participants suggested that

the tool would be improved by using less text, including bullet points, and shortening the tool to half of its original length. Some participants suggested designing a short and long version of the tool for use depending on time constraints. The unanimous call for a shorter and simpler tool raises two points: (1) the perception of time constraints on ethical decision making in the context of humanitarian aid, and (2) the relationship between ethical knowledge and ethical analysis tools more broadly.

Firstly, it is interesting that participants suggested the need for a shorter and more concise tool irrespective of the case under discussion. Although one case involved an acute emergency situation requiring a time sensitive decision, the other centred on a post conflict reconstruction project with greater latitude for discussion and deliberation of ethical issues. However, regardless of which case they discussed, participants stated that making the tool shorter, and more concise, would make it more useful in humanitarian settings. This perspective may reflect the fact that the tool used by participants was too detailed and as a result difficult to follow- a plausible explanation given the fact that participants had not received training in the use of the tool. The desire for a shorter and more concise tool may also reflect what has been described as the pervasive acceptance in emergency medicine of the need to operate within the constructs of an "ideology of scarcity", in which emergency responders come to value and are rewarded for quick problem solving and efficient processing strategies. (Rodney et al. 2013)

Humanitarian aid has also been associated with the "normalization of emergency", in which humanitarian agency culture comes to support approaches to non-emergency situations with an emergency mentality. (Hilhorst and Schmiemann, 2002) Acting with this mentality when

the situation does not warrant it may limit ethical approaches in the field by generating decisions that are poorly thought through. Pre-departure training sessions may be used to sensitize humanitarian aid workers this possibility, and at the same time provide them with a resource to support them in making complex and time-sensitive decisions in a comprehensive and systematic way.

Secondly, an apparent paradox emerges between the stated desire for a simplified ethical analysis tool on the one hand and acknowledgement of a lack of ethical knowledge and training on the other. Participants in all groups found it difficult to identify relevant ethical issues and struggled when asked to discuss ethical values, norms and principles. Very few participants made reference, for example, to the humanitarian imperative or other humanitarian principles, professional codes of ethics, principles of healthcare or public health ethics, or other elements of ethical theory. Ethical considerations were voiced as pragmatic problems to be solved. This emphasis on pragmatic problem solving was echoed in the comments of a few participants who worried that including the word "ethical" in the title of the tool would limit its usage among practitioners less likely to view problems as containing an ethical component. None of the participants had ever used an ethical analysis model and few had any in depth training in humanitarian or biomedical ethics which may have contributed not only to the lack of familiarity with ethics terminology, but to the hesitancy to adopt the use of an ethical analysis tool in the field.

In spite of these reservations, most participants had experienced similar, if not identical challenges to the case studies over the course of their humanitarian aid work, and the majority agreed that the HHEAT is something they would use in the future. This highlights

the importance of promoting organizational initiatives to provide greater ethics education and resources. In addition to providing training on use of the HHEAT, pre-departure training is an invaluable forum to introduce some common ethical themes in humanitarian aid, offer an overview of relevant ethical theory and direct humanitarians to relevant resources for consultation. This training is important to address the gaps in ethics knowledge among participants and to collectively discuss ethical questions. It is also an opportunity of balancing the comprehensive approach to using ethical analysis tools offered in the literature (Hunt and Ells, 2013) by introducing a streamlined ethics analysis tool while at the same time raising awareness and understanding of the broad ethical knowledge which may help humanitarian workers identify ethical issues and respond to them.

The tendency of participants to differentiate ethical from "pragmatic" problems should be taken seriously. Differentiating ethical issues from non-ethical issues, such as prudential issues (standards which state what would be in our best interest or prudent to do) or legal claims (standards that derive from civil authority), or even matters of etiquette (standards having to do with what is acceptable social behaviour), is important because it clarifies the nature of the choice that is being faced. Identifying a true ethical issue allows one to deliberate, judge and accept moral responsibility accordingly. (Slim, 1997) Organizational processes may facilitate the process of identifying true ethical issues. For instance, Margaret Urban Walker has described the value of creating moral spaces in institutional life in which a shared process of moral deliberation and negotiation can occur. Urban-Walker describes these moral spaces as:

> "actual spaces- places and times- where there are regular discussions, consultations, conferences, lectures, meetings, rounds and so on, that animate and propel the moral life of that institution and link it

> to the larger community of moral discourse in which it nests and to which it must account" (Walker, 1993, p. 38).

By grounding and structuring comprehensive ethical discussion, the HHEAT may prove an important resource for contributing to the development of this type of moral space and help humanitarian workers identify ethical issues when they occur. Because humanitarian work is fundamentally a moral endeavour (Barnett, 2011), efforts to promote ethical engagement and understanding are imperative.

Finally, with the aim of responding to participant requests for a shorter and more accessible version of the HHEAT while maintaining the integrity of the tool for comprehensive ethical analysis, the HHEAT was re-conceptualized as a resource with two complimentary components. First, the tool was simplified to two cue card-sized cards describing six major themes, six central questions and 16 more detailed questions. Second, a handbook was designed to accompany this shortened version of the tool. (Appendix F) The handbook provides detailed instructions on how to use the tool and a short synopsis of relevant ethical concepts and theory; it also provides a list of references for consultation. Thus practitioners will have access to a decision making tool that is quick and easy to use, but may at the same time consult the handbook for more details and information when time allows. A worksheet outlining the six major themes and central questions is incorporated into the handbook. Peer-reviewed case studies using the HHEAT for analysis are being developed and will also be made available on an open-access website. Consultation is also underway with different humanitarian healthcare NGOs to include the HHEAT in pre-departure training sessions.

It bears emphasizing that this study was not designed to investigate whether using different ethical analysis tools yields different processes or outcomes. One area for future inquiry

would be to examine whether the HHEAT is better suited to humanitarian healthcare scenarios than ethical decision making tools designed for other contexts or specific professions. Moreover, this study did not critically evaluate the final decision made by participants for ethical value or moral argumentation. Inquiry into whether the HHEAT facilitates "better" ethical decisions, or decision-making processes, compared to other tools, or no tool, may be an area for further research. A cross-over design in which a more rigorous comparison is made between ethical deliberation with and without ethical analysis tools represents an area for future study. Finally, given participant emphasis on the importance of incorporating the HHEAT into pre-departure training, it would be interesting to investigate the impact of training and education on the usefulness of the tool.

V) Limitations

Case analysis sessions were conducted using case studies, in a safe university environment and among participants who had never worked together. This is greatly removed from the realities of humanitarian healthcare practice, and represents an abstract exercise. Future research is being planned to test the use of the HHEAT in the field. Limitations of case analysis sessions, as for focus groups more broadly, include the possibility of the emergence of a false consensus wherein the opinions of strong personalities in the group overshadow the views of those who are more reserved and difficulty in data analysis due to the open-ended nature of the responses (Litosselti, 2003). Questionnaires provided an opportunity to offset this by allowing participants to express individual opinions and respond to specific questions. Questionnaires are subject to the limits of self-report, including the risk that participants may be biased to say what they think the researchers want to hear. Efforts were

made to mitigate this possibility by reminding participants that researchers were seeking honest responses and that anonymity would be protected.

VI) Conclusion

The process of refining the HHEAT through a series of six case analysis sessions generated insights into perceptions on the utility of the HHEAT for ethical deliberation and prompted some interesting reflection on ethical analysis more broadly. Participants thought that using the HHEAT supported comprehensive, rational and transparent decision making. Many felt that the tool would be especially useful in retrospective debriefing, especially after decisions which are emotionally charged or when intentions do not match outcomes. Promoting structured ethical debriefing with the use of an ethical analysis tool may help mitigate feelings of moral distress and ensure that there is an opportunity to learn from past decisions. Participants also felt the HHEAT should be introduced in pre-departure training session, and that appropriate training would promote effective use of the tool in the field and contribute to the recognition of common ethical issues arising in humanitarian healthcare contexts. Most participants had little or no training in humanitarian and biomedical ethics and pre-departure training might prove a valuable opportunity to introduce humanitarian aid workers to relevant ethical theory and resources. Participants also valued a short and concise tool; based on participant feedback, the HHEAT was simplified and shortened, and a handbook developed to accompany the tool.

Chapter 5: Conclusion

The ideals behind humanitarian healthcare action reflect so much of what is good in the modern world. Humanitarian action is a response to the suffering of others, regardless of race, gender, place or identity, and based on a commitment to do all that can be done to save lives and to place humanity above all other considerations, be it self or state-interest. (Barnett, 2011) In this ideal form, humanitarian action reflects the desire to cultivate and embody the virtues of selflessness, benevolence and compassion towards others. Although laudable, it is perhaps unsurprising that a commitment that is both so grand and ambitious in scope is fraught with moral tensions and begs important ethical questions. The ideals espoused by humanitarianism must necessarily confront the realities of the less than ideal world humanitarians navigate.

As seen in Chapter two, ethical tensions can operate on a broad level, prompting concerns of whether humanitarian aid should be considered right regardless of outcome because of deontological commitments to universal laws, rights, duties and maxims, or whether anticipating potential outcomes and calculations of risk:benefit is a necessary precondition for right action. Moreover, conceptualizing outcomes in terms of individual need, basic human rights, utility calculations or virtuous conduct in light of the facts on the ground, will have substantial implications for the scope and nature of humanitarian healthcare that is practiced. Humanitarian healthcare workers will inevitably confront situations in which they must make complex ethical decisions in contexts where resources are inadequate, patient acuity is high, and cultural and linguistic barriers exist. Moreover, for those working in these challenging ethical contexts, prior ethics training may be scarce and traditional means of

ethics support (clinical ethics consults or clinical ethics committees, professional codes of conduct, institutional directives or best practice guidelines) may not exist or be less relevant. (Hunt, 2011; Schwartz et al., 2010)

Understanding ethical theory and the judicious use of ethical analysis tools provide different, though equally important means of responding to the above considerations. The divide (some would call it a gulf) between ideal ethical theory and the realm of applied ethics has been a subject of considerable discussion in bioethics. An applied discipline that seeks to provide practical answers to real world cases; bioethics is a site where the gap between the theoretical and the practical is frequently encountered. While some meta-philosophers distance themselves from the world of applied ethics, and some clinical ethicists find the theorizing of philosophers abstract and unhelpful; a more balanced view holds that ethical reflection is a two way street. (Arras, 2007) Arras argues that philosophical theory ought to inform how to respond to individual cases and practical problems, and real world cases and dilemmas should help shape the sorts of principles and theories philosophers and academics develop. (Arras, 2007) This thesis has attempted to reconcile the importance of both of these approaches for conceptualizing the ethical tensions that arise in humanitarian healthcare aid and in formulating and justifying moral responses.

Humanitarian aid work has historically been informed by three dominant ethical theories: deontology, consequentialism and virtue ethics. Given the increasing complexity of the contexts in which humanitarianism is enacted, this discussion is likely to continue and evolve. Ethical theory provides a set of lenses through which we come to view and interpret features of the moral landscape. (Sherwin, 1999) For a Kantian, right action is that which is

done according to reason, following a universal maxim, in which the means may never be used to justify a given end. For a utilitarian, right action is dictated by an evaluation of which action will generate the greatest good for the greatest number. The end may justify the means, if the end is worthy enough. For the virtue ethicist, right action represents the complex ideal of right action, done for the right reason, with the right feeling and with the right outcome. It is a matter of cultivating individual character through mentorship and practice.

To critically engage with these theories forces a confrontation between what is accorded moral value and why.[39] Understanding ethical theory in this way enables us to think more critically about our values and assumptions, and the strengths and limitations of each. It provides a rich tradition of engagement, argument and analysis, which can inform how we articulate what is believed to be the right or the good. It captures the ways in which "there is nothing new under the sun," and elaborates the ways in which ethical theory has responded to these types of problems since the advent of humanitarianism. Engaging with other ethical theories, for example, feminism, cosmpolitanism, or theories of distributive justice, would bring different considerations to the foreground and push the discussion in new directions. Adjudicating between competing claims of the good or the right is no easy endeavour, though there is no reason to expect it should be. Reflective Equilibrium is one method described in chapter two that provides a means to engage with alternate ethical theories and relevant empirical information in order to achieve coherence in moral justification.

[39] To say nothing of the myriad other ethical theories which have not been touched upon here. (As one example, ethics of care critiques the cold calculations of utilitarianism and contests the Kantian account of autonomy. Instead, ethics of care places emphasis on interpersonal relationships and attentiveness to vulnerability and power dynamics. It might ask humanitarians to amend the question from an emphasis on what is right action, to right action for whom?)

Given that lives are at stake and the potential for the amelioration of human suffering, ethical justification of the nature and scope of humanitarian aid projects deserves scrutiny, and is widely recognized by many humanitarian organizations as a fundamental imperative. (Barnett, 2011; ICRC, 1994) Hugo Slim argues that poor morale in relief agencies may be linked to a sense of moral confusion. At a recent conference on the ethics of humanitarian healthcare aid I attended, one humanitarian worker expressed his belief that humanitarians who return from the field "burnt out", or diagnosed with post-traumatic stress disorder, may in reality be experiencing moral distress from ethical dilemmas encountered in the field. As noted in chapter four, collectively thinking through ethical issues and ways to address them, whether in pre-departure training courses, in the field, or in retrospective debriefing sessions, may improve ethical deliberation and address the feelings of moral distress that can lead to burn out and psychological distress in humanitarian healthcare workers. Understanding how ethical theory informs humanitarian practice and policy, historically and today, is essential to generating thoughtful and critical analysis of complex issues and brings new issues and responses to the foreground. As Slim points out: "A moral position which does not gloss over difficulties but sets out a clear and acceptable moral vision within such difficulties, can make a great contribution to the morale of the helpers and the helped in any situation." (Slim, 1997, p.246) A greater emphasis on ethical theory, either in pre-departure training courses, or in health care curriculums, is a necessary condition for generating this moral vision and clarity.

That said, engaging with ideal ethical theory can be a complex and time consuming affair, requiring considerable thought, engagement and education. Humanitarians and health care

workers alike may benefit from practical resources that help structure approaches to complex ethical decisions, which may often seem daunting and difficult. Ethical analysis tools are a potentially valuable instrument for structuring more comprehensive and reasoned deliberation of ethical problems. By providing a step-by-step approach to decision making, they prompt individual decision makers to break down complex moral issues into discrete parts, which may then be analyzed and considered in greater detail. These tools prove useful in a variety of different contexts and settings, may be helpful in prospective decisions or retrospective debriefing sessions, and have the potential to improve procedural elements of ethical decision making by offering a standardized procedure that facilitates documentation and accountability. However, as noted in chapter three, these tools are not without limitations, and further research into their value and utility in real world contexts is required if we are to continue to develop them as a resource for the resolution of moral dilemmas.

Developing the HHEAT represents one such attempt to investigate perceptions of the utility of an ethical analysis tool with the practitioners most likely to use it. Results from this study suggest that that humanitarian aid workers often experienced ethical issues in the field; study participants were unanimous in agreement that the HHEAT would be a valuable tool to help them work through these types of dilemmas in the future. Participant observation and feedback also revealed uncertainty surrounding ethical terminology and theory, suggesting that humanitarian health workers would benefit from greater ethics education and preparation. In response to these considerations, the HHEAT has been tailored to fit what humanitarian healthcare workers value (a shorter, simplified version of the tool), accompanied by an ethics handbook which will provide some of the supplemental ethics information and resources humanitarian workers need. Recognizing that teaching is an

important component to the effective use of analysis tools, efforts are currently underway to integrate the HHEAT into pre-departure training sessions with humanitarian organizations.

The study of ethics, as noted at the beginning of this thesis, revolves around the fundamental challenge of contemplating the *is* and the *ought* of human behavior and action. Juxtaposing ethical theory with the messy and complex "second-best world" of humanitarian contexts of war, disaster and extreme poverty will necessarily prove a difficult and contentious undertaking. There is no hard and fast line demarcating how much familiarity humanitarian workers should be expected to have in ethics, and we should not expect humanitarians to be moral philosophers anymore than we expect moral philosophers to be humanitarians. And yet, as this thesis has hopefully demonstrated, there are compelling reasons to believe that familiarity with ethical theory and the judicious use of ethical analysis tools can enrich moral judgment and reasoning, both of which are essential to the ethical practice of humanitarian healthcare aid. While the absolute truth of an ethical response might never be certain, what remains imperative is that we keep asking questions and keep thinking critically about ethical matters. Hannah Arendt famously argued that the great tragedies and horrors that occur in the world are not necessarily the result of vice or evil intent, but arise through an individual failure to think critically and deeply. For Arendt, it is thinking that allows individuals to judge for themselves and not be swayed by the actions or opinions or others.[40]

[40] See Arendt: *Eichmann in Jerusalem: A Report on the Banality of Evil* (1964); *Between Past and Future: Six Exercises in Political Thought* (1961); *The Human Condition* (1998).

Thinking forms the seed of conscience - our inner motivation for action, and judgment - the outer manifestation of critical thought. Arendt eloquently summarizes her philosophy of human morality as follows: "What I propose therefore is simple: it is nothing more than to think what we are doing." (Arendt, 1998) To think what we are doing, to be able to justify our moral beliefs and judgments may not be the sum of ethics in humanitarian healthcare action, but it is an essential component. This type of thinking requires an engagement and exploration with both ideal ethical theory and practical decision making procedures, for neither may be a sufficient response on its own. Just as upstream and downstream approaches to humanitarian aid are increasingly seen as symbiotic and complementary, so too should ideal and applied ethical theory be integrated into discussions of the ethics of humanitarian healthcare aid.

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Appendix A: Examples of Ethical Analysis Tools

Value, be, do: guidelines for resolving ethical conflict (Cameron, Schaffer and Park, 2001, p. 446)

- What should I value? Develop values that are ethically justifiable and give meaning to life, such as not hurting, doing good, caring, justice, advocacy and truth-telling.
- Who should I be? Develop excellent character by behaving with integrity according to the values from the previous question.
- What should I do? Develop a resolution to ethical conflict that is consistent with the answers to the previous two questions and takes into account both right action and good consequences.
- Note: Resolve ethical conflict by using the partial, personal, subjective perspective of ethical caring and the impartial, impersonal, objective stance of principlism to answer the questions.

Transcultural Integrative Model of Ethical Dilemma Resolution in Counseling (Garcia et al., 2003, p. 273)

Step 1: Interpreting the Situation Through Awareness and Fact Finding

- Enhancement of sensitivity and awareness
  - General: Emotional, cognitive sensitivity and awareness of needs and welfare of the people involved
  - Transcultural: Counselor attitudes and emotional reactions toward cultural groups; counselor knowledge of client's culture;
  - counselor awareness of own and the client's cultural identity, acculturation, and role socialization; counselor awareness of own multicultural counseling competence skills.
- B. Reflection to analyze whether a dilemma is involved
  - General: A dilemma occurs when counselors have opposing options.
  - Transcultural: Determining whether the identification of the courses of action involved in the dilemma reflects the counselor's worldview, the client's, or both
- C. Determination of major stakeholders
  - General: Identification of the parties who are affected and their ethical and legal relationships to the client.
  - Transcultural: Determining the meaningful parties involved based on the cultural values of the client.
- D. Engagement in the fact-finding process
  - General: Reviewing and understanding current information as well as seeking new information.
  - Transcultural: Gathering relevant cultural information such as immigration (history, reasons, and patterns), family values, and community relationships

Step 2: Formulating an Ethical Decision

- A. Review the dilemma.
  - General: Determine whether the dilemma has changed or not in light of the new information gathered in Step 1.

    - Transcultural: Ensure that the cultural information gathered in Step 1 was considered when reviewing the dilemma.
- B. Determine relevant ethical codes, laws, ethical principles, institution policies, and procedures.
    - General: Determine the ethics laws and practice applicable to the situation.
    - Transcultural: Examine whether the ethics code of your profession contains diversity standards; examine potential discriminatory laws, institutional policies and procedures; estimate potential conflict between laws and ethics resulting from a cultural perspective.
- C. Generate courses of action.
    - General: List all possible and probable courses of action.
    - Transcultural: Make sure courses of action selected reflect the cultural worldview of the parties involved. Use relational method and social constructivism techniques (negotiating, consensualizing, and arbitrating) as appropriate to reach agreement on potential courses of action.
- D. Consider potential positive and negative consequences for each course of action.
    - General: List both positive and negative consequences under each of the courses of action selected above.
    - Transcultural: Consider the positive and negative consequences of each course of action from within the cultural worldview of each of the parties involved. Again, consider using a relational method and social constructivism techniques to reach agreement on analyzing consequences.
- E. Consultation
    - General: Consult with supervisors and other knowledgeable professionals.
    - Transcultural: Consult with supervisors and professionals who have pertinent multicultural expertise.
- F. Select the best ethical course of action.
    - General: Based on a rational analysis of the consequences and ethical principles underlying the competing courses of action determine the best course of action.
    - Transcultural: Based on a relational method and a cultural analysis of the consequences of each selected course of action, choose the course of action that best represents an agreement between the cultural worldview of the client and that of the other parties involved. Use social constructivism techniques to choose a course of action mutually satisfying to key parties.

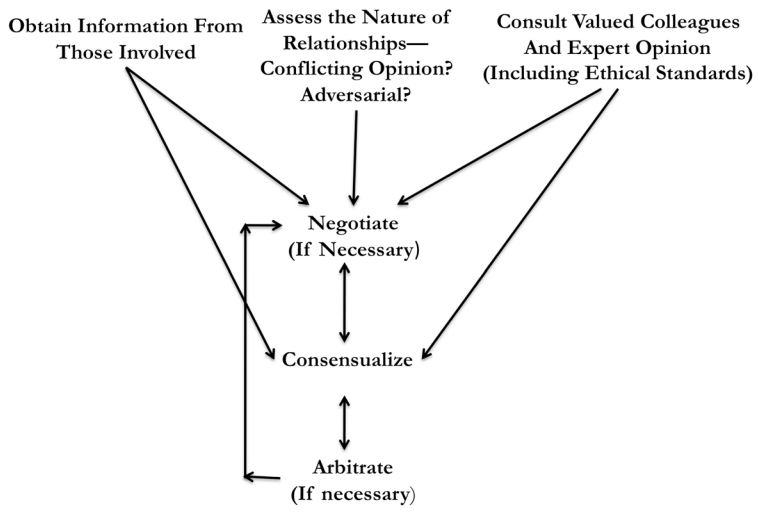
Step 3: Weighing Competing, Nonmoral Values and Affirming the Course of Action

- A. Engage in reflective recognition and analysis of personal blind spots.
    - General: Identify counselors' nonmoral values that may interfere with the implementation of the course of action selected.
    - Transcultural: Identify how the counselors' nonmoral values may be reflecting a culture different from the clients' culture.
- B. Consider contextual influences on values selection.
    - General: Consider contextual influences on values selection at the collegial, professional team, institutional, and societal levels.
    - Transcultural: In addition to the levels mentioned above, counselors consider values selection at the cultural level.

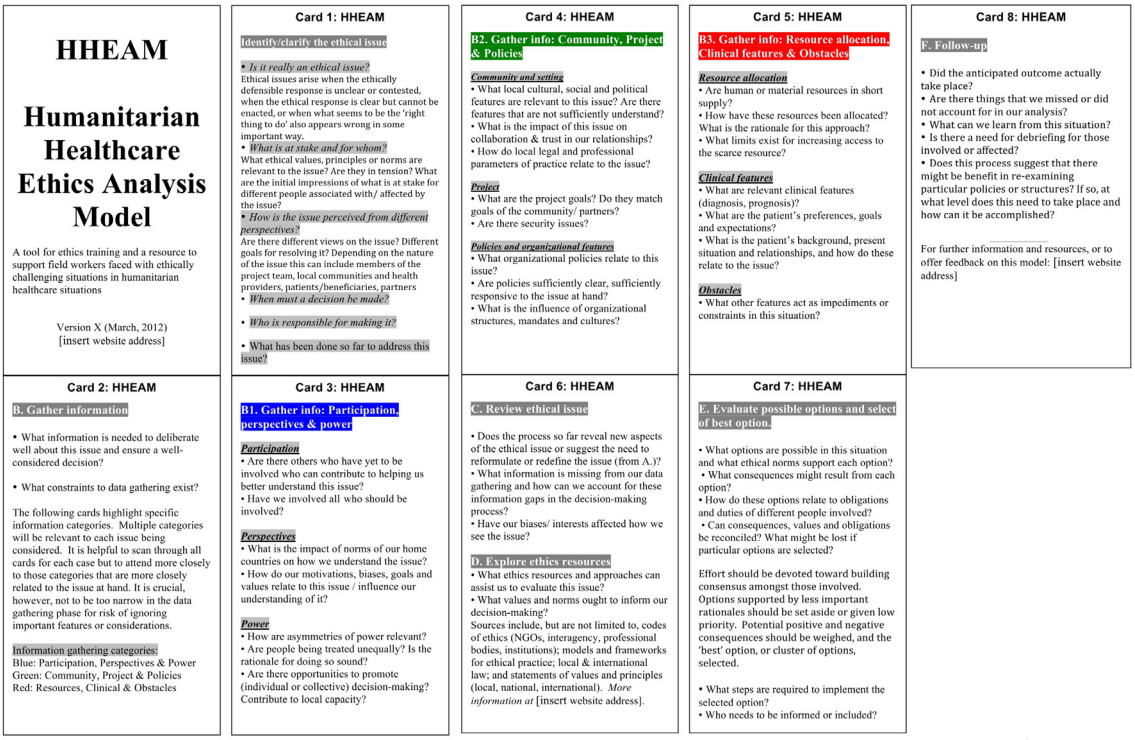
Step 4: Planning and Executing the Selected Course of Action

- A. Develop a reasonable sequence of concrete actions.
  - General: Divide that course of action into simple sequential actions.
  - Transcultural: Identify culturally relevant resources and strategies for the implementation of the plan.
- B. Anticipate personal and contextual barriers and counter measures.
  - General: Anticipate and confront personal and contextual barriers to successful implementation of the plan of action and counter measures.
  - Transcultural: Anticipate cultural barriers such as biases, discrimination, stereotypes, and prejudices. Develop effective and relevant culture-specific counter measures, for instance, culturally sensitive conflict resolution and support.
- C. Implementation, documentation, and evaluation of the course of action
  - General: Execute course of action as planned. Document and gather valid and reliable information and evaluate accuracy of the course of action.
  - Transcultural: Use a relational method and social constructivism techniques to identify measures and data sources that include both universal and culture-specific variables.

The Social Constructivism Process of Ethical Decision Making (Cottone, 2001)



Appendix B: Preliminary Version of HHEAT sent to participants[41]



HHEAM

Humanitarian Healthcare Ethics Analysis Model

A tool for ethics training and a resource to support field workers faced with ethically challenging situations in humanitarian healthcare situations

Version X (March, 2012)
[insert website address]

Card 1: HHEAM

Identify/clarify the ethical issue

• *Is it really an ethical issue?*
Ethical issues arise when the ethically defensible response is unclear or contested, when the ethical response is clear but cannot be enacted, or when what seems to be the 'right thing to do' also appears wrong in some important way.
• *What is at stake and for whom?*
What ethical values, principles or norms are relevant to the issue? Are they in tension? What are the initial impressions of what is at stake for different people associated with/ affected by the issue?
• *How is the issue perceived from different perspectives?*
Are there different views on the issue? Different goals for resolving it? Depending on the nature of the issue this can include members of the project team, local communities and health providers, patients/beneficiaries, partners
• *When must a decision be made?*

• *Who is responsible for making it?*

• What has been done so far to address this issue?

Card 2: HHEAM

B. Gather information

• What information is needed to deliberate well about this issue and ensure a well-considered decision?

• What constraints to data gathering exist?

The following cards highlight specific information categories. Multiple categories will be relevant to each issue being considered. It is helpful to scan through all cards for each case but to attend more closely to those categories that are more closely related to the issue at hand. It is crucial, however, not to be too narrow in the data gathering phase for risk of ignoring important features or considerations.

Information gathering categories:
Blue: Participation, Perspectives & Power
Green: Community, Project & Policies
Red: Resources, Clinical & Obstacles

Card 3: HHEAM

B1. Gather info: Participation, perspectives & power

Participation
• Are there others who have yet to be involved who can contribute to helping us better understand this issue?
• Have we involved all who should be involved?

Perspectives
• What is the impact of norms of our home countries on how we understand the issue?
• How do our motivations, biases, goals and values relate to this issue / influence our understanding of it?

Power
• How are asymmetries of power relevant?
• Are people being treated unequally? Is the rationale for doing so sound?
• Are there opportunities to promote (individual or collective) decision-making? Contribute to local capacity?

Card 4: HHEAM

B2. Gather info: Community, Project & Policies

Community and setting
• What local cultural, social and political features are relevant to this issue? Are there features that are not sufficiently understand?
• What is the impact of this issue on collaboration & trust in our relationships?
• How do local legal and professional parameters of practice relate to the issue?

Project
• What are the project goals? Do they match goals of the community/ partners?
• Are there security issues?

Policies and organizational features
• What organizational policies relate to this issue?
• Are policies sufficiently clear, sufficiently responsive to the issue at hand?
• What is the influence of organizational structures, mandates and cultures?

Card 6: HHEAM

C. Review ethical issue

• Does the process so far reveal new aspects of the ethical issue or suggest the need to reformulate or redefine the issue (from A.)?
• What information is missing from our data gathering and how can we account for these information gaps in the decision-making process?
• Have our biases/ interests affected how we see the issue?

D. Explore ethics resources

• What ethics resources and approaches can assist us to evaluate this issue?
• What values and norms ought to inform our decision-making?
Sources include, but are not limited to, codes of ethics (NGOs, interagency, professional bodies, institutions); models and frameworks for ethical practice; local & international law; and statements of values and principles (local, national, international). *More information at* [insert website address].

Card 5: HHEAM

B3. Gather info: Resource allocation, Clinical features & Obstacles

Resource allocation
• Are human or material resources in short supply?
• How have these resources been allocated? What is the rationale for this approach?
• What limits exist for increasing access to the scarce resource?

Clinical features
• What are relevant clinical features (diagnosis, prognosis)?
• What are the patient's preferences, goals and expectations?
• What is the patient's background, present situation and relationships, and how do these relate to the issue?

Obstacles
• What other features act as impediments or constraints in this situation?

Card 7: HHEAM

E. Evaluate possible options and select of best option.

• What options are possible in this situation and what ethical norms support each option?
• What consequences might result from each option?
• How do these options relate to obligations and duties of different people involved?
• Can consequences, values and obligations be reconciled? What might be lost if particular options are selected?

Effort should be devoted toward building consensus amongst those involved. Options supported by less important rationales should be set aside or given low priority. Potential positive and negative consequences should be weighed, and the 'best' option, or cluster of options, selected.

• What steps are required to implement the selected option?
• Who needs to be informed or included?

Card 8: HHEAM

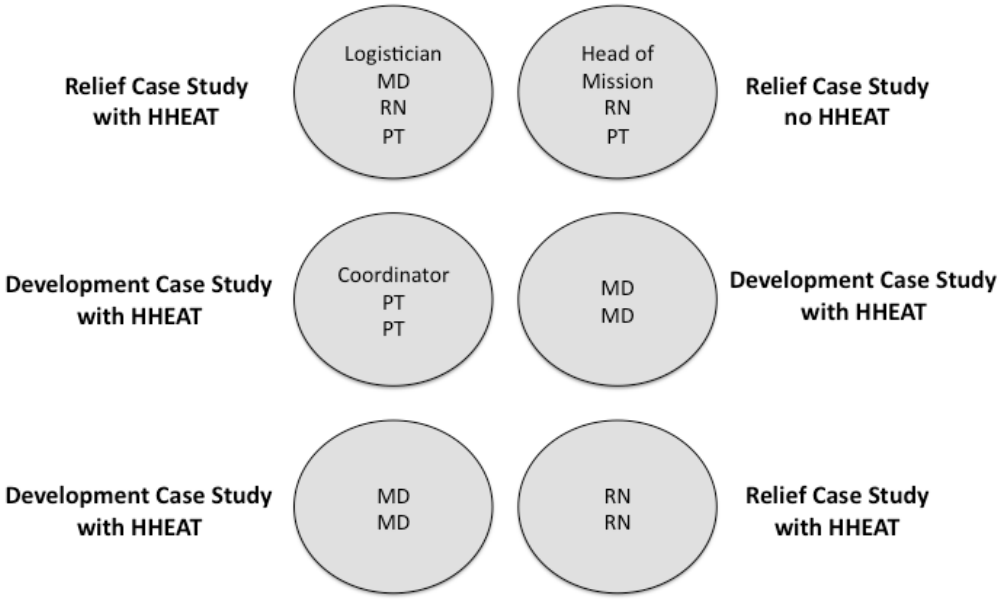
F. Follow-up

• Did the anticipated outcome actually take place?
• Are there things that we missed or did not account for in our analysis?
• What can we learn from this situation?
• Is there a need for debriefing for those involved or affected?
• Does this process suggest that there might be benefit in re-examining particular policies or structures? If so, at what level does this need to take place and how can it be accomplished?

For further information and resources, or to offer feedback on this model: [insert website address]

[41] The tool was initially titled: The Humanitarian Healthcare Ethical Analysis Model (HHEAM) and was subsequently changed to the Humanitarian Healthcare Ethical Analysis Tool (HHEAT). The primary purpose of a model is to explain an aspect or phenomena, while a tool is primarily an action oriented and pragmatic resource. The use of the word tool more accurately reflects the intended purpose of the HHEAT.

Appendix C: Figure Illustrating Case Analysis Groups



Appendix D: Copy of Questionnaire

Humanitarian Health Ethics Analysis Model (HHEAT) post focus group questionnaire

Thank you for having participated in the HHEAT focus group. The purpose of this questionnaire is to receive your impressions and feedback about the model. Your responses will assist in further refining and enhancing the HHEAT.

1. Please describe your global health/ humanitarian experiences and your role:
    a. Number and type of global health/ humanitarian postings:

    b. Total combined time providing healthcare in global health / humanitarian contexts:

    c. Professional role(s) while there:

    d. Organizations for which have you worked as a humanitarian healthcare professional:

2. Please provide comments on the vignette that was used in the focus group:
    a. How did the case used for HHEAT testing compare to events you have already encountered or are aware of?

    b. How useful was the case in presenting ethical dilemmas and stimulating discussion?

3. Comments on using the HHEAT for this case analysis:

a. Describe ways in which the HHEAT made reaching a decision easier.

b. Describe ways in which using the HHEAT made reaching a decision more difficult.

c. What points raised during the discussion did you find helpful/ constructive or unhelpful/ obstructive in analysing the ethical issues involved?

d. How comfortable are you with the decision that was reached?

e. What changes to the decision would you have liked to have been able to make?

4. Overall impressions:

a. Would this model be applicable in a variety of humanitarian healthcare situations?

b. Please compare using the HHEAT to other similar models, or to making decisions in the absence of such a model (including experiences you have had in the field when addressing an ethical issue).

c. Would you use this model in the future? Why/why not?

d. How can the model be improved?

a. What format would you think the model would be most helpful:

- o Online
- o Electronic/downloadable
- o Paper leaflet
- o Wallet cards
- o All that apply
- o Other: _____

5. Additional comments:

May we contact you for further clarification/elaboration on your responses to this questionnaire?

Yes – provide name and contact information: _____

No

Thank you for your time and valuable participation.

Appendix E: Consent Form

Letter of Information /Consent

Testing of the Humanitarian Health Ethics Analysis Model

Principal Investigator: Dr. Lisa Schwartz, McMaster University

Co- Principal Investigator: Dr. Matthew Hunt, McGill University

Research Sponsor: Canadian Institutes of Health Research (CIHR)

Purpose of the Study

In this study, we wish to test an ethics analysis model for health care practice in humanitarian aid work.

Procedures involved in the Research: You will participate in a focus group with 3-4 other health care professionals, medical residents or humanitarian project coordinators. As a group, you will be provided with a short vignette that contains an ethically challenging situation. You will be asked to evaluate the vignette as if you were the team faced with this situation. You will have 30 minutes to do so. At the end of the allotted time, you will be asked to decide how the team should respond to this situation and explain why you think that is the preferable course of action. Your group may or may not be provided with a short set of questions to use in the course of your analysis. Following the end of the group discussion you will be asked to fill out a questionnaire. Doing so will take 10-15 minutes. In the questionnaire, you will also have the option of agreeing to be contacted at a later date for further clarification or elaboration on your responses. In total, your participation in this research will require 60-75 minutes of your time.

Potential Harms, Risks or Discomforts: It is possible that it will be uncomfortable or upsetting to talk about ethically difficult situations, especially if these discussions resemble challenging situations that you have experienced in the past. However, the discussion will focus on a vignette and not your own experiences. If you wish to end you're your participation in the focus group, you are welcome to do that as well. The facilitator will have information about support resources you may choose to access following the session.

Potential Benefits: We hope with this research to provide resources and guidance to and individual health workers struggling through ethically challenging situations. These resources may not benefit you directly. However we will make them available through publications and presentations, and they may be of use to you and your colleagues.

Confidentiality: All efforts will be made to ensure your confidentiality and anonymity. We will not share any personally identifying information about you with anyone without your permission. Because of the group nature of this research, other research participants will know of your participation. We cannot guarantee total privacy. We will undertake to safeguard the confidentiality of the discussion. We ask the other members of the focus group to keep what you say confidential, but we cannot guarantee that they will do so.

If information from this study is published or presented at academic meetings, your name and other identifying information will not be used.

Participation: Your participation in this study is voluntary. If you decide to participate, you can decide to stop at any time, even after signing the consent form or part-way through the focus group. If you decide to stop participating, there will be no consequences to you.

Information About the Study Results: A final report from the study will be available on the McMaster Ethics in Health Care website http://fhs.mcmaster.ca/ethics/.

Information about Participating as a Study Subject: If you have questions or require more information about the study itself, please contact Dr. Lisa Schwartz at (905) 525-9140 ext. 22987 or Dr. Matthew Hunt at (514) 398-4400 ext. 00289.

This study has been reviewed by the Hamilton Health Sciences/McMaster Faculty of Health Sciences Research Ethics Board (HHS/FHS REB). The REB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call The Office of the Chair, HHS/FHS REB at 905.521.2100 x 42013 (McMaster) or Ilde Lepore, Senior Ethics Administrator at (514) 398-8302 (McGill).

Investigators:

Dr. Lisa Schwartz
(Principal Investigator)
McMaster University, CRL-224, 1280
Main St. W., Hamilton, ON L8N 4K1
(905) 525-9140 ext. 22987
E-mail: schwar@mcmaster.ca

Dr. Matthew Hunt
(co- Principal Investigator)
McGill University, Hosmer House
205, 3630 prom. Sir William Osler,
Montreal, PQ, 3G 1Y5
(514)-398-4400 ext. 00289
E-mail: matthew.hunt@mcgill.ca

CONSENT

I have read the information presented in the information letter about a study being conducted by Dr. Lisa Schwartz of McMaster University and Dr. Matthew Hunt of McGill University. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so, and I agree to participate in this study. I will be been given a signed copy of this form.

1. I agree that the interview can be audio/video recorded. Yes No

2. I agree to be contacted about future research and

I understand that I can always decline the request. Yes No

Please contact me at: _____

_____ _____ _____

Name of Participant Signature of Participant Date (yyy-mm-dd)

Consent form explained in person by:

_____ _____ _____

Name and Role (Printed) Signature Date

Appendix F: HHEAT (Analysis Tool)

FRONT

Humanitarian Ethics Analysis Tool

1. **Identify/clarify ethical Issue:**
   What is at stake and for whom?
2. **Gather Information:**
   What do we need to know to assess the issue?
3. **Review Ethical Issue:**
   Does information gathered lead us to reformulate the issue?
4. **Explore ethics resources:**
   What can help us make a decision?
5. **Evaluate and select the best option:**
   What options are possible and which is the "best" under the circumstances?
6. **Follow up:**
   What can we learn from this situation and what supports are needed?

http://www.humanitarianhealthethics.net/

BACK

Humanitarian Ethics Analysis Tool

1.	Is this truly an ethical issue? What is at stake and for whom? How is the issue perceived from different perspectives? When must a decision be made? Who is responsible for making it? What has been done so far?
2.	What information is needed to deliberate well about this issue and enable us to make a well-considered decision? What constraints to information gathering exist? Consider: a) Participation, perspectives and power b) Community, project and policies c) Resources, clinical features & obstacles
3.	Does the process so far reveal new aspects of the ethical issue or suggest the need to reformulate or redefine the issue? Have our biases/interests affected how we see the issue?
4.	What can assist us to evaluate the ethical aspects of this issue? What values and norms ought to inform our decision making? Consider: Codes of ethics (NGO, interagency, professional bodies); local & international law; statements of values/principles; agency policies
5.	What options are possible in this situation and what ethical values support each option? What consequences might result from each option? Can consequences, values and obligations be reconciled?
6.	What can we learn from this situation? What support do those involved need?

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HHEAT Handbook