CHAPTER 8

Empathy-Based Ethics in Medical Practice

Abstract  The application of the empathy-based ethical approach in clinical practice is examined in three scenarios. Helen’s story is described, firstly as a patient with advanced lung cancer receiving hospital-based treatment, then her story is retold with her general practitioner taking a key role in co-ordinating her care. The second case, Peter, is a man with advanced pancreatic cancer who is dying at home. He asks his general practitioner “Will you help me to die, please?” Empathy-based ethics provides a way of responding to a request for euthanasia in a humane and moral way. In the third scenario, the role of the empathy-based approach is examined with reference to the COVID-19 pandemic, looking at the differences between ethical approaches focused on individuals and public health concerns. A relational empathic approach to ethics, acknowledging our interconnection, vulnerability and shared humanity is appropriate to meet the moral challenges of the pandemic.

Keywords  Palliative chemotherapy · Euthanasia · Pandemic · Relational autonomy · Empathy-based ethics
INTRODUCTION

This chapter describes the application of an empathy-based ethical framework in clinical practice. The three scenarios used are based on an amalgam of real-life patients’ stories with changes in names and gender to preserve confidentiality.

Helen’s story is described in two ways, initially as a patient with advanced lung cancer receiving hospital-based treatment from the oncology department. Helen’s story is then retold with a different emphasis as her general practitioner takes a key role in co-ordinating her care. The two perspectives illustrate how the approach taken by doctors may dramatically alter the patient experience.

Peter is a man with advanced pancreatic cancer who is dying at home, cared for by his wife and daughter. He asks his general practitioner “Will you help me to die, please?”. Empathy-based ethics provides a way of responding to a request for euthanasia in a humane and moral way.

In our account of empathy-based ethics, a strong emphasis has been placed on relational aspects of the patient-doctor relationship. In the third clinical scenario, the role of the empathy-based framework is examined with reference to the COVID-19 pandemic. This case investigates the differences between ethical approaches focused on individuals and public health concerns.

WHAT ARE YOU GOING TO DO NEXT, DOCTOR?
CEASING PALLIATIVE CHEMOTHERAPY

Background: Helen’s Story

Helen, a 45-year-old non-smoking teacher, is married to Tom, a plumber. They have two children, Charlie and Katie aged 18 and 16. Three weeks ago, Helen developed a dry cough and pains in her lower back. She saw her GP, Dr. Woods, who referred her for X-rays, a scan and blood tests. The results of her investigations showed that Helen had advanced lung cancer with spread to her bones and liver. She was referred to the hospital for further investigation and subsequently referred to Dr. Brown, an oncologist, for chemotherapy (Anandappa and Popat 2016).
**Helen’s Story: The Biomedical Approach**

Helen met Dr. Brown with her husband in the outpatient clinic. Dr. Brown listened carefully to the history of her symptoms and of her shock of learning that she had lung cancer. She was keen to know what treatment she could have. Dr. Brown explained that her disease would be best treated by a course of chemotherapy which would help her breathlessness and fatigue, and painkillers to relieve her back pain. He explained that chemotherapy would involve coming up to the day-patient ward every three weeks. She would have blood tests and scans to monitor her response to treatment. Helen asked about the side-effects of the chemotherapy and was told of hair-loss and sickness. Helen signed a consent form and Tom confirmed that they both wanted to fight the cancer. Dr. Brown explained that he would write to her GP informing her of the treatment plan. At this initial visit, Helen did not ask about the chance of recovery as Dr Brown appeared busy and the waiting room was full of patients.

Over the course of the next six weeks, Helen felt ill before her chemotherapy, vomited for four days after the drugs and felt tired all the time. She became depressed, withdrawn and her appetite was poor. Her GP, Dr. Woods, left prescriptions for anti-emetics and analgesics for Tom to pick up from the surgery. Reviews at the outpatient clinic focused on the results of blood tests and the treatment plan. Helen became weary of hunting for a car-parking space at the hospital, her whole life seemed to be dominated by her disease and hospital visits.

After two months, a check scan revealed that the disease was progressing. Helen was distraught as she had believed that there was a hope of cure.

Helen complained to Tom, “Dr. Brown would never have put me through all this if there wasn’t a good chance of cure”.

She was admitted to the ward with increasing pain, breathlessness and low mood. She asked Dr Brown on the ward round,

“What are you going to do next, doctor?”

Dr. Brown explained that her type of lung cancer was not suitable for immunotherapy, but she could try a second-line chemotherapy drug to see if it would help to slow the progress of the disease. Helen said she felt too ill to take any further chemotherapy. Dr. Brown agreed that it would be best if she had a break from treatment and that it would be sensible to see the palliative care team while she was recuperating in the ward.
Helen met the palliative care nurse Morag, but by this time she was very weak, withdrawn and depressed. Morag sat and listened to her and suggested having her drugs for pain and vomiting administered by a syringe pump, which would give her continuous relief from her symptoms. She said she would return in the morning. That night Helen’s condition deteriorated rapidly. Tom was called by the night staff, but despite rushing to the hospital with Charlie and Katie, Helen died before they arrived.

Her husband Tom, her children Charlie and Katie were bereft, having no chance to say goodbye in a loving way. Their grief was complicated and prolonged.

**Discussion**

This version of Helen’s story highlights unfortunate outcomes of a strictly biomedical approach to patient care. After being provided with overwhelming amounts of information relating to the cancer, drug treatments and side effects, Helen opts for chemotherapy with the mistaken belief that there is a chance of cure (Aragon 2020).

Conversations during subsequent visits to the clinic were restricted to the details of the treatment plan and results of investigations (The et al. 2000). There was no discussion of Helen’s poor prognosis, it remained ‘an elephant in the room’. The oncologist did not want to remove hope by raising issues of end of life care, so entered a collusion with the patient (The et al. 2000). He finds conversations about stopping treatment difficult and stressful. Current guidelines set out when to start anticancer treatments, but not when to stop as the end of life approaches (Clarke et al. 2015). Dr. Brown does not routinely involve the palliative care team until the terminal stage of the disease (Aragon 2020).

Helen’s general practitioner, Dr. Woods, has handed over her medical care to the oncologist, so has not had any conversations to explore her values and concerns about her cancer. Dr. Woods is doubtful about the value of palliative chemotherapy, but is aware of her own lack of knowledge in this rapidly advancing field (Aragon 2020).

When patients are receiving palliative chemotherapy within the last 30 days of their life questions arise as to the appropriateness of the therapy (Nguyen et al. 2019). There is an increasing trend towards continuing palliative chemotherapy until close to the end of the patient’s life (Clarke et al. 2015; Earle et al. 2004; Zdenkowski 2013). The sad consequence in
this case is that Helen became depressed, withdrawn and had no chance to discuss her real concerns with her husband Tom, or her children, as her family were drawn into a collusion that she would eventually get better.

Her condition deteriorated suddenly and by this time her professional carers were the hospital staff. She did not have an opportunity to build a relationship with her GP and she did not know the palliative care team. As a result, she was admitted to the hospital and met a palliative care nurse only hours before she died on her own in an oncology ward.

This case demonstrates that the nature of the patient-doctor relationship is a key part of the decision to cease futile chemotherapy (Clarke et al. 2015). Determining when to withhold palliative chemotherapy at the end of life is difficult and emotion becomes an important influence (Bluhm et al. 2016). Some oncologists claim that their decision to continue late chemotherapy is patient-driven. Chemotherapy is sometimes used to palliate emotional distress and maintain patient hope even when physical benefit is unexpected (Bluhm et al. 2016). Oncologists experience stress in emotionally draining communication in a setting of prognostic uncertainty and may respond by offering futile chemotherapy (Bluhm et al. 2016).

**Helen’s Story: An Empathy-Based Ethical Approach**

In this scenario, when Dr. Woods met Helen to give her the results of the investigations, she asked Helen about her ideas of the cause of her symptoms. Helen admitted that she was frightened that it might be a cancer, as her mother died of breast cancer. Dr. Woods confirmed that the X-rays showed that she had lung cancer which had also involved her spine and liver. She gave Helen time to express her distress. Helen asked, ‘What will happen next?’

Dr. Woods suggested meeting her with her husband the following day when there would be a chance for them to raise questions and to discuss future treatment.

The following afternoon Tom and Helen met Dr. Woods. Helen was keen to know what treatment might offer. Dr. Woods asked her what she expected from treatment and Helen explained that she wanted to feel better, to have less pain and to have as much time as possible at home with Tom and her children.

She asked Dr. Woods, “Am I going to get better?”
Dr. Woods replied, “Before I answer you Helen, please tell me what you think”

Helen looked sad, “I know what happened to my Mum, I know that I am not going to survive this, but how long have I got?”

Dr. Woods replied, “It is very difficult to predict this for any individual, but had you any idea in your mind?”

Helen thought for a moment, “Charlie is going to university in six months and Katie has her GCSE exams this summer so I would like to be here for them”

“Those are realistic goals which we can work together to achieve” said Dr. Woods.

Helen asked, “It would be good to feel less pain and be able to do more, are there things that can help me?”

Dr. Woods explained the importance of taking regular analgesics and suggested involvement of a specialist palliative care nurse. It was also possible that chemotherapy might help some of her symptoms as the goal was to improve her quality of life.

Helen was happy to meet the nurse but looked anxious about the notion of chemotherapy. Dr. Woods reassured her that this would only continue if she was benefiting from it.

Helen said, “It’s such a relief to talk about this in the open, Tom and I want the time left together as a family to be special. We will talk to Charlie and Katie this evening and let them know the situation”.

Dr. Woods offered to see Charlie and Katie if they had any questions and reassured them that she would keep in touch with Helen and the oncologist Dr. Brown, through her chemotherapy if that was what she chose.

Helen met Dr. Brown with her husband in the outpatient clinic. Dr Brown listened carefully to the history of her symptoms and agreed with her that the focus of treatment of her treatment should be improving her quality of life. He explained that a trial of chemotherapy might help her symptoms of breathlessness, but if it did not then this should stop. Helen was relieved. Dr. Brown asked if she would keep in touch with Dr. Woods and said that he always referred patients in Helen’s situation to the palliative care team.

After six weeks, the trial of chemotherapy was not helping her symptoms, so Helen agreed to take a break from the treatment. Dr. Brown introduced Dr. Smith a palliative care specialist who saw Helen and Tom and suggested different analgesics and a small dose of opiate for her
breathlessness. Helen also talked about the future and emphasised that she wanted to be at home as much as possible. Dr. Smith said she was available in the background for advice and that her GP and the specialist palliative care nurse would see her regularly at her home.

Helen’s pain improved, she managed her breathlessness and felt much less anxious. She was involved in helping Charlie prepare for university and supported Katie through the traumas of GCSE’s. Dr. Brown saw her each fortnight and the specialist nurse Maggie each week. Helen found she could talk easily with them and discussed plans for a time when she would be confined to bed. She was gradually getting weaker and after two months found that she was taking a nap in the afternoons.

Her symptoms were well controlled and as she became more tired she asked Dr. Woods on one of her visits,

“When I get more ill will I still be able to stay at home? Can I die at home?”

Dr Brown explained that when the time came there would be extra help and support for her and her family and that they would do everything possible to keep her at home. She asked Helen if she had any particular concerns about the end of her life.

Helen said, “I worry that the breathing, will it get worse will I choke to death?”

Dr Woods reassured Helen by saying that if she became distressed with her breathing she could have sedation which would make her sleepy but not breathless. “You will not choke to death but just become sleepier”.

Helen agreed that would be much better and thanked Dr. Woods for her reassurance.

The specialist nurse Maggie helped Helen with her symptom control and with conversations with Charlie and Katie. She also supported Tom as he looked after his dying wife at home.

A month later Helen died peacefully at home with her husband and children around her.

**Discussion**

In this scenario, Helen and her family were more involved in decisions about her care. From the outset, her GP explored her values and goals of care, which led to agreed aims, improved understanding of prognosis and improved quality of life near the end of life (Aragon 2020).
During the discussion with Helen and Tom, Dr. Woods admitted the difficulty in making a prognosis. He took care to assess how Helen wanted to receive the information. Did she wish statistical information? or as it transpired, did she want to live to see her children through their exams and to reach university? Allowing for silence and being empathic are ways to show support when delivering prognostic information that should be initiated early for patients with advanced lung cancer (Aragon 2020).

Discussions about prognosis may be avoided, as in the first scenario, or be provided in a detrimental way, and like any difficult conversation should be introduced and discussed in a sensitive empathic way (Aragon 2020). Prognosis inherently has a high level of uncertainty, which needs to be acknowledged as Dr. Woods communicated in the second scenario.

Dr. Woods also appropriately suggested early involvement of specialist palliative care. Such early referral in advanced lung cancer has been demonstrated to result in a better quality of life, less depression and less aggressive treatment at the end of life (Temel et al. 2010). These two examples show that if clinicians do not explore the individual’s values, a key part of shared decision-making is left out (Aragon 2020). Addressing this early on as in the second scenario sets the tone for future conversations and it makes clear to patients and doctors the importance of values-informed care plans across all stages of lung cancer, and not just for end-of-life decisions (Aragon 2020).

Dr. Woods began what is described as ‘advance care planning’ from the outset in asking Helen about what was important to her in life and in her medical care. She clarified that she would remain the key health professional managing Helen’s care. Dr. Woods took care to discuss and clarify Helen’s goals, values, and preferences which were then tailored to her situation, involving her family in the discussions (Aragon 2020). Helen’s preferences were reviewed as the disease progressed as her physical condition deteriorated.

As the palliative chemotherapy did not improve her symptoms and did not significantly improve meaningful survival, Dr. Brown was able to feel comfortable in withdrawing treatment. In the second scenario, he prepared Helen for this eventuality and included referral to specialist palliative care in tandem with his treatment, not as a last-minute referral as in the first scenario. Late referral to palliative care occurs because some doctors worry that patients will lose hope or become more depressed if palliative care is discussed. Furthermore, some oncologists may believe
that they should be the professionals to provide palliative care (Aragon 2020).

As the disease progressed Helen was at home, in familiar surroundings supported by her family and health professionals she knew and trusted. She was able to discuss difficult issues of her own dying and be reassured by Dr. Woods that she would continue to be supported and receive symptom relief. Patients and their families may have no experience of seeing someone die in their own homes and health professionals are ideally placed to answer their questions and to reassure them that, for most people, dying is a peaceful and dignified process (Mannix 2017).

The second scenario shows how empathy-based ethics places the patient-doctor relationship at its centre, caring for the patient and building trust for future difficult conversations. Uncertainty is a part of clinical medicine but exploration of the patient’s values and goals is still possible (Aragon 2020) The initiation of palliative care is much more than a referral process between differing disciplines. It involves the patient and family in readjusting their hopes and expectations and working in partnership with healthcare professionals (Jeffrey and Downie 2003).

In adopting an empathy-based approach, doctors remain mindful of the emotional impact of the situation, adjusting to the different needs of different patients (and their families). They clearly demonstrate a collaborative approach with the patient and try to understand how the patient perceives the situation, rather than how they do (Owen and Jeffrey 2008). The empathic nature of the patient-doctor relationship is a key part of decision-making concerning the withdrawal of anticancer drugs towards the end of life, supporting the importance on ‘trust’ and ‘empathy’ in shared healthcare decision-making (Kraetschmer et al. 2004). Time spent with patients and their families is worthwhile work for doctors (Jeffrey 2000).

**Please Will You Help Me to Die?: A Request for Euthanasia**

*Background; Peter’s Story*

Peter, a 65-year-old retired builder is married to Joan, they have an unmarried daughter Lucy, aged 40. Peter had been treated for depression over the past three months by his general practitioner Dr. Strang. Four weeks ago, Peter developed sudden severe abdominal pain and was
admitted to hospital where a pancreatic cancer with liver metastases was
diagnosed. The cancer was inoperable and Peter did not wish any pallia-
tive chemotherapy, so was discharged home after two weeks. Lucy has
taken leave from her job as a librarian to help her mother at home to look
after Peter. Peter and the family were informed by the surgeon in hospital
that the prognosis was poor and that he might have “a few months to
live”.

Peter has severe abdominal pain and is receiving opiate analgesics
through a syringe pump. He is visited each day by a district nurse and
spends most of the time confined to his room sitting in a chair or resting
in bed. His general practitioner Dr. Strang visits him to review his pain
control. Peter tells him that he feels low, his pain keeps him awake and
he cannot see much point in going on. He looks to Dr. Strang and asks
him, “Will you help me to die, please?”. Dr. Strang paused “That is a very difficult question, can we talk about
things?”

He sat beside Peter in silence.

Peter began to weep, “I know that I’m going to die and it’s going to
be agony. I don’t want to be a burden to Joan and Lucy. Wouldn’t it just
be better to give me an injection to end my suffering now?”

Dr. Strang replied, “This must be very difficult for you, what is it that
troubles you most?”

Peter answered, “It’s being a burden, I have always been independent,
the strong one, now Joan and Lucy are having to look after me. My wife
has become my nurse”.

Dr. Strang said, “That must be hard for you to accept. What would
you have done if it was Joan who was ill and you were well?”

“I would have looked after her of course, I would have wanted to”
replied Peter.

“Well, maybe that is how it is for Joan and Lucy. They love you, want
to be close to you and care for you at this difficult time” said Dr. Strang.

Peter sat quietly “I had not thought of it like that”.

Dr. Strang said “You mentioned dying in agony Peter, is that another
worry?”

Peter replied, “Yes, I saw my grandfather die many years ago, he was
groaning in pain, no one gave him any pain relief”

Dr. Strang explained, “There have been huge advances in pain control
since then. I can promise you that we will work together to get on top
of your pain. You must tell me or the district nurse if you have any pain
and we can adjust the dose of drugs to suit you. I am so glad you have talked about your concerns Peter. I just wonder if there are any things you would like to do in the time that is left?”

“Well doctor, I would love to see some of my friends, they have stayed away because they don’t know what to say to me. Joan and I love the countryside, it would be lovely to have a visit to the river side. Lucy has just moved to a new flat and as a builder I would love to get a look at it”.

“These are all sensible aims Peter, let us get Joan and Lucy into discuss how we can achieve this. The district nurse can arrange a wheelchair and the ambulance men are happy to lift you up to the flat one afternoon. But before I leave, are you still wanting to end your life?” asked Dr. Strang.

“No, I was just so low and you have made me think that there is a point in going on. I feel much happier that you and the nurses will make sure that I won’t suffer when the end comes. I want to say Dr. Strang that we are all grateful for your care. They told me at the hospital how pancreatic cancer can sometimes appear as depression and physical symptoms only appear at a late stage”

“Thank you, Peter, I must admit I felt guilty that I might have missed something when the letter from the hospital came. We have had a good talk today and we can make a start planning for some of the things you have raised. I will be back next week but you have my number, I am happy to visit if you need me before that”.

After this conversation, Peter’s mood brightened, the dose of analgesics could be reduced and his pain settled. He and Joan and Lucy were closer and enjoyed visits to the park. Lucy was grateful to her father for his advice on some alterations necessary in her flat. Friends visited and reminisced about the happy times they had shared. Peter realised that he was valued in spite of his poor physical state. After six weeks, he died peacefully at home.

**Discussion**

Sensitive exploration of a request for euthanasia or physician-assisted suicide can reveal the real needs of the patient (Jeffrey 2006). The request for euthanasia points to a number of concerns that the patient has about dying; loss of self, loss of dignity and the social context of dying. It may take time to understand all the reasons behind the request, continuity of care is important in developing such an empathic relationship.
In Peter’s case, the patient-doctor relationship deepened as Dr. Strang sat quietly and listened to his concerns. He knew that he was not legally allowed to carry out euthanasia, but stating this at the outset might have alienated Peter (Jeffrey 2009). Dr. Strang acknowledged Peter’s distress, elicited concerns and then discovered goals that Peter wanted to achieve which would improve his quality of life and reassure him that he was still valued.

He also returned in the conversation to check if Peter still had a wish to shorten his life. As their relationship deepened, Peter thanked his GP and forgave him for the delay in diagnosis, evidence of a deep empathy as Dr Strang then was able to share his own vulnerability.

Once psychological issues are addressed, the requirement for analgesics often reduces since anxiety and depression exacerbate pain. Peter was much brighter once he appreciated that he was valued by his friends and could still contribute to his family. He mattered to the very end of his life (Chochinov 2007).

**Empathy-Based Ethics in Response to the COVID-19 Pandemic**

*Introduction*

The coronavirus or COVID-19 pandemic presents ethical challenges for patients, their families, healthcare workers, policymakers and the public. Responding to a public health crisis of this nature demands a broader relational ethical perspective than the four-principle approach of traditional medical ethics (Beauchamp and Childress 2013; Jeffrey 2020). Clinical and research ethics has traditionally focused on the individual whereas public health ethics addresses the interests of a population (Thompson et al. 2006). This shift in ethical focus is one which most healthcare workers struggle with since clinicians are trained to adopt a duty-based ethical approach, placing the individual patient at the centre of care. When health risks primarily affect an individual, respect for autonomy has a high value. However, when a population is at risk, collective interests assume a greater relevance (Baylis et al. 2008). Harsh utilitarian values may be softened by adopting relational ethical values; solidarity, duty, equity, relational autonomy, trust and reciprocity. It is essential that particular attention is paid to the socially or economically disadvantaged, in order
to achieve the best possible outcomes since these groups are most at risk (World Health Organisation 2007).

**Isolation and Social Distancing**

Isolation and social distancing impose limits on an individual’s freedom and autonomy to maximise the welfare of society (World Health Organisation 2007). The principle of reciprocity is relevant since in a situation where an individual’s rights are limited, the government has a reciprocal duty to limit any consequent burdens on the individual (Shearer 2020). In particular, the needs of vulnerable groups including; racial and ethnic minorities, elderly people, prisoners, disabled persons, migrants and the homeless should be of the greatest priority (Baylis et al. 2008; World Health Organisation 2007). The burdens of social isolation include loneliness, uncertainty, stress, depression and anxiety and even death (Roy et al. 2020). Other mental health problems arising from prolonged isolation include addiction, domestic violence and post-traumatic stress disorder (Roy et al. 2020). Grieving in isolation may be prolonged for families unable to visit their dying relative (Moore 2020).

Personal protective equipment including face masks distance health-care professionals and families from patients. Contact between patients and their families may be limited to video calls or the telephone. Developing close empathic relationships with such barriers may be challenging, doctors need time to be present with patients and to be able to communicate their concern despite having to wear face masks (Schlogl 2020).

If the measures to limit the spread of the disease are to be successful, the authorities need the public’s trust (Brody and Avery 2009). A continuing dialogue is needed between health professionals, government and society to maintain trust and solidarity.

**Relational Autonomy**

We are all dependent upon others, the interests of the individual and community are inevitably inter-related. Autonomy should adopt a relational form which takes account of the effects of exercising one’s autonomy on the autonomy of others (Dworkin 1988; Mackenzie and Stoljar 2001). Relational autonomy involves a change in emphasis from the individual self to a person embedded in a social context (Mackenzie
and Stoljar 2001). This contrasts with the current view of autonomy which stresses independence and self-interest (Dworkin 1988).

**Solidarity**
To achieve social distancing and voluntary self-isolation of large numbers of affected or vulnerable people requires the ethical concept of solidarity; where individuals are firmly united by common responsibilities and interests (World Health Organisation 2007). Solidarity involves relational empathy and virtues such as altruism, kindness and generosity, extending to include the concept of fellowship (Brody and Avery 2009; Jeffrey 2016a, b). Solidarity is a relational construct, reflecting a shared interest in survival and safety, a feeling of “we are all in this together” (Baylis et al. 2008).

**Healthcare Workers’ Duty of Care to Patients**
Doctors and nurses have a fundamental duty of care, so cannot, with integrity, refuse to care for patients with COVID-19 (Brody and Avery 2009). However, healthcare workers are assumed to adopt a view that their duty to care overrides self-preservation, consequently there is little debate about any limits to this duty of care (Brody and Avery 2009). A doctor’s moral obligation to work is not unlimited; factors such as the risks to the doctor and their family, competing family caregiving responsibilities and duties of care to other patients must be taken into account (World Health Organisation 2007). The duty of care is linked to the ethics of solidarity between NHS workers and members of society. Some doctors have died in the course of treating patients with COVID-19, so it appears that the duty to care is not dependent upon the extent of risk (Brody and Avery 2009).

**Social Obligations: Solidarity and Reciprocity**
Solidarity between health professionals and society is a key ethical value in minimising mortality and morbidity in a pandemic (Brody and Avery 2009). Society grants professionals privileges and respect and in a reciprocal way expects them to care for infectious patients. Politically, solidarity is endorsed by the authorities appealing to a concept of relational empathy and supporting healthcare workers (Jeffrey 2016b).
Reciprocal moral obligations exist on the part of governments and employers to protect and support healthcare professionals working during the pandemic (World Health Organisation 2007). Healthcare workers should not be expected to expose themselves to unnecessary risk where employers have not provided appropriate personal protective equipment (PPE) (British Medical Association 2020).

**Access to Treatment When Resources are Limited: Utility and Equity**

When considering rationing of resources from a utilitarian perspective, the ethical goal is to save as many lives as possible. However, this utility principle must be aligned with equity, the distribution of resources should be fair. Fairness through impartiality means that where life and health are involved, every individual, irrespective of age, wealth, gender, status, religion, political opinions, or merits has the same dignity, the same moral value and, therefore, the right to equal treatment in case of illness (Federal Office of Public Health 2018). Nobody should receive privileged medical treatment at the expense of other affected individuals on the basis of their ability to pay, their standing, their social position or their age (Federal Office of Public Health 2018).

**Discussion**

The poor and socially disadvantaged bear the brunt of the tough public health measures which have been introduced to contain the spread of the virus (Baker 2020). The COVID-19 pandemic is a global disaster which has exposed social realities in our communities (Baker 2020). Brody claims that our response to pandemics prompts us to question, “What sort of society do we want to live in?” (Brody and Avery 2009). A relational empathic approach to ethics, acknowledging our interconnection, vulnerability and shared humanity is appropriate to meet the moral challenges of the pandemic (Jeffrey 2020). Autonomy becomes an ethical construct with responsibilities to other members of society rather than a manifestation of selfishness.
Conclusions

This chapter illustrates the empathy-based approach to ethics in clinical practice. The two individual case histories show how an empathy-based approach reveals deeper levels of information once the patient is allowed to express their values and concerns. In an empathic relationship, the patient becomes involved in their management and gains a sense of control in situations of great uncertainty. The final scenario describes how a relational empathy-based approach may be appropriate in meeting the ethical challenges of a pandemic. The next chapter examines how the empathy-based ethical approach can be embedded in practice, education and research.

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