"The Catholic tradition holds that healing is best effected in an atmosphere of trust"

Health Ethics Guide, p. 6

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SaskEthics

Building Trust in our Organizations

One of the cornerstones of providing quality health care is building a relationship of trust with our patients, clients and residents. The Health Ethics Guide states that the compassion and trust that people find in health care acts as a protection against the growing depersonalization of society. People who are in need of care are human beings, endowed with dignity and life. None of us would disagree that to view patients and residents as mere "diseases in need of cure" or our health care and organizational workers as mere "cogs in the wheel" is diminishing and can also act to diminish trust. People who are in need of care should expect health care workers to act in their best interests, to respect their wishes and to provide health care in which the highest regard has been given to quality and safety.

The value of "respect" is often seen in the mission statements and values of both faith-based and secular organizations. Respecting others builds mutuality and solidarity with our patients, clients and residents, with their families and with our fellow co-workers. It can make the little things which demonstrate respect for others. Listening respectfully to others, being attentive to the needs of those we care for, being helpful towards visitors and our co-workers and following up on our promises to others can be the difference when it comes to building trust. Putting the needs of patients and residents first, asking questions about whether patients and residents understand information provided to them and engaging patients and residents in decision-making about their own lives are pivotal to building trust.

Imagine an elderly resident in a nursing home who now lacks capacity to make health care decisions. He is, however, able to make many decisions for himself including what he will do with his time, what he will wear, whether he would like to watch a movie instead of going to bed early and so on. If he has made an Advance Directive or spoken of his health care wishes to before losing capacity, respecting the resident involves upholding his wishes. Advocacy may also be an important part of respecting this resident if his proxy or substitute decision-maker wants to override his wishes or make choices about his daily life that he is still able to make for himself. Another elderly resident is able to make health care decisions, yet time and time again staff refer the decisions to her daughter. People who are elderly can be on the receiving end of ageism, which can involve stereotyping about their capabilities. Stereotyping may include thoughts such as "all elderly people are slow and cannot make their own decisions", "all elderly people are overly dependent on others" etc. While some elderly people may lack capacity and may be unable to make day to day decisions, stereotyping, or assuming that all older people are the same is disrespectful and lead to a breakdown in trust.

At the organizational level, attentiveness needs to be paid to the well-being of health care workers. Those in leadership roles respect health care workers and support staff when they seek their opinion about matters affecting the organization, listen to the advocacy that is occurring, recognise the unique contributions that are made by every person and the co-responsibility we all have in

making the organization one which demonstrates solidarity, and accountability. Participative decision-making and consultative planning are essential to building trust. When policies and changes are being developed, those who will be affected by them should be consulted with a view to having their wisdom inform the final product. This is important not only in ensuring that the policy or change is taken up by those who will use it but to ensure that those closest to the issue have the opportunity to make contributions which will make the policy or change effective. This, in turn, builds trust within the organization.

Joy Mendel, Ethicist
Catholic Health Association of Saskatchewan

Six commonly asked questions about Advance Health Care Directives

1. Who can make an Advance Health Care Directive in Saskatchewan?

Any person with capacity over the age of 16 years can make an Advance Directive for him or herself. The Advance Directive is the highest authority for health care decisions for a person without capacity.

2. Can a proxy or substitute decision-maker change or rescind an Advance Directive?

No. A proxy or substitute decision-maker cannot change or rescind an Advance HealthCare Directive. Rescinding or changing to an Advance Health Care Directive can only be done by the person who made the Advance Health Care Directive while he or she has capacity (or the court once that person has lost capacity).

3. What is a Proxy?

A proxy is appointed to make health care decisions on behalf of a person without capacity. A proxy is legally obliged to act according to the known wishes of the person he or she represents. Only where the person's wishes are unknown can a proxy act from the position of what would be in his or her best interests. This means the proxy acts to uphold the Advance Health Care Directive of the person he or she represents.

4. Who can appoint a proxy?

A proxy can only be appointed by a person with capacity. Proxies cannot appoint themselves.

5. Can a person appoint more than one Proxy?

Yes. Proxies can be appointed as "successive proxies" meaning they can act independently or "joint proxies" meaning they act together.

6. What if a person has no Advance Health Care Directive and has not appointed a Proxy?

Where a patient/client/resident has capacity, he or she is engaged in informed consent when a medical decision needs to be made.

Where a person does not have capacity and has not appointed a proxy, the substitute decision-maker according to the Health Care Directives and Substitute Health Care Decision-Makers Act SK, 1997 will make the decision. In the same manner as a proxy, the substitute health care decision-maker will act according to the known wishes of the person, and move to a best interests position only where the patient's/resident's/client's wishes are unknown.

NOTE: CHANGE OF DATE

'Dealing with tough situations in health care'

William F. Mitchell Bioethics Seminar

Professor Carol Taylor
Senior Research Scholar, Kennedy Institute of Ethics, Georgetown University

Carol Taylor is a well-respected nurse-ethicist who has previously visited the Saskatchewan to present lectures and seminars. Carol will address dealing with situations of ongoing conflict, difficult personalities and other tough situations in health care provision. The seminars will be offered this year in both Regina and Saskatoon.

Wednesday 7th October, Santa Maria Home Regina (Time TBA) – All are welcome to attend
Thursday 8th October, Morning - St. Paul's Hospital (Time TBA), Afternoon –
Long Term Care Session (Location and Time TBA).
(Thursday morning session will be made available via Telehealth - details to follow)