Case 5: Use of close circuit television to monitor patients in an infectious disease setting

Key words: infectious disease; privacy; consent and potential coercion; compromising patient care to minimise infection risk

A treatment unit is being set up as part of a humanitarian effort to combat an outbreak of a severe and infectious virus in a low-income country. The affected country is hot and humid. Staff are only able to work for a couple of hours in personal protective equipment (PPE) due to the extreme heat and humidity as there is no possibility of effective air conditioning. It is possible for cameras to be fixed in the treatment areas of those affected by, or suspected of having, the virus. This would enable staff to monitor patients without having to don PPE and be exposed to risk by entering the 'red zone' (the area where there is risk of infection). Fixing cameras would enable patients to be monitored remotely.

The feed from the cameras could be recorded. This would enable staff to decide how many personnel to send in to a patient needing care (e.g. if the patient collapses and falls, it would be possible to replay the tape to see whether they hit their head or if a patient is agitated). A potential longer term use for the recordings would be re-tracing the movements of anyone working in the Unit who succumbs to infection. This could potentially improve infection control routines and also assist training back in the sponsoring nation's training facility. The recording of patients could, however, be regarded as an intrusion of privacy and a failure to respect dignity. The use of recorded data for purposes other than patient care might also be regarded as a misuse of personal data.

Issues raised by the case:

1. Patients' right to privacy.

2. Justifiable breaches of patients' privacy.

3. Clinical justification (of cameras / recording, or for breaches of privacy).

4. Minimizing risk to staff, and the rise of preference utilitarianism.

5. Acceptability of delays to urgent patient care delivery.

6. Issues of consent (for camera use / recording) for both staff and patient.

Potential learning outcomes

1. Identification and consideration of ethical issues
2. Increased understanding of ethical issues and duties
3. Beginning to understand and apply consequentialist ways of addressing issues and associated problems

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4. Beginning to understand how ethical issues may be anticipated and avoided

1. Using an ethical framework that focuses on consequences, examine the arguments for and against using cameras.

Arguments FOR:

i) *Monitoring patients and their needs without having to go into the unit:*
ii) *Lessens the risk of infection to staff as staff are able to assess what is needed without having to enter the 'red zone' to determine patient needs*
iii) *Reduces staff discomfort and the need to work in PPE in extreme heat and humidity where/when not necessary*
iv) *Less time in PPE might equate to less staff fatigue/stress and risk of associated mistakes in clinical care and infection control*
iv) *Increased monitoring of patients, any patient's needs should be easily observable and therefore clinical care can be more responsive and therefore improved*
v) *Record of infection control measures taken- may prove a useful tool in tracking possible routes of infection/risk of infection*
vi) *Record of treatment of patients with EVD- can be used for future training and research purposes*

Arguments AGAINST:

i) *Treats patients as objects of surveillance rather than people – which may translate directly into how staff then treat patients.*
ii) *Staff may spend less time with patients and patients will consequently feel uncared for.*
iii) *Staff may be made nervous by cameras and may make more mistakes and therefore increase their risk of infection and infection spread.*
iv) *The local population and further populations may perceive this monitoring as intrusive and undesirable and it may lead to a loss of trust in healthcare workers/military in the UK.*
v) *Patients may feel their rights have not been respected as they haven't been asked about the cameras. Staff may also perceive that the ethical norm of the doctrine of informed consent has not been complied with- or if patients' consent has been sought it is conditional – in that no treatment is available without the use of cameras. This may be perceived as coercive and 'big brotherish' and counter to the concept of patient autonomy. This may also erode trust and confidence in the service being provided.*

2. Using a <u>deontological</u> ('duty to the patient comes first') ethical framework, examine the arguments for and against using cameras.

Arguments FOR:

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None- as all are constructed as duties that apply all of the time.

Arguments AGAINST:

i) *Significant breach of patient privacy and autonomy if consent is not obtained. (However, bear in mind whether 100% effective informed consent likely to be achieved in such a sick patient population?)*
ii) *Undignified and disrespectful of that patient's rights, humanity etc., overrides their right to disclose what, and to whom.*
iii) *Treats some individual patients as a means to an end rather than an end in themselves (e.g. for the benefit of other [future] patients / staff training / future study / research etc. - these are utilitarian / consequentialist concerns).*

3. Which of these ethical approaches do you find most persuasive, if any? Why? Overall, is the use of cameras an acceptable response in these circumstances?

This is an opportunity for learners to discuss which arguments and approach they prefer and why they do so. The only ethical framework that would justify using the cameras is a consequence based one; in moral and legal philosophy the most common form of consequentialism is utilitarianism.

Classic utilitarianism (initially developed in the 18th Century) is characterised by three elements: maximising human good / pleasure, minimising human harm / pain, and consequences (or 'outcomes'). Everything that produces human happiness / good has utility, and everything that produces pain or loss has a 'minus utility'; in other words it negatively impacts on the utility calculation (known as the 'felicific calculus'). Therefore, the name of the doctrine is utilitarianism, based on its core principle of utility.

To use the language of utilitarianism we would say: 'When evaluating 'the act' of whether or not to use cameras, the 'moral agent' (the person with the responsibility / authority to make the final decision) has decided that to use cameras yields more utility than other available actions. In other words, the benefit of using cameras in this situation outweighs the benefit of not using cameras. This is 'Act Utilitarianism' – where the principle of utility, i.e. to do whatever produces the best overall results, should be applied on a case by case basis.

There is another formulation of utilitarianism called 'Rule Utilitarianism'. This is whereby moral codes and rules are formulated by looking at what typically maximises utility. In this situation, we would look at whether the consequences of using cameras in patient care would maximise utility or not - this is very likely to give us similar results to deontological or 'duty-based' approach in this case.

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Kant's theory, which is the most commonly quoted deontological theory, states that to act in a morally correct manner, people must act out of duty ('deon' in Ancient Greek). Kant also maintained that the consequences of an action do not make something right or wrong but it is the intention of the person who carries out the action:

> *"Nothing in the world—indeed nothing even beyond the world—can possibly be conceived which could be called good without qualification except a good will."*

This generates a rule for action is known as the categorical imperative, which can be described in three ways:

- *Act only according to that maxim by which you can also will that it would become a universal law. (In other words, act only if you would rationally want to apply the same rule for behaviour universally across society).*
- *Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end. (In other words, do not treat people as a means to an end; but as an end in themselves.)*
- *Every rational being must so act as if he were through his maxim always a legislating member in a universal kingdom of ends. (In other words, human laws should allow for an element of self-governance. This to ensure that each individual is treated as though they and their individual well-being are the goal rather than being a means to an end for other people.)*

These are all reflections of the principle that moral laws (right actions) exist independent of time, place or person. Actions are good because they are right, and not the other way around (as occurs with consequentialism, which starts with some notion of what is good and then defines right action in relation to achieving/maximising this good).

4. If using cameras is an acceptable response, should there be any limits to the use of cameras? If so, what are they? Who should be able to view recordings? (Is it one per patient, one per side / bay, one per ward?)

We would have to use a construction of act utilitarianism to identify the point/s at which utility is not being served by having cameras. This should hopefully provoke some discussion within the learning group of what those situations may be - but this should include:

- *If there is no risk of the infection being spread at any particular point.*
- *If the patient does not need to be monitored, as their needs are obvious or they are able to summon help if required.*
- *If there is no future teaching / learning opportunity, or useful material to be derived from the filming.*

Depending on the weight given to each of the reasons for using cameras, participants may decide that cameras are justified for any of the reasons given in

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answer to Q1; or they may decide that cameras can only be used if they satisfy all of the reasons - or any combination of those reasons.

Likewise, the people that should be able to view the recording should be limited to those who are trying to meet the legitimate justifications of using the cameras (i.e. the treating clinicians / monitoring nursing staff).

5. Should patients' consent be gained? At what point? Should the patients be allowed to refuse consent and still receive treatment in the unit? (Or 'no filming, no treatment'?)

Valid patient consent has four elements:

1. The patient needs to have had sufficient information in order to make the decision.
2. The patient needs to have sufficient mental capacity to be able to weigh the information and reach a decision.
3. The patient needs to have reached this decision voluntarily, without coercion or duress.
4. The patient needs to be able to communicate their decision.

So the first thing to determine is whether each of these elements can be satisfied for each patient who needs to consent to the use of cameras.

The most potentially problematic criteria is voluntariness, in the sense that if patients are not admitted to the ETU because they refuse to agree to the use of the surveillance cameras, this could well be construed as coercion - which would make any consent, even if obtained, invalid.

It is commonly accepted practice that patients' consent should be obtained prior to any healthcare treatment, in that it adheres to the principle of respect for patient autonomy. This is the principle that it each individual should be free to decide what is in their own best interest. By extension, this applies to what should happen or not happen to their bodies, especially in this context as regards receiving medical treatment. Therefore, it is reasonable to say that if patients are to be put under surveillance by cameras whilst being treated for Ebola, it would infringe their autonomy if their consent is not obtained and they would have objected. The cameras are not part of 'direct patient care' (i.e. do not in themselves constitute a 'treatment') so would not be included in a general consent to be treated.

If we take a strict deontological, or even a 'rule utilitarian' view, we could formulate the need for consent in absolute terms. We should give as much value to refusal of consent as to consent, and patients should be allowed to refuse consent and still receive treatment. However, if we take a pragmatic and utilitarian view, whilst we could still think it less than ideal to treat people without consent, we could also reasonably take the view that the overall benefits and harms would be best served by treating only patients that had consented to the use of cameras.

Practically, many patients who need treatment in the ETU may well be too ill to consent (leaving the choice to the 'best interests' argument – see below) - but when

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they are in the waiting area it could be more appropriate to obtain consent there, whilst they still retain their full capacity to make decisions. At the same time, it is not clear whether it would be possible to be treated in the unit without having the camera turned on. If agreement to the use of cameras is part and parcel of being treated in the unit this may constitute coercion (see above).

6. What if a patient is incapable of consent? What are the ethical issues around gaining consent from patients who lack capacity, and how do they apply in this situation?

In the UK (and consequently on military deployment, as this is the legal jurisdiction that UK forces are under at all times, regardless of location), Mental Capacity Act 2005 applies when a patient lacks capacity.

To have mental capacity as defined by the Act an individual must be able to:

- *Understand the information that is relevant to the decision they want to make.*
- *Retain the information long enough to be able to make the decision.*
- *Weigh up the available information to make the decision.*
- *Communicate their decision. Communication can include talking, using sign language, or through simple muscle movements such as squeezing someone's hand or even as simple as blinking.*

Patients should be assessed (by the treating / responsible clinician) as to whether or not they have the ability to make that particular decision at that specific time. Therefore it is possible that an individual will have capacity to make a relatively simple decision, but not have capacity to make a more complex decision (such as agree or disagree with treatment decisions).

Everyone in the UK has the right to make either an advance directive (living will) and / or grant Power of Attorney to someone of their choosing to make decisions on their behalf if they should ever in the future lack capacity. Therefore, in cases where there is an advance directive, the healthcare team must take into account the directive and follow any refusal of consent for specified treatments. What an advance directive cannot do, however, is to make the healthcare team perform treatments that they do not believe to be in the patient's interests. Effectively, it gives patients a right to veto certain treatments only. Where there is a Power of Attorney in place for health and welfare matters this gives the proxy a right to make decisions on the patient's behalf. That will include the right not to consent to certain medical treatments, but it does not mean that the proxy decision maker/s (usually a relative or relatives - as this power can be shared if specified by the patient) can insist on a particular treatment if the healthcare team does not believe it is the patient's best interests.

If there is no Advance Declaration or Power of Attorney in place (and this will virtually always be the case when treating local populations whilst on military deployment), then the decision will be made by the healthcare team 'in the patient's best interests'. The Mental Capacity Act 2005 has listed what factors should be taken into account when determining what a patient's best interests are:

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- ***Do not*** *assume that the decision should be based on the person's age, appearance, condition or behaviour.*
- ***Do*** *consider if the decision can be postponed until the person has sufficient mental capacity to make the decision for themselves.*
- ***Do*** *involve the person who lacks mental capacity in the decision as much as possible.*
- ***Do*** *find out the person's views (current or past), if possible, and take these into account.*
- ***Do*** *consider the views of others, such as carers and people interested in the person's welfare, where appropriate, and take these into account.*
- ***Do not*** *be motivated by a wish to bring about the person's death if the decision relates to life-sustaining treatment.*

In this particular context, the guidance (i.e. UK directives) would mean that relatives or friends – if available – should be consulted prior to admittance to the ETU about use of cameras. This consultation should not, however, cause delay in providing urgently needed treatment or management of unpleasant symptoms. This may mean that a patient will be legitimately admitted without being able to perform such checks. Where relatives/friends are able to provide information, the team then need to decide on balance what is in the patient's best interests. This mean balancing whether to be admitted to the ETU (which would give the patient the optimum chance of survival) with the use of surveillance cameras; or not to be admitted (which would increase their chances of suffering and death, but their privacy would be maintained). Also bear in mind the potential for bias in having two doctors alone decide on a patient's 'best interests'.

Objectively, and without any other information, admittance and treatment in the ETU would seem to be prima facie *where the patient's best interests lie. However, if contradicting information was given to the team by friends or relatives (e.g. that the patient has strong religious / cultural views to the effect that filming would violate their core beliefs), then the decision about what is in this patient's best interests would be much harder to make. In a country where such cultural views predominated, it would be wise for organisations to consult the local population about the use of cameras on arrival.*

7. To what extent would you be prepared to impinge upon an individual's liberty and privacy by overruling their autonomy for 'the greater good'?

This question is here in order for leaners to reflect upon what their values are: liberty and freedom of action and expression are seen as fundamental human goods, or rights. Classically we are taught the only limits to these goods are when one person's liberty infringes upon another's liberty. However, there are lots of common examples where our liberty is infringed because of 'the greater good' - airport security checks, surveillance cameras in town centres, stop and search policies etc. The justification in those cases is that the infringement of liberty is relatively minor, and a serious harm may occur if such impingements did not take place. We even have some infringements of our liberty for our own good (with the same justification) - e.g. the law on the requirement to wear a seat belt in a car, or a safety helmet on a

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motorcycle etc. Learners need to think how their personal morals / beliefs in liberty and privacy would reflect on this ETU camera situation.

8. Should the consent of all staff also be gained as their movements will also be captured?

Similar principles and arguments as used for the assessment of patients' consent should be examined with a couple of key differences:

1. *Military staff are under orders – and therefore their autonomy has arguably already been exercised to give consent to serve in the military*

2. *The harm that they suffer if they do not consent will not be physical but may involve work/ military penalties. Our understanding of consent is that it is voluntary so does the attachment of a penalty make it coercive, even in a military setting? Answer here depend on the extent to which one considers that one can agree to be bound by rules and conventions. On the one hand, we generally so agree to be so bound (i.e. rules of the road). On the other hand, it is sometimes argued that people do not recognise the extent to which they are not really free to choose. For example, we can find it hard not to choose in ways that adhere to cultural norms.*

3. *Staff are not vulnerable in the same way as patients are to an intrusion on their privacy whilst at work. There is a sense in which from the point of view of staff (and leaving aside patient confidentiality etc.) they should be willing to conduct all of their interactions with patients as though they were conducted in public and open to public scrutiny. There are patient-centred reasons why this is not possible (like protecting confidentiality) but the actions of staff are not confidential or private in the same sense as those of their patients. Thus, the question might be put: in the absence of objections based on the interests of their patients, why would staff NOT agree to be recorded during the course of their duties.*

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