

HIV AND ETHICS

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Summary

A variety of ethical, moral, legal, professional, and even personal issues emerge within the context of working with HIV+ patients. Many ethical issues are complex and challenging dilemmas. Psychologists are often concerned about the legal and ethical responsibilities involved in HIV work. How can psychologists protect the confidentiality of professionally obtained information when, under provincial and/or federal law, they may be required to protect sexual or needle-sharing partners from HIV infection? Is it ever permissible to breach confidentiality – especially when you know others are at risk? Do psychologists have a duty to warn? What are the ethical challenges around suicide and euthanasia? How do psychologists determine boundaries in their HIV work when the client is isolated, experiencing declining health or confronting neurological impairment? These themes and others are addressed in this workshop on ethics in HIV work. The workshop aims to help participants to develop skills for formulating a variety of responses to ethical challenges, and it provides a model for the ethical decision-making process.

Guiding Principle

Psychologists working in HIV require an understanding of ethical issues as well as a model to guide the process of ethical decision-making.

Learning Goals

Participants will

1. Increase their awareness of and comfort with ethical challenges involved in HIV work.
2. Develop information and guidelines to empower and support ethical decision-making.
3. Become familiar with the Canadian Psychological Association and provincial codes of ethics and/or guiding principles for ethical practice.
4. Develop personal and professional boundaries associated with ethical issues.

HIV and Ethics

Introduction

Psychologists and other health professionals working with HIV-positive clients will inevitably encounter ethical dilemmas. Some are relatively straightforward and easy to resolve; others can be confusing and perplexing. The challenging situations, in HIV work, require a thoughtful and thorough processing of professionally relevant codes of ethics (with guiding principles for conflict resolution) in order to decide upon the most ethical courses of action.

The ethics module contains guidelines for processing ethical decision-making and case studies with vignettes which exemplify some common ethical challenges. The emphasis is on issues concerning confidentiality versus duty to warn, and on euthanasia/assisted suicide, since these two areas commonly arise in HIV work and can at times be quite perplexing.

HIV is a preventable, fatal condition primarily transmitted sexually or via blood. Unfortunately, the disease continues to be viewed by many with intolerance, discrimination and stigma (Herek & Cogan, 1995). Today, as in the past two decades, many of the ethical issues are laden with social, political, legal and emotional implications. Often there are neither easy, conclusive answers nor ideal solutions. Each situation, on a case-by-case basis, requires special consideration and scrutiny.

One must abide by the law and adhere to relevant legal requirements, but sometimes even the laws are open to interpretation and debate. The fact that HIV/AIDS has been the most litigated disease in American history (Stryken, 1997), and that more and more legal cases are appearing in Canadian courts, is a testimony to the many and difficult challenges a person faces when addressing HIV-related conflicts.

For example, The Canadian AIDS Society (CAS) and the Canadian HIV/AIDS Legal Network recently published a news release expressing concern about a Supreme Court of Canada decision released in September 1998 after an HIV-positive man from British Columbia was charged for having sex without disclosing his status. The Supreme Court ruled that it is a criminal offense for an HIV-positive person to engage in consensual sex without disclosing positive HIV status.

This module is focused on ethical, not legal, dilemmas; however, direction regarding legal foundations and precedents can be found in sources such as *The Canadian HIV/AIDS Policy and Law Newsletter* (see reference list of this module), and from the Canadian HIV-AIDS Legal Network in Ottawa (1-613-230-3580), Gostin (1990), Doughty (1994), Pinoty (1995) and Jurgens (1995). Legal consultation is also generally available through lawyers who provide counsel to local hospitals, clinics, universities, and HIV-AIDS service organizations. Most of these types of institutions also publish medical and health ethics newsletters.

Stryker (1997) has summarized much of the current literature and research regarding ethical issues in the treatment of HIV. He discussed issues associated with duty to treat (e.g., health care workers' fear of infection, and their prejudices regarding homosexuality, the sex trade and drug use); with barriers to testing for people who believe they may be infected (e.g., fear of discrimination and isolation) and problems with mandatory testing; with pediatric infection (e.g., disclosing a child's status to schools, daycare centres) and the family; with the negative impact of disclosure to friends, family and children, or in the workplace; with competence and decisions about life-sustaining treatment; with designing and implementing advance directives, guardianship and wills; with assisted death and suicide; and with confidentiality and duty to warn. Other issues that may present ethical quandaries include involuntary psychiatric hospital admissions, cognitive impairment and loss of rights – especially regarding driving, parenting, and independent living (see Legal and Ethical Issues in HIV Disease in *HIV and Psychiatry*, 1997), women at risk for violence if they disclose to sexual partners (Rothenberg & Paskey, 1995) and availability of condoms and clean needles in prison, mental illness institutions, Aboriginal communities, group homes, and inner-city streets. Often such types of issues are very controversial.

Confidentiality and Duty to Warn

When do health care professionals have a duty to warn a person at risk? When is it unethical to breach confidentiality and interfere with individual rights and civil liberty? Confidentiality and trust are the hallmarks of the therapeutic alliance; clients open up, expose themselves and reveal intimate aspects of their lives because they believe that their privacy will be honoured. Misdeeds, secrets and at times illegal or dangerous activities are disclosed in therapy. HIV-infected clients may discuss their sexual and/or needle-using activities and reveal practices that are putting others at risk. Such dialogues provide the opportunity to work through and resolve barriers to safer sex or clean needle use. Barriers such as denial, anger, guilt, ignorance, misinformation, revenge, fear of rejection, lack of assertiveness and low self-esteem can be complex and need to be addressed expeditiously in counselling so that unsafe behaviours can be changed and unsuspecting people at risk be informed.

For basic information for psychologists and their clients, the Canadian Hemophilia Society and Health Canada have published a revised and updated version of *HIV and Safer Sex, The Choice is Yours* (1998), which clearly outlines preventive interventions and risk factors. With sensitive and supportive counselling (e.g., see DeRosa & Marks, 1998, for interventions), clients typically demonstrate willingness to cooperate and take on responsibility to protect others from infection. However, since some people are HIV-positive and do not know it, and since some do not disclose their positive status, all people have a responsibility to protect themselves.

In the very rare circumstance in which an HIV-positive individual refuses or is unable (due to mental illness or cognitive impairment) to inform or protect another, it may become the ethical responsibility of the counsellor to follow through on her or his duty to warn. If so, it is important to consider the following guidelines:

- < It is justified to exercise your duty to warn when:
- all efforts to assist the client to cooperate have failed
 - the victim is unsuspecting and his or her identity is known to you
 - the client refuses to consent to have you or public health authorities notify contacts
 - the risk of transmission is high (considering the hierarchy of risk activities; for example, fellatio and cunnilingus are relatively low risk)
 - consultation with colleagues, supervisors or legal advisors confirms the ethical responsibility to warn or have public health authorities take on the task
 - the process and reasons for breaching confidentiality are well documented and recorded in client file.
 - It is most respectful and usually indicated to inform the client that contact will be made with a third party either through public health authorities or you.
 - If possible, do not reveal the identity of the client when notifying a potential victim.
 - Due to the possibility that the therapeutic alliance may be damaged following a breach, consider working with another professional (e.g., physician, psychiatrist) to take on the “bad guy” role of warning while you continue the counselling.

Adapted from Cohen, E. (1995), Jurgens, R. (1995), Driscoll, J.M. (1992), Landau-Stanton et al. (1993). Please see the list of references in this module.

Breaching confidentiality can usually be avoided and is therefore an ethical intervention of last resort. If, however, one concludes that a breach is necessary, collaboration with other professionals and good record-keeping are absolutely essential.

Assisted Suicide and Euthanasia

Suicidal ideation and plans are common in people living with HIV at any phase in the spectrum of the disease and for a variety of reasons. Neron (1996) found that in her sample of HIV-positive subjects, 69 percent reported that they planned to have an assisted death and that such a plan provided a sense of relief and helped them cope with the prospect of future deterioration and death. Suicidal thoughts and discussion can have an adaptive function when they instill a sense of control and empowerment. It is important, however, to differentiate between suicidal ideation that is a symptom or consequence of a depressive or anxiety disorder and can be relieved when the disorder is treated, and suicidal ideation that is a rational idea intended to occur when suffering or pain or quality of life become intolerable. Although some people adjust to limitations and change their outlook about a hastened death, others do not.

The types of ethical quandaries that arise typically include decisions about the degree to become involved (or not) when a client discusses plans and intends to deliberately end life. To clarify terms, Ogden (1994) uses assisted death as an umbrella term that includes both euthanasia (one person's

act that affects another, resulting in relief from suffering and death) and assisted suicide (when a person intentionally takes his or her life with the assistance of another.)

In Canada it is illegal for health care workers to actively participate in either; however, case law results vary in terms of culpability. What would you do if a client of three years of therapy requested your presence with him as he died in the final stage of AIDS from a self-administered overdose (see the “Len” case study in this module)? Would you leave a palliative home visit or call 911 if you learned while you were there that, at his request, your client’s wife had recently injected him with a lethal dose of morphine? How do your own beliefs or philosophies influence suicide discussion in psychotherapy? Does lengthy discussion in sessions function to reinforce suicidal intent? Would it be unethical if you did not take action to prevent an assisted death after a client informed you of the time, place and plan?

It is not, at times, easy to determine where to draw the line since there is not usually one, correct answer in ethical dilemmas. One can only work through the conflicting principles, consult with colleagues, document carefully, stay within the law, and decide upon the direction that is evaluated as the “most ethical” choice. The *Canadian Code of Ethics for Psychologists* and the *Companion Manual* (1991) are essential and helpful resources.

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Canadian Code of Ethics for Psychologists

The Four Ethical Principles with their Respective Values and Standards

This is an “Aspirational Code,” not a code of conduct.

I. Respect for the Dignity of Persons	II. Responsible Caring	III. Integrity in Relationships	IV. Responsibility to Society
1. General Respect (1-4)	1. General Caring (1-5)	1. Accuracy/Honesty (1-9)	1. Development of Knowledge (1-2)
2. General Rights (5-8)	2. Competence and Self-Knowledge (6-12)	2. Objectivity/Lack of Bias (10-13)	2. Beneficial Activities (3-12)
3. Non-Discrimination (9-10)	3. Risk/Benefit Analysis (6-12)	3. Straightforward/Openness (14-22)	3. Respect for Society (13-16)
4. Informed Consent (11-19)	4. Maximize Benefit (18-25)	4. Avoidance of Deception (23-29)	4. Development of Society (17-26)
5. Freedom of Consent (20-23)	5. Minimize Harm (26-33)	5. Avoidance of Conflict of Interest (30-33)	5. Extended Responsibility (27-28)
6. Fair Treatment/Due Process (24-26)	6. Offset/Correct Harm (34-39)	6. Reliance on Discipline (34-38)	
7. Vulnerabilities (27-31)	7. Care of Animals (40-45)	7. Extended Responsibility (35-36)	
8. Privacy (32-37)			
9. Confidentiality (38-40)			
10. Extended Responsibility (41-42)			

Adapted from the Canadian Psychological Association (1991), *Canadian Code of Ethics for Psychologists*

The Code can be downloaded via <http://www.cpa.ethics.html>

Exercise “X” and “Y” Case Studies

Hand out a copy of Case Study “X” vignette to each person in half of the group and a copy of Case Study “Y” to each person in the other half. Instruct workshop participants as follows:

“After reading your case study, please write out your answers to each of these five questions. We will discuss your answers as a group once you’ve finished.”

1. What is your impression of the client?
2. What are your reactions to this client?
3. What is the ethical issue?
4. How would you resolve it?
5. What, if anything, would you do?

Case Study “X”

X was referred to you by her HIV specialist. You have had two sessions with her. She is newly diagnosed with HIV, 20 years old and living with her 40-year old partner/pimp, Todd, in the inner city. Todd was recently released from prison where he served 10 months for violently assaulting X. They have resumed a “stormy” common-law relationship.

X is a tall, overweight, brash woman who is dishevelled, swears often, and smells of alcohol and body odour. She ran away from home at age 16, and, to support herself, she began hooking on the street. X quickly developed the skills of manipulating people to get what she wanted and needed. She told you her rip-off scheme for obtaining and using people’s credit cards. X, at 18 years, met Todd, who was well off financially. She maneuvered her way into his condo and claimed that the odd beating was worth the lifestyle he provided her.

X was tearful and distressed. She explained to you that she was certain she had been infected, while Todd was in jail, by a “trick” who paid extra but refused to wear a condom. She said that Todd insisted she always use condoms with tricks and that she usually did. X further explained that she and Todd did not like condoms and had never used them for their own sex. They had both tested negative for HIV, HEPC and other STDs before they became sexually active and X reported that she figured Todd was still negative. X claimed she will not disclose her HIV-positive status to Todd “because he’ll beat me to death for being so stupid.”

Case Study “Y”

Y was referred to you by her HIV specialist. You have had two sessions with her. She is newly diagnosed with HIV, 20 years old and living with her 40-year old partner/pimp, Todd, in the inner city. Todd was recently released from prison where he served 10 months for violently assaulting Y. They have resumed a “stormy” common-law relationship.

Y is a very pretty, shy, slender, soft-spoken woman with curly blond hair and large innocent-looking blue eyes. She ran away from a bad foster home at age 17 and tried to live on her own, working as a waitress. Y, at 18 years of age, met Todd who was fairly well off financially, took in Y to live with him and introduced her to hooking for fast money.

Y was tearful and distressed. She explained to you that she was certain she had been infected, while Todd was in jail, by a “trick” who paid extra but refused to wear a condom. She said that Todd insisted she always use condoms with tricks and that she usually did. Y further explained that she and Todd did not like condoms and had never used them for their own sex. They had both tested negative for HIV, HEPC and other STDs before they became sexually active and Y reported that she figured Todd was still negative. Y claimed she will not disclose her HIV-positive status to Todd “because he’ll beat me to death for being so stupid.”

Seven Steps in Ethical Decision-Making

An ethical dilemma arises when the psychologist has conflicting obligations to different people or groups, or when an ethical principle conflicts with some other value (such as the law), or when ethical principles themselves seem to conflict. The challenge for the psychologist is to resolve the dilemma by balancing and honouring the principles involved, rather than simply choosing one principle over others.

Seven steps in ethical decision-making are:

1. Identification of ethically relevant issues and practices.
2. Development of alternative courses of action.
3. Analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action on the individual(s)/group(s) involved or likely to be affected (e.g., client, client's family or employees, employing institutions, students, research participants, colleagues, profession, society, self).
4. Choice of course of action after conscientious application of existing principles, values and standards.
5. Action, with a commitment to assume responsibility for the consequences of the action.
6. Evaluation of the results of the course of action.
7. Assumption of responsibility for consequences of action, including correction of negative consequences, if any, or re-engaging in the decision-making process if the ethical issues is not resolved.

Confidentiality and Prevention of HIV Transmission: Issues for Providers to Consider

(adapted from Statement of Ad Hoc Committee on Psychology and AIDS, American Psychological Association)

Psychologists have expressed considerable concern about meeting the legal and ethical responsibility to protect the confidentiality of professionally obtained information and the possibility that one may have, under provincial or federal law, the responsibility to protect sexual or needle-sharing partners of HIV-infected clients from HIV infection. In response to these concerns, consider the following suggestions when facing difficult situations involving HIV-infected clients/patients:

1. Psychologists should abide by provincial laws and regulations. Most provincial laws provide that professionally based information, including the fact that someone is HIV-infected, must be kept confidential unless the client consents to disclosure. Psychologists should determine what provincial statutes and case law require and permit in their jurisdiction. If there is no legal exception to confidentiality for HIV infection or for endangerment to third parties, and consent to disclose is not given, then the information should remain confidential.
2. When appropriate, providers should seek to assist HIV-infected clients to adopt and maintain behaviours for preventing and reducing the risk of HIV infection. If the provider does not feel competent to assist a person with these issues, the provider should seek consultation or refer the client to another appropriate resource.
3. Where provincial law permits or requires a provider to notify public health authorities or endangered third parties about the risk of HIV infection, the provider should exercise this option or responsibility with great care. In general, the presumption should be that confidentiality on behalf of the client shall be maintained except in extraordinary circumstances where individuals are unwilling or incapable of reducing the risk of infecting sexual or needle-sharing partners. To help determine what their clinical and legal responsibilities are in a specific situation, it is advisable for psychologists to consult with peers and/or attorneys knowledgeable about HIV issues.
4. Providers are encouraged to work through, and with, public health officers who are experienced in confidential and anonymous contact tracing and partner notification strategies that may protect the identity of a client/patient.
5. The determination that a known third party is at risk for HIV infection, and the decision to act to protect the third party, constitute a difficult, complex professional judgement to

be made by the provider on a case-by-case basis, based on his or her assessment of the situation. In making that judgement, the provider may consider various factors, including the following:

- a. whether the provider knows of an identifiable third party risk;
 - b. whether the provider believes there is a significant risk of harm to the third party by virtue of the client's conduct;
 - c. whether the provider believes that the third party does not suspect that he or she is at risk;
 - d. whether the client has been counselled to notify the at-risk partner and has refused, or is considered unreliable in his or her willingness or competence to notify the partner;
 - e. whether there are available public health officials engaged in contact tracing and partner notification strategies whom the provider can lawfully notify of the risk of HIV transmission to third parties.
6. If a decision to contact third parties or public health officials is made, it is wise practice for the provider to:
- a. maintain appropriate, detailed records regarding the provider's rationale for a decision whether to notify third parties as well as the procedures used;
 - b. where feasible, inform the client that the contact is going to be made;
 - c. where feasible, avoid using the name of the client or identifying information in making the contact.

American Psychological Association (1996).
APA HOPE Program: AIDS-related trainings for mental health practitioners.
Washington: APA.

Confidentiality and HIV Transmission

- “ Determine what provincial and federal statutes and laws require and permit.
- “ Consult with peers and lawyers knowledgeable about HIV issues.
- “ Information should remain confidential if there is no legal exception to confidentiality for HIV infection or for endangerment to third parties.
- “ Assist the client in reducing the risk of infecting others.
- “ Determine if there is an identifiable third party at significant risk who does not suspect that he or she is at risk.
- “ Assist the client in working through barriers to notifying at-risk partners.
- “ If the client continues to refuse to notify unsuspecting partners, and the law requires or permits, work with public health officials engaged in contact tracing and partner notification.
- “ Maintain detailed records of steps taken and the rationale for each step.
- “ Inform the client that contact is going to be made with third parties.
- “ Where feasible, avoid using the name of the client or identifying information in making the contact.

Adapted from Sestito (1996), Jurgens (1995) and APA HOPE Materials (1996). Please see the reference list in this module for complete references.

Breach of Confidentiality

Confidentiality may be breached in third party situations only when **all** of the following conditions have been met:

- “ It is known that the infected individual will not or cannot carry out the responsibility to warn others known to be at risk;
- “ Reasonable efforts have failed to persuade the patient to give voluntary consent to disclose;
- “ There is a high probability both that harm will occur if the confidential information is not disclosed, and that the disclosed information will in fact be used to prevent harm. This is most easily established in the instance of a patient’s specific threat of imminent physical violence or harm against a specific person;
- “ The harm that others at risk would suffer would be serious harm;
- “ Adequate precautions are taken to guarantee that only necessary information is disclosed, thus protecting the identity of the infected person.

The health care worker should tell the infected individual of his or her intentions to notify a third party.

NOTE: Virtually all court interpretations of the Tarasoff decision indicate that confidentiality may be broken only if there is intent to harm and **if there is an identified victim**. Further, some courts have ruled that breaching confidentiality when these two conditions are not met is a sufficient breach of the professional relationship that the client may be eligible for compensation for damages.

Group Discussion Exercise

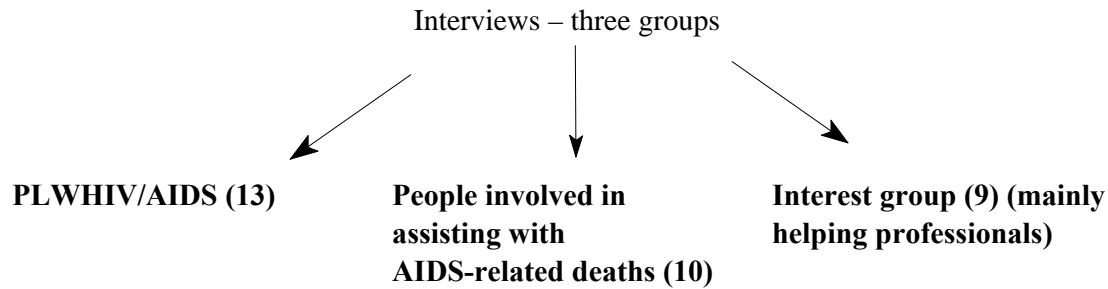
What is your philosophy or position/belief around euthanasia and assisted suicide?

What would you do in the face of an ethical dilemma with one of your patients? A friend? Spouse? Parent? Child?

Where would you draw the line in terms of your involvement in a peaceful and dignified death?

Study on Euthanasia, Assisted Suicide and Suicide

(1996) Carol Neron



Results:

- " **70 percent of PLWHIV/AIDS** (assessed as not depressed) stated they planned to have an assisted death, 15 percent said no, 15 percent were undecided.
- " The **Assisted Death Group** participated in about 30 deaths (five voluntary euthanasia, one non-voluntary euthanasia, remainder assisted suicides); 90 percent said they had no regrets about assisting and would do it again.
- " **Interest Group** perceived that wishes for assisted death are due to depression, lack of support, fears of pain and despondency.

Case Examples — Questions for Discussion

After reading your case example, answer the following questions:

1. What are the therapeutic issues?
2. What are the ethical issues?

Re: Ethical Decision Making:

3. What are the possible courses of action to take?
4. What are the risks and benefits of each course of action?
5. What is the selected action?
6. What are the consequences of the action?

BILLY

Billy is an attractive, 25-year-old gay man. He lives alone in a bachelor apartment downtown. Billy has been working as a waiter in a trendy French café, but is on sick leave while he recovers from his first opportunistic infection (PCP). He learned of his positive status when diagnosed with PCP. His T4 count was 180 mm³ upon discharge from hospital; his viral load was 250,000 copies/ml.

Billy realized he was gay while in junior high school, but remained in the closet, disclosing his homosexuality to only his closest female friends. Due to the conservative, intolerant views of his parents, he was fearful of coming out. Billy engaged only in anonymous sex, one-night stands with men from gay bars, the bath houses, or the peep shows. His sexual activity was typically precipitated by alcohol and/or IV cocaine use. Often he engaged in unprotected high-risk sexual activity and he was embarrassed to insist on the use of condoms. Billy believed he was one of the “lucky” people who would not become infected. Following his recovery from PCP, Billy was feeling pessimistic, depressed and angry, and continued his high-risk, unprotected sexual and drug use activities. He was referred to you for psychotherapy by his HIV physician. During the first session, he expressed a great deal of rage and explained to you that he wanted to “get back at the world and get out there and infect anyone who crossed his path.”

JOHN

John has been married to Cindy for 15 years. They have two children, 11 and 13 years old. John self-referred for counselling with you because he has been feeling anxious and distressed due to flu-like symptoms he's had over the past few weeks. Two months earlier, he'd had an anonymous unprotected sexual encounter with a man. John fears he may have been infected with HIV and could be experiencing sero-conversion. John explained that he has had sex with men, on and off, throughout his marriage – but could not bring himself to tell his wife about his bisexuality. He claims he loves his wife and children, but believes he would be rejected if he disclosed. The possibility of HIV infection would further complicate the issue. John is resistant to being tested himself, to using condoms with his wife and to disclosing to her. He wishes the whole thing would go away.

LEN

Len, a 34-year-old single, gay physician, has been a client for about three years. He has attended sessions on a monthly basis, confided in you his personal history, worked through and resolved issues related to his homosexuality, his family relationships, his past intimate partnerships, and his declining health. The therapeutic alliance is strong as is mutual respect and admiration.

Recently, Len was diagnosed with CMV retinitis and, in spite of treatment, quickly lost his vision. Significant wasting followed, and within a couple of months Len was bedridden at home. His rapid deterioration was difficult for both him and you. He knew his death was imminent; he claimed to have lost hope for a satisfactory quality of life, as well as for the will to live. Len reported that he'd said his good-byes and experienced closure in connection with his relationships and issues. He wanted to die, peacefully, with dignity, at a time of his choice. Len explained that he had on hand the medication he needed for a rational suicide, that he wished to administer them to himself, but to have you – with whom he knew safety and trust – to sit with him and hold his hand while he died.

MARIE

Marie is a 34-year-old Native, HIV-positive woman. Her husband died of AIDS last year. Marie is now a single parent for three children, aged 4, 7 and 9 years. The youngest is HIV-positive but asymptomatic.

Marie lives in the inner city and receives social assistance. She uses the food bank occasionally to compensate for the use of money for cocaine. Although Marie's parenting skills are weak, she loves her children and has managed to care and provide for them adequately.

Marie has seen you for counselling, on and off, over the past three years – primarily for crisis intervention, cocaine management, parenting skills, and support. Recently you have observed worsening signs and symptoms of what you suspect to be HIV-associated dementia. You are concerned about the children, given Marie's symptoms (i.e., impaired attention, concentration, memory and judgement, apathy, irritability, and unsteady gait).

MICHELLE

Michelle has been seeing you for supportive psychotherapy since she got sick and was diagnosed with AIDS two years ago. Her family rejected her completely when she disclosed her HIV status and drug addiction to them. Michelle helped care for three of her friends who died with AIDS, and comforted them through their final days. Michelle has very few resources and very little support. She has been taking protease inhibitors for the past six months but unfortunately her viral load has remained very high. Over time, Michelle has become dependent on you for emotional support, guidance and understanding. She is now very sick, frail and unable to care for herself adequately. She is lonely and scared. She's asked you to come once a day to help her eat, arrange an advance directive and funeral, and to spend time with her. You are very aware of her extreme isolation, loneliness and fear of death.
