Applying the Four Quadrant Model of Ethical Decision-Making to an HIV Disclosure Case Study in Lebanon

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Abstract

This paper evaluates the utility of applying the four quadrant model of ethical decision-making, consisting of medical indications, patient preferences, quality of life, and contextual features, to a nonconsensual HIV disclosure case study in Lebanon. The contextual features of this case include HIV disclosure policies, stigma of HIV, responsibilities of professionals, and the roles of the family and community which outline the specific challenges of this ethical dilemma. While the model provides an organized process of thinking through the multifaceted concerns surrounding nonconsensual HIV disclosure, the social worker in this case did not see a clear path forward and relied on the wisdom of her supervisor for direction. Thus, the model may not be appropriate cross-cultural social work practice. This paper highlights the challenges of employing such a tool in specific cultures across the global and indicates that there are continued hurtles for social workers who practice cross-culturally.

Keywords: four quadrant model, HIV disclosure, ethical dilemma, ethics, international social work

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Social work is an ever-expanding international profession (DuBois & Miley, 2013),and in the last two decades considerable attention has been given to recalibrating Western-originating philosophical values and ethics that tend to dominate scholarly discourse in the hopes of developing principles that incorporate global perspectives and norms of the profession (International Federation of Social Workers [IFSW], 2018; IFSW, 2020). Therefore, tools and assessment instruments developed in one part of the world and employed in another require evaluation of their utility in multicultural settings. In particular, social workers navigating ethical dilemmas where the context of the community influences their decision-making may find the ethical decision-making process particularly challenging.

In 1982, Jonsen, Siegler, and Wins lade published *Clinical Ethics* to address health-related ethical dilemmasin which they describe the four quadrants methodology of analyzing clinical ethics cases, one of which addresses contextual concerns. For the past several decades this approach has been applied by various healthcare professionals in parts of the United States and the United Kingdom (Sokol, 2008), and the model is now being considered for international uses and HIV care coordination. Although *Clinical Ethics* is now in its 6th edition, a literature search revealed only a handful of academic papers demonstrating the method at work in real life case studies and in multicultural settings. Specific to social workers in HIV care coordination, scant research has examined this model for working with dilemmas of HIV non-disclosure. Therefore, a case study experienced by a trained Lebanese social worker is processed through the four-quadrant model to evaluate the instrument . Please note, some identifying information in the case study has been altered to protect the privacy of those involved.

Case Study: Hassan is a 19 year-old man being treated for HIV in Beirut, Lebanon, and he believes he was infected with HIV this past year due to intravenous drug use. Hassan has taken antiviral mediation for the past three months and is six months sober. In the last month, Hassanalso tested positive for Hepatitis C but has not yet started treatment. He told his social worker that he has not yet disclosed his HIV or Hepatitis C status to his

girlfriend, Fatima, and that she is currently two months pregnant with their child. Fatima is 18 years-old and an active intravenous drug user. She is not a client of the host agency, and Hassan reported he does not know Fatima's HIV or Hepatitis C status. Hassan has reported Fatima is trying to stop using drugs due to her pregnancy. While both adults still live at home with their families, they have hidden the pregnancy from their parents as pre-marital sex is against the families' faith. Hassan told his social worker that she is the only other person who knows about the pregnancy. Since disclosing this information, the social worker has tried to convince him to bring Fatima in to get tested in order to get the treatment needed if she is infected, but the social worker believes that Hassan is intentionally stalling and not being cooperative. However, rapid response is needed due to the risks of transmitting HIV or Hepatitis C to Fatima and the unborn child. What should the social worker do?

Questioning to disclose a client's HIV status is a regular and challenging ethical and human rights concern for social workers and other health professionals around the world (Obermeyer, Baijal, &Pegburri, 2011). These concerns may be particularly challenging to Western-trained social workers who work in countries that do not have the legal and social frameworks to support Western non-disclosure ideals in relation to HIV transmission. In these instances, how can social workers balance the medical confidentiality, safety, and wellbeing of people living with HIV and the cultural norms and rights of those involved? When faced with these difficult ethical dilemmas, a systematic approach to sort through this challenge in reaching an ethical decision or recommendation for a client. Therefore, the purpose of the paper is to understand the goodness-of-fit between the four quadrants approach to ethical decision-making and HIV disclosure within the international social work profession.

The Four Quadrants Approach

The four quadrants approach consists of four broad topics: medical indications, patient preferences, quality of life, and contextual features (Jonsen, Siegler, &Winslade, 2010). Each topic is represented by one of the four quadrants, within each quadrant are specific inquiries. *See Table 1.* The creators of this model stressed each quadrant is essential to the ethical decision-making process (Jonsen et al., 2010). Take specific note of the suggested hierarchy of the quadrants going from top down and left to right. The medical indications portion appears first, followed by the patients' preferences, and quality of life. Visually, the contextual features quadrant appears to be given the least priority. However, these contextual features are of specific interests to social workers intending to be culturally competent when practicing internationally.

Table 1. The Four Quadrants Model from Jonsen, Siegler, &Winslade (2010)

Medical Indications	**Patient Preferences**
Beneficence and Nonmaleficence • What is the patient's medical problem? History? Diagnosis? Prognosis? • Is the problem acute? Chronic? Critical? Emergent? Reversible? • What are the goals of treatment? • What are the probabilities of success? • What are the plans in case of therapeutic failure? • In sum, how can this patient be benefited by medical care, and how can harm be avoided?	***Respect for Patient Autonomy*** • Is the patient mentally capable and legally competent? Is there evidence of capacity? • If competent, what is the patient stating about preferences for treatment? • Has the patient been informed of benefits and risks, understood this information, and given consent? • Has the patient expressed prior preferences (e.g., advance directives)? • In sum, is the patient's right to choose being respected to the extent possible in ethics and law?
Quality of Life	**Contextual Features**
Beneficence, Nonmaleficence, and Respect for Patient Autonomy • What are the prospects, with or without treatment, for a return to normal life? • What physical, mental, and social deficits is the patient likely to experience if treatment succeeds? • Is the patient's present or future condition such that his or her continued life might be judged as undesirable? • Are there plans for comfort and palliative care?	***Loyalty and Fairness*** • Are there family issues that might influence treatment decisions? • Are there provider (physician, nurse) issues that might influence treatment decisions? • Are there financial and economic factors? Religious or cultural factors?Are there problems of allocation of resources? • Is there any conflict of interest on the part of the providers or the institution?

Medical Indications

The medical indications quadrant is the suggested starting point of any ethical case analysis (Jonsen et al., 2010). It requests health workers to review the critical issues surrounding a client's health, identify treatment options, and determine how the client can be benefited, if at all, by treatment (Jonsen et al., 2010). According to Hassan's social worker, his health would greatly benefit from Hepatitis C treatment, and his treatment would lessen the risk of transmission to others, including Fatima and the unborn child. Additionally, Fatima would benefit from being tested for HIV and Hepatitis C to better identify her current health needs and neonatal care. Without treatment, mother to child HIV transmission rates from range from 15-45% (WHO, 2015). These rates can be reduced to levels below 5% with effective interventions (WHO, 2015). Hepatitis C has a mother to child neonatal transmission rate of about 5% with or without treatment (Mok, Pembrey, Tovo, & Newell, 2005; WHO, 2015). However, there may be a slightly smaller risk (about 3% neonatal transmission) for those mothers who are also being treated for HIV through antiretroviral therapy (ART) (Snijdewind et al., 2015). Therefore, it would be medically ideal if the social worker could provide HIV care coordination and counseling to Fatima in order to better understand her risk factors, current HIV/Hepatitis C status, and health needs. Unfortunately, there is much unknown about Fatima's condition as the social worker only knows what Hassan has told her.

Patient Preferences

The patient preferences quadrant focuses on the wishes of the client (Jonsen et al., 2010). Hassan appears competent and is not under the influence of substances. Three months ago, when he first told his social worker about Fatima, he agreed to bring her in for testing, but he has delayed this process and refused to share her contact information with his social worker. Since that disclosure, Hassan shuts down when asked follow-up questions about Fatima or her neonatal care. It appears as though he does not want Fatima to know about his HIV or Hepatitis C status, and he has not shared why he is reluctant to disclose this clarifying information with the social worker. Based on recent behavior, the social worker is concerned Hassan may stop meeting with her all together if she continues to press the issue. The social worker is also mindful that her ongoing rapport with Hassan may influence his sobriety status, treatment consistency, and long-term health needs.

Additionally, Hassan is financially dependent on his parents and they have been very active, both financially and emotionally, in his treatment for HIV and substance abuse. Hassan's parents call the social worker regularly and expect the social worker to talk candidly about Hassan's case so they can ensure appropriate treatment at home. Hassan told the social worker his parents would not let him see Fatima if they knew about her pregnancy. The social worker is concerned that if Hassan's parents find out she knows about Fatima and does not tell them, they may terminate Hassan's treatment with her agency. She ultimately fears the disruption in his treatment may jeopardize his long-term health. Fatima's preferences are not known in this situation.

Quality of Life

All treatment interventions should aim to maintain or improve a client's quality of life (Jonsen et al., 2010). When evaluating the suitability of a treatment decision, it is important to consider how it will impact the client's quality of life and how likely it is to achieve the overall goals of treatment (Jonsen et al., 2010). In the case study, Hassan reported being happy about the pregnancy and wanting the responsibility of fatherhood. However, the social worker thinks she may be putting Fatima and the unborn child at risk of contracting life-complicating viruses by supporting Hassan's decision to stay quiet. If Fatima is positive for either HIV or Hepatitis C, it could strain Fatima's relationship with Hassan and make co-parenting challenging.

In addition, Hassan is currently looking for a job. His parents are hesitant for him to become employed because they are afraid if he has his own money, he will start using drugs again. With or without a job, the social worker has concerns that Hassan will be able to take full reasonability to ensure the financial stability and medical care of himself, his girlfriend, and their soon-to-be child.

Contextual Features

As the authors (Jonsen et al., 2010) of this model acknowledged, every interaction with a client occurs within a larger social and political context. This final quadrant invites workers to consider contextual features and their relevance to the ethical analysis of the case. These features may include political, religious and cultural factors,

confidentiality issues, financial, and the impact of the decision on the patient's family, community, or progression through treatment. The quadrant also encourages workers to reflect internally on any biases that might inform treatment decisions. As this final quadrant is less defined than the others, relevant issues may need to be parsed out into broader themes to create additional quadrants (Jonsen et al., 2010). In Hassan's case, the laws and procedures around HIV disclosure, HIV stigma, and the expectations of shared health information with his family complicate the analysis and are broken down into their own mini-quadrants.

HIV Disclosure Policy. While HIV status is considered protected in Lebanon, unless there is a serious risk of transmission to other people, health professionals or employers do not always respect confidentiality protocols with few (if any) consequences due to extreme stigma and cultural norms. In other countries in the Middle East, the majority of HIV testing is mandatory (e.g., part of the job hiring process) with little guidance on disclosure (Hermez, Petrak, Karkouri, &Riedner, 2010). Legal regulations, nationally, locally, and institutionally, will influence the type of institutional support for disclosure at health facilities that enable social workers and other health professionals to support their clients around disclosure.

For those countries with guidelines, laws, and policies that may authorize but not require health professionals to inform sexual partners about their clients' HIV-positive status, such as in Lebanon, the UN High Commissioner for Human Rights and UNAIDS (2006), suggests considering the following questions: 1) Has the HIV-positive person has been thoroughly counseled? 2) Has counseling failed to achieve appropriate behavioral changes? 3) Has the HIV-positive person refused to notify or consent to notification of partner(s); and 4) Does a real risk of HIV transmission to the partner(s) exists? In Hassan's case, the answer is 'yes' for all of these questions. Based on this guidance from the UN, the social worker has the option to inform Fatima of Hassan's HIV status due to her risks without his consent.

HIV Stigma. As stated previously, intense institutionalized stigma and discrimination around HIV has been a major challenge to prevention efforts in the Middle East (Abboud, Noureddine, Juijer, DeJong, &Mokhabat, 2010; Mumtaz; Riedner, & Abu-Raddad, 2014). In this region, there has been relatively little published research on ways to address HIV-related stigma and attitudes as discussing sexuality remains taboo and societal views continue to be very conservative and largely hostile towards intravenous drug use, premarital sex, and same-sex sexual behavior, which perpetuates silence around HIV transmission and makes estimating prevalence rates difficult.

Roles of Families and Communities. In locations where access to health and social services is deficient and kinship care continues to be strong, families may be perceived as being accountable for people who are unwell and therefore have a right to be knowledgeable about the HIV positive status of their family member (Li et al., 2007; Yoshioka &Schustack, 2001; Satyanarayana, Chandra, Vaddiparti, Benegal, &Cottler, 2009). If, as in India, close involvement of the family is thought to be in the best interest of the patient, then a social worker's breach of confidentiality can be seen as choosing to conform to local social norms rather than to national standards (Datye et al., 2006).

Roles of Professionals. In studies throughout the Middle East and parts of Africa, workers describe stress and uncertainty about how to respond when patients' refuse to disclose their status to partners or put children at risk (Evans &Ndirangu, 2009). For example, in Uganda, HIV counselors described wanting more guidance about what to do when members of discordant couples refused to disclose their HIV status to one another (Medley & Kennedy, 2010). Angotti et al. (2014) discussed the strain between social and ethical norms of rural African communities and the testing and disclosure standards based on Western concepts that emphasize individual rights. Such evidence suggests that policy debates about confidentiality and facilitated disclosures of HIV status are pertinent to difficult challenges that care workers face in their daily work, and that if common ground can be found between the values of patient privacy and protection of public health, then this should be converted into better guidance to health workers (Angotti et al., 2014).

Physicians are given final authority to decide on disclosure in some countries, as detailed in a comparative study in Asian and Middle Eastern countries where 80% of Saudi physicians stated they would reveal a patient's HIV status to his or her family without consent (Mobeirrek et al., 2008). Practitioners may think they know better than low-income or uneducated clients, particularly women, and they involve family members as a way of identifying hierarchies within families in order to make health decisions on behalf of patients (Chandra, Deepthivarma, &

Manjula, 2003). A qualitative study from Lesotho found that when health professionals kept patients' HIV status strictly confidential, some family caregivers lacked crucial information needed to secure appropriate medical care for their loved ones (Makoae&Jubber, 2008).

Recommendation Based on the Four Quadrant Model

Completing the ethical decision-making model allows the social worker to think through these important considerations and documenting the opposing sets of values before making a decision: Those designed to respect clients' confidentiality and those meant to assist and protect those around the client. Social workers may be challenges by conflicting values and may feel that disclosure to family members is preferable, either to rally support for an HIV-positive person or because they feel responsibility to those around that person if patients refuse to disclose themselves (Seidel, 1996). Based on the findings from working through the model with the case study, the social worker has the option and legal backing to inform Fatima of her risks. However, the legal support to disclose does not assuage the social worker's fears of long-term damage to Hassan's treatment. While the model provides a structured process of thinking through the multifaceted concerns surrounding disclosure, the social worker did not see a clear path forward and relied on the wisdom of her supervisor for direction.

Discussion

A persistent question for social workers across the globe, highlighted by this case study, is: "What are universal truths in social work ethical practice?" Will social work values and ethical principles always be reliant on local perspectives and customs or are some standards relevant to all societies? Is it correct to assert that social work practicioners across the globe should promote social and economic equality, uphold the dignity and worth of people, and strengthen the recognition of the importance of human relationships? As an international profession, can we commit to supporting, influencing, and enabling structures and systems that address the root causes of oppression and inequality?

Since the arrival of strict confidentiality statues and regulations (e.g., HIPPA in the United States, etc.) around the world, Western-trained social workers are mandated to protect client confidentiality (Reamer, 2013). In many cultures, with some exceptions (e.g., dangers with potentially imminent risk), social workers and other paraprofessionals are limited in sharing their client's private information to the client's family members without explicit consent. Yet many cultures consider the family unit to be so primary in the care of the client that social workers are anticipated to provide relevant information about their clients to family members, as the privacy of the client is considered secondary (Reamer, 2013). Not all cultures recognize the Western ideals of informed consent. (Nijhawan et al., 2013). Moreover, there are cultures where the family members share private information to the social worker about the client anticipating that the social worker will not relay this information back to the client (e.g., if a client has a poor health prognosis, the family is planning to put the client in a nursing home, etc.) (Mobeireek et al., 2008).

The relevance of the universalism vs. relativism debate has increasingly grown as more and more social workers work cross-culturally both internationally and in diversifying countries (Healy & Link, 2012). Stakeholders in the international human rights movements wrestle with extent to which individual human rights overtake assertions of national or cultural norms. For example, the African scholar Cobbah (1987) objects to what he labels "the individualistic bias of human rights treaties (p. 316)." He states that universal declarations are "a product of Western liberal ideology" and cites similarities between this cultural standardization and colonial rule (Cobbah, 1987, p. 316). Fearing the type of cultural change that human rights promotes, Cobbahposits the international promotion of human rights may be akin to a Trojan horse sent in to corrupt African principles. Likewise, the *African (Banjul) Charter on Human and Peoples' Rights*(ACHPR, 1981) posits the necessity to "eliminate every discrimination against women" (p. 10) but also highlights the duty to "preserve the harmonious development of the family" and to uphold traditional values (as cited in Murrey, 2001, p. 9). The *Banjul Charter* (1981) suggests international treaties should incorporate principles of communalism, such as respect, restraint, hierarchy, responsibility, and reciprocity, and "groupness, sameness and compatibility" rather than individual freedoms (as cited in Murrey, 2001, p. 9). Some of these values may be more likely to be accepted by social work (such as responsibility and reciprocity) than others (like hierarchy and restraint) in aim of social justice.

Social work's core values and codes of ethics from numerous countries and international groups demonstrates a high level of similarity in regard to fundamental social work values (DuBois & Miley, 2013; IFSW, 2020), suggesting a modest amount of universalism, but individual practitioners may employ a relativist argument attractive in certain situations. For example, some social work principles and ethical decision-making models fail to recognize the legitimacy ofa communalist perspective of some countries, as articulated by the *Banjul Charter*(2001), and strongly favor the individualistic perspective. In its most aggressive and competitive form, individualism overlooks the value of mutual support, community building, beneficence, and cooperation. Conversely, a communalist perspective holds important values that should be attuned toin global international social work principles and future ethical decision-making models in diverse international communities.

Implications for International Social Work Practice

The discussions of universalism vs. relativism are bound to continue in the decades ahead as the profession continues to grow and diversify. For those professions who are Western-trained or employ Western-created interventions and ethical decision-making tools, such as the four quadrant model, must consider what is in the best interest of their clients alongside what can be known from the evidence-based and culturally-informed literature. One particularly challenging aspect of this discussion is that while there is growing consensus on some international ethical issues, others must be informed by the specific cultural norms and policies. Ideas of self-determination, confidentiality, and client privacy are crucial aspects of ethical practice everywhere, the application of those ideas may differ greatly across various contexts. Therefore, practitioners must not employ these principles indiscriminately with their clients without fully understanding the culture, norms, policies, and contexts in which they work. Therefore, it is strongly encouraged for social workers engaged in cross-cultural work to complete a scathing internal inventory for potential ethical hubris. Social workers can follow in the footsteps of cultural anthropologists who for decades have emphasized the importance of entering another culture with empathy, humility, and a deep respect for the worldview of those with whom they work (La Brack& Bathurst, 2012).

Application of the Four Quadrants Approach in International Social Work

How appropriate, then, is this tool for international social work use? It appears the tool is beneficial for social workers who want to systematically think through and document the various ethical aspects of a case, which can be helpful when justifying decisions. However, the vague and non-directive nature of the four quadrants model does not often end with a *clear answer* for practitioners, as indicated in our case study, which social workers should be aware of before spending valuable time completing the quadrants. For international application, on the other hand, being vague and non-directive about a case's contextual features could be framed as a strength of the tool. Notably, someone who understands the local customs, values, and ethics may employ the tool more successfully than an outsider. For example, a social worker raised and educated in Lebanon would be more likely to prioritize the contextual features more accurately when working with Hassan than a U.S.-trained social worker. If global social work associations want to enhance the application of the four quadrants approach for international social workers all, they may wish to consider developing an accompanying piece prioritizing a hierarchy of values or concerns for specific countries and/or regions in more culturally relevant ways. However, without a clear understanding of the most important values and concerns of a specific nation or geographic region, the four quadrant ethical decision-making model cannot be recommended for international social work use. Even with a pristine understanding of local values, non-consensual HIV disclosure has irreparable consequences to clients. Instead, social workers should seek guidance from skilled clinical supervisors and peers to support their client with the difficult decisions of how and when to disclose their HIV status to their loved ones.

Conclusion

Hopefully, this beginning analysis to assess the goodness-of-fit of the four quadrant model within the international social work profession demonstrated that ethical decision-making is highly complex in cross-cultural contexts. There is a challenging and ongoing discussion of the extent to which social worker values can be applied

universally (IFSW, 2018; IFSW, 2020). The four quadrant approach for case analysis and decision-making has both strengths and limitations, and overall, is recommended for instances with social workers who want to clearly document their systematic analysis of ethical dilemmas, but not for social workers who want a specific recommendation from the model. In addition, more research and evaluation are needed to explore how the ideas of communalistic values can be better incorporated intoWestern and international ethical decision-making practices.

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