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Principles of Medical Ethics

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WHAT IS BIOETHICS?

Bioethics, a subset of ethics, applies ethical principles and decision-making methods to actual or anticipated moral dilemmas facing clinicians in order to find reasoned and defensible solutions. Given the nature of our pluralistic society, we derive these moral precepts from a variety of sources including general cultural values, philosophical and religious moral traditions, social norms embodied in the law, and professional oaths and ethical codes. All of these sources claim moral superiority. The goal of bioethics is to help us understand, interpret, and weigh these competing moral values (American College of Emergency Physicians Ethics Committee, 1997). The clinical application relies on case-based (casuistic) reasoning, usually giving most weight to patients' autonomy and values.

In contrast to professional etiquette, which relates to standards governing the relationships and interactions between practitioners, bioethics involves basic moral values and patient-centered issues (Arras, 2001). Specifically, bioethics deals with relationships between providers and patients, providers and society, and society and patients.

As Arras wrote, the purpose of medicine's professed morality is "to give physicians an identity as professionals, rather than as self-interested tradespeople, and a basic education in some key medical virtues" (Arras, 2011). Arras goes on to say that ethics as it is applied to medical practice should

- emphasize those duties (like confidentiality) that help to make the practice of medicine possible;
- incorporate traditional maxims that are useful as general rules of thumb (e.g. "Do no harm"); and

- adopt a set of fiduciary responsibilities with a strict duty to place patients' welfare ahead of one's own financial (or other) interests (Beauchamp & Childress, 1989).

BIOETHICS AND EMERGENCY MEDICINE

Although ethical issues abound in emergency medicine, they often go unrecognized. These issues stem from pre-hospital and emergency department (ED) clinicians' four imperatives: to save lives when possible, to relieve pain and suffering, to comfort patients and families, and to protect staff and patients from injury. This is complicated by emergency physicians' typical lack of prior relationships with their patients, whose trust is based on institutional and professional assurances rather than on an established personal relationship (American College of Emergency Physicians Ethics Committee, 1997). In addition, patients often arrive with acute illnesses or injuries requiring immediate interventions, and emergency physicians have little time to gather additional data, consult with others, or deliberate about alternative treatments. Patients with acute mental status changes may be unable to participate in decisions regarding their health care.

This chapter addresses the relationship of law, religion, and bioethics; foundational ethical theories and the derived principles; values and virtues; ethical oaths and codes; applying bioethics to clinical situations; and bioethics committees and consultants.

RELATIONSHIP BETWEEN LAW, RELIGION, AND BIOETHICS

How does bioethics differ from law? Both give us rules of conduct to follow based on societal values. But although good ethics often makes good law, good law does not necessarily make good ethics (Beauchamp & Childress, 1989). Emergency physicians often look to the law for answers to thorny dilemmas. Yet, except in the rare cases of "black-letter law," wherein very specific actions are mandated, these issues are best served by turning to bioethical reasoning, using bioethics consultations, or applying previously developed institutional bioethics policy (see Chapter 2).

Whereas, in homogenous societies, organized religions see themselves as keepers of society's values, most Western societies are multicultural, with no single religion holding sway over the entire populace (Arras, 2001). Since ED patient populations practice a number of religions, a patient-value-based approach to ethical issues is necessary. The question

physicians must ask is, "What is the patient's desired outcome for medical care?" (Arras, 2001). It is important to note that religion influences modern secular bioethics, which uses many religion-originated decision-making methods, arguments, and ideals. In addition, clinicians' personal spirituality may allow them to relate better to patients and families in crisis (Beauchamp & Childress, 1989).

Most religions have a form of the Golden Rule – "Do unto others as you would have them do unto you" – as a basic tenet. Problems surface, however, when trying to apply religion-based rules to specific bioethical situations. For example, nearly all religions accept the dictum, "Do not kill." However, the interpretation of the activities that constitute killing, active or passive euthanasia, or merely reasonable medical care vary with the world's religions, as they do among various philosophers.

FOUNDATIONAL ETHICAL THEORIES

Foundational ethical theories represent grand philosophical ideas that attempt to coherently and systematically answer the fundamental questions "what ought I do?" and "how ought I live?" Philosophers continue to elaborate or reconstruct fundamental ethical theories, many with elements from ancient ethical systems developed in India and China, and within the Jewish, Christian, Islamic, and Buddhist religions.

The "mid-level" ethical principles that guide clinical practice and bioethical thought stem from these foundational theories. While ethicists generally appeal to these principles when defending a particular action or proposing public policy, it is worthwhile having a passing familiarity with the nature of the foundational theories – some of which are quite contradictory. There are two main "foundational" theories of ethics: utilitarianism and deontology.

Utilitarianism, based on John Stuart Mill's and Jeremy Bentham's writings, is one of the more functional and commonly used ethical theories. Sometimes called *consequentialism* or *teleology*, it promotes good or valued results rather than using the right means to achieve those results. This theory promotes outcomes that most advantage the majority in the most impartial way possible. (Simplistically, it may be said to propose achieving the greatest good for the greatest number of people.) It is often advocated as the basis for broad social policies. Nevertheless, trying to define what is "good" or who comprises the affected community exposes major problems with this theory (Iserson, 1993).

Deontology holds that the most important aspects of our lives are governed by certain unbreakable moral rules. Deontologists (*deon* is the Greek word for duty) believe in rules that prescribe right actions (duties). One example of a list of "unbreakable" rules is the Ten Commandments. Adherents hold that these rules may not be broken, even if following the rule leads to results that may not be "good." The philosopher Immanuel Kant is often identified with this theory.

Other commonly cited ethical theories include:

Natural Law. This system, often attributed to Aristotle, suggests that man should live life according to an inherent human nature, in contrast to man-made or judicial law. Yet the two are similar since both may change over time despite the frequent claim that natural law is immutable. Natural law is often associated with particular religious beliefs, especially Catholicism. The claim that the medical profession has an inherent morality mirrors natural law.

Virtue Theory. This theory asks what a "good person" would do in specific real-life situations. It stems from the writings of Aristotle, Plato, and Thomas Aquinas in which they discussed such timeless and cross-cultural character traits as courage, temperance, wisdom, justice, faith, and charity. The Society for Academic Emergency Medicine adopted a virtue-based Code of Conduct.

Some modern philosophers have proposed "anti-theories," including various combinations of casuistry, narrative ethics, feminism, and pragmatism. Unlike the foundational "top-down" theories, they favor the "bottom-up," case-based approach, emphasizing each case's messy uniqueness and challenging *principilism*, a system of ethics based on the moral principles of autonomy, beneficence, nonmaleficence, and justice (Iserson, 2000). This approach addresses, to some extent, the main problems with foundational theories, which are so general and abstract that they are difficult to apply to actual cases. Still, as with all unifying ethical theories, it is unclear which theory or combination of theories clinicians should use (Iserson, 1993). Fortunately for non-philosophers, "the boundaries between these rival methodologies have blurred significantly in the intervening years, so much so that all of these methods might now be said to be mutually complementary, non-exclusive modes of moral inquiry for doing ethics in the public domain" (Iserson, 2000). The situation becomes even clearer using mid-level bioethical principles.

MID-LEVEL PRINCIPLES

"Mid-level principles" derived from ethical theories are less general and abstract than theories. These ethical principles are "action guides,"

role-specific duties that physicians owe to patients and consist of various "moral rules" that comprise a society's values (Iserson, 2011). For example, when examined closely, the principle of autonomy (respect for persons) includes the values of dealing honestly with patients; fully informing patients before procedures, therapy, or becoming involved in research; and respecting patients' personal values.

How Have We Derived Modern Bioethical Principles?

Rather than drawing from one foundational theory, the bioethical principles we use stem from multiple sources. The most widely accepted principles were developed from extensive experience followed by the public and legal debate generated by controversial cases. Bioethicists select elements from well-known philosophers' writings to bolster or refute arguments; they reject or ignore the rest. As Jonsen wrote, "Bioethics has no dominant methodology, no master theory. It has borrowed pieces from philosophy and theology . . . (and) fragments of law and the social sciences have been clumsily built onto the bioethical edifice" (Iserson, Biros, & Holliman, 2012). The resulting ideas are then adapted to the needs of the modern medical environment.

For example, bioethicists often quote Emanuel Kant when discussing patient autonomy and respect for persons. Kant's philosophical theory, which he molded from elements of his predecessors' theories, was again remolded by the National Commission for the Protection of Human Subjects. To fit Kant's ideas into a modern setting, they took "a sliver from the timber of Kant's mind and reconceptualized it in the context of the problem posed by research with human subjects" (Iserson et al., 2012). This is not Kant, but a derivation: Kant would have rejected individualistic self-rule, the basis for modern ethics' idea of "autonomy."

Likewise, other core bioethical principles stem from various bits and pieces of classic philosophy and historical precedent. Beneficence generally comes from the consequentialist theory of utilitarianism, nonmaleficence strongly relates to medicine's historical professionalism, and the idea of distributive justice stretches from Plato to Rawls.

Melding medicine's goals with societal morality, law, religious values, and societal expectations for the profession, Beauchamp and Childress popularized the most commonly cited mid-level principles: autonomy, beneficence, nonmaleficence, and distributive justice. These four principles provide a handy medical ethics template and a practical, although often

difficult-to-apply checklist when considering the moral implications of
specific cases (Iserson, 1993, 2011).

Physicians and some philosophers claim that medicine has its own
internal set of moral rules, sometimes referred to as "internalism." These
have been defined as:

- "'Essentialism,' according to which a morality for medicine is derived
  from reflection on its 'proper' nature, goals or ends.
- 'The practical precondition account,' according to which certain
  moral precepts are derived as preconditions of the practice of
  medicine.
- 'Historical professionalism,' according to which the norms governing
  medicine are decided upon solely by the practitioners of medicine; an
  ethic about physicians, by physicians, and for physicians. And, an
- 'Evolutionary perspective,' according to which professional norms in
  medicine evolve over time in creative tension with external standards
  of morality" (Arras, 2011).

A question that naturally arises is whether ethical principles are uni-
versal or local constructs for medical purposes. For individual clinicians,
the bioethical principles they follow and the values that stem from them do
not change because of geography. Clinicians practicing or teaching within
cultures other than their own have a responsibility to continue applying
their core ethical principles while being sensitive to the local population's
values (Iserson & Heine, 2013).

COMMON ETHICAL PRINCIPLES

Beneficence. Beneficence is doing good. Most health care professionals
enter their career to apply this principle; it has been one of the medical
profession's long-held and universal tenets. Physicians demonstrate bene-
ficence when they treat or prevent disease or injury.

Nonmaleficence. The basic tenet that all medical students are taught is
nonmaleficence: *primum non nocere* (First, do no harm). It stems from
recognizing that physicians can harm, as well as help, their patients. This
principle also includes preventing harm and removing harmful
conditions.

Justice. The concept of comparative or distributive justice (in contrast to
the judicial system's retributive and compensatory justice) encourages
clinicians to act with impartiality or fairness, suggesting that comparable
individuals and groups should share similarly in the society's benefits and

burdens. Although it forms the basis for many society-wide policy deci-
sions about the allocation of limited health care resources, it is not the basis
for ad hoc physician–patient decisions at the bedside. Triage decisions
conform to this principle when they are applied uniformly and impartially
to all patients (Iserson et al., 2008).

Autonomy. For several decades, patient autonomy has been the over-
riding professional and societal bioethical value in most Western countries.
It is the counterweight to the medical profession's long-practiced patern-
alism (or parentalism), wherein a practitioner acts on what he believes is
"good" for the patient, whether or not the patient agrees. Grounded in the
moral principle of respect for persons, autonomy recognizes the right of
adults with decision-making capacity to accept or reject recommended
health care interventions, even to the extent of refusing potentially life-
saving care. Physicians have a concomitant duty to respect their choices
(Arras, 2001).

One important and often misunderstood aspect of autonomy is that
individuals with decision-making capacity can voluntarily and verbally
assign decision-making authority to other people (e.g. family) for a
specific decision or time period, such as when they are in the ED. Since
patients may exercise their autonomy only if they have decision-making
capacity, emergency clinicians must be able to determine this at the
bedside so that surrogate decision-makers may, if necessary, become
involved (see Chapters 7–10 for specifics). Basic bioethical research prin-
ciples (Chapter 12) stem primarily from the basis for autonomy, the
respect for persons as individuals.

OTHER PRINCIPLES

Communitarianism. A counterbalance to autonomy, communitarianism
considers the larger picture of the patient's life, including his or her family
and his or her community, when puzzling through a bioethics case or
developing public policy. The principle generally holds that the commu-
nity's good and welfare outweighs an individual's rights or good and that
deliberations should involve communal (e.g. family, elders) discussions
(Iserson, 1993). Many cultures rely on communitarian deliberations when
making medical choices and use this pattern for public policy decisions.
When making bedside ethical decisions, physicians should determine,
whenever possible, not only their patient's individual values, but also
whether their patient subscribes to an individualistic or communitarian
ethic (Beauchamp & Childress, 1989).

Confidentiality. Based on a respect for persons (as is autonomy), patient confidentiality has been a cornerstone principle of the medical profession since antiquity. It presumes that what patients tell physicians during the medical encounter will not be revealed to any other person or institution without the patient's permission (Beauchamp & Childress, 1989). Various U.S. federal and state laws have both emphasized and carved out exceptions (mandatory reporting; see Chapter 4). With the advent of minimally secure electronic medical records, the ability to maintain patient confidentiality has become even more difficult.

Privacy. Often confused with confidentiality, privacy is a patient's right to sufficient physical and auditory isolation so that he or she cannot be seen or heard by others during interactions with medical personnel (Beauchamp & Childress, 1989). ED crowding, patient and staff safety issues, and ED design limit patient privacy in many cases. The increasing use of telemedicine to render advice and guide procedures and the common practice of filming ED patients places a strain on both patient privacy and confidentiality (Iserson, 2006).

VALUES AND VIRTUES IN EMERGENCY MEDICINE

Values describe the standards that individuals, institutions, professions, and societies use to judge human behavior. They are the moral rules derived from ethical principles. Virtues describe admirable personal behavior that Aristotle and other philosophers claim is derived from natural internal tendencies (Jonsen, 2007).

Values

Values, the standards by which human behavior is judged, are learned, usually at an early age, through indoctrination into the birth culture, from observing behavior, and through secular (including professional) and religious education. They are moral rules, promoting those things we think of as good and minimizing or avoiding those things we think of as bad. Societal institutions incorporate and promulgate values, often attempting to solidify old values even in a changing society. In pluralistic societies, clinicians must be sensitive to alternative beliefs and traditions because they treat people with multiple and differing value systems. Not only religious, but also family, cultural, and other values contribute to patients' decisions about their medical care; without asking the patient, there is no way to know what decision they will make.

Although many people cannot answer the question "What are your values?" physicians can get concrete expressions of patients' uncoerced values by asking what they see as their goal of medical therapy and why they want specific interventions. In patients who are too young or are deemed incompetent to express their values, physicians may need either to make general assumptions about what a normal person would want done or to rely on surrogate decision-makers.

Institutional, Organizational, and Clinician Values. Institutions, including health care facilities and professional organizations, have their own value systems. Health care facilities often have specific value-related missions. Religiously oriented or affiliated institutions may be the most obvious of these, but charitable, for-profit, and academic institutions also have specific role-related values. Professional organizations' values often appear in their ethical codes (Arras, 2001).

Clinicians also have their own ethical values, based on religious, philosophical, or professional convictions. Although conscience clauses permit clinicians to "opt out" when they feel that they have a moral conflict with professionally, institutionally, or legally required actions, they are generally required to provide timely and adequate medical care for the patient – which may be particularly difficult to achieve in emergency medicine.

Virtues

Virtues, as Aristotle described them, stem from natural internal tendencies. The *virtuous person concept* can be summed up with the ancient saying: "In a place where there are no men, strive to be a man" (Kuczewski, 1998). Virtuous behavior stems from a sense of duty and the perception that it is the right thing to do, rather than from a desire to garner personal benefits. These ideal, morally praiseworthy character traits (e.g. showing kindness) are evident across many situations throughout the person's lifetime. Virtues that may be inherent in emergency medicine clinicians include courage, safety, impartiality, personal integrity, trustworthiness, and justice (American College of Emergency Physicians Ethics Committee, 1997).

Courage allows one to carry out an obligation despite reasonable personal risk. The courageous clinician also advocates for patients against incompetent practitioners and those who attempt to deny them care, autonomy, or confidentiality. Emergency clinicians also exhibit courage when they assume reasonable personal risk to care for violent or contagious patients and during disaster responses.

Safety balances unreasoned courage. In both in the pre-hospital and ED settings, clinicians must face not only environmental hazards, but also potentially dangerous patients, visitors, and bystanders. In these situations, emergency clinicians' first priorities must be their own safety and that of their coworkers. This does not imply that clinicians should ignore patient safety, but only that they should first ensure their own safety if they or their colleagues are at risk (Arras, 2001). Whether emergency physicians should respond to major disasters relies on considering this virtue and carefully analyzing the risks involved (Larkin et al., 2009).

Impartiality prompts the emergency physician to provide unbiased, unprejudiced, and equitable treatment to all patients, no matter their race, creeds, customs, habits, or lifestyle preferences – most of which will differ from those of the clinician. This virtue extends to the many ED patients who are poor, intoxicated, and have poor hygiene, little education, mental disturbances and value systems at odds with those of the physician. A difficult aspect of this virtue is treating perpetrators of violent crime with the same regard as victims.

Personal integrity spurs clinicians to adhere to their own reasoned and defensible set of values and moral standards, which is basic to thinking and acting ethically. This virtue incorporates *trustworthiness*, which prompts the clinician to protect his or her sick and often vulnerable emergency patients' interests through exercising ethical principles.

Truth-telling remains a somewhat controversial virtue within the medical community (Arras, 2001). Although many champion absolute honesty to the patient, honesty must be tempered with sensitivity and compassion; honesty does not equate to brutality. In recent years, poor role models, a lack of training in interpersonal interactions, and bad experiences may have diminished the perception of truth-telling as a physician virtue. However, if clinicians withhold information strictly for their emotional, legal, or financial benefit, this behavior suggests serious ethical deficits.

ETHICAL OATHS AND CODES

Since ancient times, medical practitioners have formulated and established professional rules of behavior. Although its precepts clash with modern bioethical thinking, the existing part of the Hippocratic Oath