1 Why study healthcare ethics?

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Studying any discipline is worthwhile simply for the knowledge it brings and the skills in reasoning that can be learned and honed. For healthcare professionals, study – formal and informal – is part of the vocation: competence and excellence are not benchmarks to be achieved once in a lifetime and then relegated to the shelves, as one might a sporting trophy. Rather, the health professions demand a commitment to lifelong learning. Part of that professional commitment is an awareness of and engagement with the ethics of health and healthcare. The skills of this philosophical discipline are just as vital as clinical skills and the various dimensions of physiological and psychological knowledge that are essential for the work of a healthcare professional.

Why ethics?

Ethics has been an important sub-set of philosophy since the time of the ancient Greeks. For those early philosophers, there were three big questions to be answered by every human being and every society:

- What does it mean to be or to exist?
- How do we know – what is knowledge and how do we go about knowing?
- How should we live – what is a good life?

It is the third of these questions that is the core concern of this book.

Without covering the whole of the history of philosophy or the even history of ethics, it should be noted that across the three millennia since the time of the ancient Greeks, the question of how we should live has been debated and tested in every culture and every age. The debate has covered how societies and cultures should operate and what constitutes the good life at a particular point in time. These questions have been asked by people of all levels of education, responsibility, fields of employment and political persuasions.

In terms of the collection of disciplines that come under the banner of healthcare, there has always been one part of the broad topic of ethics that has been of particular interest – for instance Hippocrates taught his followers that all physicians had to always act to preserve life and alleviate suffering, but also that they must keep confidential anything they heard or saw while with a patient or in their home. In medieval times, the question of the use of bone materials from the dead and from animals to repair skull damage of those injured in war was a significant question. Still later, the use of the early anaesthetic ether to ease birth pains was very controversial in the late nineteenth and early twentieth centuries. It is also fair to note that these discussions established only broad parameters for a separate body of thinking on the ethics of healthcare.

Hippocratic Oath – classical version

I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my *ability* and *judgment* this oath and *this covenant*:

- To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art – if they desire to learn it – without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.
- I will apply *dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.*
- *I will neither give a deadly drug* to anybody who asked for it, nor will I make a suggestion to this effect. Similarly *I will not give to a woman an abortive remedy*. In purity and holiness I will guard my life and my art.
- *I will not use the knife*, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.
- *Whatever houses I may visit, I will come for the benefit of the sick*, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.
- *What I may see or hear in the course of the treatment* or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, *I will keep to myself*, holding such things shameful to be spoken about.
- If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honoured with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

(cited in Miles, 2005).

For medical professionals, abiding by the principle of non-maleficence as outlined in the Hippocratic Oath was challenged by the activities involving medical professionals in World War II. Experiments conducted by Dr Josef Mengele in Nazi Europe and by physicians attached to the Japanese military galvanised the world. The initial phase of the post-war Nuremberg Trials was conducted from November 1945 to October 1946. These trials aimed to prosecute prominent members of the political, military and economic leadership of Nazi Germany in the immediate period following the war. Subsequent trials ensued, including from December 1946 to August 1947, which resulted in the prosecution of 20 medical doctors involved in experimentation upon prisoners and the extermination of millions of persons in concentration camps and hospitals during the war. The experiences of World War II also had a significant impact on the nursing profession. Kappeli (2007) argues that it was during this period that 'the final loss of innocence of a humanitarian profession under the conditions of a dictatorship occurred' (2007: 248). In 1939, a law for the regulation of the nursing profession was enacted in Germany, with nurses required to swear an oath of loyalty to the Führer of the German Reich. In this way, nurses became involved in all the measures of Nazi health policies, including euthanasia programs and experimentation on prisoners (Kappeli, 2007). Some nurses refused to participate in the implementation of some Nazi medical policies that led to the harm and death of patients in their care. Despite this, nurse academic Rebecca McFarland-Icke states that during World War II, German nurses 'made choices, and their choices added up to the betrayal of thousands of people who were utterly dependent on them' (1999: 13). Interestingly, scholarship about healthcare ethics and the role of nurses in activities of the Third Reich has increased over the last few decades, with a large focus on conscience, moral distress and coercion in decision-making. There has also been significant academic discussion on the question of whether this experience of nursing in Germany during the war has any relevance for nursing as a profession in the twenty-first century. Key areas of focus in this academic discussion relate to the role of nurses in Nazi euthanasia programs, as well as that of nurses in the area of palliative care, particularly in countries where assisted dying and euthanasia are legal.

Following the Nuremberg Trials, international human rights charters, health professional charters, codes of conduct and codes of ethics were developed. Each of these was created in response to the atrocities against human persons that occurred on all fronts during World War II – not just in Europe. In 1948, the Declaration of Geneva was adopted by the General Assembly of

the World Medical Association. This has been labelled as the Hippocratic Oath 'Mark II': it is regarded as a modernisation of the ancient medical professional code that aimed to affirm a physician's dedication to the humanitarian goals of medicine. Three key statements in the Declaration of Geneva (World Medical Association, 1948) are:

- I solemnly pledge to consecrate my life to the service of humanity.
- The health of my patient will be my first consideration.
- I will not use my medical knowledge to violate human rights and civil liberties, even under threat.

Such a Declaration was deemed to be essential by the medical profession at this time, given the implicit involvement of doctors in the atrocities of World War II. At the same time as the Declaration of Geneva was being formulated, the United Nations (UN) was created with the purpose of developing an international community that vowed never to allow the atrocities that occurred during the war to occur again in human history. World leaders who formed part of this first General Assembly of the United Nations decided to develop a charter that guaranteed the rights of all human persons. In 1948, the United Nations General Assembly adopted The Universal Declaration of Human Rights (UDHR). The Preamble of the UDHR (United Nations General Assembly, 1948) states the following:

> Now, Therefore THE GENERAL ASSEMBLY proclaims THIS UNIVERSAL DECLARATION OF HUMAN RIGHTS as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

As a founding member of the United Nations, Australia played a prominent role in drafting the Universal Declaration. The head of Australia's delegation to the United Nations was Dr H.V. Evatt, who became President of the UN General Assembly in 1948. In this same year, the UDHR was adopted. Ratification of the UDHR covenants has been made by the Australian Commonwealth Government, and our courts are encouraged to take into account the stated provisions of the Declaration. The Commonwealth Government has passed specific legislation that gives effect to many of the

rights set down in international instruments such as the UDHR. These include:

- the *Australian Human Rights Commission Act 1986*
- the *Age Discrimination Act 2004*
- the *Disability Discrimination Act 1992*
- the *Race Discrimination Act 1975*
- the *Sex Discrimination Act 1984*.

The Australian Human Rights Commission (AHRC) administers these Acts, and is empowered by federal law to hear and conciliate complaints from individuals who believe their rights have been breached.

Following the UN General Assembly's adoption of the UDHR, the next most prominent international declaration that had direct ties to the wartime atrocities was the Declaration of Helsinki, which was codified at the 1964 World Medical Association Congress. This new Declaration had the purpose of being a 'statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data'. Again, the involvement of health professionals in the unethical and murderous experimentation on human persons in the name of science during World War II was at the forefront of the Declaration of Helsinki. This Declaration has become the foundation of many ethical codes of conduct and legal frameworks regulating research of human subjects, including the Australian National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research, implemented nationally in 2007.

Ethics in the context of the twenty-first century

To set the scene for this chapter and this book, it is helpful to consider how we live today and how we think about the way we live today. A number of circumstances that have shaped our society are pertinent here. The 1960s was a time of discovery of the joy of living, having moved on from the tragedy of the experience of a world at war in the 1940s and the literal rebuilding of social and economic life in Western society. The world – at least what was termed 'the Western world' – was reasonably prosperous; the shackles of the economic Depression of the 1930s and the legacy of two world wars had been shaken off

and new movements abounded. Instead of embracing material prosperity, to some extent we embraced love, generosity and altruism. We decided that civil rights were important, that personal freedoms were worth defending, that the brotherhood of man (as it was described in those days) should become the solidarity of all people, although there was little acknowledgement that substantial changes like feminism – or at least the equality of women – were here to stay. People embraced technological change, and medical advances were (and remain) hugely popular; the space race captured our imaginations; the environmental movement began. Probably two of the most significant social changes that occurred at this time were the development of effective, cheap, reliable female-focused contraception and, linked to this, the desire/need for women to pursue careers of their own.

It is worth reflecting on our reactions to many of these joyous initiatives. We still have the contraceptive pill, but the 1960s dream of unfettered free love came up against AIDS and sexually transmitted diseases; the *freedom* for women to continue working after marriage and particularly after having children has become an *obligation* for them to do so. It is with some irony that those with significant disposable resources – 'the rich' – choose to return to work quickly, while those with very limited resources and little ability to find flexible employment – 'the poor' – are coerced into returning to poorly paid employment. Medical advances mean that it is frequently possible to keep people alive long after their brain has ceased to function – or, indeed, in the absence of a brain at all! Today the burning question is less about the preservation of life and more about how long we should keep going – and, more controversially, whether as a society we should allow or encourage or demand that people in certain health conditions should have their lives intentionally ended. Healthcare professionals are increasingly required to assess overall health needs and become community care assessors rather than being able to focus on their own areas of clinical and professional expertise. Career aspirations within most professions mean that you need to develop quite different skill sets: to advance very far in nursing, teaching or social work, you need to be good with budgets. Each division of an enterprise has a devolved budget, and one of the markers of your success as a manager, coordinator or team leader is the balancing of that budget. Finding new ways to limit expenditure or generate income is simply expected. It is one of the pragmatic reasons for the development of inter-professional approaches to healthcare and, while still in its infancy, to the development of inter-professional approaches to the *ethics* of healthcare.

Because of all these sets of circumstances, our ethical constructs, frameworks and guidelines are under significant stress. The guidelines, precepts and rules of the past may no longer seem relevant – or, at least, are in a situation where they are open to major questioning. In other words, as you read this you are thinking about it and assessing it in quite different ways than might have been the case for your parents or grandparents at your age and point in their careers. These illustrations highlight why the subject-matter of ethics is interesting, and why it should be of interest to you. Professionally, it is vital that you take the time to think and learn as much as you can because you will need to know and understand what you think and why you think it in order to best serve your patients/clients and your profession. As you read the various sections of this book, you should try to retain in the forefront of your mind two questions: What do you *really think* about the issues raised in the book? And *why* do you think what you do?

Studying 'professional ethics'

When an occupation has been determined to be one of the 'professions', it is considered to have a body of specialist knowledge obtained through substantial study, a set of required applied skills organised around that knowledge and a developed sense of ethics or ethical standards that guide the members of the profession in their practice of professional knowledge and skills. As Freegard (2007: 94) indicates, 'The standards to which members of a profession are to hold themselves are usually expressed in a professional code of ethics or conduct, which is promulgated and enforced by their professional association'. Such codes of conduct and ethics are normative frameworks to guide health professionals' moral conduct in their day-to-day clinical practice. Many professional bodies have position statements that form the basis of the collective affirmation of ethical conduct required of members within their profession in situations of moral uncertainty in practice. Of interest, prominent Australian healthcare ethicists Kerridge, Lowe and Stewart (2009) argue that the modern emphasis on professionalism in healthcare has gone too far. They state:

> Professionalism centres on the practitioner, and discussions about the professionalism seem sometimes to even ignore the existence of the patient. It is important for all health professionals to bear in mind that patient autonomy, patients' rights and patients' needs and desires are key … not the autonomy, rights and interests of the profession. (2009: 120)

However, it could be argued that normative frameworks such as professional codes of ethics form the basis of the moral, social and professional values that are foundational and particular to members of that profession. They also provide evidence to society of the call for health professionals to protect and promote the welfare of persons in their care, and to avoid any self-interest that may pose a threat of harm or risk to the patient or client. They also affirm that the patient–health professional relationship is not just a service provision one typical of a free-market approach to consumerism. Health professionals bring to their daily role values, experience and knowledge that are not just prescriptive of a charter, code of conduct or ethical positions statement or code. The reciprocal nature of care between health professional and patient/client does not ignore the health professional's own rights in service provision and clinical practice. Most professional codes of ethics for health professionals, nationally and internationally, acknowledge this reciprocation and relationality between patient, their family, the community and the health professional. Therefore, such normative ethical frameworks for health professionals provide an orientation to the health professional and the general community with regard to expected behaviour and conduct in the provision of healthcare.

Professional codes of ethics for health professionals have evolved from international declarations and charters made following World War II. The 3rd General Assembly of the World Medical Association, held in London in October 1949, adopted the first Code of Medical Ethics that outlined the duties of physicians to patients, society and their profession. The International Council of Nurses first adapted a Code of Ethics for the nursing profession in 1953. This Code has been reviewed and revised several times since, with the most recent version being in 2012. The first Australian Code of Ethics for Nurses was developed and implemented in 1993 under the auspices of the Australian Nursing Council, the Royal College of Nursing, Australia and the Australian Nursing Federation. The most recent version of the Code of Ethics for Nurses and Midwives practising in Australia was released in 2008. In each of these Codes, eight value statements affirm the profession's commitment to respect, promote, protect and uphold the fundamental rights of people who are both the recipients and providers of nursing and midwifery healthcare in Australia. Speech Pathology Australia has also developed a Code of Ethics (2010) that aims to highlight the fundamental professional responsibilities of speech pathologists, and to affirm the highest standards

of integrity and ethical practice. The Australian Association of Occupational Therapists' National Code of Ethics (2001) is founded on the principles of beneficence, non-maleficence, honesty, veracity, confidentiality, justice, respect and autonomy. Currently in Australia, the health professional groups of paramedicine and physiotherapy do not have professional codes of ethics statements.

These professional codes of ethics form the basis for fostering collaboration among members of health professional teams in the clinical setting. These codes have some common foundational values and principles; however, they also present variance based on scope of practice, professional regulation and accreditation. Traditionally, ethical reasoning in healthcare has been the domain of the medical profession, and usually focuses on the doctor–patient relationship. However, through the education of other health professions in ethical reasoning, the development of professional position statements on contentious issues in clinical practice, the implementation of professional codes of ethics and the involvement of nursing and allied health professionals in institutional healthcare ethics teams, ethical reasoning has become increasingly collaborative, and relies on an inter-professional approach. Interestingly, there is a lack of research on such collaboration between health professionals on ethical issues encountered in practice. Clark, Cott and Drinka (2007) argue that inter-professional moral reasoning is essential, due to the expanding scope of practice for health professionals in the clinical setting. They state that:

> The field of interprofessional education and practice is beginning to recognise the need for greater conceptual clarity and theoretical sophistication, so it is an opportune time to develop a comprehensive framework that will help to delineate issues and chart areas for further exploration in interprofessional ethics. (2007: 601)

As a healthcare organisation develops, and the numbers of health professional services and therefore teams also increase, the moral obligation of the providers of care from a professional and institutional context also needs to be recognised and developed. Inter-professional ethics, as an emerging field of professional discourse, is essential to respond to the changing needs of healthcare service delivery, and the increasing involvement of professional groups other than the traditional medical model in the deliberation on ethical issues in healthcare.

Bioethics or the ethics of healthcare?

As previously highlighted, the specific discipline of bioethics was one of the legacies of World War II. Because of the context that gave rise to this area of study the focus has tended to be very specific: largely focused on the situations of people in Western countries, and often just focused on specific issues such as end of life care, reproductive technologies, transplantation, resource allocation and experimentation. The responses developed have varied in their approach, but there have been three dominant forms of reasoning that have been applied to bioethics.

The most pervasive of these has been what has been termed the 'principles' approach, which is exemplified in the work of James Childress and Thomas Beauchamp (2012). These scholars identified four key principles:

- respect for autonomy – people should consent to treatments and to being party to research
- non-maleficence – healthcare professionals should always avoid harming patients/clients
- beneficence – healthcare professionals should always seek to benefit their patients/clients
- justice – resources should be allocated fairly within a healthcare system.

This approach has informed most professional codes of ethics. It is a form of prescriptive ethics – no action can be legitimate if it violates one of the principles. One of the key strengths of a principles approach has been the ease with which people can remember the terms – autonomy, non-maleficence, beneficence, justice – and then apply them. One of the key issues is that those terms are very context driven, meaning that they are not easily applicable in cultural or social contexts other than a Western construct. For example, the principle of beneficence – to do good – is not the same in a war zone as it is in a major metropolitan area in peacetime; nor is healthcare delivery in a desperately poor nation the same as it is in a wealthy nation.

Another major approach is utilitarianism. This approach to philosophy, and more particularly to ethics, derives from the philosophers Jeremy Bentham (1748–1832) and John Stuart Mill (1806–73). In its purest form, it holds that one should always act to maximise the good. What 'the good' might be is construed differently by different people: for some, it is hedonistic or equated