

Section 1

Professional Ethics in Obstetrics and Gynecology

Chapter

1

Professional Ethics in Medicine

GOAL

This chapter provides a historical and philosophical introduction to professional ethics in medicine, based on the ethical concept of medicine as a profession.

OBJECTIVES

- On completing study of this chapter, the reader will:
- Define ethics, medical ethics, bioethics
- Define professional ethics in medicine
- Describe the two components of ethical reasoning
- Identify the discipline of ethical reasoning
- Describe the ethical concept of medicine as a profession
- Describe the five professional virtues of professional ethics in medicine
- Describe the four ethical principles of professional ethics in medicine
- Describe the advantages of professional ethics in medicine
- Answer the question: Why should physicians commit to the ethical concept of medicine as a profession?

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Key Concepts

Absolute ethical obligation	Bioethics	Discipline of ethical reasoning
Absolute ethical principle	Biopsychosocial concept of health and disease	Distress
Argument-based ethical reasoning	Common morality	Enthusiasm
Beneficence-based clinical judgment	Conflict of commitment	Ethical analysis
	Conflict of interest	Ethical argument
	Consequentialism	Ethical concept of medicine as a profession
	Deliberative clinical judgment	Ethical judgment

Ethical obligation	Ethical principle of respect for	Pain
Ethical principle	autonomy in professional	Patient
Ethical principle of beneficence	ethics in medicine	Prima facie ethical obligation
in medical ethics and bioethics	Ethical reasoning	Prima facie ethical principle
Ethical principle of beneficence	Ethically impermissible	Professional ethics in medicine
in professional ethics in	Ethically ideal	Professional virtue of
medicine	Ethically obligatory	compassion
Ethical principle of healthcare	Ethically permissible	Professional virtue of humility
justice in professional ethics in	Ethics	Professional virtue of integrity
medicine	“First do no harm”	Professional virtue of self-
Ethical principle of justice in	Harm principle	effacement
medical ethics and bioethics	Judgment	Professional virtue of self-
Ethical principle of	Medical ethics	sacrifice
nonmaleficence in medical	Medically reasonable alternative	Public trust
ethics and bioethics	Moral science	Quest for certainty
Ethical principle of	Moral philosophy	Quest for reliability
nonmaleficence in professional	Moral theology	Secular ethical reasoning
ethics in medicine	Morality	Specification
Ethical principle of respect for	Morally ideal	Speculation
autonomy in medical ethics	Morally impermissible	Suffering
and bioethics	Morally obligatory	Virtues
	Morally permissible	Voluntary
	Organizational culture	

1.1 Professional Ethics in Medicine and Professional Ethics in Obstetrics and Gynecology

In this book we provide an historical, philosophical, clinically comprehensive, and practical account of professional ethics in obstetrics and gynecology. The goal of professional ethics in obstetrics and gynecology is to identify what is ethically permissible, ethically obligatory, ethically impermissible, and ethically ideal in patient care, clinical innovation and research, organizational culture, and health policy and advocacy concerning female, pregnant, and fetal patients.

In this book we understand professional ethics in obstetrics and gynecology to be a subfield of professional ethics in medicine. We therefore begin with an account of professional ethics in medicine in this chapter and then adapt this account to obstetrics and gynecology in Chapter 2. In this chapter we distinguish professional ethics in medicine from medical ethics and from bioethics and then set out the commitment to the ethical concept of medicine as a profession, which serves as the basis of professional ethics in medicine. To set the stage for these two

explanatory tasks, we begin by introducing the reader to ethics and ethical reasoning.

1.2 Ethics and Ethical Reasoning

Diagnostic and prognostic reasoning both require precision of thought and speech so that each team member’s thinking can be reliably communicated to other team members. The safety and quality of patient care depend on precision of thought and speech, because errors in communication pose preventable threats to patient safety and quality. For example, the patient’s feet are inferior to the patient’s pelvis, even when the patient in the operating room is in the Trendelenburg position. The patient’s sternum is anterior to the patient’s heart, even when the patient is face down on an examination table.

1.2.1 Ethics

Ethics is an essential component of patient care, clinical innovation and research, organizational culture, and health policy advocacy. Ethics deploys concepts – ethical principles and virtues – that have a precise meaning, making effective identification and professionally responsible management of ethical challenges

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possible. Indeed, “ethics” itself has a precise meaning and so we begin with an account of ethics and ethical reasoning.

Ethics is the disciplined study of morality with the goal of incrementally improving it, based on reasoned ethical judgments. *Morality* comprises our actual beliefs about behavior and character that are morally impermissible, morally permissible, morally obligatory, and morally ideal. *Morally impermissible* means that a form of behavior or character should not occur, e.g., sexual abuse of patients. *Morally permissible* means that a form of behavior may occur in circumstances in which there are multiple forms of behavior or character supported by ethical reasoning, e.g., waiving professional fees when volunteering in an international medical mission. *Morally obligatory* means that a form of behavior or character should occur, e.g., leading a professionally responsible informed consent process for hysterectomy with an adult patient with intact decision-making capacity. *Morally ideal* behavior invokes perfectionism: always striving for a perfect and therefore highly valued outcome even while knowing that one may fall short, e.g., providing adequate emergency management in the field in response to a mass-casualty event.^{1,2} *Morally ideal* also means that it is morally obligatory to make incremental progress toward the highly valued outcome.

Morality is formed from multiple sources, including family, geography, group, history, law, personal opinion, philosophy, religion, and tribe. Morality is thus pluralistic, which can become a source of conflict about what is morally impermissible, morally permissible, morally obligatory, and morally ideal.

1.2.2 Ethical Reasoning

1.2.2.1 Clinical Judgment

Judgment is the process of reliably classifying an entity by applying clear and justified criteria. When these criteria are idiosyncratic, a judgment has value only for the individual who has formed it. When these criteria are authoritative – drawn from a source that others should acknowledge as important and applicable – a judgment has value both for the individual who formed it and for others.

Consider clinical judgment, which begins with the facts of the matter: signs; symptoms; and the results of history and physical examination, laboratory analysis, and imaging. Evidence-based causal explanations are then formed to explain these results in terms of

pathology: abnormal anatomy, or pathophysiology. These explanations are then arrayed by probability in a differential diagnosis based on biopsychosocial criteria for normal and pathological anatomy and physiology. This process results in clinical diagnosis, prognosis, and plan of care, all of which vary directly in reliability by strength of evidence for them. The reliability of clinical judgment is a function of being deliberative: evidence-based (an appeal to the best available, critically appraised evidence), rigorous (especially in the effort to identify and reduce the influence of bias), transparent (the physician can explain his or her judgment to other clinicians, especially team members, and the patient), and accountable (to meet accepted standards of patient safety and quality). Even when evidence is lacking, the other components of deliberative clinical judgment can and therefore should be satisfied. The common response that “there isn’t evidence for everything” does not apply to deliberative clinical judgment.

Deliberative clinical judgment is intellectually authoritative for physicians and other clinicians and therefore for patients. Patients should take seriously deliberative clinical judgment about their condition and its clinical management in their subsequent decision-making process with their physicians. The intellectual authority of deliberative clinical judgment has the potential to influence the patient’s decision-making process. It is a mistake, however, to conclude that this intellectual authority controls her decision making.

1.2.2.2 Ethical Judgment

Ethical judgments about what is ethically permissible, obligatory, impermissible, and ideal are analogous. Authoritative ethical judgments are reasoned judgments. Reasoned ethical judgments result from an intellectually rigorous process that always starts with the facts of the matter, to avoid *enthusiasm* (beliefs that lack an evidence base) and *speculation* (beliefs that do not pass muster even as plausible hypotheses). Reasoned ethical judgments apply clear criteria to classify character, behavior, organizational culture, and health policy and advocacy as ethically permissible, ethically obligatory, ethically impermissible, and ethically ideal.

1.2.2.3 Two Components of Ethical Reasoning

Criteria must be relevant to the facts of the matter and must also be justified, i.e., supported by reasons that appeal clearly expressed ethical concepts: principles and virtues. This is known as *ethical analysis*. The

implications of these clearly expressed concepts must then be precisely identified and shown to follow from the clearly expressed concepts. This is known as *ethical argument*. The result of this intellectually rigorous, practical process is reliable classification of behavior, character traits, organizational culture, or health policy and advocacy as ethically permissible, obligatory, impermissible, or ideal. This classification varies in reliability directly by the strength of the basis of the criteria in ethical principles and virtues and the rigor of the application of such criteria to the facts of the matter.

Ethically impermissible means that a form of behavior, character, organizational culture, or health policy and advocacy should not occur. *Ethically permissible* means that a form of behavior, character, organizational culture, or health policy and advocacy may occur in circumstances in which there are multiple forms of behavior, character, organizational culture, or health policy and advocacy supported by ethical reasoning. *Ethically obligatory* means that a form of behavior, character, organizational culture, or health policy and advocacy should occur. *Ethically ideal* behavior invokes perfectionism: always striving for a perfect outcome even while knowing that one may fall short. Health policy is sometimes expressed as an ideal, e.g., the goal of providing every patient with a source of payment, such as universal health insurance.

1.2.2.4 Preventing Common Errors in Ethical Reasoning

Clinical judgment aims to improve patient care by preventing common errors in clinical reasoning and its communication. So too, ethical judgments aim to improve morality, by preventing errors in ethical reasoning and its communication. (See Table 1.1.) Common errors in ethical reasoning include (1) starting with conclusions about what is ethically permissible, obligatory, impermissible, or ideal and then searching for friendly reasons, i.e., ethical concepts and their implications (or, more technically, premises), which gets ethical reasoning backwards; (2) mere opinion, which is the assertion of a conclusion without any effort to identify relevant premises; (3) appeal to majority opinion, which is always at high and unmanageable risk of biases of various kinds, including biases of which those in the majority may be unaware; (4) appeal to one’s position of power in an organizational hierarchy, which establishes only that one has and may exercise such power but does not establish how one *ought* to do so; (5) equating legal judgment about what is impermissible, permissible,

obligatory in the law with what is impermissible, permissible, obligatory in the professional ethics of medicine and of obstetrics and gynecology; (6) intuitions or initial, untested judgments that must be examined critically before they become eligible for being authoritative;^{3,4} (7) making the most noise or otherwise being good at gaining the attention of others, which is not a form of reasoning at all; (8) speculation, i.e., making up hypothetical clinical situations (also known as “thought experiments”) that have little or no bearing on clinical reality, e.g., exploring the ethics of genetic manipulation in patients on the assumption that such intervention is clinically safe;⁵ and (9) not situating argument in context of other arguments, i.e., failing to identify and respond to already existing ethical reasoning on a topic, especially those that differ from one’s own ethical reasoning.

Table 1.1 Errors in ethical reasoning.

Name of error	Error made
Starting with conclusions and searching for friendly reasons	Gets ethical reasoning backward, because ethical reasoning starts with reasons to reach conclusions
Mere opinion	Asserts a conclusion with no supporting reasons
Appeals to majority opinion	No prevention of bias in reasons and conclusion
Appeal to power	Replaces authority of reasoning with organizational authority
Equating legal judgment with ethical reasoning	Accepts legal reasoning with no critical appraisal from the perspective of professional ethics in medicine
Appeal to intuitions	Accepts initial judgment without critical appraisal from the perspective of professional ethics in medicine
Making the most noise	Gaining attention of others without the support of ethical reasoning
Speculation	Making up examples that lack clinical application
Not situating argument in context of other arguments	Failing to identify and respond to already ethical reasoning on a topic, especially those that differ from one’s own ethical reasoning.

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1.2.3 The Discipline of Ethical Reasoning

One achieves the discipline of ethical reasoning by always and only making judgments that result from ethical analysis and argument. More colloquially, one achieves the discipline of ethical reasoning by going where ethical analysis and argument take one and nowhere else. This is also known as argument-based reasoning.⁶ (See Chapter 6.) If the ethical judgment that results from ethical reasoning is considered unacceptable, one must (1) critically appraise the ethical reasoning by identifying and correcting errors of ethical analysis and argument and (2) produce an alternative, well-reasoned ethical judgment. If critical appraisal does not result in an alternative ethical judgment, one must consider oneself intellectually prohibited from dismissing the initial ethical judgment as unacceptable. One must therefore change one's mind by adopting the initial judgment.

If one does not submit to the intellectual discipline of ethical reasoning, one should not expect to be taken seriously by those committed to professional ethics in medicine and therefore to professional ethics in obstetrics and gynecology. Instead, one should expect to be challenged and then supported by those committed to the discipline of ethical reasoning to achieve well-reasoned ethical judgments. One should not take such a response personally, but professionally, by recommitting to the discipline of ethical reasoning.

1.2.4 Critical Appraisal of Argument-Based Ethical Reasoning

Argument-based ethical reasoning can be critically appraised for its clinical utility in managing ethically challenging cases, just as evidence-based clinical judgment and practice can be appraised. The critical appraisal of evidence-based clinical reasoning is systematic and disciplined; so too for argument-based ethical reasoning. Critical appraisal is an essential component of the discipline of ethical reasoning and has four steps.

1. Does the article address a focused ethics question?
2. Are the arguments that support the results of the article valid?
3. What are the results?
4. Will the results help me in clinical practice?⁶

Like all clinically applicable literature, a paper in the professional ethics of obstetrics and gynecology should have a focused clinical ethical question, for example: How should a gynecologist respond when a premenopausal patient who has no symptoms or pathology requests a hysterectomy to prevent future pregnancies? The validity of ethical argument has three components. First, as explained in Section 1.2.2.3, ethical analysis should produce concepts that are clearly stated. Second, ethical argument is deployed to identify the implications of these clearly expressed concepts. Third, ethical analysis and argument should be grounded in a review of the pertinent literature, to catalog concepts that are clinically pertinent and how they have been clearly or unclearly expressed. Ideally, this should be a structured review with the search terms and databases specified. We should note, however, that many papers in normative ethics lag behind the standards of the evidence-based literature. The results should be expressed in a way that is clinically applicable. Results should be considered helpful when they provide clear guidance to clinical decision making and behavior based on it. Finally, articles that are identified in a structured review can be scored for their answers to these four questions.⁷

There is a continuum in professional ethics in obstetrics and gynecology literature from opinion without supporting argument to rigorous work based on rigorous ethical analysis and argument. Using the preceding four questions as a critical appraisal tool will equip the reader to distinguish the quality of ethical reasoning along this continuum. The lower the score assigned to a paper, the greater is the potential for bias and the need to take recommendations with a jaundiced eye. (See Chapter 6 for teaching critical appraisal of argument-based ethical reasoning.)

1.2.5 Two Approaches to Ethical Reasoning: The Quest for Certainty and the Quest for Reliability

In the history of Western philosophical ethics (also known as moral philosophy) there are two main approaches to ethical reasoning. Diego Gracia has characterized these as the *Quest for Certainty* and the *Quest for Reliability*.⁸

1.2.5.1 The Quest for Certainty

The quest for certainty assumes that the moral life requires certainty of ethical judgment deriving from foundations that are beyond doubt. This approach originates in the philosophy of Plato (ca. 427–ca. 347 BCE), with its appeal to unchanging, eternal “forms” as the basis of all knowledge. The quest for certainty is also known as foundationalism, typified by the appeal to Reason in the moral philosophy of Immanuel Kant (1724–1804) and its famous categorical imperative to treat all persons as ends in themselves and never as merely means. This categorical imperative can be denied only by embracing irrationality.⁸

1.2.5.2 The Quest for Reliability

The quest for reliability, in strong contrast, aims for ethical judgments that we can act on with confidence that we have good reasons, which always remain open to revision and improvement. The quest for reliability requires a commitment to the virtue of humility, which is a corollary of the professional virtue of integrity. The quest for reliability originates in the moral philosophy of Aristotle (384–322 BCE), who, it should be noted, was also a physician and scientist and thus already comfortable with judgments characterized by reliability and not certainty.

This approach continued in the work of the eighteenth-century Scottish moral sense theorists, such as David Hume (1711–1776)⁹ and the American pragmatist William James (1842–1910)¹⁰. Hume took himself to be doing moral science and reporting his primary discovery, the principle of sympathy. Sympathy is a constitutive, causal process in human moral physiology (seated in the heart) that naturally inclines us, as a matter of habit, to enter into the lived experience of others and thereby become motivated to protect and promote their interests as our primary concern and motivation.⁹ In the early twentieth century, a philosophy of reliability known as pragmatism emerged, pioneered by James,¹⁰ which appeals to shared commitments to what ought to be valued as the basis of ethical judgment.⁸ These commitments create their truth in our lives and the lives of others. For example, it is true that the United States is a secular, democratic republic provided that enough people in the United States commit to the rule of law grounded in the United States Constitution.

1.2.5.3 Professional Ethics in Medicine Is the Quest for Reliability

Clinical judgment is a quest, not for certainty, but for reliability of clinical judgments about the condition of the patient and its professionally responsible clinical management. Ethical reasoning should reflect the context in which it is deployed, as Aristotle teaches in his *Nicomachean Ethics*.¹¹ We will therefore understand professional ethics in medicine and in obstetrics and gynecology as the quest for reliability, not the quest for certainty.

1.3 Medical Ethics and Bioethics

The discourse of professional ethics in medicine is often equated with the discourse of medical ethics or the discourse of bioethics. In this book we emphasize the differences between professional ethics in medicine and medical ethics and bioethics. (See Table 1.2.)

1.3.1 Medical Ethics

Medical ethics is the disciplined study of the morality of physicians and patients, clinical innovation and research, and health policy and advocacy, with the aim of improving medical morality. A major source for medical ethics, in its millennia-long history, is moral theology, because religions give meaning to the life cycle, for the stages of which physicians are often present. Other sources include family, geography, group, history, law, personal opinion, philosophy, religion, and tribe. Medical ethics is a global tradition of inquiry found in all cultures and regions, dating from Before the Common Era (BCE), based on the sacred texts of Judaism, Buddhism, and Hinduism and philosophical texts such as those of Confucius (551–479 BCE) and Plato.¹²

From its ancient origins medical ethics has been pluralistic, drawing on diverse and potentially incompatible sources to guide physicians, patients, and communities in matters of clinical practice and, starting as early as the eighteenth century, research. In the long history of medical ethics no single approach has arisen with the intellectual authority to transcend this pluralism. As a result, medical ethics is neither transreligious, nor transcultural, nor transnational.

1.3.1.1 Philosophical Medical Ethics

A potential exception should be noted: Philosophical medical ethics claims to be transreligious, transcultural, and transnational. This claim has initial plausibility,

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Table 1.2 Medical ethics, philosophical medical ethics, bioethics, and professional ethics in medicine.

	Medical ethics	Philosophical medical ethics	Bioethics	Professional ethics in medicine
Transreligious	No	Yes	No	Yes
Transcultural	No	No	No	Yes
Transnational	No	No	No	Yes

because philosophical discourse is secular in that it makes no appeal to sources of divine or transcendent, cultural, or political origin. Philosophical medical ethics thus reliably claims to be transreligious. However, the claim of philosophical medical ethics to be transcultural and transnational is suspect, because there are profound and irresolvable methodological differences in world philosophy.

Consider a distinct contrast. Western moral philosophy endorses the “moral point of view” in which each individual counts for one and no more than one in ethical reasoning, which is a way of expressing the concept of equality. The moral point of view is highly abstract and is therefore not based on human relationships. Confucianism rejects this approach, making the relationship between the obedient child and his parents central, in which family counts for more than one. This is known as “filial piety.” One has ethical obligations to everyone to benefit them but one’s obligations to one’s family always take precedence. This relationship-based approach rejects an appeal to the moral point of view and its highly abstract concept of equality.

There are also major differences within contemporary Western medical ethics. For example, the concept of solidarity (we are all in this together and should come to each other’s aid) plays a central role in European medical ethics. Solidarity can be understood as a powerful response to the physical, natural, moral, and human catastrophe of World War II: solidarity can prevent recurrence of such catastrophe. Solidarity, at best, plays but a peripheral role in American medical ethics. The United States had a very different experience of World War II, from which it emerged with comparatively very limited physical, natural, and human cost. American individualism, many believed, had triumphed. It should come as no surprise that respect for individual autonomy is a central ethical concept (for those who quest for reliability) or the central ethical concept (for those who quest for certainty) in American bioethics.

No single approach has emerged in the long history of global philosophical ethics that successfully transcends these profound philosophical differences. Thus, while the claim that philosophical medical ethics is transreligious holds up well, the claim to be both transcultural and transnational does not withstand close scrutiny.

1.3.1.2 Limitations of Medical Ethics

The discourses of medical ethics are thus limited. This limitation has implications for the successful deployment of medical ethics, which should occur in four steps: (1) specifying the disciplinary source(s) invoked, followed by ethical analysis and ethical argument as used in that discipline; (2) identifying whether the quest is for certainty or reliability; (3) identifying the implications for what is ethically permissible, obligatory, impermissible, and ideal for physicians and patients in clinical practice, clinical innovation and research, organizational culture, and health policy and advocacy; and (4) acknowledging the religious, cultural, and national limits of resulting ethical judgments in a pluralistic society and pluralistic world.

1.3.2 Bioethics

Bioethics is the disciplined study of the morality of healthcare professionals, patients, healthcare organizations, innovation, biomedical and clinical research, healthcare policy, and advocacy with the aim of improving bioethical morality. Since its origins in the later 1960s and early 1970s (some claim the United States as the country of origin,¹³ others the United Kingdom¹⁴), bioethics has become a global field of inquiry.¹⁵ The result is a multidisciplinary field of inquiry, the sources of which include allied health professions, law, literature, medicine, moral theology, narrative studies, nursing, philosophy, policy studies, qualitative and quantitative social sciences, and religious studies (a secular discipline).¹⁶

In the United States the field of bioethics was first created by physicians (who were sophisticated students of moral theology and moral philosophy), moral theologians, religious studies scholars, legal scholars, and moral philosophers. With a handful of exceptions, the humanities and legal scholars specialized in traditional areas of their disciplines; specialization in bioethics came later.¹³ Bioethics is now robustly multidisciplinary.

1.3.2.1 Limitations of Bioethics

The distinctive strength of bioethics is that it is a remarkably pluralistic field. This strength is also a limitation. Like medical ethics – and for the very reasons described in Section 1.3.1 – bioethics is neither transreligious, nor transcultural, nor transnational. This limitation has implications for the successful deployment of bioethics, which should occur in four steps: (1) specifying the disciplinary source(s) invoked, followed by ethical analysis and ethical argument as used in that discipline; (2) identifying whether the quest is for certainty or reliability; (3) identifying the implications for healthcare professionals and patients, healthcare organizations, and health policy and advocacy for what is ethically permissible, obligatory, impermissible, and ideal in clinical practice, clinical innovation and, organizational culture, and healthcare policy; and (4) acknowledging the religious, cultural, and national limits of resulting ethical judgments in a pluralistic society and pluralistic world.

1.4 Ethical Principles and Virtues in Medical Ethics and Bioethics

The ethical concepts deployed in both medical ethics and bioethics are known as ethical principles, sometimes deployed alone and sometimes in conjunction with virtues. Ethical principles function as guides to ethical judgment and behavior based on it. Ethical principles can be absolute, i.e., not subject to justified limits. A pacifist, for example, may adopt an exceptionless respect for human life and therefore judge all forms of killing human beings to be ethically impermissible, even in self-defense. Ethical principles can also be limited: they guide ethical judgment and behavior unless in ethical reasoning they are shown to be overridden by another ethical principle or virtue. Limited ethical principles are known as *prima facie* ethical principles.¹⁷ For example, in Roman Catholic

moral theology there is an ethical obligation not to kill human beings as *prima facie*: induced abortion and capital punishment are ethically impermissible but killing in self-defense and in war that meets the criteria for being a just war are ethically permissible.

In the quest for certainty in ethical reasoning, ethical principles are typically classified as absolute. In the quest for reliability in ethical reasoning, ethical principles are always classified as *prima facie*. In this book, ethical reasoning in professional ethics of medicine and of obstetrics and gynecology appeals to *prima facie* ethical principles, as explained in the text that follows and in Chapter 2.

Virtues are traits of character that are judged to be worth cultivating because they also guide ethical judgment and behavior based on it. The pluralism of methods in medical ethics and bioethics is especially evident in the wide range of virtues to which various forms of medical ethics and bioethics appeal, including caring, compassion, discernment, trustworthiness, integrity, and conscientiousness.¹⁷, pp. 34–44 There is, however, no agreement in medical ethics or bioethics on the relevant virtues. In the professional ethics of medicine and of obstetrics and gynecology, as explained in Section 1.5, the core *professional virtues* comprise integrity, humility, compassion, self-effacement, and self-sacrifice, as we will explain later in this chapter. Virtues play little or no role in the quest for certainty in ethical reasoning. In striking contrast, virtues are essential in the quest for reliability in ethical reasoning and therefore for professional ethics in medicine generally and professional ethics in obstetrics and gynecology specifically.

1.4.1 The Four Ethical Principles in Medical Ethics and Bioethics

1.4.1.1 The Ethical Principle of Beneficence in Medical Ethics and Bioethics

In moral philosophy, ethical principles tend to be expressed in general, often highly abstract terms. The ethical principle of beneficence in medical ethics and bioethics generates the *prima facie* ethical obligation to act in a way that results in a net balance of good over harmful consequences for those affected by one's behavior. In the technical discourse of moral philosophy, beneficence is a consequentialist principle.¹⁷ Beauchamp and Childress, coauthors of one of the most important and influential books on bioethics,

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put it concisely: “The principle of beneficence refers to a statement of moral obligation to act for the benefit of others.”¹⁷, p. 203 “Good” and “harmful” are explicated in diverse ways, depending on the variant of philosophical consequentialism from which these concepts are drawn.

1.4.1.2 The Ethical Principle of Nonmaleficence in Medical Ethics and Bioethics

The ethical principle of nonmaleficence in medical ethics and bioethics generates the prima facie ethical obligation to act in a way that prevents or does not cause a net balance of harmful over good consequences for those affected by one’s behavior. Beauchamp and Childress again put it concisely: “One ought not to inflict evil or harm.”¹⁷, p. 151 “Harm” is explicated in diverse ways, depending on the variant of philosophical consequentialism from which these concepts are drawn. Some texts use instead the word “nonmalfeasance.” This is a mistake, inasmuch as malfeasance refers to misconduct of elected and other government officials who violate their oath of office or the criminal or civil law.

1.4.1.3 Beneficence and Nonmaleficence in the History of Medical Ethics

The ethical principles of beneficence and nonmaleficence have deep roots in the history of medical ethics. Thomas Percival (1740–1804), who wrote the first text in the global history of medical ethics entitled *Medical Ethics*, may have been the first to use the word “beneficence.”¹⁸ A version of nonmaleficence can be found in the Hippocratic text *Epidemics*, the unknown author of which enjoins physicians “to help, or at least to do no harm.”¹⁹ Another version of nonmaleficence is the very common injunction, “first do no harm.” The Latinized variant, “primum non nocere,” is attributed to the American physician and medical ethicist Worthington Hooker (1806–1867).²⁰ Note that “first do no harm” is not the discourse of *Epidemics*, which makes beneficence the primary principle, with nonmaleficence secondary. Thus understood, “to help, or at least to do no harm” can be read as nonmaleficence functioning as a limiting principle on beneficence: when the physician has a weak evidence base for clinical judgment and a proposed course of clinical management based on such weak clinical judgment, the physician should proceed with great caution, to prevent net clinical harm to the patient.

1.4.1.4 The Ethical Principle of Respect for Autonomy in Medical Ethics and Bioethics

The discourse of rights appears in the global history of medical ethics as early as 1772, in the first text on professional medical ethics, John Gregory’s (1724–1773) *Lectures on the Duties and Qualifications of a Physician*²¹: “Every man has a right to speak where his own life is concerned, or that of a friend.”²¹, p. 33 This right derives from the physician’s sympathy-based obligation (taken from David Hume (1711–1776)) to identify and respond to the lived experience of illness of the patient. The concept of rights based on the capacity for autonomous decision making and action comes much later, with the invention of the field of bioethics in the late 1960s and early 1970s.

We rely, again, on the concise formulation of the ethical principle of respect for autonomy in medical ethics and bioethics provided by Beauchamp and Childress: “To respect autonomous agents is to acknowledge their right to hold views, to make choices, and to take actions based on their values and beliefs.”¹⁷, p. 106 Autonomous agents “act (1) intentionally, (2) with understanding, and (3) without controlling influences that determine their action.”¹⁷, p. 104 The ethical principle of respect for autonomy creates the prima facie ethical obligation to acknowledge and implement the informed and voluntary decisions of others and not interfere with behavior based on such decisions, except when behavior creates a significant potential to result in harm to others, especially serious, far-reaching, and irreversible harm. This is known as the harm principle in bioethics, a variant of the ethical principle of nonmaleficence.

1.4.1.5 The Ethical Principle of Justice in Medical Ethics and Bioethics

The fourth ethical principle in medical ethics and bioethics is the ethical principle of *justice*. The general formulation of this ethical principle is “attributed to Aristotle: Equals must be treated equally and unequals must be treated unequally.”¹⁷, p. 250 The ethical principle of justice in medical ethics and bioethics creates the prima facie ethical obligation to treat groups of individuals equally or with fairness. There is profound disagreement in the histories of Western and global philosophical ethics and moral theology about how the “justice,” “equality,” and “fairness” should be