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OPINION

What is medical ethics?

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S U M M A R Y

The attempt by humans to formulate principles and codes for moral behaviour is a feature of all known civilizations. Ethics, or moral philosophy, came about with the Sophists of Greece in the fourth century BC, some critics of medical ethics claim it is just sophistry. The critics are right in a way, not in the sense that ethical debate is subtly deceptive or necessarily sophisticated, but only in the sense that examination of critical ideas of moral conduct and techniques by which to discuss moral problems has its roots in Sophist Greece. The relationship between doctor and patient has always had a moral component, hitherto this component has been assumed. Swearing the Hippocratic oath and or qualification was deemed to be sufficient moral education. However the changes in biotechnology, changes in research ethics and profound sociological and cultural changes have made this assumption untenable. Knowledge of formal ethical models and an understanding of ethical principles have been inserted back into the medical curriculum where once it was studied as part of philosophy. This review summarises current ethical teaching. 1. Ethics: the discipline dealing with what is good and bad and with moral duty and obligation, a set of moral principles: a theory or system of moral values.[1] 2. Medical Ethics: The application of ethical reasoning to medical decision-making.[2] 3. Moral Philosophy: Ethics; also: the study of human conduct and values.[1]

1. What is ethics?

Ethics, or moral philosophy, is a branch of Philosophy concerned with norms and values, rights and wrongs and what ought or what not ought to be done. In other words coming after reflection, argument and analysis, to a sense of what one ought to do under given sets of circumstances. The relationship between physician and patient has been of interest since ancient times, principally concerning the moral obligations of physicians in preventing disease and treating the sick and injured. The physician was deemed to be acting for the good. However the revelation that physicians had been involved in unethical experimentation, and other atrocities, upon humans in Nazi Germany during WW11 seems to have been a turning point questioning the assumption of the good of the physician, leading to The Nuremburg Code on research ethics in 1946 and subsequent declarations.

In the past forty years, technological advances such as artificial ventilation, transplantation and dialysis, along with rise of the concept of autonomy and the decline in paternalism, changed both the ability of medicine leading to prolong life but also the attitude of patients and society to the newfound abilities of medical science. An example still debated is when might it be right to withdraw artificial ventilation and whether withdrawal is ethically different from withholding it? Medical ethics (or Bioethics) has become the study and critical analysis of the ethical issues that arise in the interrelationships between law, medicine, life sciences, theology and biotechnology.

2. Ethics and the law

The law is important and relevant and the practice of healthcare takes place within a framework of laws and regulations relevant to the particular jurisdiction. The fact that something is legal however does not entail that is moral. Nor is the converse true. The Apartheid laws in South Africa and the Anti Jewish Penal Codes in Germany in the 1930s are example of “laws” which we might consider to be unethical. Abortion was legalised in the UK in 1967. Does this mean it was morally wrong before the law changed but not afterwards? There is a distinction and the American jurist; Earl Warren put the relationship succinctly in 1964;

> In civilized life, law floats in a sea of ethics. Each is indispensable to civilization. Without law, we should be at the mercy of the least scrupulous; without ethics, law could not exist.[3]

3. Common sense and subjectivity

A common criticism of formal ethics discussions is that the problems that are discussed can be dealt with a bit of common

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sense. Training as a healthcare provider and applying common sense is all you need, not studying moral theory. There is an element of truth to this, for in day-to-day practice doctors and nurse have for generations worked in an ethical manner. Notwithstanding the various "evil" doctors and nurses in history for the most part the training and self selection of people in the caring professions ensures a high level of "ethical conduct", and simply learning moral theory does not make one more ethical than learning the ten commandments makes one a Christian. However we are more often now presented with problems which common sense cannot solve. In the event of a Pandemic flu how will we decide whom to ventilate, would it be morally correct (if illegal) to assist the death of a suffering patient at there request and what is the difference between withholding and withdrawing treatment? These problems are not commonsensical and require explicit moral deliberation to resolve them. It also commonly said that morality is all subjective, however there are common moral norms in most societies such as prohibition of murder or incest. Even when there is a lack of consensus on a matter, for example as in assisted suicide, does not mean there is no objective truth to be found or that it is not worthwhile looking for it.

4. Ethics and religion

For religious believers the answers to ethical problems are often to be found in sacred texts such as the Bible or the Koran and in the various commentaries and discussions that have flowed from them. There are two main problems with using religion as a basis for ethics. The major and most fundamental problem was formulated by Plato in the Euthyphro[4] Is the good simply good because God commands it, or does God command it because it is good? If the former is true then morality is mere obedience to an arbitrary will. If the latter is true then morality is independent of the will of God, so recourse to knowledge of the divine, at least in ethics, is redundant. A second problem arises, as reliance on religious tenet will involve applying such principles to situations unheard of or undreamt of when the religion was first promulgated. It is not always easy to reconcile ancient religious texts with modern medicine. Another problem is how to convince those who don't share a religion that they should accept its ethical tenets.

5. Ethical models

Ethics is, broadly speaking, divided into four basic theories of right and wrong actions. Utilitarianism, Deontological or rights based theories (Kantianism), Virtue Ethics (into which we may include feminist ethics) and the Four Principles approach. The four principles approach, which is the most commonly taught model in medical schools, is based on the concepts (or principles) of Justice, Beneficence, Non-Maleficence and Autonomy. It is perhaps the pre-eminent theoretical model used in the health sciences. Virtue Ethics has its roots in the ancient Greek philosophy of Aristotle. Virtue ethicists believe that the rightness or wrongness of an action is embedded in the character of the individual. The deontological approach is most famously associated with the German philosopher Kant, who argued that agents must act rationally and consistently to be moral. Finally Utilitarianism is a moral theory, which weighs the consequences of an act. The morality of an act is crystallised by the consequences, this sort of analysis is exemplified by the usage of outcome measures for populations such as in vaccination.

5.1. The four principles

Beauchamp & Childress[5] first unveiled the four principles approach to medical ethics in 1979. Since that time they have become very popular and have become the standard model for medical ethical discourse and teaching in UK medical schools.

5.1.1. Autonomy

Respect for autonomy is the principle of respect for decision-making capacities of autonomous persons allowing them to make reasoned informed choices. Autonomy can be divided into autonomy of thought, that of intention and that of action. Respect for autonomy has developed into a professional obligation, which is both a negative obligation-we must not constrain autonomous choice; and a positive obligation we must ensure that patients are able to be autonomous as much as is possible. This entails proper disclosure of information relevant to the decision-making process and actively looking to promote autonomy by ensuring understanding. In the context of illness it is probable that there is some degree of impairment of autonomy. In the critical care setting all aspects of autonomy may be significantly impaired.

5.1.2. Beneficence

Healthcare professionals have a moral obligation to act in such a way as to benefit their patients. This is the principle of beneficence preventative medicine and in public health programs. This principle of Beneficence has its limitations though. How much risk is it obligatory for a doctor or nurse to take when treating a patient? Those HealthCare Professionals in the armed forces have voluntarily taken on a different level of risk, but in the event of a pandemic infectious disease it is arguable how much risk doctors and nurses are obliged to take. Beneficence also has to be tempered with other factors. An autonomous patient has a right to refuse or decline a treatment even if it is thought to be in his or her best interests, the respect for individual autonomy trumps beneficence in this example. Beneficence has also to be tempered by Non-Maleficence and Justice.

5.1.3. Non-Maleficence

The principle of non-harming is also central to medicine. However it is a truism that all treatment has the potential to do harm. Invasive monitoring on the ITU involves a risk of complication and will cause some discomfort or pain as will any surgical procedure. The harm caused needs to be proportional to the benefit.

5.1.4. Justice

Justice in this context is concerned with the fair distribution of health resources.

Doctors often feel that this "distributive justice" impacts on the relationship between them and the patients under their care, arguing that their obligations are to their patients and that the responsibility for allocation of resources does not function at the bedside. However marginally beneficial intensive care may be justifiably limited on the basis of societal consensus that its cost is too high in relation to the value of its outcome. The American Thoracic Society bioethics task force stated in 1997 "extraordinary expenditures of resources for marginal gains unfairly compromise the availability of a basic minimum level of healthcare services for all".[6] Such issues have great relevance in the context of dealing with pandemics.

The four principles approach has proved very popular and is amenable to use in many differing situations and forms a workable template in practice. However it does have limitations. It is difficult to see how one orders the principles in complex situations and how one settles conflicts between principles. In much common discourse solutions to ethical problems have been reduced to a simple recitation of the four principles without consideration of

the abstract concept of what the principles actually mean, as if a solution can be simply achieved just by invoking the principles. Clearly interpretation of them in the context of a problem is desirable. However notwithstanding any criticisms, the success of the four principles approach is testament to their utility.

6. Utilitarianism

For the purposes of generalisation utilitarianism can be defined as a consequentialist philosophy whereby actions are held to be right or wrong by virtue of their consequences. It has its roots in the writings of Jeremy Bentham and John Stuart Mill and is fundamentally based on the "fact" that suffering is evil and happiness is good. Acts are considered right when they maximise net welfare. The rightness of an act (or healthcare intervention) is crystallised in terms of the welfare of the persons, or population, concerned. The sum of the positive and negative effects are aggregated. Thus for any given healthcare intervention the overall balance of benefit over harm is what is assessed by a consequentialsit analysis.

Healthcare planning, strategic decisions over resource allocation and decisions as to how to allocate resources in pandemics or emergency situations are good examples of where consequentialist analysis is sued in contemporary healthcare. The health economic analyses of the National Institute for Health and Clinical Excellence using such tools as the QALY, the quality adjusted life year, and vaccination programs also have a consequentialst, aggregating basis to them. The herd immunity produced by vaccination may not necessarily benefit a specific person nor might an identifiable person benefit from a treatment recommended by NICE but in both cases the health gains to the population are maximised. Utilitarianism has always suffered from the problem of consequentialist conception of morality and virtue that any means can be used to justify a good enough end. To use a controversial issue, if autism were actually caused by the MMR vaccine in a small number of children then the net benefits to the population would justify this harm to them when viewed through a consequentialist lens. This seems to be almost counter intuitive, conflicting in some way with our common morality.

Utilitarianism can be seen as too demanding and also to a certain extent diminishes individual responsibility. For each action or decision, an agent makes a calculation of net benefit to determine whether the consequence produces an overall increase in happiness of all concerned, at that point and in the future. Imagine a field of dominoes laid out in random patterns, how could you predict which will fall when a single domino is pushed over? A utilitarian would also state that I, having pushed the first domino over, must have responsibility for all the other falling dominoes. This may be true of the dominoes but human beings are not dominoes and make decisions as to how to act. The utilitarian removes their responsibility for their actions because their "falling" is a consequence of the first domino falling. As Benn points out "the results of assigning responsibility so promiscuously is that no one is really responsible for anything"[7].

Utilitarianism implies that people should give up what they have at all times to benefit others who are in greater need. This is not consistent with social mores now or in the past. In advocating the approach that all should behave in such a manner it devalues those who do so, as it does not distinguish between obligatory actions and supererogatory. [A supererogatory action is one that goes beyond what we might call the call of duty, the normal and accepted degree to which we should act]. The demand to maximise happiness, however defined, would have implications for how can we define the geographical limitations of our obligations. We would be obliged to forego intensive care in the UK until those resources had been used to bring the level of healthcare in developing countries up to our basic standard. A laudable aim, but not practical in a political or sociological sense.

7. Deontology and Kant

Deontological moral theories are broadly speaking in opposition to consequentialist theories in that the morality of an action is a function of the act itself rather than the consequences. Moral rightness consists of acting rationally and consistently, independent of empirical or other motives. Emmanuel Kant, an eighteenth century Prussian philosopher is seen as a father of modern deontology. He believed that humans had autonomy of will and could by acting rationally in accordance with a "supreme moral law" ensure the rightness of their actions. He formulated the "categorical imperative" that stated that we should always treat rational humanity as an end in itself and never merely as a means to an end. He stressed that we should only act on principles that we would wish to become universal laws, and stressed the independent moral worth of a person.

Kantianism has been criticised for being too absolute, he was unequivocal that the supreme moral laws applied without exception. Thus to lie, even to save a life, would be a moral wrong. The absolutist stance also gave no weight to concepts such as being good, caring or helping others and seems out of keeping with our "common morality".

More recently W D Ross in the early 20century refined deontological concepts stating:

> *The moral order…is just as much part of the fundamental nature of the universe (and…of any possible universe in which there are moral agents at all) as is the spatial or numerical structure expressed in the axioms of geometry or arithmetic.*[8]

He described seven prima facie duties;

Fidelity – Fulfilling promises (implicit and explicit)
Reparation – Making up for wrongful acts
Gratitude – Repaying for past favours
Non-maleficence – A duty to not injure others
Justice- Promoting the distribution of happiness
Beneficence – A duty to improve the condition of others Self-improvement.

Despite criticisms of lists and the absolutist nature of deontology it has strong contemporary resonance. The general medical council has a list of "duties of a doctor".[9]

Make the care of your patient your first concern
Protect and promote the health of patients and the public
Provide a good standard of practice and care
Treat patients as individuals and respect their dignity
Work in partnership with patients
Be honest and open and act with integrity.

8. Virtue Ethics

Virtue Ethics has its roots in ancient Greece in the teachings of Plato and Aristotle. Plato discussed four key virtues: wisdom, courage, temperance and justice. Aristotle considered that when people acquire good habits of character, they are better able to regulate their emotions and their reason. Virtue ethicists thus think that right and wrong cannot be defined in terms of pre set moral principles or rules. The distinction is made between right and wrong by being sensitive to situations in a moral sense or expressing fundamentally good or admirable character traits. In virtue ethics, the motives and character of the agent are what

counts. They help us reach morally correct decisions when we are faced with difficult choices.

As a principle for developing good moral characters, being virtuous is appealing. As a means of solving difficult ethical problems though it seems to have some disadvantages. How do we determine what is the "right" sort of character and how does just having the right sort of character ensure a correct decision? Similarly how do we distinguish or rank differing virtues. Perhaps as an ethical model it says more about the psychology of morality than the nature of moral truth.

9. Which model and when?

No one model can provide a solution to all ethical dilemmas and it would be surprising it were so. Kantianism seems to grate against human psychology, utilitarianism may be too demanding, virtue ethics a bit fuzzy and the four principles may seem a little too simplistic. They all have their shortcomings. We may though make a broad distinction between macro ethical problems such as resource allocation across society and choices as to what treatment is best for a given disease and the micro ethics of dealing with patients on an individual level. Healthcare in general has a strong utilitarian basis as described above. Optimising which treatment for sepsis involves pooling data and producing a population based recommendation. That recommendation may not be valid for an individual, indeed we cannot be certain that any treatment will work definitely for a given individual, but we know we can maximise the outcome for a group. At the micro level whilst, a degree of maximising outcome occurs the relationship between the doctor or nurse and the patient is more about being "a good person", doing the right thing for him or her. It is perhaps at this level that the four principles come into their own. Using medical ethics helps us formally conceptualise what are often complex issues. The varying models give us tools to explain the moral reasoning behind our analyses and decision-making process.

Conflict of interest

None.

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