Chapter Two

Professional Codes and Ethical Theories

1 Professional Codes

Health professionals have long been concerned with ethical issues arising in practice, and they have developed statements of key ethical principles as guides in making decisions in professional practice. This chapter begins by looking at one of the oldest and most influential of the medical codes.

1.1 The Hippocratic Oath

The following version of the Hippocratic Oath is taken from Owsei Temkin and C. Lillian Temkin (1967, 6).

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

2. 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 to no one else.

3. 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.

4. I will neither give a deadly drug to anybody if 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.

5. 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.

6. 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.
7. 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.

8. If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored 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.

1.1.1 Self-Test  The following self-test can help explore how well you understand the Oath and some of its implications for concrete issues. The answers, with some explanation, are in the following section, but do not consult them until you have grappled with the self-test.

**True/False Questions**

1. True/False  The Hippocratic Oath is an ancient Egyptian document.

2. True/False  In the Hippocratic Oath, a physician promises never to perform an abortion.

3. True/False  It is a violation of the Hippocratic Oath for medical school faculty to accept salaries.

4. True/False  The Hippocratic Oath is a pagan pledge.

5. True/False  In the Hippocratic Oath, a physician promises to keep information about patients in confidence unless disclosure of this information is required by law.

6. True/False  In the Hippocratic Oath, a physician promises never to perform surgery.

7. True/False  In the Hippocratic Oath, a physician promises never to have sexual relations with patients.

8. True/False  In the Hippocratic Oath, a physician promises never to administer any drug that has potentially lethal effects.

9. True/False  The Hippocratic Oath implies that treatment might be forced upon patients if they unwisely refuse to consent to it.

10. True/False  The Hippocratic Oath forbids homosexual practices by physicians.

11. True/False  The Hippocratic Oath condones the institution of slavery.

12. True/False  The Hippocratic Oath states that a physician may choose whom to serve as patients.
Multiple-Choice Questions

A. You are a medical student. Your physiology professor is a nice guy—for example, he regularly goes to the local pub with his students on Friday afternoons. The only problem is that he never has any money on these occasions, so the students must always pick up the check. He always promises to pay the students back but to date has made no move to do so. What should you and your fellow students do about this?

   a. Confront him about this annoying practice, pointing out that he promised (when he took the Hippocratic Oath) to conduct his life, as well as his art, in "purity and holiness."

   b. Choose another pub to frequent, without telling him where you will be. This kind of freeloader you can best do without.

   c. Resolve to keep picking up the check for his drinks. After all, the code requires that you will give your teachers a share of your money when they are in need.

   d. Confront him and tell him honestly that you find this practice annoying. The code requires, after all, that you "deal honestly with colleagues."

Answer the remaining questions as if you were the physician involved in the case.

B. Mrs. V. brought her young granddaughter along when she came for her appointment. You notice bruises on the child’s neck that seem very likely the result of child abuse. What (if anything) should you do?

   a. Ignore what you have seen, since the requirement of confidentiality forbids you from reporting this to anyone even if you had proof to back up your suspicions.

   b. Report your suspicions to the authorities, since you are required by law to report anything you observe "which is of such a nature as to reasonably indicate that it has been caused by brutality, abuse, or neglect."

   c. Point out the bruises to the grandmother and give her a chance to explain them before you decide whether to report them to the authorities.

   d. The code offers no guidance on this matter.
C. A patient in the final stages of a terminal illness tells you openly that he plans to kill himself by taking a deliberate overdose of a certain one of his medicines. You realize that this amount of this medicine will not kill him, but he would succeed if he took the rest of the bottle of another of the drugs he is on. What (if anything) should you do?
   a. Inform him that the other drug would be effective in achieving his purpose, since you owe your primary loyalty to helping the patient carry out choices he has made.
   b. Actively intervene to prevent the patient from attempting to kill himself, since the life of your patient is your first concern.
   c. The code forbids you from informing him that the other drug would be effective in ending his life.
   d. The code offers no guidance on this matter.

D. You have been treating Mr. Z. for two years in your office for severe back and leg pain that you have diagnosed as sciatica. You learn by chance that recently Mr. Z. slipped and fell while getting out of a taxicab, and, claiming he never had a backache for a day in his life before the accident, he is suing the cabdriver for injuries. What (if anything) should you do?
   a. Do not report your experience with this patient to the cabdriver’s lawyer, since doing so would violate the patient’s confidentiality.
   b. Report your experience with this patient to the cabdriver’s lawyer, since Mr. Z. is suing him unjustly and you have pledged to protect against injustice.
   c. Make no contact with the cabdriver’s lawyer, but be prepared to testify if they learn that you have been treating Mr. Z. in the past. At that point, you will be required by law to reveal information about treatment.
   d. The code offers no guidance on this matter.

E. From a friend at a party you learn that a physician in your community is doing a flourishing business administering vitamin shots, at high prices, for all sorts of maladies ranging from colds to “tiredness” to more serious illnesses. What (if anything) should you do?
   a. Expose this improper practice and have the physician reprimanded, since you have pledged to promote the honor of the profession.
   b. The code forbids you to intervene in any way, since this friend is not a patient of yours.
c. The code forbids you to say anything to your friend about the inappropriateness of this treatment, since you must preserve confidentiality toward the other physician.

d. The code offers no guidance on this matter.

1.1.2 Answers

1. **False.** The Oath is ancient, dating from about the fourth century B.C. However, it was *not* Egyptian in origin. It comes from ancient Greece. It was probably not written by Hippocrates himself (although he was the founder of the school from which it derives). [See Temkin and Temkin (1967) and Reich (1978), "Codes of Medical Ethics."] The Oath was not initially acknowledged by all physicians. The Hippocratic school was only one of several "schools" of physicians in Greece at the time, and the Oath was not accepted by the other schools.

2. **True.** This is one of several surprising provisions of the Oath, given the historical context in which it was written. Abortion was not generally frowned upon in Greek culture (although the primitive nature of the methods available made it dangerous to the mother). Not only was abortion available, but many Greeks practiced infanticide, exposing babies to die if they were born with defects. (There was a strong cultural ideal of having one's firstborn child to be a son; as a result, being *female* was considered a defect in the firstborn child and thus was sufficient reason for exposure.) Suicide was also accepted with approval by many Greek citizens and thinkers.

3. **False.** The provision this relates to is the promise to teach the art of medicine "without fee or covenant," but it applies only to the *offspring of one's teachers*. Other students are required to sign the covenant (i.e., the first paragraph of the Oath), and presumably they may be required to pay a fee for instruction as well. The only application this provision could have to present-day medical education might be to forbid charging tuition for the children of faculty members.

4. **True.** If by "pagan" is meant "non-Christian," then it surely is a pagan pledge. The deities invoked are those of the Greek pantheon. This element of the Oath was a source of discomfort to early Christian physicians who rediscovered it several centuries after it was written. In the second century A.D., one early Father of the Christian Church changed this reference in the Oath and retitled it "The Hippocratic Oath Insofar as a Christian May Swear To It."
5. *False.* This is a "trick" question. The statement of the principle of confidentiality in the question comes not from the Hippocratic Oath, but from Section 9 of the 1957 AMA Principles of Medical Ethics. The confidentiality provision in the Oath is stronger than this. It mentions no exception for legal reporting requirements or the like, stating categorically that "I will keep to myself" confidential information about patients.

One basis for tempering the strength of the Oath's confidentiality principle is its application only to that "which on no account one must spread abroad." However, it is left to the discretion of the individual physician to determine what falls inside this scope, so it would still not mandate revealing information just because the law requires it.

6. *True.* This provision (paragraph 5) must be an embarrassment to those medical students who take this Oath at their graduation ceremonies just prior to reporting for a residency training program in surgery. The origin of this provision is a mystery to scholars. Surgery was hazardous in the fourth century B.C. but was performed in desperate cases; some physicians of the Hippocratic School are even on record as having performed surgeries. There was no sharp division between internal medicine physicians and surgeons in Greek culture (as there is in British medicine, for example). Several explanations for this provision have been debated, but it may be most satisfactory to accept it as an idiosyncrasy of its authors—one of several ways in which the Hippocratic Oath is a product of its time and place and may need to be revised to provide a satisfactory basis for contemporary medical practice.

7. *True.* This is the clear implication of paragraph 6 of the Oath. The issue of sexual relationships with patients has received much attention in recent years, especially in the psychiatric community. Some psychiatrists today defend the sexual liaison as a therapeutic tool, but most medical groups agree with the strong provision of the Hippocratic Oath on this topic.

8. *False.* The pledge is made (in paragraph 4 of the Oath) not to give "a deadly drug," but this is most plausibly interpreted to refer only to drugs *designed* to produce death (e.g., poisons). Any drug has the potential of lethal side effects (at least in the rare patient who is sensitive to the particular substance contained in the drug), but the Oath's provision was not meant to rule out treatment by drugs altogether. (NOTE: This distinction between "direct effects" and "side effects" will appear again later in the book. It is central to a principle known as "the doctrine of the double effect," an important doctrine of Roman Catholic moral theology with implications for abortion, euthanasia, and other issues discussed below. For further discussion of the principle see Appendix I, Section 2.1.3.)
9. True. This may be put a bit strongly, but the Oath clearly makes no provision for seeking informed consent from patients prior to treatment. The physician pledges to apply therapies "in accordance with my ability and judgment," not in terms of the patient's judgment or preferences.

This paternalistic orientation becomes even clearer with the next sentence of the Oath (especially in light of scholarly comments based on a study of the references to it in other parts of the Hippocratic Corpus). The "harm and injustice" refers to harms the patient might bring upon themselves through improper diet and life-style, not to things others might do to the patient.

10. False. Homosexuality was practiced openly in Greek culture, and the Hippocratic Oath does not demand any especially restrictive sexual ethics in general for physicians. What it does rule out (in paragraph 6) is sexual relations of any type with one's patients or members of patients' households.

11. False. The reference to slaves in paragraph 6 might constitute a tacit endorsement of the institution. However, the content of the reference suggests a quiet opposition to slavery. Virtually every society that has had an institution of slavery has had a "double standard," in which sexual exploitation of slaves was acceptable. Thus, by applying the same standards against sexual exploitation of both slaves and free persons, the Hippocratic medical community plants seeds of doubt about the institution of slavery.

12. False. This is another "trick" question. This provision is found in Section 5 of the 1957 AMA Principles, not in the Hippocratic Oath.

A. It looks as though you are stuck with the check, according to the Hippocratic Oath. Confronting him about his annoying habit (option a or d) would hardly be consistent with the demand to treat one's teachers as "equal to my parents," especially considering the deference with which Greek sons and daughters were expected to treat their parents. The quote in option d is not from the Hippocratic Oath.

B. As pointed out by question 5, the Hippocratic Oath does not recognize a legal demand to reveal information as sufficient basis for abridging confidentiality, so option b is ruled out. (The phrase quoted in this option is from the Tennessee statute requiring reporting of suspected child abuse.)

The Oath forbids the physician from reporting confidential information gained "in the course of treatment or even outside of treatment" (as specified by option a). However, nothing in the Oath forbids the physician
from making inquiries of the patient, or (if suspicions of abuse are strengthened on the basis of the grandmother’s answers) even initiating counseling with the patient. This in no way is a violation of confidentiality; and indeed, it might be seen as a laudable attempt to “keep [one’s patients] from harm and injustice.”

C. c. Paragraph 4 of the Oath clearly implies this option. On option a, see the comments on true/false question 9. The Hippocratic Oath recognizes no loyalty to patient self-determination, but only to the patient’s best interests as determined by the physician.

The Oath might require active intervention to prevent the patient from carrying out his plan (option b) if this were judged to be an instance of “harm and injustice.” The issue of classifying and evaluating patients’ requests will be discussed at length in Chapter 4.

D. a. This falls within the province of confidentiality, which is inviolable. The attempt to justify an abridgment of confidentiality on ground of “protecting against injustice” (option b) will not do, since this principle applies to injustices patients do to themselves, not those they do to others. The Oath makes no allowance for legal demands to reveal information (option c).

E. d. The phraseology in option a is taken from the 1957 AMA Principles. The Oath does not demand that practitioners monitor the practices of their colleagues. It does provide for a duty to uphold the honor of the profession in two ways: 1) by upholding the highest standards in one’s own practice and 2) by developing a sense of “brotherhood” with other members of the profession.

Confidentiality governs only information gained in connection with relationships with patients, not those with other physicians, so you would not be forbidden from expressing your view on this form of treatment to your friend (option c). Nor would you be forbidden to discuss this with your friend merely because she is not your patient (option b). However, although it would permit such discussions, nothing in the Oath implies that it is the physician’s duty to warn persons of the improper practices of fellow professionals.
1.2 AMA Principles of Medical Ethics

The Hippocratic Oath is centuries old. The process of formulating codes of ethics, however, continues. As recently as 1980 the American Medical Association adopted a new code, presented below. (Compare this to the 1957 version of the AMA Principles, which can be found many places, including the Appendix in Volume 4 of The Encyclopedia of Bioethics.)

American Medical Association
PRINCIPLES OF MEDICAL ETHICS (1980)

PREAMBLE: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community. (Judicial Council of the AMA 1984, ix)
1.2.1 Self-Test

True/False Questions

1. True/False Principles of medical ethics are developed primarily to uphold the dignity and honor of the profession.

2. True/False A physician has a special responsibility to seek changes in laws or other requirements contrary to the best interests of the patient.

3. True/False The Principles expressly prohibit receiving a commission for the referral of patients.

4. True/False A physician who considers responsibilities to self is unethical, for all that counts ethically is the duty to patients.

5. True/False The Principles explicitly acknowledge that other health professionals have rights the physician must respect.

6. True/False The Principles explicitly prohibit secret, proprietary remedies.

7. True/False A physician should never tell a patient an outright lie, not even when anything other than a lie would undoubtedly cause the patient to refuse the recommended treatment.

8. True/False The Principles explicitly acknowledge that a physician shall be free to choose whom to serve.

9. True/False A physician shall reveal confidential information whenever it becomes necessary in order to protect the welfare of the community.

10. True/False A physician has no responsibility to be active in politics.

11. True/False A physician has a duty to use the talents of other health professionals whenever the patient requests it.

12. True/False A physician has a responsibility to inform patients about the latest medical advances relating to their condition.

13. True/False A physician should respect the right of society to arrange the environment in which medical services are provided.

14. True/False A physician has no responsibility to society beyond rendering competent medical service to the patient.

15. True/False Claims of "patients' rights" are not given any acknowledgment in the Principles.
**Multiple-Choice Questions**  From the multiple-choice questions in the self-test on the Hippocratic Oath, choose the option implied by the 1980 AMA Principles.

1) In which cases would the 1980 code lead to a different choice than the Oath?
2) In what cases would it lead one to choose the same action but for a different reason? 3) In each case in which there is a difference between the two codes, which do you think is more satisfactory as an ethical guide?

1.2.2 Answers

1. *False.* The Preamble to the Principles states their primary purpose as "for the benefit of the patient."

2. *True.* Section III states this responsibility explicitly.

3. *False.* This is not *stated* in the Principles, as it was in Section 7 of the 1957 version. However, it may still be implied in provisions such as that in Section II, which requires the physician to "deal honestly with patients."

4. *False.* The Preamble acknowledges the propriety of recognizing responsibility to self. Ethics need not be *totally* selfless.

5. *True.* Section IV states this explicitly, although it does not delineate what these rights are.

6. *True.* The duty to "make relevant information available to patients, colleagues, and the public" (Section V) amounts to a prohibition on secret remedies.

7. *True.* Section II of the Principles says: "A physician shall deal honestly with patients." Chapter 1 described the Judicial Council's interpretation that this rules out lying.

8. *True.* This is explicitly stated in Section VI. The only acknowledged exception to this freedom is in emergency situations when no time for "choosiness" is available.

9. *False.* The stated exception to the principle of confidentiality comes from the 1957 form of the Principles. The 1980 form acknowledges only one exception: "the constraints of the law" (Section IV). Presumably this means the physician will reveal information whenever required to do so by law.

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1. Interpreting the Principles and applying them to specific situations is delegated to a five-member body of the AMA known as the Judicial Council. Key policy statements drafted by this body are contained in a booklet entitled *Current Opinions.* Quotations from this body of professional ethical thinking are found throughout this text. With regard to the present question, the Judicial Council considers a commission for referral to be prohibited. [See *Current Opinions*, Section 6.03: "Fee Splitting" (Judicial Council 1984).]
10. False. Both Sections III and VII entail such a responsibility. The only effective means "to seek changes in those requirements which are contrary to the best interests of the patient" is through the political process, the most direct means to "contribute to an improved community" in many situations.

11. False. The obligation is to make use of such talents "when indicated" (Section V). Thus the physician must evaluate the medical indications underlying the patient's request before deciding whether to comply with it.

12. False. Here again, the responsibility is to "make relevant information available to patients" (Section V). But some recent medical advances may not offer promise for this particular patient, even if they do relate to the patient's general condition. Clinical discretion and judgment are required to decide what information to share and how to impart it.

13. False. In Section VI the Principles insist that the physician shall "be free to choose . . . the environment in which to provide medical services."

14. False. Additional responsibilities are described throughout the Principles, especially in the Preamble and Sections III, V, and VII.

15. False. Section IV acknowledges "the rights of patients," although the content of these rights is not specified. This is the first time a professional code claims the responsibility of honoring the rights of clientele.

A. d. Section II contains the phrase quoted in this option. There is nothing in this code to rule out the harsher action of option b, nor to demand the generosity of option c, so both of these would be permissible. The appeal of option a is to the Hippocratic Oath, so it would also not be available here.

B. b. Section IV of the Principles clearly indicates that confidentiality should be abridged when required by law, and the law in many states (as in Tennessee, whose statute is quoted in this item) requires reporting indications of child abuse.

If there is genuine ambiguity about the nature of the bruises, it might be proper to offer the grandmother a chance to explain how they occurred (option c): but unless her explanation is compelling enough to remove any "reasonable indication" of child abuse, you must report your suspicions to the appropriate authorities. The law does not give physicians the authority to make a final determination as to whether child abuse has occurred. This authority is delegated to child protective services agencies.

C. a. This is a controversial answer that can be supported with reference to the 1980 Principles. Several sections can be interpreted in a way that leads to this conclusion, although in each case the interpretation may be challenged. Section I of the Principles speaks of showing "respect for human dignity"; this can be taken to include helping the patient carry out a
considered choice. (This issue is discussed at length in Chapter 4.) Section II is also relevant here: to "deal honestly with patients" would surely include providing information of this nature. (Truth telling is dealt with at length in Chapter 1). Section V speaks of a duty to "make relevant information available to patients," and this can be interpreted as requiring the physician to provide the information about the other drug, since that is relevant to the patient's considered choice.

D. c. The only grounds specified for revealing confidential information is when it is required by law, so it would be improper to reveal anything to the lawyer now, as option b suggests. It may be frustrating to stand helplessly and watch an obvious injustice occur, but the principle of confidentiality stated here offers no alternative as long as there is no legal requirement that applies to the situation. However, if the cabdriver's lawyer should happen to find out that you had treated Mr. Z. and called you to testify, then you would be expected to reveal the information.

E. a. Section II clearly imposes a duty to expose these practices. It is advisable, however, to investigate this friend's charges further before taking drastic action with regard to them.

1.3 American College of Physicians Ethics Manual

A committee appointed by the American College of Physicians (ACP) developed an Ethics Manual in 1984. Too extensive to reproduce here, it can be found in the *Annals of Internal Medicine* (American College of Physicians 1984b). The Manual is also available in booklet form from the American College of Physicians (1984a).

The following questions analyze this code in the same way the previous ones did the other codes. Use the Manual if possible. Otherwise, speculate about the answers and read the "'Answer'" section, which contains extensive quotations from the Manual.²

1.3.1 Self-Test

*True/False Questions*

1. *True/False* In the last analysis, the patient, not the physician, determines what medical treatment is right for him.

2. *True/False* A physician who refers patients for participation in clinical investigations need not independently assess whether the

² For the reader's convenience, quotations from the Manual will be followed by page citations from both the original booklet [ACP 1984a *(Manual)*] and from *Annals of Internal Medicine* [1984b *(Annals)*].
study provides adequate protection of human subjects. This is the responsibility of the institutional review board.

3. True/False A physician’s assessment of a patient’s quality of life should never figure in clinical decisions.

4. True/False The patient’s diagnosis, prognosis, or treatment should not be discussed with the patient’s family without the patient’s express consent.

5. True/False A physician ought to keep information about patients in confidence unless its disclosure is required by law.

6. True/False It may be ethically proper to continue to support the body, even when clinical death of the brain has occurred.

7. True/False When families oppose decisions to withhold supportive therapy for religious or other reasons, their wishes should be followed.

8. True/False Resuscitation should be initiated when—and only when—there is a prospect of restoring the patient to a state of reasonable comfort and function.

9. True/False Active voluntary euthanasia is never ethically justified.

10. True/False When a patient faces a terminal event, the decision to resuscitate should be made by the patient himself.

11. True/False A physician is not free to choose which patients he will serve if no other physician is available, as in some isolated communities.

12. True/False Even if a patient indicates he prefers to have his physician make all the decisions, the physician should persist in efforts to keep the patient informed of what is being done.

13. True/False If the patient elects to try a nonscientific remedy, the physician is ethically justified in severing all relationship with him.

14. True/False Society has a right to control and regulate professional activities according to its own best interests.

15. True/False Delegation of treatment or technical procedures to non-physician practitioners relieves the physician of ultimate responsibility for these aspects of the patient’s management, since these professionals are independently licensed and regulated by the state.
Multiple-Choice Questions  From the multiple-choice questions in the self-test on the Hippocratic Oath, choose the option that is implied by the ACP Ethics Manual. 1) In which cases would the ACP Manual lead to a different choice than the Oath? 2) In what cases would it lead to a different choice than the 1980 AMA Principles of Medical Ethics? 3) In what cases would it lead one to choose the same action as one or both of these codes, but for a different reason? 4) In each case in which there is a difference between any two of the codes, comment on which you think is more satisfactory as an ethical guide.

1.3.2 Answers  In connection with these answers, relevant sections of the Manual are quoted with the key statements in italics (all emphasis added).

1. True.

Patient Autonomy

Each patient is a free agent entitled to full explanation and full decision-making authority with regard to his medical care. John Stuart Mill expressed it as: "Over himself, his own body and mind, the individual is sovereign." The legal counterpart of patient autonomy is self-determination. Both principles deny legitimacy to paternalism by stating unequivocally that, in the last analysis, the patient determines what is right for him. Because physicians invest so much in acquiring the necessary knowledge for making the best diagnostic/therapeutic decisions, it is often difficult for them to accept the fact that what is the "best" decision for a particular patient (in the opinion of the patient) may not be the "right" decision for the patient (in the opinion of the physician). [ACP 1984a (Manual), 25–26; 1984b (Annals), 264]

2. False.

Clinical Investigation

... the premise on which all ethical research is based is mutual trust and respect between research subjects and physicians. This premise requires that physician-investigators involved in designing or carrying out research plans, or both, have primary concern for the potential subjects of these investigations. Also, those physicians who refer patients for such studies must be satisfied that the research plans provide adequate protection of human subjects.

... Physicians referring their patients for participation must satisfy themselves that the research plans provide for informed consent, adequate assurance of safety, and an acceptably low risk/benefit ratio.

... Further, in drug trials, physicians must feel free to advise their patients to withdraw from the trial and return to a standard mode of therapy or additional treatment, if such actions seem indicated." [ACP 1984a (Manual), 22–23; 1984b (Annals), 263–264]
3. False.

Quality of Life

Quality of life is the subjective satisfaction expressed or experienced by an individual with his current physical, mental or social situation. *Assessment by a physician of a patient’s quality of life can feature prominently in making clinical decisions.* It is wise for physicians to be aware of the personal and subjective values that may contribute to such evaluations. Thus, the assessment may vary according to a physician’s age, present health, history of personal illness, cultural background, and long-standing knowledge of the patient as a person. Clinical decisions that hinge on assessing the quality of life should be undertaken with great care and with full cognizance of the subjectivity of the assessment, with full patient participation, or, if that is not possible, with participation of knowledgeable and concerned relatives or guardian. Under ordinary circumstances, a physician’s judgment about the quality of life of a patient should not be unilateral. [ACP 1984a (Manual), 26; 1984b (Annals) 264–265]

4. True.

Care of the Hopelessly Ill

...The problem should not be discussed with his family unless the patient authorizes such a discussion.

...Physicians should not breach the confidential nature of the physician/patient relationship by discussing the patient’s care with persons who are not authorized by the patient to be made aware of the patient’s diagnosis, prognosis, or treatment. [ACP 1984a (Manual), 28; 1984b (Annals), 265]

5. False.

Confidentiality

The patient’s right to confidentiality of his medical record is a fundamental tenet of medical care. The physician must keep secret all that he knows about the patient and release no information without the patient’s consent, unless required by the law or unless resulting harm to others outweighs his duty to the patient. If the physician thinks that his commitment to the patient’s welfare overrides his duty to obey a court order, he may ethically refuse to give to the courts information not released by the patient but must be prepared to accept the legal consequences of his actions. [ACP 1984a (Manual), 9; 1984b (Annals), 132]

6. True.

Care of the Hopelessly Ill

The physician has a responsibility to ensure that his hopelessly ill patient dies with dignity and with as little suffering as possible. The preference of the patient in regard to use of life-support measures should be given the highest priority. *There may be circumstances in which the physician may elect to support the body when*
clinical death of the brain has occurred, but there is no ethical standard that dictates he must prolong physical viability in such a patient by unusual or heroic means. [ACP 1984a (Manual), 26–27; 1984b (Annals), 265]

7. False.

Care of the Hopelessly Ill

If the patient's preference is contrary to the desires of his spouse or others, the latter have no legal, ethical, or moral standing to enforce their desires unless a court declares the patient to be legally incompetent and appoints a guardian to make treatment decisions for the patient.

When a do-not-resuscitate order has been written the physician must ensure that the patient is as comfortable as possible. A decision to withhold supportive therapy, while ethically sound, may not be acceptable to some families for religious or other reasons. Their wishes must be considered but not necessarily followed. The physician must be the final arbiter in decisions related to a patient, placing the wishes of the patient above all other considerations. [ACP 1984a (Manual), 28–29; 1984b (Annals), 265–266]

8. True.

Care of the Hopelessly Ill

Having reviewed the data on the clinical status of the patient, the physician must make a judgment as to whether any known treatment can restore the patient to a state of reasonable comfort and function. When treatment is judged useless, writing or giving a verbal order not to resuscitate such a patient is ethical.

A corollary observation: If a physician decides that the disease process or other medical condition that the patient has would not positively be affected by the initiation of resuscitative efforts—in other words, if resuscitative efforts would only prolong the dying process—then a decision to write a do-not-resuscitate order is ethically proper. [ACP 1984a (Manual), 27–28; 1984b (Annals), 265]


Care of the Hopelessly Ill

Euthanasia: Active voluntary euthanasia is legally prohibited. However, euthanasia is a classic ethical dilemma that occurs when the ethical responsibility of the physician to preserve life, maintain the quality of life, or both, conflicts with his covenant with the patient who desires an end to pain and suffering that he considers no longer endurable or when immediate family members request termination of life for patients who are comatose or otherwise unable to exercise intellectual control.

The social, religious, and political implications of euthanasia have been discussed exhaustively. They remain controversial and will not be discussed here. While there is no resolution of the problem on ethical grounds, there are major legal prohibitions against euthanasia in the United States today. [ACP 1984a (Manual), 30; 1984b (Annals), 266]
10. True.

Care of the Hopelessly Ill

If the patient is a mentally competent adult, he has the legal right to accept or refuse any form of treatment, and his wishes must be recognized and honored by his physician. He can decide whether he wishes to be resuscitated when faced with a terminal event. [ACP 1984a (Manual), 28; 1984b (Annals), 265]

11. True.

A physician is free to accept or refuse to see a patient unless:
1) no other physician is available, as in some isolated communities;
2) emergency treatment is required under which circumstances the physician is morally bound to provide care, and, if necessary, to arrange for proper follow-up; and
3) the patient and the physician are assigned to each other under a closed-system arrangement. [ACP 1984a (Manual), 8; 1984b (Annals), 132]

12. True.

Informed Consent

Despite our best efforts genuine informed consent may elude us. Physician bias may be difficult to erase. There may be misunderstandings on both sides; scientific medical words often have different meanings to the patient and to the physician, and patients may use folk medical terms unintelligible to physicians. The complexities of the illness may be beyond the patient’s comprehension, or he may be too frightened or sick to make a responsible decision. Also, some patients prefer to have their physicians make all the decisions. Under these circumstances the physician must assume responsibility for the patient’s welfare and proceed to do what he thinks is best for the patient, but always in terms of what he thinks the patient would want for himself. The physician should persist in his efforts to keep the patient informed about what is being done. [ACP 1984a (Manual), 11–12; 1984b (Annals), 133]

13. False.

The Physician and Non-Scientific Medical Systems

Requests by patients for care outside the orthodox medical system pit the physician’s commitment to provide optimal medical care against the patient’s acknowledged right to choose what care he will get and from whom. Such a request warrants the physician’s considerate attention. Before advising a patient the physician should determine the reason for the change: dissatisfaction with current care or merely inducement by claims for the non-scientific treatment. Next, the physician should be sure that the patient understands, in the spirit of informed consent, his condition, treatment, and outlook. He and the patient can then discuss realistically and dispassionately what the patient can expect from the two methods of care. The physician should not abandon the patient if he should
elect to try a non-scientific remedy and should accept his decision with grace and compassion. The physician should not participate in such treatment. [ACP 1984a (Manual), 14–15; 1984b (Annals), 134]

14. False.

The Physician and Society

. . . Society has a vested interest in the professional activities of physicians and others in the health care field and will seek to control and regulate such professional activities to its own best interests as it perceives them. Society has conferred great authority on medicine in the belief that physicians will use such power for the benefit of patients. Society has the right to require that physicians be competent and knowledgeable and that they practice with consideration for the patient as a person. [ACP 1984a (Manual), 18; 1984b (Annals), 135–136]

15. False.

The Relationship of the Physician to Other Health Professionals

The interests of the patient have primacy in all aspects of the patient-physician relationship. The physician should act as an advocate and coordinator of care for his patient and should assume appropriate responsibility, especially when utilizing the help of other health professionals. The physician should deal only with competent health professionals when sharing the care of the patient. Delegation of treatment or technical procedures must be limited to persons who are known to be competent to conduct them with skill and thoughtfulness; the physician who is primarily in charge of the patient's care must retain ultimate responsibility for all aspects of the patient's management. Society has identified the physician as possessing the necessary training to undertake this responsibility and has granted a specific license to exercise this authority and responsibility. This relationship is implied between patient and physician. [ACP 1984a (Manual), 19; 1984b (Annals), 136]

A. b. Unlike the Hippocratic oath (from which the quote in c is taken), the ACP Ethics Manual has no special demand for respect for one's teachers. Unlike the 1980 AMA Code (from which the quote in d is taken), no special duty of honesty toward colleagues is explicitly demanded. Thus, you should act toward this fellow as you would anyone else who engaged in behavior you find objectionable.

B. c.

Medicine and the Law

Disclosure: In several areas of this manual we have discussed the physician's responsibility to the patient vis-a-vis his responsibility to society. The basic premise is that a physician bears primary responsibility to his patient, except in those rare instances in which the societal need heavily outweighs all other considerations. When the law specifies that a physician must inform others concerning an illness or a request for medical help, and such revelations could
cause serious distress or disability to the patient, the situation is even more difficult. If the problem cannot be resolved by convincing the patient about the advisability of complying with the law, the physician must make a very difficult choice; he must decide if he is willing to violate the law for the sake of his covenant with the patient or make the decision to obey the law and jeopardize the trust of the patient. Either course of action carries significant consequences. [ACP 1984a (Manual), 31–32; 1984b (Annals), 267]

C.  
   a. See the passage quoted under true/false question 1 for the weight given to patient autonomy in this code.

D.  
   b or c. See the passages quoted under true/false question 5 and multiple-choice question B. The choice between b and c hinges on your judgment of the relative weights of the moral factors.

E.  
   a.

Inadequate or Incompetent Colleague

It is unethical and harmful to the entire process of medical care for a physician to disparage for malicious reasons the professional skill, knowledge, qualifications, or services of another physician or to imply by word, gesture, or deed that a patient has been poorly managed or mistreated by a colleague. Use of such improper disparagement as a means of inducing a person to become one's patient is unethical. Care to avoid such improper inducement is especially necessary for the physician who has been called into consultation by another physician.

Of equal importance, it is unethical for a physician not to disclose fraud, professional misconduct, incompetence, or abandonment of a patient by another physician. The trust invested in physicians by patients and the public requires such disclosure to appropriate authorities. [ACP 1984a (Manual), 16–17; 1984b (Annals), 135]

1.4 Limitations of Professional Codes

Examination of these three medical codes reveals their limitations as guides to decision making in professional practice. Codes can be a helpful starting point in decision, and these shall be cited throughout this book. They are not, however, sufficient by themselves to guide decision. There are a number of difficulties.

1.4.1 Conflicts Between Codes   In the case involving suspected child abuse, different codes may yield conflicting directives. The Hippocratic Oath regards confidentiality as important enough to forbid revealing this information, even if society has determined it has a compelling need to know this sort of information and has established a legal reporting requirement. The 1980 AMA Principles, on the other hand, place the obligation to obey the law above the principle of confidentiality. The ACP Ethics Manual differs from both of the others, allowing both for revealing information not required by law (when required by a compelling social purpose) and refusal to reveal information that the law requires (on
occasions in which loyalty to one’s patient is judged more important than honoring the law). Which of these codes is one to follow?

1.4.2 Conflicts Within Codes There are similar conflicts between provisions of the same code. For example, the 1980 AMA Principles contains injunctions to ‘‘deal honestly with patients’’ (Section II) and to show ‘‘compassion’’ (Section I). But what does this say about a situation in which the physician judges that to tell a patient the truth about his diagnosis would be an act of cruelty? Should one be honest and compromise the standard of compassion, or be compassionate and compromise the standard of honesty? (This issue is discussed at length in Chapter 1.) The code leaves one caught in its conflict.

1.4.3 Vague Provisions Sometimes provisions in a code require interpretation before they can be applied to a situation. Consider, for example, the Hippocratic Oath prohibition against ‘‘giving any deadly drug.’’ What counts as a ‘‘deadly drug’’ for purposes of this provision: any medicine with potentially lethal effects (which would include virtually all chemical substances), or only one whose primary and intended purpose is to kill (i.e., a poison)? Even more vague is the phrase in the Oath’s confidentiality provision specifying that the physician ought to protect those pieces of information ‘‘which on no account one must spread abroad.’’ What does this include, and what does it exclude? Additional interpretation is needed to apply this provision to concrete situations.

The 1980 AMA Principles have similar vague statements. Regarding the question about the suicidal patient, the phrases ‘‘respect for human dignity,’’ ‘‘deal honestly with patients,’’ and ‘‘make relevant information available’’ are all subject to interpretation. The same applies to the provision in Section IV that ‘‘a physician shall respect the rights of patients.’’ What rights? Furthermore, patients may claim many rights that practitioners do not acknowledge as genuine. The code provision does nothing to arbitrate these sorts of disputes.

1.4.4 Unacceptable Implications Sometimes the code provisions are clear, but some physicians may find them unacceptable on moral grounds. The most obvious example is the prohibition on surgery in the Hippocratic Oath. Perhaps that was justified in ancient Greece, when the lack of not only asepsis but also elementary anatomy made surgery a highly dangerous enterprise. But given today’s sophisticated knowledge, skill, and techniques, prohibiting surgery would deprive patients of lifesaving and palliative possibilities.

More controversial are the absolute prohibitions in the Oath against abortion and mercy killing by means of drugs. As discussed in Chapter 4, many have come to conclusions at odds with the Oath. Should these people ignore their convictions and follow the code provision? Or ought the code be regarded as advisory, as a provisional guide to action, to be amended on certain occasions?
The American College of Physicians insists, with regard to diagnoses of terminal illness, that "the problem should not be discussed with his family unless the patient authorizes such a discussion" [ACP 1984a (Manual), 28]. However, some regions of the country and social groups expect a greater degree of openness with the family than is provided for here. The family is regarded in these areas as the unit of intimacy; free exchange of information within the unit is therefore a natural expectation. In this situation a patient would be astonished (and perhaps offended) at being asked his permission to have his medical case discussed with other members of his family; the family might be offended at having information exchange delayed while permission was sought from the patient. Furthermore, this approach may conflict with the practical necessity of talking with the family in order to corroborate the patient's history.

1.4.5 Incompleteness Finally, there are many ethical decisions on which the codes offer no advice at all. The Hippocratic Oath speaks of three sorts of therapies: diet (paragraph 3), drugs (paragraph 4), and surgery (paragraph 5). What of ethical issues arising in connection with radiation therapy? By what standard are they to be resolved? What of the issues posed by the newly developing techniques of genetic manipulation? Nothing in the Oath can guide decisions in these areas in a direct way. (Even the ACP Ethics Manual, though far more up-to-date than the Hippocratic Oath, leaves some questions unanswered—and new questions daily challenge its limits.) Professional codes can be neither the final court of appeal nor the whole basis of decision making in health care practice. Although they are an important tool in deciding what to do (and they are used in other chapters in connection with specific cases and issues), they must be supplemented by more general, fundamental principles of ethical theory. A preliminary examination of these follows.

2 Fundamentals of Ethical Theory

2.1 Ethical Judgments

At least three judgments are associated with ethical issues.

2.1.1 Evaluative Judgments Judgments governing what is worthwhile or valuable to have or to do are evaluative judgments. For example, one might say, "That is a good car because it gets excellent gas mileage" (or "because it is comfortable to drive" or "because it looks pretty"). Or one might say, "A career in medicine is a worthwhile goal because you have the satisfaction of helping people" (or "because you can make lots of money" or "because you will find this sort of work absorbing"). In more general terms, one might judge that "the only
thing that really matters is how much pleasure you get out of life. Even if you learned all there is to know, your life would not be satisfying unless you had lots of enjoyment from your knowledge."

All these are evaluative judgments. They state goals people set in their lives (e.g., career), or they furnish the basis for choices one makes along the way (e.g., car).

2.1.2 Judgments of Moral Obligation These are the judgments that come to mind when one thinks of ethics. They concern the choice of actions to be taken or not in a given situation. One might say, "You really ought to write him a letter. He has written you several times, and you promised to reply if he wrote." Or one might say, "You have a duty to attend the concert. Your sister is performing, and she will be disappointed if you are not present." Or one might speak of "obligations," "rights," "the right thing to do," "what one should do," etc.

These are obligation judgments. They embody insights about the proper choice and basis of choice of actions or omissions.

One set of obligation judgments is often singled out for special attention: claims of rights. As shown later in this chapter, rights claims have some special features. For one thing, the demand for action falls not on the person who possesses the right, but on the party or parties against whom the right is possessed. For example, if I have a right to be paid five dollars by you on Friday (because I loaned five dollars to you yesterday and you promised to pay me back on Friday), then the duty involved (i.e., to repay me) falls upon you, although I am the one who possesses the right. However, in spite of these distinctive features, it is most plausible to treat rights as a subclass of obligation judgments, since their focus is on the proper choice of actions and omissions.

2.1.3 Character Judgments or Judgments of Moral Evaluation These concern evaluation of persons in their capacity as moral agents and assigning praise and blame to them for what they have done or have failed to do. Evaluations of agents' motives and character are central to these judgments. One might say, "I think he is reprehensible for having done that." Or one might say, "I admire her for having the courage to do a thing like that."

Character judgments embody insights about the kind of person one ought to be, the kinds of motives one ought to develop, and the kind of character one ought to cultivate.

2.1.4 Self-Test Examine each passage below and indicate whether it expresses an evaluative judgment (E), an obligation judgment (O), or a character judgment (C).

1. E/O/C "A jug of wine, a loaf of bread—and Thou beside me singing in the wilderness. Oh, Wilderness were Paradise enow!" (Omar Khayyam, Rubaiyat)
2. *E/O/C* "Brutus was an honorable man." (William Shakespeare, *The Tragedy of Julius Caesar*)


4. *E/O/C* "Is life so dear, or peace so sweet, as to be purchased at the price of chains and slavery? Forbid it, Almighty God! I know not what course others may take, but as for me, give me liberty or give me death!" (Nathan Hale)

5. *E/O/C* "I should not hold it desirable that either a man or a woman should enter upon the serious business of a marriage intended to lead to children without having had previous sexual experience." (Bertrand Russell, *Marriage and Morals*)

6. *E/O/C* "Man must live for his own sake, neither sacrificing himself to others nor sacrificing others to himself." (Ayn Rand)

7. *E/O/C* "Everyone who receives the protection of society owes a return for the benefit, and the fact of living in society renders it indispensable that each should be found to observe a certain line of conduct toward the rest." (John Stuart Mill, *On Liberty*)

8. *E/O/C* "It is desirable that in things which do not primarily concern others, individuality should assert itself. Where, not the person's own character, but the traditions or customs of other people are the rule of conduct, there is wanting one of the principal ingredients of human happiness." (Mill, *On Liberty*)

9. *E/O/C* "The sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant." (Mill, *On Liberty*)

10. *E/O/C* "It is not by wearing down into uniformity all that is individual in themselves, but by cultivating it and calling it forth, within the limits imposed by the rights and interests of others, that human beings become a noble and beautiful object of contemplation." (Mill, *On Liberty*).

11. *E/O/C* "A person whose desires and impulses are his own—are the expressions of his own nature, as it has been developed and modified by his own culture—is said to have character. One whose desires and impulses are not his own, has no character, no more than a steam-engine has a character." (Mill, *On Liberty*)
2.1.5 Answers

1. *E.* One's concept of a "paradise" is clearly an evaluative issue. Nothing is said about whether one *ought* to try to attain this state (the obligation issue) or what sort of person one is for regarding this as so important (the character issue).

2. *C.* The moral quality of Brutus' character or achievements is addressed here (by Mark Antony, in the famous funeral oration), not specifics about the rightness or wrongness of any particular actions he took (the obligation issue), nor anything about things he valued or the value he contributed to others (the evaluative issues).

3. *O.* This is a clear case of an obligation judgment. A demand is made that one refrain from certain actions. Preserving the life of others is valuable (the evaluative issue), and a person of high moral character would honor this demand (the character issue). However, although both of these judgments are closely related to the demand being made, they are not directly the subject at issue at this point.

4. *E.* This passage is harder to classify, but its primary thrust insists on the value of liberty. Liberty, Nathan Hale is saying, is more valuable than life itself—something worth dying for, something such that life without it is "not worth living."

5. *E.* The key word in this passage is "desirable," which gives the clue that an evaluative judgment is being made. The author is not claiming any duty or laudable motive or trait of character, but states merely that this would, in his judgment, be a good thing for one to do.

6. *O.* The key word here is "must," which indicates an obligation judgment.

7. *O.* The clue is the word "owes." Things we owe we have the duty to repay.

8. *E.* Key words are "desirable" and "human happiness." Individuality is claimed to be a good thing to develop.

9. *O.* The clues are words less common in obligation contexts than others you have encountered, but they indicate that duty is the subject. The words are "warranted" and "rightfully."

10. *C.* The clue to classification is in the last phrase. The claim that humans can "become a noble and beautiful object of contemplation" involves an evaluation of their moral qualities. [NOTE: Not all value judgments of persons are necessarily character judgments. One may consider persons and relationships with them (e.g., friendship) to be goals worth pursuing—an evaluative judgment.] However, more than that is going on here. The judgment made deals directly with the evaluation of persons from a moral viewpoint.
11. C. The word "character" is the clue that an evaluation of moral qualities is being offered.

2.2 Some Points About Ethical Theory

One way of showing the distinction between these judgments is to recognize that contrasting judgments can be made about an issue. One might say, for example, that a certain action was the best thing you could do (evaluative judgment), and perhaps it was even the right thing to do (obligation judgment), but it was not the admirable thing to do (character judgment). Suppose for example, you notice a wallet fall from a person’s pocket. You go to considerable trouble to return it intact, but analysis of your motives reveals that your reason for doing so was your expectation of a large reward. (The wallet was expensive looking, and you saw the person get into a limousine after dropping it.) You may not be admired for what you did, although everyone would agree that your action was right and good.

Alternatively, one might say that a certain action was the right thing to do (obligation judgment) and an admirable thing to do (character judgment), but it was not the best thing to do (evaluative judgment). This might apply to some of the tragic choices faced daily in medical care. A patient with a terminal illness requests to be kept alive as long as possible, and the health providers comply. The suffering of the patient, family, friends, and caregivers may lead one to say it would have been best for all if the patient had not lingered so long, but honoring the patient’s request seems to be the right thing to do, and the respect for the patient this decision embodies prompts admiration.

Further examples that vary the combinations of these three forms of judgment could be given, but these two should establish that these three types of judgments are distinct.

These three sorts of judgments vary in their strength or weight. The strongest of all these judgments are generally rights claims. If one has a right to some thing, that certain values could be promoted by violating it does not justify overriding that right. For example, if I have a right to be repaid the five dollars you borrowed from me, it is not acceptable for you to explain to me that you found a better use for the money. (See Appendix 1, Section 2.1.1 for discussion of this example.) No clear-cut principles of ranking can be stated, but in general, obligation judgments are the most stringent or weighty. Character-judgments rank next, and evaluative judgments are least weighty.
2.3 Key Concepts

2.3.1 Autonomy

A. Concept of Autonomy  The notion of autonomy or self-determination was central to the discussion of informed consent, information exchange, and confidentiality in Chapter 1. It will be cited frequently in discussions throughout the book, so it is important to appreciate what it involves. The most helpful definition of autonomy comes from Principles of Biomedical Ethics (Beauchamp and Childress 1983, 59–60):

"Autonomy" is a term derived from the Greek autos (self) and nomos (rule, governance, or law) and was first used to refer to self-rule or self-governance in Greek city-states. The most general idea of personal autonomy is still that of self-governance: being one's own person, without constraints either by another's action or by psychological or physical limitations. The autonomous person determines his or her course of action in accordance with a plan chosen by himself or herself. Such a person deliberates about and chooses plans and is capable of acting on the basis of such deliberations, just as a truly independent government is capable of controlling its territories and policies. A person of diminished autonomy, by contrast, is controlled by or highly dependent on others and is in at least some respect incapable of deliberating or acting on the basis of such deliberations.

This definition suggests that autonomy is multifaceted. There are a number of parameters along which autonomy may vary in degree.

Some people have gone further than others in formulating life plans, and the extent of applicability and coherence of sets of life plans may differ. Albert, for example, may have chosen one life goal: to practice medicine. He may be uncertain about or indifferent at present to other life issues, such as whether to marry and have a family. In contrast, Benita may have decided on two goals: medicine and motherhood. This means that, other things being equal, Benita will be more autonomous than Albert with respect to relevant specific choices, since she has two lodestars to guide her deliberations; Albert may face uncertainty. For example, Benita will find the unpredictable hours characteristic of obstetrics a consideration against pursuing this specialty and the regular hours characteristic of pathology an argument in its favor, whereas Albert may have no basis for preference on this choice at present.

This apparent advantage may vanish, however, if there are inherent conflicts between the multiple goals. Thus, someone who has chosen as life goals both 1) to avoid risk and 2) to experience the thrill of death-defying feats will have far less of a basis for deliberation about specific choices than one who has chosen either of these goals without the other.
There also may be variations (even between persons with equivalent sets of life plans) in the degree to which life plans are referred to when specific choices are being made. Thus, for example, Albert will be more autonomous than Benita with regard to choosing college courses if he makes his selections with an eye toward medical school admission requirements and strategies, whereas she chooses largely on the basis of the convenience of the time and place the courses are offered.

Another element of autonomy the definition emphasizes is the matter of acting on the basis of one's deliberations. For example, Albert and Benita may have calculated correctly that high grades in organic chemistry are requisite to achieving their goals of practicing medicine; but if Benita translates this realization into action through hours of diligent study, and Albert spends his evenings at the campus pub lamenting his low scores in the subject, then Benita is in this respect more autonomous than Albert. (Some may object that Albert merely exercised his autonomy differently than Benita. However, given the inconsistency of his choice with his life goal of a career in medicine, Albert's choice amounts to diminution of autonomy on his part. This would be true even if another of his life goals were to enjoy himself as much as possible, since that goal conflicts with his career goal.)

Since "a person's autonomy is his or her independence, self-reliance, and self-contained ability to decide" (Beauchamp and Childress 1979, 56), it is paradoxical to suggest that some elements of autonomy depend on the actions of others; but such is the case. For example, young children may find it difficult (if not impossible) to be autonomous unless their parents provide the opportunity for them to make decisions on their own. The rare, unusually rebellious child may achieve autonomy in some decisions in spite of parental opposition, but this will be the exception.

Another key example, discussed in Chapter 1, is the provision of information to the agent by others, which can greatly affect the agent's autonomy. Information is a central component in the process of deliberation, and thus one will be less effective in applying life goals to a situation if relevant information is lacking. For example, suppose that Carlos and Diane develop end-stage renal failure. If Carlos is never informed of the existence of one possible treatment modality (e.g., kidney transplantation) and Diane is told of all the options, she will be more autonomous than Carlos with respect to this choice, for she will be able to deliberate more effectively about which option is best in terms of her life goals. The same implication about degrees of autonomy applies to other types of information. If Diane is not told about material risks or discomforts of some of the modes of therapy, the effectiveness of her deliberations would be diminished and so would autonomy with respect to the choice.

Mental status may make a difference in degree of autonomy. Two people may be presented with identical information, but mental incapacity (e.g., mental retardation, senility, some forms of mental illness) may make one of them incapable of effectively using the information in deliberation. Something similar
may happen, to a lesser degree, when a person is in a highly emotional state. Severe depression, for example, may impair one’s deliberation: one may simply not care about the information given to him.

The actions of others also can interfere with autonomy through constraint. Others may limit a person’s range of choices through coercion, e.g., threatening unpleasant consequences. The person who gives his wallet to the armed robber threatening “‘Your money or your life!’” does not make a fully autonomous decision. Less drastic forms of coercion, manipulation, or constraint also diminish autonomy.

There is at least one more parameter of variance with respect to autonomy. Uncertainties in the situation can influence the degree of autonomy with respect to choice. If Elmer is deliberating between two familiar routes from his house to his office and Frieda is choosing between two unexplored routes from her base camp to the site of an exploratory archeological dig (selected by aerial surveys), then Elmer’s choice is more autonomous than Frieda’s, since he does (and can) know more about his choice than she does (or can) about hers.

This understanding of autonomy makes its achievement an ideal goal unlikely to be fully attained in practice. To be completely autonomous would require a fully articulated set of life goals that is coherent and comprehensive. One must also make all life decisions on the basis of deliberation by reference to these goals. This leaves no room, for example, for action based on the whims of the moment. It is an impossible goal in practice and indeed, there might be questions about whether so fully rational an approach to life is desirable.

Since complete autonomy is a practical impossibility, one must be content to make comparisons of partial autonomy, and even these are not without difficulties. Ranking the relative importance of these various sources of differences in autonomy is a puzzling task. For example, does lack of information diminish autonomy more than a state of depression that interferes with use of this information in deliberation? No general answer to these types of questions is possible. A case-by-case and feature-by-feature comparison is the most that can be given.

In general, individuals are “autonomous” if they are mentally competent and otherwise capable of exercising autonomy; a person “exercises autonomy” with respect to a particular choice if her decision exhibits enough features cited above to make the decision deliberative.

B. Importance of Autonomy The importance of an autonomous state can be considered in different ways in ethical theory. At this point, some will be listed and explained. Which is most appropriate will be discussed in later chapters as each relates to specific issues.

Autonomy can be regarded as a positive value, something worth having or pursuing. Thus, each person is urged to see the development and exercise of autonomy as a personal goal, and one should recognize it as a goal for others. But there are many worthy goals, and how autonomy ranks in relation to the others
would have to be determined before one could know how it ought to influence our choices.

Also in the realm of evaluative judgments, autonomy might be regarded in part as a *disvalue*. This kind of independence and freedom might be seen not as a benefit but as a *burden*. Making one's own decisions can take considerable effort, and taking personal responsibility for decisions and their consequences can stir considerable anxiety. This feature of autonomy might affect the way it is weighted against other goals. It might suggest, for example, that autonomy sometimes conflicts with the goal of happiness, and thus we have to sacrifice one of these to obtain full measure of the other.

In the realm of obligation judgments, several variations are possible. It might be regarded as merely *morally acceptable* to respect autonomy in others. It would not be morally wrong to consult others to determine their autonomous wishes and honor them in one's actions, but there would be no obligation to do this.

A stronger claim is that individuals have a *moral obligation* to respect autonomy in others: this is not only a nice and acceptable thing to do, but it would be *wrong not to*.

A different but related claim is that each person has a moral obligation to develop and practice autonomy in *his own actions*. The implication is that failing to do so is morally wrong.

It is probably most common to speak of autonomy as a moral right of the individual. The implications of this claim are examined in Section 2.3.3.

In the realm of character judgments, one might regard autonomy in the agent herself and/or the tendency to respect autonomy in others as *virtues*, that is, as traits to be admired and praised.

These possibilities are explored in later chapters. For now, the point is to understand the differences between these claims.

C. Professional Autonomy Related to personal autonomy is the notion of autonomy of professional practice. The central point is the agent's self-directed deliberation, action, and independence from external influences. The opposite of professional autonomy is social control of professional practice, which, as you saw in Chapter 1, Section 1.2.5, is widespread. Keep in mind the value—to both the practitioner and the patient(s)—of this dimension of autonomy.

2.3.2 Paternalism The concept of paternalism arises from the image of the benevolent but stern sort of father who makes decisions for his children without giving them any say in the matter. He always "has their best interests at heart," and his decisions often may be in their best interests (although they may be based on incorrect judgments about what their best interests are). His choices may be what they would choose themselves if given the opportunity, but he fails to give them the chance to participate in the decision making. (*How much* of a difference this makes and *why* are questions examined at length throughout this book.)
A comment on terminology here: Some authors use the term "paternalism" instead of "parentalism" on the grounds that the latter is sexist. The image of a dominant father, however, with its sexist overtones, is an important element of the notion's meaning, so we use the traditional term "parentalism."

Generalizing from the image of the dominant father, one can say that a person is acting paternalistically whenever he or she does something for or to another person 1) without that person's consent and 2) on the basis of the justification that "this is for your own good." Thus parents are acting paternalistically toward a small child when they yank away a bottle of poison the child is about to drink. Surely this instance of paternalism is fully justified. More controversial, though, would be for a parent to yank a bottle of beer away from her adult child "because you have had enough," yet this would still be an act of paternalism.

That paternalism involves acting without the person's consent puts it directly at odds with autonomy. To act paternalistically toward a person is ipso facto to deny, or to fail to respect, his or her capacity for independent deliberative choice. Thus the considerations given above in favor of autonomy would all count automatically as considerations against paternalism. If exercising autonomy is a value, then paternalism is thereby a disvalue (since it counters an exercise that is valuable). If autonomy is a duty, then paternalism is morally wrong insofar as it interferes with carrying out one's duty. If autonomy is a right, then acting paternalistically violates that right.

2.3.3 Rights Claims of rights abound nowadays. Indeed, recent years have seen several "Bill of Rights" documents issued on behalf of patients. However, few who make these claims are aware of the philosophical complexities and questions raised by rights claims.

Rights demarcate a sphere of action within the discretion of the agent. Typically, it is within the power of the possessor of a right to choose whether to exercise the right or waive it. For example, if you have a right to be paid five dollars on Friday by someone (because he borrowed that amount from you and promised to pay it back), it is always within your power to release him from the obligation by saying: "Forget about paying it back. Let's call it a gift." In doing this, you would waive your right to be repaid.

One person's rights are another person's obligations. In the preceding example, your right to be paid five dollars is related to an obligation on your debtor's part to pay you the five dollars. In other examples the number of people who have obligations correlative to your rights may be much larger. Your right to freedom of speech, for example, is related to an obligation on the part of everyone else not to interfere with your speaking.

Some rights impose duties on others that require them only not to interfere with certain actions of the right-holder. (An example of this is the right to free speech.) These are called negative rights. Others, called positive rights, demand action by
the other party. (An example of a positive right is the right to be paid back five dollars.)

The strongest and clearest rights claims are those established on a firm basis, e.g., by the law of the land. One serious difficulty with claims of moral rights is that their basis is much less clear. A related point is that the strongest rights are backed by mechanisms of enforcement that add “bite” to the individual claims made by the rights-holders. Again, the best example is in legal rights, such as the right to security of private property, which is protected by criminal penalties for theft.

In the following discussion, keep these points in mind. Variations in the basis of rights, in mechanisms of enforcement, and/or in the scope of the correlative group obligated to grant the right can make a significant difference to the strength of such claims.

Look back at the discussion of confidentiality in the previous chapter, especially the professional code principles (Chapter 1, Section 4.3). All these principles take the form of obligation judgments. Terms employed to express the principle include “should,” “must,” “shall,” “owes,” and “a right.” Protecting confidentiality is something required (and failing to protect it would be wrong) and not merely a good thing to do (an evaluative judgment) or an admirable thing to do (a character judgment).

The principle of confidentiality is most naturally interpreted as stating a right of the patient. It has all the features of typical rights: 1) The obligation falls on someone other than the possessor of the right. In the case of confidentiality, action to preserve confidentiality is the responsibility of the health professional. 2) The patient can choose to waive this performance by the other party. In the case of confidentiality, this occurs when the patient authorizes release of information to others. 3) Since protecting confidentiality requires measures beyond mere non-interference, this is classified as a positive right. 4) The promulgation of this principle in professional codes such as those cited furnishes one basis for the right, and 5) mechanisms for professional discipline underwrite it with a certain “bite.”

If autonomy is spoken of as a right, the chief question is whether it is a negative right, i.e., the obligation of others is limited to refraining from interfering with one’s attempts to exercise autonomy, or whether it is a positive right, i.e., others have a duty to take positive steps to promote the development and exercise of autonomy. In turn, what of the scope of the group with the corresponding obligation? It may not be excessively burdensome to ascribe a duty of non-interference to everyone who comes into contact with the patient, but a duty of active assistance may amount to a considerable burden, and thus it is less plausible to impose it on everyone involved. In particular, what is the responsibility of physicians here? These issues underlie the discussion in Chapter 1 about the nature of the doctor-patient accommodation and the physician’s responsibility in information exchange and informed consent.
3 Review Exercise

3.1 Instructions

The parts of this exercise make use of the following case. Read the case carefully and answer the questions with reference to it.

3.2 Case: “To Make the Parents Happy”

This case was taken from Brody (1981, 25).

You are a pediatrician in a private practice. A mother and father bring in their four-year-old daughter, who has been complaining for three days of slight fever, runny nose, and irritability. Some of the irritability has rubbed off on the parents, and they demand rather abruptly that you prescribe an antibiotic for the child.

According to your diagnosis, the child, with high probability, has a viral infection. At any rate, the infection seems to be self-limiting and you feel that no medication is required. You know that antibiotics can do no good in viral conditions and that the indiscriminate use of antibiotics is considered poor medical practice.

Your first inclination, therefore, is to explain this to the parents and prescribe no medication, while encouraging them to call back if the child gets worse.

However, you see that the parents have a hostile attitude, and you are aware that it is standard practice among many pediatricians to prescribe antibiotics just to save themselves the explanation and to “make the parents happy.”

You are certainly not looking forward to taking the time to give the parents a full explanation, and even so they might call another doctor or go to an emergency room.

What should you do?

3.3 Questions

1. What is the central ethical issue in this case?

2. What kind of issue is it: evaluative, obligation, or character? Defend your answer. (See Section 2.1 for this distinction.)

3. Is the patient in this case (i.e., the child) an autonomous individual? Explain why or why not, by reference to our discussion of the concept of autonomy in Section 2.3.1.

4. Are the child’s parents exercising autonomy in this situation? Why or why not? (Be sure to comment on the variety of factors that influence autonomy—in particular, the issues of rationality, information, and constraint.)

5. Identify at least one factual issue central to a decision in this case. Can you identify one conceptual issue that is central here?
3.4 Options for Action

The author of this case (Brody 1981, 26) identified the following alternatives for action by the pediatrician:

1. Prescribe a mild antibiotic; no explanation.
2. Try to explain why an antibiotic would not be indicated, without committing yourself to any action. If, after a few minutes, it seems that the parents do not understand or are still dissatisfied, give up and prescribe a mild antibiotic.
3. Explain to the parents the pros and cons of prescribing an antibiotic, ask them what they want, and follow their wish.
4. Same as above, but in addition to giving the pros and cons, add that you strongly recommend against prescribing. However, you will do it if they desire.
5. State, “I am not going to give your daughter an antibiotic because . . . ” and then explain, taking as long as required to answer all the parents’ questions.
6. State, “I am not going to give your daughter an antibiotic because in my professional judgment it can’t do any good and may do some harm.” Answer a few questions, but if they are dissatisfied after you have spent a few minutes with them, end the conversation by saying that if they don’t like it they can see another doctor.

3.5 Additional Questions

1. Can you think of other options? Describe them.
2. Would any of these options (those presented in the text or those you suggested) embody paternalism? Defend your answer by reference to the discussion of paternalism in Section 2.3.2.
3. Is the pediatrician professionally autonomous in this situation? To what extent (if any) is professional autonomy compromised by the social setting of practice, the structure of prescription laws, and other factors in the context?
4. Look over any one of the medical codes discussed earlier—the Hippocratic Oath, the 1980 AMA Principles of Medical Ethics, the ACP Ethics Manual. Does this code offer guidance for the situation in this case? Defend your answer by drawing on the key provisions of the code.
5. What do you think the health practitioner should do? Defend your answer.
References

ACP: See American College of Physicians.

Further Reading

A discussion of autonomy and paternalism (including a Kantian defense of the limits of justified paternalism).

Codes of Medical Ethics
I. History (Konold D)
II. Ethical Analysis (Veatch RM)

A thoughtful critique of the Hippocratic tradition and exploration of issues to be included in a professional ethic adequate to today’s issues.
Medical Profession
I. Medical Professionalism (Pernick MS)
II. Organized Medicine (Burrow JG)
Paternalism (Beauchamp TL)
Patients’ Rights Movement (Annas GJ)
Rights
I. Systematic Analysis (Feinberg J)
II. Rights in Bioethics (Macklin R)
Appendix: Codes and Statements Related to Medical Ethics (Introduction by RS Gass)