

# Illustrations of Ethical Principles/Concepts as They May Figure into Consultations

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The following is a short list of ethical principles/concepts that come up regularly in Ethics Committee consultations. The notes provided here are not intended to serve as formal definitions or expositions but as illustrations of how these common principles/concepts figure practically into ethical discussions around patient care.

**Autonomy** — The principle of autonomy—or perhaps better termed, the principle of *respect* for autonomy—is pervasive in present day medical ethics. It is the foundation of informed consent and key to the very idea of patients' rights. However, while the word might literally be translated as "one's own law," the exercise of autonomy is well circumscribed by public laws and institutional policies. For practical purposes, Clinical Ethics Committees tend to approach issues of autonomy by asking, "Has the patient been assessed to be *competent* at present to make a particular health care decision?" [Under Pennsylvania law, competency may be assessed by an attending physician, and, if a patient is determined to be *incompetent*, then the law stipulates the processes by which health care decisions are made.] A patient who is competent has rights and responsibilities spelled out in hospital policy, including the right to participate in decision-making about the care plan and the right to refuse treatment even when such refusal goes against medical advice. The principle of autonomy respects a patient's personal values and wishes, and it supports the ascendancy of a patient's own health care decisions over what a care team believes may be "best." Autonomy is sometimes disputed as a guiding principle because it can conflict with cultural traditions that revolve around groups rather than individuals or because it is seen to overlook subtle forces that may act to coerce a patient. [Autonomy is one of four key principles—together with beneficence, nonmaleficence, and justice—widely used in ethics consultations since the late 1970s, after the publication of *Principles of Biomedical Ethics*, by T. L. Beauchamp and A. F. Childress.]

**Beneficence** — This is the principle that focuses on *doing good*. Of course, what exactly constitutes "the good" is debatable, especially when there is perceived to be conflict between means and ends, or when action benefiting one person may be in tension with consequences for many people [—see "distributive justice" in Justice, below]. In clinical ethics, the principle of beneficence is often very useful to help clarify what the "good goals" are for everyone involved and for the care plan. However, in practice this principle seldom stands alone but is paired with the principle of nonmaleficence in an assessment of benefits vs. burdens.

**Benefits vs. Burdens** — Clinical ethics consultations frequently involve discussing the potential benefits of a care plan in light of its potential burdens to the patient—and this approach is preferred nowadays, especially in end-of-life care situations, over of the older conceptual framework of "futility." Of course, benefits-and-burdens assessments occur in various and sometimes narrowly focused contexts in the hospital (such as in a medical assessment about whether the practical benefits of a treatment outweigh the burden of its side effects), but clinical *ethics* consultations usually seek the broadest possible perspective here. The Ethics Committee might well encourage patients, families, and caregivers facing a difficult decision to discuss the benefits and burdens of the care plan not only in light of the medical goals and the physiological effects of treatments, but in light of such factors as the patient's own overall goals, the patient's general values and expressed wishes, the patient's sense of quality of life and his/her lived experience of the decision-making process and of particular treatments. Moreover, Ethics Committees keep alert to how different people can see the same things in a patient's situation and yet have different senses of benefits and burdens. For instance, the benefits and burdens of a blood transfusion may be assessed very differently by patients who are Jehovah's Witnesses than by care team members who hold other beliefs.

**Casuistry** — This is an old concept that has regained popularity in bioethics in recent years. The casuistic approach looks to a past case that is paradigmatic of some aspect of a present case (—the root of term the *casuistry* is from the Latin for "case"), and it then uses the past case as a guide to the present one. It is an approach similar to the way clinicians use "classic" cases as guides, and so it tends to fit easily into clinical ethics consultations. It is sometimes useful to ask, "Is there a classic case like this?" However, casuistic ethics depends upon the very existence of "classic" cases that are *widely accepted as models for ethical reasoning and action*, and then upon their proper interpretation and application to a particular case at hand. In the context of modern health care, marked by cultural pluralism and dramatic changes from the past, casuistry can be problematic.

**Double-Effect** — The principle of double effect has developed largely out of Catholic moral philosophy and is now commonly applied in clinical ethics. In short, it asserts as ethical an action that is intended to be helpful but that may have *unintended but not unforeseen* negative consequences. The classic example in health care is that of the patient who at the end of life is in great pain: as long as analgesics are given solely for the purpose of addressing the patient's pain—and are not intended to hasten the patient's death—then even if the analgesics do happen to hasten the patient's death (which is a foreseeable possibility), the administration of the medication can still be said to be ethically sound. This is why the proper administration of analgesics in end-of-life care may carry some risk of hastening death but not carry a risk of constituting an act of euthanasia.

**Justice** — The concept of justice, in clinical ethics consultation, is frequently applied as a rule of simple fairness, often with a sense of egalitarianism, though ultimately it can have as many senses as there are ideas of right and wrong. Because it is quite abstract and potentially ambiguous, Ethics Committee members seldom bring it up explicitly during consultations. However, when a consultation participant does invoke the principle of justice, it is often a flag for some deeply and passionately held view that can demand special attention in the discussion process. In health care in general, the principle of justice is often raised in terms of the problem of scarce resources—this is the essence of the idea of *distributive* justice: put pragmatically, "How can we offer health care resources 'justly' when their scarcity requires some compromise to ideal distribution?" In an ethics consultation, interpersonal tensions may escalate when issues of distributive justice are raised in apparent conflict with the priority of some participants intent upon providing the maximum resources to an individual patient. For example, in a consultation revolving around organ transplantation, the care team may speak about the equitable distribution of organs according to a system that is not well serving the patient at hand, but for that individual or his/her family, any argument for distributive justice may seem cold, appear personally dismissive of the pressing need of the patient, and exacerbate the patient's or family's feelings of *injustice* about overall circumstances. Justice is a difficult principle to apply directly in clinical ethics, but the question, "Is this action just?" is always appropriate to keep in mind.

**Means and Ends** — The question of whether—and to what degree—ethics should focus on the outcomes of actions ("the ends") or on the qualities of the actions themselves ("the means") is addressed by a number of differing schools of thought that are each complex and open to much academic debate. In clinical ethics consultation, the practical issue often is simply how to proceed when decision-makers perceive an ethical tension between a desired outcome and a proposed means to achieve it. Now in many cases, what may appear at first to be a conflict over means and ends is actually rooted in some confusion about goals. For instance, a family and a care team can be at odds over the appropriateness of a particular care plan as a means to a goal, when in reality the family and the care team have different goals or ends in mind. It is therefore often useful to ask for the sake of clarity, "What are the goals we are working toward?" and "Why have certain elements of the care plan been proposed?" However, sometimes there is genuine conflict over how to think about means and ends because of fundamentally conflicting ethical perspectives. A participant who is a firm consequentialist may be focused on the ethical outcomes of actions, whereas a deontologist may be intent upon constituent actions in terms of ethical duties (*-deon* is from the Greek for "duty"). In this situation, the purpose of a consultation is not to attempt to reconcile broad schools of thought but to explore how decision-makers may work together to achieve some consensus about a patient's care plan within the policies of the hospital (reflecting best medical practices and law).

**Nonmaleficence** — This is the principle that enjoins health care providers not to cause harm to others. It is essentially the principle that is formulated in medical tradition as "first, do no harm" or, in the Latin, *primum non nocere*. The complexity of this principle lies in the concept of harm itself: namely, "What really constitutes harm?" After all, patients often experience some pain as the result of treatments, and in many cases (surgery, for instance) the body is essentially hurt for the purpose of greater healing. So, while the principle of nonmaleficence raises valuable questions—e.g., "Is harm being done, and how?"—the practice of clinical ethics usually folds this principle, together with beneficence, into the larger assessment of benefits vs. burdens.