

Lecture Notes 2010 – 2011. Code: Med.02.01-v2-11.10

Medical Law

Topic 2 (of 10): Ethics. **Lecture 1** (of 4):

Introduction to Medical Ethics: (1)

Aim:

To explain the meanings of 'ethics'; to review provisions of some principal ethical codes for registered medical practitioners; to outline elements of some of the principal ethical theories; and to place the foregoing in the context of the transition to 'Bioethics'.

Objectives:

After careful study of this topic you should be able to:

1. Explain the meanings of the words 'ethics' and 'bioethics';
2. Discuss provisions, and explain the inherent limitations, of the principal ethical codes applicable to 'doctors';
3. Outline the approaches of the principal types, or families, of ethical theories and review these in the transition to Bioethics.

“Traditional” Medical Ethics and Codes of Ethics

In *Healthy Respect: Ethics in Health Care*, **Downie and Calman** point out that 'the term 'ethics' has various meanings and associations'. In fact, they outline three meanings, viz;

First, it can refer to that branch of philosophy also called moral philosophy. ... Ethics in this sense is a theoretical study of practical morality and its aim is to discover, analyse and relate to each other the fundamental concepts and principles of ordinary practical morality.

Second [it means] ordinary morality as it is found in a professional context. [Here] 'morality' and 'moral decision' [are synonyms for] 'ethics' and 'ethical decision'.

The *third* sense of 'ethics' refers to codes of procedure [which] underlie professional activity and ... apply across cultural and national boundaries.

The focus of the following notes *on traditional medical ethics* is on ethics in its 'third sense': medical ethics being the umbrella term for the codes which regulate and guide the behaviour of doctors in their dealings with each other and with their patients.

Morality and Ethics

The first two meanings of ethics *supra* seem to indicate that ‘morals’ and ‘ethics’ may be regarded as synonymous. Indeed, apart from ‘ethics’ being of Greek derivation and ‘morals’ derived from Latin, **Pattinson**¹ is happy to “ ... use the terms “morality” and “ethics” interchangeably”. Moreover, he asserts² that:

“A proper understanding of medical *ethics*, as a branch of applied ethics, requires an understanding of *moral theory*”.

By contrast, **Jackson**³ asserts that:

“‘Morality’ often implies a restrictive code of conduct, which sets out the difference between right and wrong. ‘Ethics’ tends to refer to the systematic analysis of what it might mean to lead a decent life. Medical ethics is a branch of applied ethics, and it is principally concerned with how we should go about resolving particularly difficult questions that arise from the practice of medicine”.

Perceived Need for, and Limitations of, the Codes

Given that “every human being of adult years and sound mind has a right to determine what shall be done with his own body...” (*Schloendorff*) because “over himself over his own mind and body the individual is sovereign” (*Mill, On Liberty*); that “there is no special law in this country that places doctors in a separate category and gives them extra protection over the rest of us” (*R v. Arthur*); and that “...every legal duty is founded on a moral obligation” (*R v. Instan*), then it is easy to deduce that the legal duties of a doctor towards his patient are based on moral obligations that respect the principle of the patient’s autonomy; and that many of those obligations are those that one would expect to find encapsulated within the well-known, respected codes of medical ethics, of which the Hippocratic Oath is, undoubtedly, the most well-known.

The oldest and/or the most respected codes cannot be expected to contain references to all the obligations of a doctor, however, given that medical science is continually breaking new ground and that it is unrealistic and perhaps unnecessary to expect any degree of uniformity in approach from the medical profession either at the time of developing new techniques and/or treatments or after the ‘new’ technique/ treatment has become established. The law has recognised the latter by sanctioning more than one ‘*Bolam* standard’. Moreover, the law might fail not only to reflect current issues of moral debate, there may be doubts as to whether the law should be permitted to be invoked in a particular issue – e.g., surrogacy, abortion, selective non-treatment of severely handicapped neonates and euthanasia. Indeed, in issues relating to the allocation of scarce medical resources, the general rule is that the allocation is made on moral grounds only, the law having no role to play.

¹ **Pattinson, S.D.** *Medical Law and Ethics*, 2nd edn., 2009. London: Sweet & Maxwell, fn.2 on p3.

² *ibid.*, p3.

³ **Jackson, E.** *Medical Law Text, Cases and Materials*, 2nd edn., 2010. Oxford: OUP, pp1-2.

Thus, whereas well-established, respected codes of medical ethics would be expected to contain guides to the standard of behaviour of doctors towards their patients, sound theories of medical ethics have to be developed in order not only to underpin the codes but also to provide guidelines to thinking about the responses to new, possibly controversial, areas of medical research. This gives rise to two issues:

- (i) Should ethics be focused on the *standard of behaviour of doctors towards their patients*, or should they be *patient-centred* with more focus on respect for patient autonomy; and
- (ii) How, if at all, can or should traditional medical ethics be modified to accommodate advances in medical science?

By way of addressing the above, this lecture merely notes a few points to illustrate why bioethics is beginning to replace the focus on the more traditional role of medical ethics after first noting elements of the more well-known codes. Lectures 2 & 3 then focus on the two main theoretical approaches to medical ethics; and the final lecture focuses on justice and the allocation of scarce medical resources.

Codes of Ethics and their Inherent Limitations

Probably by far the oldest of the medical ethical codes is the **Hippocratic Oath**: it is thought to be at least 2500 years old. Nevertheless, “ ... it raises many contemporary issues. The importance of teaching and learning, the good of patients and the avoidance of harm, the problems of abortion, the need to know one’s limitations, professional conduct and confidentiality are all stressed.” (*per Downie and Calman*). Indeed, the **Hippocratic Oath** makes specific references to the ethical duties of:

Beneficence - that the doctor will act ‘ ... for the good of my patients’;

Non-Maleficence the doctor will ‘ ... never do harm to anyone’; and

Confidentiality - in that information (confidences) ‘ ... which ought not to be spoken of abroad, I will keep secret and will never reveal.’

Not only is euthanasia illegal in the U.K. [cf. position in Holland], it is also expressly rejected in the Hippocratic Oath with the doctor avowing never to ‘ ... prescribe a deadly drug, nor give advice which may cause [his patient’s] death’. However, the vow not to ‘ ... give a woman a pessary to procure abortion’ isn’t necessarily ‘in line’ with what a doctor may actually do in practice: it is a matter for his conscience and, from a legal perspective, abortion is permitted under circumstances prescribed in the Abortion Act 1967 as amended. The conscience clause [enabling a doctor to refuse to take part in a non-therapeutic abortion] is probably unique in that it permits him to opt out of providing a legally recognised service for a female patient without breaking his contract with the Health Authority: and this is so even though his decision isn’t a ‘medical decision’.

[The individualistic approach to abortion is recognised in the Declaration of Oslo (1970): see below].

Knight (*Legal Aspects of Medical Practice*) says of the Hippocratic Oath: “ ... its basic tenets remain as valid as ever, ... [but] the archaic language and formulation ... have become anachronistic, leading to its restatement in the [World Medical Association] **Declaration of Geneva** [1968].”

Under the **Declaration of Geneva** a doctor affirms that: ‘I solemnly pledge myself to consecrate my life to the service of humanity ... [and that] the health of my patient will be my first consideration.’ The first consideration, perhaps, but not the only one; and there is no indication of whether improvement in a patient’s health could be effected by way of non-disclosure of information, for example. If it could, it is not clear whether this would be approval for ‘the end justifies the means’ approach. Still, it was upon the *Declaration of Geneva* that the **World Medical Association** based its **International Code of Medical Ethics** (1949, revised in 1968 and 1983). Amongst the provisions of the *International Code* is the duty of a doctor to ‘preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him’.

Declaration of Oslo

This is a statement on *therapeutic abortion* that recognises:

‘Diversity of response to this situation results from the diversity of attitudes towards the life of the unborn child. This is a matter of individual conviction and conscience which must be respected. ...

If the doctor considers that his convictions do not allow him to advise or perform an abortion, he may withdraw while ensuring the continuity of (medical) care by a qualified colleague.’

Other codes include the **Declaration of Helsinki** (1964, revised 1975 and 1983) which provides recommendations for *biomedical research involving human subjects*, one of which is that ‘ ... the interest of science and society should never take precedence over considerations related to the wellbeing of the subject’. The possibility of the doctor being excused from obtaining *informed consent* should be noted.

The Declaration of Tokyo (1975, revised 1983) which emphatically states that ‘The doctor shall not countenance, condone or participate in the practice of *torture* or other forms of *cruel, inhuman or degrading procedures* ...’. Also, it is noteworthy that if a prisoner decides to go on ‘hunger strike’ then: ‘The decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.’

Inherent Limitations

Downie and Calman suggest that the inherent limitations in the ethical codes include: the perception that the medical professional ‘is [1] *given* his ethics - perhaps even literally

given them in a handbook - whereas it is at least as true that the professional *brings with him* his own individual values to his professional life. ...

2. whereas any profession must lay down rules or duties for its members ... there are many aspects of health care which are not expressible in rules. For example, certain attitudes, such as compassion, ... are not wholly reducible to rules.

3. Codes have tended to be exclusive to *one* profession, whereas [the authors argue] health care is best delivered by *teams*. And just as codes do not stress the importance of teams so they assume ...

4. an exclusive professional/patient relationship; the individual professional must do the best he can for the individual patient. But this is to ignore the pressing importance of the *economic side* to health care. ...'

More to the point, perhaps, "conventional medical ethics [as encapsulated in the codes discussed] [has] tended to marginalize both the patient's perspective and the broader social causes of ill health"⁴. **Susan Sherwin**⁵ addressed these points by noting that:

"Until very recently, conscientious physicians were actually trained to act paternalistically toward their patients, to treat patients according to the physician's own judgement about what would be best for their patients, with little regard for each patient's own perspectives or preferences. The problem with this arrangement, however, is that health care may involve such intimate and central aspects of a patient's life – including, for example, matters such as health, illness, reproduction, death, dying, bodily integrity, nutrition, lifestyle, self-image, disability sexuality, and psychological well-being – that it is difficult for anyone other than the patient to make choices that will be compatible with that patient's personal value system ..."

[Moreover]

"Within the medical tradition, suffering is located and addressed in the *individuals* who experience it rather than in the *social arrangements* that may be responsible for causing the problem. Instead of exploring the cultural context that tolerates and even supports practices such as war, pollution, sexual violence and systematic unemployment – *practices that contribute to much of the illness that occupies modern medicine* – physicians generally respond to the symptoms troubling particular patients in isolation from the context that produces these conditions".

The shift in focus from paternalism to autonomy coupled with advances in biomedical sciences (and the moral dilemmas that result from them, e.g., organ transplants and assisted reproduction techniques) has led to this area of study having a wider remit than traditional medical ethics and being named **Bioethics** which is concerned with:

" ... not the development of, or adherence to, a code or set of precepts, but a better understanding of the issues. Second, it is prepared to ask deep philosophical

⁴ **Jackson, E.** *Medical Law Text, Cases and Materials*, 2nd edn., 2010. Oxford: OUP, p3.

⁵ Suffice it to say that a slightly longer extract of her article is reproduced in: **Jackson, E.** *Medical Law Text, Cases and Materials*, 2nd edn., 2010. Oxford: OUP, p3

questions about the nature of ethics, the value of life, what it is to be a person, the significance of being human. Third, it embraces issues of public policy and the direction and control of science”⁶.

In summary, it is seen that the traditional codes are ‘products’ in the sense that they contain the outcome of deliberations: but they give no indication of the theoretical framework on which they were constructed. Moreover, they are guides as to what practices a ‘good’ doctor would follow. They do not focus on patient autonomy and, while they reflect some very contemporary values (confidentiality, e.g.) they were developed and followed long before medical science made the significant advances of the past fifty years.

Types of Ethical Theory

As noted by **Beauchamp and Childress**: ‘A well-developed ethical theory provides a framework of principles within which ... can [be] determine[d] morally appropriate actions.’ There are two principal types of theory: **consequentialist** and **deontological** – with very brief references given to other types, *infra*.

The essence of a **consequentialist** theory is that an action is right or wrong according to the consequence it produces: the theory is not dependent on any intrinsic features such as veracity (i.e. telling the truth). **Utilitarianism** is the principal *consequentialist* theory.

In contrast, the essence of a **deontological** theory is that there is some feature of an act other than, or in addition to, its consequences which makes it right or wrong. There are a number of deontological theories and they compete with each other as well as against consequentialist theories. Some theories are based on religion, others have no religious basis. The principle theory for study in this course is that of Kant’s non-religious deontological theory in which a person is a moral agent if he acts from a sense of duty and not merely in accord with duty.

It will be noted (in lecture 4) that whether one regards oneself as a utilitarian or a Kantian, four moral principles can be supported, *viz*; autonomy, beneficence, non-maleficence and justice. The focus on moral principles as opposed to families of theories has given rise to **principlism** and associated, in particular, with **Beauchamp and Childress**.

Virtue ethics takes the focus away from patient autonomy and redirects it on the character-based traits that are necessary for human flourishing, such as honesty, compassion, kindness, justice. When values conflict, however, the theory offers no solution as to how one can act virtuously.

⁶ This is an extract from a book edited by Peter Singer and Helga Kuhse and a longer extract is contained in **Jackson, E.** *Medical Law Text, Cases and Materials*, 2nd edn., 2010. Oxford: OUP, p4.

Casuistry is another approach to solving a moral dilemma for which no pre-existing principles apply. Instead, they are 'discovered' and developed on a case-by-case basis in much the same way that the common law developed. Of course, one difficulty is deciding whether a case under discussion (on abortion, say) is "relevantly similar to murder (the killing of an innocent human being), or is it relevantly similar to contraception (allowing women to control their reproductive capacity)?"⁷

References

Beauchamp, T.L. & Childress, J.F. *Principles of Biomedical Ethics*, 6th edn., 2009. New York: Oxford University Press;

Gillon, R. *Philosophical Medical Ethics*. Chichester: Wiley, 1985, Ch. 2;

Jackson, E. *Medical Law Text, Cases and Materials*, 2nd edn., 2010. Oxford: OUP, Ch.1;

Pattinson, S.D. *Medical Law and Ethics*, 2nd edn., 2009. London: Sweet & Maxwell, Ch.1.

Short Answer Questions

1. Explain: (a) why we need codes of medical ethics; and (b) the nature of, and what you consider to be some of the principal provisions of, the Hippocratic Oath.
2. Where applicable, how do codes of ethics differ in their provisions relating to abortion and what duty is a doctor placed under if his convictions do not permit him to advise on or perform an abortion?
3. It may be of great interest to science and, perhaps, to a large section of society in general that human beings should be cloned if the technology is available. What code(s) of ethics and what moral theory / theories might have provisions relevant to the debate on the acceptability or otherwise of cloning?

⁷ Extracted from **Jackson, E.** *Medical Law Text, Cases and Materials*, 2nd edn., 2010. Oxford: OUP, pp18-19

