

Lecture Notes 2004/2005 (Code: Med-02.02-v1A-11.04)

## Medical Law

**Topic 2** (of 10) **Lecture 2** (of 4):

### Introduction to Medical Ethics: (2); Deontological Theories

**Aim:**

To provide an outline account of ethical theories based on notions of duty.

**Objectives:**

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

1. Explain what is meant by ‘deontology’, and outline theories that believe in: (i) God as the creator of people and moral laws; and (ii) those theories that conclude, merely, that God exists.
2. Outline Kant’s theory and, in particular, discuss what is meant by the categorical imperative and universal laws;
3. Present a detailed critique of Kant’s theory.

### Types of Ethical Theory

*Beauchamp and Childress* note that: ‘A well-developed ethical theory provides a framework of principles within which ... can [be] determine[d] morally appropriate actions’. Of the two principal types of theory – *consequentialist* and *deontological* – it is the latter that focuses on some feature(s) of an act other than, or in addition to, its consequences which makes it right or wrong, with the feature(s) being based on some notion of *duty*.

#### 1. Deontological Theories

Deontological theories of medical ethics encompass both religious and non-religious theories. *Gillon* notes that: ‘The great religions typically justify their deontological theories on one or both of two grounds. The first is that God has commanded the people He has created to obey his moral laws and it is their moral duty to obey the creator. The second is that the laws of nature include moral laws that bind everyone, including God’. Currently, neither of the religious perspectives commands a great deal of support from the medical profession.

The most important non-religious, deontological theory was that developed by *Immanuel Kant*. *Kant* believed that a theory of morality had to be constructed without reference to God’s existence. This was a necessary outcome of the rational nature of human beings. [N.B.: *Kant* then went on and used ethical arguments to establish, as far as he was

concerned, anyway, the existence of God and to conclude that there is an eternal life]. *Kant* also believed that rational beings recognised themselves to be bound by the ‘supreme moral law’. Referring to *Kant*’s theory, *Gillon* stated:

This supreme moral law stemmed from the fact that rational agents (or persons) intrinsically possessed an absolute moral value ..., which rendered them members of what he called the kingdom of “ends in themselves”. Not only did all rational agents recognise themselves as ends in themselves [as opposed to a means to end] but, in so far as they were rational, they also recognised all other rational agents to be ends in themselves, who should be respected as such.

[i.e., dentologists observed the application of the principle of respect for autonomy].

**The main question which *Kant*’s moral theory was designed to answer** could be framed in one of several ways. In essence, it was: ‘*What is a moral action as contrasted with a non-moral one?*’ *Kant* believed that the answer to this question could be elicited by distinguishing acts done from ‘inclination’ and acts done from a ‘sense of duty’.

However, irrespective of whether a moral act is done from ‘inclination’ or from having a ‘duty’ or ‘obligation’, it is a requirement that it is the act of a free agent: i.e. it is not an act done from compulsion or via constraint on behaviour. It then becomes necessary for an ‘inclination’ to be distinguished from an ‘obligation’. An obligation is that which one ought to do despite one’s inclinations to do otherwise. Where no obligation exists, it becomes a matter of inclination / taste what one should do. *Kant* was of the opinion that an agent (person) was acting morally only when (s)he suppressed her/his feelings and inclinations and did that which (s)he was obliged to do. Thus, ‘doing one’s duty’ is the fulfilling of an existing obligation and it is only when a person recognises that (s)he ought to perform a duty because (s)he has incurred an obligations that (s)he has incurred an obligation that (s)he is a genuinely moral person. *Morality, then, according to Kant, is intimately associated with duties and obligations.* A person who performs a duty for fear of the consequences of **not** doing it is *not* a moral person: e.g. a person who repays a debt merely because (s)he is afraid of the potential imprisonment for not paying it. In essence, a person is moral when acting ‘from duty’ [‘moral action’] and not merely in ‘accord with duty’, (‘prudential action’) or as *Kant* said: ‘... we can readily distinguish whether the action which agrees with duty is done from duty or from a selfish view’. Thus, *the basis of morality is in the motive from which the act is done and a person is moral when he acts from a sense of duty.* A moral person who acts from a sense of duty [i.e. performs a ‘moral action’] is a person of ‘good will’.

In summary, <i>Kant</i> ’s answer to the question: ‘ <i>What is a moral action as contrasted with a non-moral one?</i> ’ is: A moral action is one done from a <b>sense of duty</b> ; and a moral person is one who acts <b>from duty</b> , <b>not</b> from <i>inclination</i> or even <i>in accord with duty</i> .
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With regard to a person knowing what his/her duty is in a particular situation, *Kant* says that as human beings are rational creatures they ought to behave in a rational way, i.e. every person fought to behave as if his/her conduct were to become a **universal law**. This means that every action must be judged in the light of how it would appear if it were to be a universal code of behaviour. On this basis, telling lies, even if expedient, could not be accepted as moral under any circumstances because if lying was to be regarded as a

universal law to which people ought to conform, morality would be impossible. Thus the claim of therapeutic privilege – the euphemism for lying, in *Hatcher v Black* (1954) – would be rejected. The moral action of a doctor in responding to a patient’s questioning would be that stated by **Lord Bridge** in *Sidaway* where his Lordship said that when questioned by an autonomous patient: “... the doctor’s duty must ... be to answer both truthfully and as fully as the questioner requires”.

An action of truth-telling, based on a sense of duty and independent of the consequences, given without any qualification, is an example of the *categorical imperative*.

A *categorical imperative* lays down a rule that, if followed, will ensure that the person acting on it is behaving morally – i.e., *a categorical imperative gives rise to a universal law*.

Another way of formulating the categorical imperative is to: ‘ ... act as to treat humanity, whether in thine own person or in that of any other, in every case as an end withal, never as a means only’. Quite simply, this means we should respect other people because they are rational human beings like ourselves. If another person was regarded and treated *only* as a means to an end, or ‘created’ for a primary purpose of saving the life of another, that is, created as a means to achieving merely what we want, then that would amount to disregarding his/her humanity and, in effect, treat that person as a thing: there would be no respect for his/her status as a rational human being.

Such arguments underpin the criticisms of the American couple, the *Ayalas*’ who, at the end of 1989, decided to try for another child who would be a potential bone marrow donor for his/her teenage sister who was suffering from leukaemia. (The child, a girl, was, in fact, born in 1990. The tissue was compatible and a successful transplantation was performed early in 1991. Indeed, before the girl had reached her third birthday, she was a bridesmaid at her elder sister’s wedding).

Similarly, a Colorado couple, the *Nash*’s, were criticised by some commentators when it was revealed in October 2000 that they had used genetic pre-selection techniques (pre-implantation genetic diagnosis or ‘PGD’) in order to ensure that the rare illness suffered by the elder daughter, Molly, (aged 6 years) was not passed to their new baby, Adam, from whose umbilical cord stem cells were taken in order to provide Molly with a bone marrow transplant.

(Q: Are the cases above instances of ‘All’s well that ends well?’ – or do they merely represent a happy ‘ending’ of situations – planned births with the fate of others in mind – which should never have been permitted to develop?).

Whereas the American ‘creation-of-life’ cases have led to much commentary, in England the Court of Appeal, in the tragic case of *In re A (minors)(Conjoined twins: medical treatment)* 2000 *The Times*, October 10<sup>th</sup>, had to decide whether it was in the interests of both babies to undergo a separation when *death* for M, the weaker twin, was the certain consequence of the operation. In deciding that the separation was lawful and, in doing so, dismissing the appeal of the parents, **Ward LJ** found it legitimate to bear in mind the actual quality of life each child enjoyed and might be able to enjoy and he balanced the interests to

arrive at the least detrimental choice which was to permit the operation and give **J**, the stronger twin, “the prospects of a normal expectation of a relatively normal life”.

The lawfulness of the operation was based on necessity: clearly there could be no duty to try and save “M’s life before its brief allotted time span was completed” (*per Brooke LJ*) when they conflicted with those of **J** and she was the only twin with a reasonable prospect of leading a normal life.

### **Applicability of a Deontological Theory to Codes of Medical Ethics**

The apparent applicability of a deontological theory to codes of medical ethics was noted by *Gillon* who stated that:

At first sight medical ethics, as reflected in the codes of such bodies as the *World Medical Association*, seem to fit well into an absolutist deontological ethical system for they contain some moral rules that apply without exception and that explicitly or implicitly reject considerations of overall happiness and suffering. For instance, the *Declaration of Tokyo* categorically rejects doctors taking part in torture.

However, with regard to ‘moral rules that apply without exception’, “Kant’s position is relentlessly uncompromising”.<sup>1</sup> This leads to a requirement of further analysis of Kant’s position.

### **Criticism of Kant**

Kant’s theory was a monist theory i.e. it relies (or purports to rely) on a single moral principle. This gives rise to a major criticism that it does not deal with cases where there is a conflict of duties. So in a situation where truthfully answering a patient’s questions would conflict with a doctor’s positive duty to prevent harm to that patient (beneficence) an impossible situation arises: the doctor cannot tell the patient the truth and claim that he has done all he can to prevent the patient worrying – which may be necessary for the success of an operation, as in *Hatcher v Black* – yet according to the Kantian position he should do both. This logical problem, that can arise if a theory is both pluralist and absolutist and if its principles conflict is summed up by *Gillon* who says:

Suppose, for example, I accept the principles that I should never harm others and that I should never deceive others; if both principles are absolute and I am faced with a situation where somebody would be harmed if I did not deceive him I am logically incapable of acting rightly.

It has been said that Kant’s *absolute* (i.e. unqualified) assertion that, for example, we should never tell lies is unnecessarily restrictive: that moral rules are to be interpreted as *generalisations* not as categorical propositions to which there are no exceptions. The obligation to tell the truth, for example, only need be adhered to provided that no other overriding factors are present, or provided that all other conditions are equal. So, if a doctor acting from a sense of duty believes that lying to a patient is, ultimately in the patient’s best interests then what *Ross* has called the ‘*prima facie obligation*’ to tell the

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<sup>1</sup> *Seedhouse, D. Ethics: The Heart of Healthcare*, 2/e. Chichester: Wiley, 1998, p121.

truth becomes subordinated to the doctor's duty to act in the patient's best interests (beneficence) and *Hatcher v Black* may be regarded as 'good law'.

## Summary

The important stages to remember are:

A rational agent acts morally when he:

- Is a free agent (i.e., not acting under compulsion / coercion); who
- Acts *from* a sense of duty; and who behaves as if
- His conduct was to become a universal law.

An abridged formulation of the *categorical imperative* is to 'act as to treat humanity, ..., in every case as an end withal, never as a means only'.

## References

**Beauchamp, T.L. & Childress, J.F.** *Principles of Biomedical Ethics*, 4/e. New York: Oxford University Press, 1994, pp45-47 & 56-62;

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**McHale, Fox & Murphy.** *Health Care Law: Text and Materials*. London: Sweet & Maxwell, 1997, pp71-94;

**Seedhouse, D.** *Ethics: The Heart of Health Care*, 2/e. Chichester: Wiley, 1998, pp114-123;

**Stauch, Wheat & Tingle.** *Sourcebook on Medical Law*, 2/e. London: Cavendish, 2002, Ch.1, esp. pp6-21.

## Questions to consider

1. When, if ever, is it ethical to withhold information from a patient who is about to undergo an operation that has an inherent risk 1 – 2% of leaving the patient paralysed even if it is carried out competently?
2. Tom is in need of a kidney transplant. Jerry is prepared to sell a kidney (which is tissue compatible) for £10,000. You are the surgeon who can perform the transplant and the decision on whether or not the transplant takes place is solely dependant on your acceptance / rejection of the commercial trade in organs. Explain why you would / would not perform the operation.
3. When, if ever, is it permissible to create life for the purposes of saving another?
4. When, if ever, is it permissible to allow one life to die – or even to kill – in order to save the life of another?
5. When, if ever, is it permissible to prevent the creation of life and/or to sanction abortion?
6. Why, if at all, is it logical to permit abortion under certain circumstances but always to treat euthanasia as murder?
7. When, if ever, is it permissible to breach a patient's confidentiality?
8. What are the strengths and weaknesses of Kant's theory of ethics?
9. Should the medical professions be guided by codes of ethics or strict legal regulation?
10. Look again at Q's 1 & 2: you perform both operations successfully. Surely, that indicates that "all's well that ends well", and that Kant's theory is an irrelevance in the contemporary doctor-patient relationship?