

Good and not so good medical ethics

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ABSTRACT

In this paper, I provide a brief sketch of the purposes that medical ethics serves and what makes for good medical ethics. Medical ethics can guide clinical practice and biomedical research, contribute to the education of clinicians, advance thinking in the field, and direct healthcare policy. Although these are distinct activities, they are alike in several critical respects. Good medical ethics is coherent, illuminating, accurate, reasonable, consistent, informed, and measured. After this overview, I provide specific examples to illustrate some of the ways in which medical ethics could go wrong as a caution and a reminder that taking on the role of an ethicist involves serious responsibilities that must be exercised with care.

The philosophic tradition with which I identify, calls things 'good' for a variety of reasons and calls activities 'good' when they achieve some desired purpose.¹ For example, in chapter 6 of his masterpiece, *Leviathan*, Thomas Hobbes provides a perspicacious definition of 'good.' There he explains

But whatsoever is the object of any man's appetite or desire, that is it which he for his part calleth good; and the object of his hate and aversion, evil; and of his contempt, vile and inconsiderable. For these words of good, evil, and contemptible are ever used with relation to the person that useth them: there being nothing simply and absolutely so; nor any common rule of good and evil to be taken from the nature of the objects themselves; but from the person of the man.²

In Chapter 8, he goes on to observe that, in

the difference of men's passions; that love and dislike, some one thing, some another... there is nothing to observe in the things they think on, but either in what they be like one another, or in what they be unlike, or what they serve for, or how they serve to such a purpose.³

In that light, my observations are reflections on what I take to be good in serving the various purposes and functions that medical ethics has come to have. I also offer arguments that may convince readers to accept my perspective.

GOOD MEDICAL ETHICS

Medical ethics is useful in a variety of tasks. It can and should guide clinical practice, contribute to the education of clinicians, advance thinking in the field, inform biomedical research, and give direction to healthcare policy. These are significantly different activities, but they are alike in several critical respects. Good medical ethics is coherent, illuminating, accurate, reasonable, consistent, informed, and measured.

In clinical contexts, medical ethics is typically called upon to resolve ethical dilemmas. Clinicians

are well trained to exercise their professional judgement and make medical treatment decisions. When the decision is less medical and more about the patient's goals and values, clinicians have limited training for addressing the choices that have to be made. They often experience the situation as a mess and feel ill prepared for resolving the matter. In such circumstances, a good medical ethicist can clarify the issues, offer a roadmap for navigating ethical dilemmas, and help clinicians to sort out the relevant issues from those that are more tangential.

In medical education, medical ethics should play a significant role in preparing trainees to steer through the ethical dilemmas that arise frequently in clinical practice. A medical ethics curriculum that is integrated into all years of training should focus on the development of the core competencies that all medical professionals need to have. A good programme will aim to foster understanding of basic medical ethics concepts, develop skills in clinical moral reasoning, and nurture the attitudes and virtues that incline medical professionals to do their duty and be exemplary physicians.

Academic contributions to medical ethics are good when they advance the field. They provide insights, clarify issues, challenge accepted views, provide useful guidance for clinicians and researchers, and spur further discussions. They are well argued, well organised, and well written.

Similarly, ethics contributes to biomedical research when it lays out the factors that require attention in animal and human subject research. Philosophical thinking can guide study design by explaining how to answer research questions efficiently while also being humane and respectful.

Additionally, good medical ethics makes valuable contributions to the development of healthcare policy. Input from a medical ethicist should be well informed about issues in moral and political philosophy and well informed about the relevant medical facts and health systems concerns that are at issue. Good medical ethics offers arguments that are measured, fair, and presented in the interest of the appropriate stakeholders.

While I have attempted to accurately state what good medical ethics is, I recognise that my statements are vague and, therein, somewhat jejune. I also acknowledge that more precision is in order. Yet, as I see it, the only way to be more informative about what good medical ethics is requires explaining what bad medical ethics is. In this case, bad medical ethics wears the trousers.

Here's what I mean. In *Sense and Sensibilia*, when trying to distinguish what is real from what is not, philosopher JL Austin identified the kind of situation that I am confronting and offered a solution.⁴ He noted that sometimes saying what something is



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not is more informative than trying to explain what it *is*. So, while I may not be able to say what good medical ethics is in an informative way, and recognising the limits on what can be said in the allotted space, I shall proceed by identifying and illustrating some of the ways that medical ethics goes wrong. I will choose instances to exemplify my points from medical ethics' different roles and across the breadth of the field.

NOT SO GOOD MEDICAL ETHICS

Incoherent—An important role of medical ethics is to point out features of medical practice that require some measure of reform or adjustment. For the most part, and in many respects, however, we regard medical practice to be quite admirable. For that reason, good medical ethics should cohere with what we regard as good medical practice.

Regrettably, however, most approaches to medical ethics view the field as an application of common morality. This is famously the case for the methodology advocated by Tom Beauchamp and James Childress,⁵ the methodology promoted by Bernard Gert, K Danner Clouser, and Charles Culver,^{6,7} and the methodology suggested by feminist medical ethicists. Edmund Pellegrino and David Thomasma⁸ are among the very few who maintain that the ethics of medicine is different from common morality. Even though all these authors teach us a great deal and present numerous valuable insights, I find their overall theoretical approaches to medical ethics wanting.

Comparing those standard medical ethics theories with widely accepted clinical practices, shows that common morality versions of medical ethics are incoherent.⁹ For example, according to common morality, whatever we see or hear can be shared: exceptions to that presumption require a promise or a non-disclosure agreement. In medicine, by way of contrast, confidentiality is the rule. In common morality, beneficence is an imperfect duty: acts of kindness are nice, but optional. In medicine, however, beneficence is the defining duty, and clinicians are committed to acting for the good of patients and society. For the most part, putting your own good before the welfare of patients is not an option. Common morality instructs us to presume that people are autonomous and it requires us to accept their decisions that affect only themselves, and leave them alone. In medicine, conversely, good clinicians are supposed to assess decisional capacity whenever patients refuse clearly beneficial treatment and to intervene to the extent necessary (eg, by repeating, encouraging, cajoling, involving family members, treating over objection). And for feminists who see reciprocal caring as the basis of morality,¹⁰ it is baffling to explain in their terms just how clinicians can have responsibilities to infants, the cognitively impaired, or patients in a vegetative state. I could go on with examples, but I trust that these are sufficient to make the case that the fundamental presumption that medical ethics is just an extrapolation of common morality is incoherent when held up against good medical practice.

Not illuminating—Frequently, the cases that trouble clinicians involve ethical dilemmas. A dilemma can be framed as a question about which of two important principles should be upheld in the particular circumstances or which of two irreconcilable paths is more consistent with the patient's goals. Thus, many people rely on a simplistic version of the four-principles approach for adjudicating medical ethics dilemmas. Typically, they list the ways in which each principle is related to the decision at hand. As Clouser and Gert pointed out in their insightful article, *A Critique of Principlism*,¹¹ the four principles do not provide a mechanism for resolving dilemmas. Similarly, the four-topics approach advocated by Albert Jonsen, Mark Siegler, and

William Winslade,¹² offers no guidance for how to use the collected information to adjudicate a problem. So, ultimately, neither approach provides illumination in resolving dilemmas.

At the same time, insisting on attention to all four principles, or all four topics, can divert attention from key issues and introduce needless confusion by focusing on tangential matters. A formulaic approach that requires rote-wise ticking off principles or topics can be unproductive and distracting without clarifying the issue or helping to resolve the problem. It is more useful to help the team identify the specific issues that create the dilemma and elicit information that is relevant to resolving the matter. It is then important to offer reasons for prioritising one important concern over the other.¹³ And when no particular resolution is obvious, clinicians should be helped to identify additional facts that could inform a decision about which path to take.

Inaccurate—Medical ethics is supposed to serve as a moral compass. Others call upon the field to be edifying and to provide guidance. Instead, medical ethics frequently muddies the waters and points people in the wrong direction.

The 'best interest standard' is a case in point.¹⁴ It is widely invoked in medical ethics as the criterion for clinical decisions and clinical behaviour. It sounds like mother's milk and it has become the reigning standard in both medicine and law. Nevertheless, clinicians who have more than one patient and more than one responsibility are frequently not acting in the patient's best interest. Imagine a bleeding accident victim brought into a crowded emergency room. When a physician attends to this patient's urgent needs before seeing the patient who arrived earlier with less urgent needs, we believe the physician is doing the right thing, although she is not acting in the best interest of the patient who is left to wait longer. When multiple patients require medical resources or attention, some patient's best interest has to be sacrificed for the good of another. When achieving educational goals requires some extra examination or practice by someone low down on the learning curve, again, the patient's best interest is sacrificed. When research goals require extra tests or extra time, again, the patient's best interest is sacrificed.

Although the patient's interests must always be considered, and clinicians must always strive to achieve optimal outcomes for each patient, often good clinical practice does not actually reflect every patient's best interest. Using 'best interest' language is inaccurate, and it presents a distorted picture of what medicine is and should be.

The doctrine of double effect and the killing and letting die distinction are more glaring examples of misdirection originated by medical ethicists. When medical ethicists promote a simplistic understanding of these concepts as principles of medical ethics, their inaccuracy encourages people to accept fallacies as truths. In effect, the fallacious thinking licenses clinicians to practise negligence, which in any other setting would be identified as blameworthy. As teachers and as guides, medical ethics should be committed to accuracy.

Unreasonable—Simplicity is appealing. People like simple rules because knowing the rules seems to make it easy to avoid wrongdoing. Yet, every simple rule has exceptions. Morality requires making difficult judgements, taking responsibility for them, and living with the uncertainty of not knowing if you made the right call.

In medical ethics, simplicity has its usual appeal. When a medical ethicist fails to distinguish circumstances that require following the rule from those that require a deviation, however, the result is not good. Consider privacy and informed consent, two key factors that should be carefully assessed in clinical practice

and biomedical research. When these factors are taken to be absolute standards, medical ethicists make unreasonable demands.¹⁵

To make this problem vivid, imagine the child bike-riding policy that someone committed to preventing harm would advocate. Bike-riding would be prohibited, because there is no way to allow the activity and absolutely guarantee that no child would suffer harm. It is obvious that a 'no bike riding' policy would be unreasonable because it would also obstruct the development of important learning and skills.

Yet, those who are absolutely committed to assuring, for example, privacy protection and informed consent, frequently advocate policies that are similarly unreasonable. Whereas privacy and informed consent must be considered, in contexts including health policy, clinical practice, education, and research, assuring absolute privacy and prohibiting any interaction for which informed consent cannot be elicited, introduces unreasonable risks and imposes unreasonable burdens. Regarding these protections as 'absolutely essential' fails to appreciate that ethics always requires discernment.

Similar problems are created when medical ethicists regard any risk to a 'vulnerable' individual as a violation of an inviolable moral rule. Risks should always be considered in context. Often enough, risks that are unlikely and harms that are small and fleeting may be justified even when those at risk can be regarded as vulnerable.

Inconsistent—Although Ralph Waldo Emerson chided 'a foolish consistency is the hobgoblin of little minds,'¹⁶ when a point is incisive, it should be applied consistently. Yet, if you actually pay attention to the running script of bioethicists, a lot of inconsistency gets by.

For instance, one valuable insight of contemporary medical ethics is the importance of respect for patient autonomy. Yet, in the medical ethics literature, we find people employing this concept with meanings from opposite ends of the interpretation spectrum, and sometimes the very same individuals take opposing and inconsistent views in different contexts. In clinical ethics, we find medical ethicists presuming that every patient (including children, the demented and those who are minimally conscious) has autonomy that must be respected. At the same time, we find ethicists paternalistically protecting research subjects by advocating that research participants must demonstrate near-perfect understanding of a research study before they can be accepted as participants. On the one hand, medical ethicists appear overly inclusive in their extension of the term in the clinical domain, whereas their use of the concept becomes overly narrow in research. At the very least, medical ethicists should acknowledge that the two contrasting positions on autonomy are inconsistent. Strangely, they don't even seem to notice.

Another related example arises in palliative care. There, physicians and their medical ethics supporters typically champion respect for autonomy and the personal goals of patients and their family members who choose to forgo aggressive life-prolonging interventions. Yet, when patients and family members choose another course, they are frequently derided for not acting in the patient's 'best interest' and are bludgeoned with charges of failing to 'liberate' the patient from the ventilator. Again, the inconsistency goes unnoticed and without reproach.

To labour the point, here are additional inconsistencies. Ethicists who staunchly demand genetic privacy in research, may also assert the 'duty to warn' in clinical genetics which would require violations of the genetic privacy of individual patients who have actually relied on medical confidentiality and expressed their opposition to sharing their personal information. In the context of human subject research, ethicists often insist that

the focus must be on the research participants only, regardless of the impact that an inefficient and wasteful study design might have on the broader affected community. Frequently enough, these same ethicists will advocate for considering the welfare of all humanity in public health and environmental matters. And many ethicists are quick to debunk duties to future generations in arguments for participating in research while they vigorously endorse duties to future generations again when they discuss environmental concerns. I am not here supporting any of these positions, but drawing attention to the inconsistencies that abound in our field. Although there may be circumstances for shifting one's focus of concern, the change in perspective should be noted and explained. It is not good when bioethics is insensitive to conceptual sloppiness of this magnitude.

Not informed—Medical ethics decisions affect the lives of others. People in clinical settings, within institutions and in the broader society rely upon the counsel of medical ethicists. Their reliance entails responsibilities to get the recommendations right.

The easiest way for an ethicist to get things wrong is to offer a recommendation that is uninformed. Sometimes it is hard to know what you don't know. But the more novel the issue is, the greater the responsibility to delve into the facts. This point is important both in offering recommendations and in voicing criticism. Without pointing fingers, suffice it to say that offering ethical recommendations or decisions without first educating oneself about concerns and details, and without hearing from key medical and scientific personnel, can amount to culpable ignorance rather than good medical ethics. And when colleagues request guidance from an ethicist, the response requires informing oneself about the issues as thoroughly as time allows. Often, this will require consultation with people who have relevant experience, a literature search, reading, thinking, and critical analysis. An ethicist who merely responds by reciting the vapid platitudes of medical or research ethics without an adequate appreciation of the issues fails to fulfil her obligations. Ineffectual babble is not advice. At the very least, the ethicist should make a sincere effort to gather the facts, digest the material, and offer reasoned recommendations or at least a framework for sorting through the problem.

Not measured—Investing effort in checking facts to assure the accuracy of your positions and avoiding exaggeration by carefully choosing your words can be dull. Measured statements rarely make it into the spotlight. Drama gets attention.

Whistle blowing about someone in your own institution tends to end careers. Yet, for some medical ethicists, hyperbolic attacks on people and projects from other institutions, accompanied by rabble-rousing letter-signing campaigns, appear to be the preferred form of argument. Medical ethicists have been known to pronounce that shouting fire at the first whiff of smoke is actually a medical ethics duty. Medical ethicists of this persuasion embrace the role of muckraker, but their enthusiasm for sounding alarms often leads them to cry foul when there is no muck. They demonise individuals and research projects when very little is amiss and take no responsibility for the untoward consequences of their own behaviour.

This is not at all to deny that offering criticism is an important medical ethics role. Identifying problems and bringing them to the attention of people who can address them, and sometimes to the general public, is a legitimate medical ethics responsibility. But how it is done makes all the difference. On the one hand, we have the example of *The Human Radiation Experiments*,¹⁷ a report that provides a well researched and incisive critique of radiation research conducted during and after World War II. Readers and policy makers can rely upon it for providing an

accurate record of what occurred and a thoughtful analysis of the events in measured terms. Similarly, criticism of the Jesse Gelsinger case¹⁸ and the cytokine storm case¹⁹ was pointed, instructive and effective in demanding thoughtful attention to risk in potentially dangerous first-in-human studies. On the other hand, the chorus of criticism of the Surfactant, Positive Pressure, and Oxygenation Randomised Trial (SUPPORT) study,²⁰ the Kennedy Krieger lead paint study^{21 22} and the PolyHeme study²³ were, in my view, less balanced and somewhat counterproductive.

An example that struck me as unbalanced criticism played out in the medical ethics literature. It began on 3 February 2010 with a Letter of Concern from Bioethicists, organised by fetal-dex.org and signed by many medical ethicists.²⁴ The letter was sent to the Food and Drug Administration (FDA) Office of Paediatric Therapeutics, the Department of Health and Human Services (DHHS), Office for Human Research Protection (OHRP), and the universities where Dr Maria New held or holds appointments. It charged Dr New with violating human subjects' research ethics in studies of the off-label use of dexamethasone during pregnancy. It was followed by several publications in *The Hastings Center Report* that reiterated the charges and several articles in the *American Journal of Bioethics* in defence of Dr New. Ultimately, on 30 August 2010, the FDA, DHHS and OHRP issued a letter exonerating Dr New.

Dr New graduated from Cornell University in 1950 and the Perelman School of Medicine at the University of Pennsylvania in 1954. It is fair to assume that she is no longer young. Living through the publicity and the investigations would be a major ordeal for anyone, and it was especially hard on her. Even though there were no findings of any wrongdoing because she had never conducted dexamethasone studies, in the end, Dr New was moved out of her office and into an off-campus facility. As far as I know, those who signed the accusing letter and authored the extremely harsh attacks in the medical ethics literature have never apologised or accepted any blame for launching their public attacks which turned out to be unfounded. Good medical ethics should be far more responsible and cautious.

CONCLUSION

Long ago, Aristotle remarked that when you try to do the right thing, it is hard to hit that target.²⁵ That is because there are so many ways to go wrong. In this discussion, I have tried to point the way to doing good medical ethics by identifying some of the ways that medical ethics could go astray. Because there are so many hazards, attention must be paid. Whereas it may be hard to hit the bull's eye, a reasonably cautious medical ethicist should, at least, be able to avoid the most obvious and egregious mistakes.

As I have tried to explain, putting yourself forward as a medical ethicist encourages the public and medical professionals to rely upon your teaching and advice. What you advise has consequences, and those consequences can be dangerous to others. Thus, good medical ethicists need to be alert, cautious and above all, humble.

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