Bringing context into ethical discussion: what, when and who?

Lucy Frith

Arguably one of the strengths of the discipline of medical ethics is its close attention to the context in which ethical dilemmas, questions and issues play out. As a discipline that is concerned with helping and supporting practitioners, policy-makers and the public to address the ethical aspects of healthcare provision and practice in the best way they can, context is crucially important. As McMillan puts it, 'ethics should be grounded' in the practical realities of the situation.[1] What, where and who are important questions that set the parameters of the debate and, to some extent, frame the subsequent solution or decision. What is happening in a particular case, what is the source of controversy, is it a conflict of values, regulations or professional viewpoints? Where does it take place, under which rules, jurisdiction or in which professional setting? And who does it involve? Whose rights, interests or decision-making capacity do we prioritise? All these contextual questions need to be carefully articulated before it is possible to draw any normative conclusions.

The importance of context is clear in this issue's 'Engagement without entanglement: a framework for non-sexual patient–physician boundaries' by Appel.[2] What might be seen as entirely appropriate behaviour in one context, for example, when I help out a friend and let them stay in my house for a few weeks while they recover from an operation, is entirely inappropriate in another—in the context of the doctor–patient relationship. Appel points out that the importance of boundaries in the doctor–patient relationship has been recognised since ancient times, but certain types of boundary crossing have not received sufficient attention in the literature: non-sexual relationships and doctor–patient relationships in specialities other than psychiatry. To address this he proposes, 'a three-prong test for physicians to determine whether non-sexual interactions that transcend traditional patient–physician boundaries are ethically permissible.' He goes on to say, 'By using a more rigorous, principle-based analysis that not only incorporates intent and potential benefit, but also concerns for entanglement and concordance, physicians should be able to navigate non-sexual boundary issues with more consistency and confidence.' One of the three principles he sets out is that 'the physician and patient should have the same understanding of the motive and purpose underlying any engagement that transcends the traditional patient–physician relationship', what Appel calls concordance. But how do we know what the traditional patient–doctor relationship is and correspondingly what are appropriate actions and types of associations within that? Here context is key, and the sociocultural context of these relationships are important for our understanding of the traditional patient–physician relationship and what it should look like in any particular setting. How we, as practitioners and patients, navigate ourselves in the professional medical space requires a good understanding of what is appropriate in that context. Appel's paper, by delineating elements of non-sexual relationships that might become problematic, such as entanglement, and establishing principles for such boundary crossing—that it produces benefit for the patient and that all parties should have the same understanding of the motives and purpose—helpfully provides criteria by which to judge particular actions.

Responding to Hardman and Hutchinson's[3] paper on the relationship between medical practice and ethical theory, Wagner[4] claims that one implication of their argument, that the teaching of ethics to medical students, doctors in training, should de-emphasise philosophical ethics and focus instead on pedagogical activities more closely related to everyday concerns, should be resisted. These everyday concerns might be taught by exposing medical students to patients' accounts, providing detailed case studies that demonstrate the specificities of the context in which the ethical issue, question or dilemma takes place. While case studies and putting a human face to the topics that medical students grapple with is helpful, as Wagner points out, philosophical ethics and associated moral theories and principles can be useful tools for helping us think through the different elements of complex ethical situations. He grounds this claim on the argument that you can conceptualise ethical theories as models, quoting Bailer-Jones, who states, 'A model is an interpretative description of a phenomenon that facilitates (epistemic) access to that phenomenon.'[4] Wagner goes onto argue, 'I suggest that an ethical theory can plausibly be interpreted as a model in the aforementioned sense, and moreover, that applying several different ethical theories to an ethically complex situation in an ecumenical, pluralistic frame of mind can be understood as employing the multiple model approach to comprehending, and acting in, that situation.' Here, ethical theories can be used to help us think through the different elements of a situation, what consequences might be produced? If we take a certain course of action does that involve breaching another ethical imperative such as not deceiving a patient? Are we acting well—virtuously, etc? Daniel Callahan and Art Caplan have made similar suggestions. Callahan has noted ethical principles can be seen as 'ways of organising our moral thought, giving it a shape and formal structure'.[5] Caplan says that ethical theory and principles are, 'tools by which moral issues can be examined from a variety of perspectives….A fully developed applied ethic would afford the moral philosopher an opportunity to examine the delicate interplay that occurs among fact, social roles and prescriptive principles in reaching moral decisions.'[6] Therefore, a medical ethicist has an expertise in both normative theories and concepts, but should also be an expert in the descriptive ethics of their chosen area—the context. Thus, ethical theories can be used to discern areas of disagreement, to clarify terms and reveal ambiguities. As such, ethical theories can be used as a tool of analysis, as I have argued elsewhere.[7] Just as sociologists use social theories to elucidate the fabric of social life, ethical theory can be used to elucidate the ethical aspects. These accounts of the use of ethical theory are based on different underlying theoretical assumptions, but all see ethical theory as a body of knowledge that can be brought to bear on different issues and used as an analytic tool—helping us to understand the complexities, and arguably the context, of ethical issues more clearly.

As the context changes different ethical concerns come to the fore, demonstrated by Samuel and Richie's[8] paper in this issue. 'Reimagining research ethics to include environmental sustainability'[8] examines 'the need to reimagine research ethics frameworks to include notions of environmental

Correspondence to Dr Lucy Frith, Centre for Social Ethics & Policy, The University of Manchester, Manchester, UK; lucy.frith@manchester.ac.uk

sustainability' using date-driven health research as a case study. The use of data, particularly big data, is a relatively new development in how health research can be conducted and has already generated a substantial amount of ethical discussion.[9] Climate change, arguably, should have provoked more discussion in the medical ethics literature than it has to date,[10] but hopefully this is being rectified[11]—and this is a context that we ignore at our peril.

Twitter Lucy Frith @lucy_frith

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ORCID iD
Lucy Frith http://orcid.org/0000-0002-8506-0699

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