

Part III

Medicolegal and Ethical Encounters

Chapter 17

Ethics and Bioethics

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Truth Telling
Principles of Biomedical Ethics
Autonomy

Beneficence (and its Counterpart, Nonmaleficance)
Justice

It may seem strange to some that there is a chapter touching on bioethics in a textbook of legal medicine. Many physician readers might think that the practice of law has little to do with ethics, and the legal readers might be forgiven for failing to perceive much effect of ethical discourse in contemporary medical practice. Both these viewpoints are unfair, and it is consistent with the role and mission of the American College of Legal Medicine (ACLM) to show how ethical discourse has a significant influence on the interface between law and medicine.

Both law and medicine, when practiced at their best, seek to do what is right and good, and ethics helps both disciplines better define and ultimately achieve that objective. The contemporary construction of bioethics was first well formulated in the United States in the mid-1970s by the statement of the four principles of bioethics elucidated by Beauchamp and Childress.¹ These principles, which are intended to guide the resolution of all ethical dilemmas in biomedicine, have become at once the mantra of ethicists and the generally accepted guiding principles for all bioethical discourse. They are as follows:

1. Autonomy of the person
2. Beneficence
3. Nonmaleficance (which some see as an element of beneficence)
4. Justice

With these goals to guide personal morality, directing as it does all aspects of professional behavior, the performance of physicians, attorneys, and medicolegal specialists will generally tend toward the good and urge others to do so as well.

There is considerable need for ethical thought in the twenty-first century as the practice of both medicine and law tends more and more to regard commercial concerns as

an appropriate if not a principal concern. As a result, professionals training for practice in these fields should certainly be given a basis for understanding ethical issues and generating ethical discourse in their medical and law schools so that an effective balance between commercial concerns and moral principles may suffuse medicolegal problem solving. It has been widely argued that the resurgent feeling of need for ethical evaluation has resulted from the rapid progression of medical technologies in various fields, making it technically possible to do so many things that previously were not considered because they could not be done. The thesis is that because we can do so many more things, we are ever more impelled to ask ourselves whether we ought to do those things. Although clearly those issues have been involved in the needed resurgence of ethical discourse, in the twenty-first century different and perhaps even more profound changes appeared in our society and in the way we delivered health and legal services. These changes have worked even more strongly to bring ethical issues into relevance. Certainly many of the issues posed by the exponential growth of "managed care" involve intense ethical concerns and have prompted a resurgence of interest in the subject.

Perhaps in part, as a result of the rise in general levels of education, the broad sweeping prominence of concepts of autonomy has driven the idea of benevolent paternalism, which in the past had been a large part of the ethos of both law and medicine, into the background. The desire, in fact the demand, of patients, families, and clients to understand all of the alternatives and to make meaningful choices, whether or not they are considered wise by professional advisors, has forced physicians and attorneys to think in ever more ethically oriented terms about what they tell people, what they counsel them about, the

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alternatives they put to them, and the way in which they interact with patients' choices. As with any change, there is some resistance within the professions, but many believe that overall these changes in attitude will be a great advantage to the professions, their patients and clients, and society in general.

Ever more physicians and attorneys will need to concern themselves as much with what ought to be as with what could be, and it is hoped that, together with colleagues in other interested disciplines, they will be equipped to engage in an ethical discourse that will effectively inform and guide those deliberations.

In recognition of the increasing importance of ethical guidance in medical and medicolegal practice, many organizations interested in those fields publish codes of ethics and ethical opinions designed to assist professionals in considering bioethical issues. Guidance is offered by the American Medical Association's Ethical Code from time to time interpreted by the published opinions of the Council on Judicial and Ethical Affairs. The Canadian Medical Association has also promulgated a Code of Ethics following up on a study conducted over several years by its Committee on Ethics.

These general guidelines are supplemented by ethical codes provided by a number of medical, medicolegal, and legal societies. The ACLM has adopted its own Code of Ethics for medicolegal practice, which it is hoped will be of assistance at the interface of law and medicine. In addition there are international codes, such as the Declaration of Geneva, the International Code of Medical Ethics, the Declaration of Tokyo, the Declaration of Oslo, and the Declaration of Helsinki. In their latest revised editions, many of the codes provide additional guidance to supplement traditional medical texts, such as the Oath of Hippocrates. A number of governmental agencies and research funding bodies also have devised and made available ethical guidelines that will be helpful.

Ethical codes in medicine and law contain constant principles but are ever changing in response to rapid and important changes in their environment. An example of proposals for change in ethical codes as social conditions evolve may be seen in the Tavistock Principles proposed and discussed in the last several years² and the continuing revisions to the Declaration of Helsinki by the World Medical Association.³

TRUTH TELLING

As previously indicated, there is much in the obligation between a physician and patient that is like the fiduciary relationship with which attorneys are familiar. The imbalance of power between the physician and the patient dictates that society must hold the physician to owe the highest duty of fidelity, honesty, and lack of self-interest to his or her patient. The physician must tell the patient the truth, the whole truth, and nothing but the truth and must act at all times in the best interests of the patient, forsaking any personal interest that conflicts with that of the patient. He or she must not deal secretly with others who are

contrary in interest to the patient and must at any time reasonably account to the patient for his or her activity on their behalf. Physicians' duties related to confidentiality and conflict of interest arise from this fiduciary relationship. The changing and expanded role of physicians in the management of the delivery of health care means that the nature and quality of those activities must be constantly and carefully evaluated against the obligations that accompany the title of physician.

What then should be the obligation of the physician when he or she knows that a serious mistake has been made in the patient's treatment? One might think that it would be the clear obligation of the physician to disclose any error made, to assist the patient as much as possible to recover from that error, and to seek any recompense to which he or she might be entitled. Indeed most learned professions, including the law, recognize such obligations in their ethical codes and guidelines. It is interesting and somewhat regrettable, however, that the medical profession by and large does not recognize this obligation or certainly does not in the large part practice as if it were recognized. The culture of blaming, which is part of medical training; the litigious nature of the medicolegal field; and physicians' abhorrence of the idea that they could be responsible, through simple human error, for adverse outcomes suffered by patients make physicians reluctant to discuss errors and certainly reluctant to disclose them. The famous study from the Institute of Medicine, edited by Linda Kohn, Janet Corrigan, and Molla Donaldson,⁴ discusses this phenomenon at length and points out how far the medical profession has to go in recognizing and dealing with error and in prescribing and fostering open communications with patients and their families when error occurs.

Generally it is the burden of learned professions to spend time and considerable effort assisting patients in understanding complex and unfamiliar concepts (e.g., during the process of obtaining informed consent and directions for action). As physicians continually improve their skills and attitudes in this aspect of their practices, it would serve them well to consider how those same skills might be applicable to honest communication with patients and families when adverse outcomes occur. If physicians truly believe themselves to be obligated to act as advocates for their patients in the health care system and if the profession wishes to retain its good reputation for honesty and skill and the public trust that it thereby enjoys, this issue should certainly be on the front burner of professional discussion in the next few years. Without pointing any fingers from a professional corner that is far from entirely blameless, attorneys and ethicists may be able to help in this consideration and should make every effort to do so.

Telling the truth surely must be one of the principal hallmarks of all professional callings, particularly in the field of legal medicine. All trainees in that field should recognize this fact and should work through the complicated discussions that surround this seemingly simple concept. Competence to deal with such issues should be seen as a prerequisite for entering independent professional practice.

The fiduciary nature of the relationship between physician and patient represents that fundamental trust that is the essence of the interaction between physicians and the community. It is the basic reason that people trust physicians. Much in the rest of this book describes the legal result of the outrage people exhibit when they feel that their trust has been betrayed, and this backlash serves as evidence of a basic public expectation that physicians will honor that ethical trust. In an era when so many influences and so much money seek to draw the physician's loyalty to agendas other than those of the patient, there is a growing need for frank discussion among physicians, attorneys, and social policymakers as to what these expectations are and should be.

For physicians, the trust between them and their patients is fundamental to patients seeking care and to their compliance during the provision of care. For the medical profession, the meeting of those public expectations when moves are afoot to divide physicians' loyalties in the health care system is essential, and to that end, considerable public discussion and ethical discourse must happen.

An example of emerging policies favoring honesty and disclosure can be found in the website of the University of Toronto Joint Centre for Bioethics and the Sunnybrook & Women's College Health Sciences Centre, one of the largest university hospitals in Canada.⁵

PRINCIPLES OF BIOMEDICAL ETHICS

The basic principles set out and elucidated in ethical codes serve to guide decision-making. They are often individually imprecise or indecisive and may even be in conflict, and thus ethical discourse serves to analyze and determine the best approach to the good in individual cases and factual situations. The study of ethics thus involves the development of facility in ethical discourse, mostly through the study of worked case examples rather than as a general philosophical discussion. It is perhaps for this reason that bioethical analysis has become so helpful and popular in the medicolegal context, mirroring in its methods as it does, the way in which the substantive elements of the medical and legal disciplines are generally analyzed.

The classic sources of medical ethics were in the continental line of humanist philosophy, which had as its goal to seek rules capable of universality. Modern examples of this line of thought are the Declarations of the World Medical Association and the World Health Organization, arising from the Universal Declaration of Human Rights of 1948. This set of fundamental principles is rooted in an analysis of the evils of World War II and is declared to be of fundamental and universal applicability. The principles are equality among human beings, protection of individual liberties, respect for the dignity of all persons, and privacy. The more modern formulation of fundamental principles has been largely adopted for bioethical discourse and considers *autonomy*, *beneficence*, *nonmaleficance*, and *justice*, although many would consider *nonmaleficance* a part of *beneficence* and some would add *compassion*.

The more recent proposals of the Tavistock Group and the newer revisions of the AMA Code show other formulations that may be helpful.⁶

AUTONOMY

The word *autonomy* is derived from the Greek *auto nomos*, or self-rule, and involves in essence the idea of individual free choice or what citizens of Western democracies often call *freedom* or *liberty*. In the bioethical sense the concept is that physicians and attorneys have an obligation to respect the free choice of the patient or client and more than that to facilitate in every reasonably possible way the making of such a free choice by each client or patient. In medical terms the concept is that the patient should control what happens to him or her in a medical sense by the exercise of free will and free choice. As early as 1914, Justice Cardozo pronounced the most famous and lasting statement of this principle when he wrote, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."⁷

Western societies have put a high value on free choice and liberty, and thus respect for even foolish or eccentric decisions is ultimately required because of the perception that the sort of society that does not require respect for autonomy is profoundly unacceptable. In practical terms, relating to medical encounters, a patient is often not in a position without the assistance of the physician to marshal enough information about the choice to be made that his or her unassisted preference could be considered genuinely autonomous. Thus for physicians and patients the concept of autonomy resolves itself into the patient's right to receive information sufficient to allow a reasonable person to make an intelligent decision and the patient's right to make a decision as to whether to accept or refuse the recommended medical treatment. From this practical interpretation of the importance of autonomy arise our legal rules relating to informed consent and what has come to be called *informed refusal*. This is but one example of how law takes ethical discourse and makes it into a practical requirement for everyone involved. An understanding of the ethical analysis of autonomy makes it easier to understand why informed consent is required and easier to enter into a legal debate about what the elements of that consent should be and how the law should characterize and implement the requirement.

Law is mostly about limits on autonomy, for clearly autonomy is limited. Whereas each individual should be free to make autonomous decisions about issues that affect only his or her own rights and interests, there must be limits on purely autonomous decision-making when the rights and interests of others are affected. To use a popular phrase, "Your rights end where my nose begins." Many of the issues that arise from "hard times" in medicine and the need to consider prioritizing and rationing available medical services are about the proper limits on autonomous decision-making, and this is discussed in the following section.

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Wishes

In medicine, encounters between physicians and patients in which treatment recommendations would ordinarily be made often occur in circumstances in which the patient is not, at the time of treatment, able to express his or her wishes or exercise the right of autonomy. Increasingly in today's society, patients are able to foresee that there may be a time later in life when they are in a situation in which they wish to influence the decisions about their care but are unable to articulate their wishes at the time. Contemporary thought dictates that if wishes were previously expressed and are known to those recommending treatment, the previously expressed wishes ought to be respected as the best available indicator of the patient's autonomous choice. Previous wishes also must be interpreted carefully, and an attempt should be made to understand how those wishes might apply to current circumstances that significantly differ from what the patient might have been contemplating when the previous wishes were expressed.

Various types of formal advance directives have become popular and are now part of most health care settings. Many forms of living wills or advance directives are available, and many jurisdictions have dealt in statute with the way in which such documents should be used and interpreted. There does not seem to be any ethical reason that a person should not be able to contemplate at one point in his or her life circumstances he or she believes may occur later and exercise autonomous choice regarding responses to those circumstances at an earlier time. Equally there does not seem to be any obvious reason why physicians should not respect choices made at an earlier time provided there is no reasonable ground to believe that they have changed in the interval.

A number of prominent cases in the United States have brought forcefully to the attention of the public the extremely stressful situation for families created when the prior wishes of persons in a persistent vegetative state have not been clearly and precisely recorded before the need to understand them arose. The highest courts have made it clear that valid prior wishes are to be respected and, indeed, are constitutionally protected, but respect for such wishes can only avoid family strife and protracted litigation if the prior wishes have been clearly expressed and recorded. These cases have emphasized the importance of expressing those wishes and physicians and attorneys can urge and assist their clients/patients to make effective declarations of their wishes and to communicate their attitudes and desires to their loved ones.⁸

Many early living wills were quite simple and did not give much detail about the patient's wishes. Physicians often had difficulty interpreting these simple directives, and this limited their utility in facilitating the autonomy expressed. A patient's statement that he or she "did not wish to be kept alive artificially" did not provide much practical guidance to physicians treating the patient in a later critical illness. Did the patient mean that he or she did not want cardiopulmonary resuscitation but did want other supportive treatments? Did the patient mean that he

or she did not want artificial life-supporting treatments or any treatment at all? Did the patient mean that he or she did not wish to be kept alive by artificial means only when suffering from a predictably terminal illness for which no reasonable treatment is available, or did the patient mean that he or she did not wish to be given a brief, although admittedly artificial, form of treatment that would quickly bring an acute episode under control? In the last few years, all of these questions have resulted in much more well-thought-out forms of advance directives that ask patients more detailed questions about their preferences and give much more helpful guidance to physicians. A number of bioethical institutes have issued such documents, which seem to be both helpful and in high demand.⁹

In the event of the apparent need for acute intervention to save life or limb, the default condition, at least in the bioethics of the Western world, has been generally accepted as being in favor of life-saving treatment. The majority of ethical discourse suggests that it is reasonable to presume that most people wish to be saved at least from acute danger. This presumption must be interpreted carefully, however, against the zeal of the physician or others to provide care that may be curative but may have been prohibited. The physician, relative, or other whose personal feelings may strongly dictate in favor of treatment, must not be allowed to cavalierly ignore the principle of patient autonomy. A recent Canadian case illustrates this principle.¹⁰

A 57-year-old woman was brought unconscious to the emergency room. She had suffered significant injuries, including a head injury and multiple lacerations of her upper body, face, and scalp, in a severe motor vehicle accident. The attending physician conscientiously believed that the patient would die from exsanguination quite shortly and that he must administer a blood transfusion to save her life. In searching the patient's belongings, nurses found a card in her wallet stating that she was a Jehovah's Witness and would never wish to receive blood products or transfusions. Although this card was signed, places provided for a date and for a witness's signature were blank. The attending physician knew about the card and administered the transfusion anyway. The patient recovered and sued, alleging battery. The court found that the transfusion had been necessary from a medical standpoint and that it had saved the patient's life. The court also found that the physician was fully aware that this treatment was against the patient's wishes and contravened her direction. The physician was found to have committed battery, and damages were awarded in the amount of \$20,000. The court held that, where the patient's refusal was based on religious grounds, it would not apply a test of reasonableness to them. The court held that it could not and would not absolve the physician from his responsibility to respect the patient's autonomous choice by finding the patient's religious convictions to be unreasonable.

Substitute Decision-Makers

The principle of autonomy should not be considered to be restricted to the patient's own choice whether personally

expressed or expressed by advance directive. The patient may appoint a substitute decision-maker to serve in the event of his or her incapability, and in many jurisdictions statute law provides for decisions to be made on behalf of the patient by others. The decisions made by substitutes are to be treated in all respects as if the patient made them personally. Most of the laws recognize that the substitute decision-maker is in as much need of information from the physician as the patient would be if making the decision and require disclosure of such information. Most such statutes provide that if the physician is persuaded that the substitute decision-maker is not acting in the best interest of the patient or is not acting in accordance with the best knowledge available of the patient's actual wishes, he or she may seek the guidance of a court when practical.

Although it is clear that the principle of autonomy should be respected as a fundamental principle of medical ethics, it is equally clear that respect for that principle does not mean that the patient's wishes must be accepted and complied with in every case. Medical ethics does not require physicians to accede to patient choices that are illegal, illicit, or self-destructive. For example, patient demands to illegally prescribe drugs or to assist the patient in self-destruction or self-destructive activity may properly be resisted. It is more difficult to analyze the physician's proper response to a patient's choice that is unhealthy or foolish but falls short of impropriety. It is nevertheless clear that freedom of choice includes the freedom to make foolish choices, even choices that may be quite harmful or destructive, and these freedoms are not limited to choices in medical care but extend to lifestyle choices, such as the use of drugs, alcohol, tobacco, and other unhealthy lifestyles.

Of particular concern is the patient's request that the physician end his or her life or assist him or her in doing so. In most jurisdictions it is not a criminal offense to commit suicide, but in some jurisdictions it is an offense to assist or counsel another person to commit suicide. The principle of autonomy, as we have discussed, should not be interpreted as a requirement to always do what the patient wants, but at the same time the physician is dedicated to making the patient better if possible or making the patient feel as much better as possible, and classic texts dictate against the taking of life or the doing of harm.

Good palliative care often requires extreme measures to relieve pain and suffering, using powerful drugs that also may shorten the patient's life. This double effect has come to be accepted as a proper approach both ethically and legally in most jurisdictions, and treatment designed to reduce the suffering of a patient of a reasonable character is not interpreted by most as the doing of harm even though it may be reasonably foreseen to shorten the patient's life.

Positive actions taken by the physician to end or shorten the patient's life are criminal in most jurisdictions and are seen as sufficiently significant breaches of the principle of nonmalfeasance that many feel they cannot be justified by claims of respect for a patient's autonomous decision to die. In several European countries and North American jurisdictions, tentative steps have been taken to relax the legal rules surrounding euthanasia, and there is a fierce

discussion in the ethical community and an equally fierce political and legal dispute in North America regarding the proper response to this situation. The proper ethical principle to apply and the societal determination of the conflict of principles between respect for autonomy and nonmalfeasance are yet to be resolved in most jurisdictions and will continue to be the subjects of intense ethical discourse and litigation for some years to come. Indeed, the recent litigation extending to the United States Supreme Court dealing with legislation in the state of Oregon providing for a form of physician assistance to patients with terminal illness electing to end their lives well illustrates the vehemence of feelings on such issues.¹¹

This debate will indeed be exacerbated by the fact that patients with serious life-ending illnesses survive longer because of the efficacy of their treatments, and their states of reduced function and thus reduced ability to exercise their autonomous choice create problems. As patients' ability to express their choice is reduced by their illness, it often becomes more and more difficult to determine whether their expressed wishes are their genuine choice or whether their apparent capability to make choices is illusory. The recent trend has been to expand this discussion from the special concern of ethicists and palliative care physicians to a broader effort to interest all doctors and spread knowledge of the issues much more widely in the profession. This approach is likely to make incremental changes in the quality of attention to many more people at the end of their lives, and with more attention being paid to these issues in the legal community as population aging demands those services, we might reasonably hope for increased ethical involvement and improved outcomes in the next few years.

Refused Autonomy

Sometimes patients, particularly those with long-term, chronic illnesses that have made them dependent in many ways, do not wish to make choices and do not wish to have information about their illness. Sometimes this state of dependency extends to the patient's stated desire to simply depend on the physician to provide treatment in his or her best interest (in a maternalistic way) rather than be told all of the facts on which choices might be based. The principle of autonomy requires respect for patient wishes and decisions but should not be interpreted as requiring patients to make those decisions if they do not want to make them.

Ethical Issues That Arise from the Principle of Autonomy

A number of ethical issues in law and medicine are not directly part of the principle of autonomy but arise from it. Prominent among these are privacy, confidentiality, and its limits; the duty to warn; and the physician-patient relationship as a fiduciary obligation.

Privacy and Confidentiality

Most authors include considerations of privacy and confidentiality in the discussion of the principle of autonomy

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because privacy is viewed as a principle closely related to autonomy. The right of self-determination or self-rule, particularly in today's society, in many ways revolves around the right to keep to oneself intimate information and thought. Dissemination of a person's most closely held secrets and thoughts robs the individual in many cases of the ability to exert self-determination and violates the self of the individual in a way that destroys autonomy. In both medicine and law the ancient texts require the maintenance of patients' or clients' secrets to the exclusion of all others, and almost every licensing and self-governing authority in both professions enforces strict rules to ensure the maintenance of patient or client confidences.

This principle is generally thought to be more than just an ethical precept; it is indeed a practical necessity for the practice of the profession. The attorney cannot effectively represent a client who out of fear of disclosure fails to tell the attorney every relevant detail about the matter, and similarly the physician must obtain from the patient a history, including every relevant detail no matter how embarrassing it may be or how much it might subject the patient to public odium if disclosed. For these reasons, patients and clients clearly must know that the ethics of the profession prohibit the practitioner from disclosing any information obtained through the physician-patient or attorney-client relationship. Only in this way will the patient or client be encouraged to be forthcoming, and only in this way will optimal services be delivered.

In contemporary society there is so much health information electronically shuttled around the world in computer banks for the purpose of billing, quality management, statistical analysis, and research that it perhaps is not surprising that there have been a number of notable incidents in which privacy has not been accorded the value that it once was, and the confidentiality interests of the patient or client have been violated or ignored. A large Royal Commission Inquiry in Ontario, Canada, some years ago revealed widespread abuses of patient confidentiality by attorneys, insurance companies, and government agencies, and similar improprieties have been disclosed from time to time all over the Western world. Given the devastating effects that inappropriate disclosures may have on patients and given the ever-increasing spread of this information by electronic means, it perhaps is not surprising that there has been a resurgence of interest in the confidentiality of health information, and a number of jurisdictions have attempted various legislative means of ensuring privacy through regulations. From the point of view of the physician and attorney, the privacy rights of the patient, as part of the ethical principle of autonomy, should be viewed as extremely important and, wherever possible, should be highly respected. Rules requiring the maintenance of patient and client confidentiality should be carefully respected and should be broken only for a good reason or when required by law.

Recent wide proliferation of large-scale and even international E-Health projects has made privacy considerations in health care even more acute in the industrialized world. Indeed much of the impetus behind the formation

of international bioethics societies has come from concerns in this area. There the primacy of autonomy values such as privacy meets different view in other parts of the world where individual freedoms are seen as less important than population and community concerns. Of course, in every society, some overriding public interests will require breaches of confidentiality on the established principle that autonomy always has its limits and that, in appropriate circumstances, the autonomy of the individual must yield to the higher interests of the public and the state.

Most professional rules provide that confidentiality may be breached when such breach is required by law. Mandatory reporting laws related to infectious disease, unfit drivers, unfit commercial pilots, and gunshot and grievous wounds are proper legal and ethical justifications for breach of confidentiality.

In both the United States and Canada a plethora of new laws and regulations regarding privacy and confidentiality of health information has recently been introduced in response to public concerns about health information in the information age. Implementation of regulations often made without much input from clinicians may pose a number of serious problems as ethical principles come into conflict with hard practicalities in the delivery of health services.

The Duty to Warn

Of particular interest are situations in which the autonomy and confidentiality interests of a patient or client conflict with the personal safety interests of another person. When a patient indicates to an attorney, therapist, or physician that he or she intends to kill or seriously harm another person, it is often difficult to balance these interests. On the one hand, attorneys and physicians know that normal people often casually make statements of that kind without any real intent of carrying them out. They also are aware of a number of widely reported and tragic circumstances in which patients or clients who made such threats, which were not reported, went on to carry them out at the cost of the life of the threatened person. Because the prediction of general dangerousness is so difficult and may be impossible, it will often be extremely problematic for the practitioner to determine any reasonable basis on which to make a prediction as to when such threats might be carried out and when they might safely be treated as merely part of a normal, if strained, professional interview.

In many jurisdictions the law now requires that practitioners err on the side of safety by imposing a duty to warn individuals who are the subject of such threats in breach of confidentiality even if it does not seem likely that the threats will be carried out.¹² This erring on the side of prevention of harm is favored by most ethicists as a sound decision, erring toward the achievement of the good. The literature now discloses reasonably good consensus as to warning signs suggesting that such threats are more likely to be carried out. Such warning signs are a definite and an immediate plan to take action, the apparent means to take action, a recent acquisition of the named weapon, availability of the victim to the perpetrator, and the description

of a detailed plan of attack. If such signs are present, the knowledge that an actual attack is more likely will further ethically justify warning the putative victim.

The Physician–Patient or Attorney–Client Relationship as a Fiduciary Relationship

The ethical requirement to respect autonomy of the patient as the principal pillar of bioethics causes consideration of the nature of that relationship. This is one of the areas where the professions of law and medicine have somewhat divergent views as to the implications of the ethical principle for the relationship of the professional with the patient or client.

In the legal profession, most codes of ethics of the bar and most legal licensing statutes establish clearly that the attorney–client relationship is a fiduciary relationship of utmost trust and fidelity and requires complete disclosure, utmost honesty, and utmost fidelity. For example, most bar codes strictly require the attorney to inform the client if any mistake, error, or misconduct occurs and to advise the client to obtain independent counsel. In most bar rules the records and papers pertaining to a transaction, when properly paid for, belong to the client and must be delivered forthwith, and in the attorney–client relationship everything that passes between the attorney and his or her client must be strictly accounted for and a full accounting must be delivered at any time it is demanded.

In contrast, the relationship between the physician and patient is not viewed by most medical societies and licensing authorities as so clearly of a fiduciary nature. Although the physician is expected to do his or her best for the patient and to see himself or herself at all times as principally obligated to the patient, many ordinary features of a fiduciary relationship are not accorded as much importance. The ownership and delivery of medical records are not nearly so clear, and there is no recognized obligation on the part of the physician in most jurisdictions to inform the patient of any error or misconduct or to suggest the obtaining of an independent and alternate caregiver. The concept of therapeutic privilege, which allows the physician the privilege in some circumstances to withhold the truth from the patient on the basis of his or her opinion that the truth might hurt the patient psychologically or make him or her resort to rash action such as refusing treatment, still seems to have some currency in sectors of the medical profession. There also continues to be some legitimacy accorded the idea that the use of placebos and other therapeutic fibs is necessary for cure in some situations. All of this speaks interestingly of the somewhat different approach to the incidents of autonomy in the two professions.

BENEFICENCE (AND ITS COUNTERPART, NONMALFEASANCE)

Beneficence is the duty to do good, be caring, and to help and support on all occasions. Nonmalfeasance is the duty to endeavor to do no harm, and both concepts certainly

date at least from the time of the Hippocratic Oath in which the physicians swore, “I will follow that system of regimen which according to my ability and judgment I consider for the benefit of my patients and abstain from whatever is deleterious and mischievous.”¹³

Every medical student is taught that the first precept of medicine is to do no harm and that secondarily everything should be done to benefit the patient and to be supportive, caring, and helpful whenever possible. The physician is meant to relieve suffering, produce beneficial outcomes wherever possible, avoid bad outcomes, and enhance the patient’s quality of life if possible. This concept is connected with the concept of autonomy, which directs that the physician do what the patient wishes whenever possible, and most often that will be to relieve the patient’s suffering and provide a cure. Doing no harm is a value inculcated in all physicians, but some have considerable difficulty recognizing when unreasonable persistence in treatment that is designed to do good in the face of a clinical situation in which further treatment is useless because it cannot alter the ultimate and inevitable outcome is not beneficial and may be malfeasant.

Although it is true that there are often great difficulties in determining in medical terms when a treatment passes from the therapeutic to the futile, it will often be a function of patient autonomy to make that decision with the best information the practitioner can provide. In any event the principle of nonmalfeasance requires that the physician be alert to circumstances in which futility may supervene beneficent attempts at a cure, and unreasonable persistence in treatment stops being beneficent and starts constituting malfeasance.

For a further discussion of the concept of medical futility see several guideline documents and discussions.⁴

JUSTICE

The fourth principle of bioethics is justice, and in simple terms justice can be thought of as fair play or at the very least freedom from unfair discrimination. As resources to provide health care become more constrained, problems related to the principle of justice will become more important in the ethical discourse of biomedicine. It is likely in the future that the discussion of this fourth principle will assume an ever-greater predominance in the discourse and may approach the prominence heretofore accorded to autonomy.

In many ways the issues that flow from the principle of justice may be seen as the antithesis of those that flow from autonomy. Justice deals with the fair distribution of the system, with whether patients get what they reasonably may consider their due from the health care system, and with the definition of what is a fair distribution of the resources that are available. If autonomy dictates that the patient’s interest is always foremost and what is best for the patient should be first in the physician’s mind, the principle of justice dictates that the physician must have concern for the fair distribution of the system’s resources and for ensuring that they are not distributed in a way that depends on inappropriate discrimination.

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A common formulation designed to distribute services fairly is that patients should exercise their autonomy to receive such services as they desire provided that the system can and will provide only those services that are judged to be medically necessary. Of course, many years of experience in health administration and health insurance administration demonstrate that determining what is medically necessary is the most difficult and problematic determination that must be made within those systems. What is really needed? Are treatments that are designed to make the patient better necessary, and are those that are designed to make the patient feel better unnecessary? How would it be reasonably determined whether a treatment designed to make a patient get better has a sufficient and reasonable likelihood of doing so that the resources of the system should be directed to it in preference to meeting some other patient's needs or demands? To what extent may treatment be denied to patients because there is no scientific evidence that it will make them better in the face of their persistent and apparently honest assertion that the receipt of the treatment makes them feel better?

Are some patients entitled to a greater share of the system's resources because of their station in life or contributions to society? Are highly intelligent contributors to science worth more than poorly educated workers? Are wealthy persons who have made huge contributions to the public welfare to be given preference over the poor? Is it legitimate to consider a patient less entitled to system resources if he or she suffers from a disease to which his or her own behavior, such as substance abuse or smoking, has avoidably contributed? Is a patient's entitlement to health care cumulative over a lifetime? Does there come a point where the patient has used so much of the resources of the system that he or she is not entitled to any more until the needs of others have been satisfied?

In determining whether to allocate resources to the patient it may be legitimate to consider the likely benefit to the patient and to increase the allocation of resources to those who are more likely to benefit or whose quality of life is likely to be improved. Is it legitimate to increase the allocation of resources where the duration of the benefit is likely to be greater rather than lesser or where the patient's condition is more urgent than that of a competing patient? Are some treatments, although likely to be successful and very beneficial, simply so resource intensive that they should not be given because they just consume too much of the available pie for the benefit of one individual? Box 17-1

Box 17-1. Acceptable Criteria for Resource Allocation Among Patients

Likelihood of benefit to the patient
Improvement in the patient's quality of life
Duration of benefit
Urgency of the patient's condition
Amount of resources required for successful treatment

shows the opinion of the Council on Ethical and Judicial Affairs of the American Medical Association with respect to some of these issues.¹⁵

Recent studies¹⁶ have tried to develop a more comprehensive framework for managing questions of fair distribution of scarce medical resources and have suggested four overarching ideals:

1. Improving health
2. Fair sacrifice
3. Trust
4. Self-determination

From these are said to flow five procedural principles delineated to realize these ideals:

1. Fair consideration—the interests of each individual need to be considered in the formulation of policy.
2. Openness or publicity—policies should be made available to those affected by them.
3. Empowerment—individuals should have the opportunity to participate in the formulation of policies.
4. Appeal—individuals should have mechanisms for objecting to policies and their implementation.
5. Impartiality—those entrusted with developing and implementing policies should not have a conflict of interest.

As the ratio of total population to working population rises in the near future, these considerations will need to be more intensively explored since some medical resources and the means to pay for them will become ever more scarce. The ethical considerations are bound to be important and to come into potential conflict with expedient priorities.

How should the independent practitioner allocate his or her time as a resource between the many patients who will assert demands for care? Is it inevitable that physicians will give more time and effort to patients they like or whose disease is treatable than to those who are obnoxious or whose condition is intractable?

Can a physician properly participate in organizations for the delivery of care that insert questionable incentives into the physician's attempts to do justice to his or her patients? Is it appropriate for a physician to participate in a managed care plan that provides a large percentage of his or her yearly remuneration as a bonus, which the physician receives only if he or she meets a goal to restrain service delivery, meaning he or she will have to work hard not to give care and not to refer patients? Is it appropriate for a physician to practice within a scheme that forbids him or her to discuss with the patient alternatives for care that are not offered by the patient's benefit plan? Should society permit or prohibit those sorts of schemes?

If it is not possible to achieve optimal justice in every patient encounter, ethical discourse suggests that at the very least inappropriate discrimination must not be tolerated. All professional practitioners understand that their practice must be as free as possible from inappropriate discrimination and bias, and certainly all are aware of the inappropriateness of discrimination based on race, religion, national origin, gender, sexual orientation, or political opinion. However, there is considerable literature to suggest that the practice of medicine, perhaps often without intention, has contained a good deal of bias on some, if not all, of those

grounds, in particular on the basis of age, race, and gender. Numerous variance studies done in a number of jurisdictions demonstrate that there appear to be variations in relation to access to care between patients of different ages, genders, and racial origins for no reason that appears to be grounded in science or medicine. It must be presumed that many subtle factors that are hard to identify often combine to produce such discrimination. Clearly, in the name of the justice principle, bioethics requires each practitioner to search his or her practice and all practice protocols in which he or she is involved for the subtle influence of prejudice and discrimination and to eliminate it whenever and wherever possible. Of course it is sometimes extremely difficult for practitioners to perceive these differences or to even be aware of the possibility of their existence. Thus it will be the role of the bioethicist and bioethics committees to assist practitioners in identifying elements of their practices or programs in which infractions of the justice principle may exist. This use of the ethical discourse ought not to be seen as a search for "bad apples" or rule infractions but as a necessary assistance to practitioners, groups, and health institutions in eliminating these most subtle but important infractions of the justice principle.

At the same time there are a few circumstances where scientific principles properly discriminate between age groups, gender groups, and races on the basis of demonstrable real differences between them. Considerable study will often be required to distinguish between situations of subtle discrimination and situations in which scientific and medical considerations dictate an appropriate discrimination between persons and groups with regard to access to, or the nature of, treatment offered.

Limitations of space have permitted only a brief outline of the basic principles of bioethics in a medicolegal context. It is hoped that this chapter and the way in which ethical discourse presents an opportunity to reflect in a different way on the medicolegal dilemmas evident elsewhere in this book may stimulate the interest of the reader in further exploring ethics as a medicolegal tool.

Endnotes

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