

## Chapter 2

# The Underlying Principles of Ethical Patient Care

Medical ethics is based on a series of ethical principles that are particularly relevant to medical practice and patient care. The principles were first developed by Tom Beauchamp and James Childress in their 1979 book, *Principles of Biomedical Ethics*, now in its fifth edition. Since then they have become recognized and used by those who work in medical ethics, training medical students and residents, working as ethics consultants in health care institutions, and serving on hospital ethics committees. These principles are included in the “common morality,” so they will be accepted by most members of the society. They are derived from classical ethical theories and are presupposed by traditional codes of medical ethics.

The principles of medical ethics make several contributions to patient care and decision making in the medical context. They offer a way to approach ethical dilemmas that arise in the course of practicing medicine, making difficult health care decisions, and interacting with patients and their families. The principles provide a way to organize our thinking about ethical issues in patient care and a shared language for health care providers to discuss these issues. Finally, the principles call attention to aspects of a medical situation that might be overlooked, and remind us that medicine is, ultimately, an ethical enterprise.

Beauchamp and Childress introduced four basic principles of medical ethics: Principles of 1) *Beneficence*, 2) *Non-Maleficence*, 3) *Respect for Autonomy*, and 4) *Justice*. In this book we have expanded the original list of four principles to include the *Principle of Respect for Dignity* and the *Principle of Veracity* to include elements of patient care and medical decision making that are not explicitly covered by the original four principles, such as emotions and relationships; privacy and bodily integrity; religious, social, and cultural differences; and the importance of good communication skills.

## The Principle of Beneficence

*Medical practitioners should act in the best interests of the patient.*

More specifically, they should prevent harm, remove harm, and promote good for the patient. In the delivery of health care, the relevant harms to be prevented or

removed may include pain and suffering, disease, disability, and death. Similarly, the relevant goods to be promoted may include well-being, health, proper functioning, and life. When applying this principle, it must be determined whether a proposed medical treatment will prevent or remove harm, or promote good for the patient. However, there may be disagreement about this. For example, while death is normally considered a harm to be prevented and life a good to be promoted, there may be medical situations in which this description is questioned. Family members may believe that the good for their loved one in a persistent vegetative state is continued life, even if this requires long-term artificial nutrition and hydration, and that death is the harm to be prevented. Health care providers, however, may believe that continued life, artificially maintained, is the harm to be prevented, while a natural death may be good for this patient.

## The Principle of Non-Maleficence

*Medical practitioners must not harm the patient.*

This principle is based on the ancient maxim “First, do no harm” (*primum non nocere*). With the addition of this principle, the requirement to act in the best interests of the patient becomes more complicated. Again, disagreements may arise over the identification of harms for individual patients and specific medical interventions. In addition, medical interventions normally involve both harms and goods, often described as risks and benefits. This means that the *Principle of Beneficence* and the *Principle of Non-Maleficence* will often need to be applied together. Combining these two principles requires both an identification of the risks and benefits of a particular intervention and a comparison of the harms done, the harms prevented or removed, and the goods promoted for the patient. The result of these considerations will determine what is in the patient’s best interests.

For example, when practitioners consider prescribing a particular medication, they must weigh the expected beneficial effects with the potential harmful side effects. As a result, providers can recommend the medication as being in the best interests of the patient, considering both the potential risks and the expected benefits.

In another example, a physician who writes a Do Not Resuscitate order for a frail elderly patient in the process of a natural death knows that this will result in the death of the patient. The physician in this case may believe that a natural death will not actually harm the patient but is, instead, a good to be promoted. Even if death is considered to be a harm, the practitioner has determined that CPR would cause more harm than the harm of death for this patient. Other health care providers, as well as family members, may disagree, considering the risk of broken ribs and other results of aggressive and invasive interventions to be less harmful than death.

## The Principle of Respect for Autonomy

*Capable patients must be allowed to accept or refuse recommended medical interventions.*

“Autonomy” is defined as the capacity for self-determination or the capacity to make one’s own decisions. In the health care context, this capacity involves the ability to make and communicate health care decisions. Respect for patient autonomy requires that those with this capacity be permitted to accept or refuse treatment alternatives recommended by their physicians. Of vital importance to the application of this principle is the requirement of *voluntary informed consent*. Capable patients must be provided with full, relevant, and truthful information about recommended treatments and any reasonable alternatives, including expected benefits, potential risks, and the results of refusing treatment altogether. They must understand this information and make a voluntary decision without coercion or undue influence.

Controversies arise here over the determination of who is capable of making these decisions. For many patients this will be obvious, based on their age or medical condition. One controversy involves mature minors, young people below the legal age of consent (18 years). Some have argued that the cognitive development of those who are 15 to 17 years of age qualifies them to make their own medical decisions. Another area of controversy involves those in the early and middle stages of Alzheimer’s disease.

One solution is to evaluate the individual patient’s capacity to make medical decisions, recognizing that these patients may be able to make some decisions and not be able to make others, depending upon the amount and difficulty of the information involved and the consequences of that decision. Those whose decision-making capacity is questionable should still be provided with information they can understand and be allowed to make age- and capacity-appropriate decisions.

## The Principle of Respect for Dignity

*Patients, their families and surrogate decision makers, as well as health care providers, all have the right to dignity.*

The *Principle of Respect for Dignity* is meant to apply to everyone involved in the medical encounter. It is based on the fundamental idea that all persons should be treated with respect and dignity. Respect for persons and respect for their dignity applies whether or not health care decisions are being made, and even to those who are not capable of making their own decisions. Respect for people’s dignity includes respect for their emotions, relationships, reasonable goals, privacy, and bodily integrity. Respecting these personal characteristics requires that they be acknowledged and taken into consideration in all medical encounters and in all aspects of patient care.

The *Principle of Respect for Dignity* applies to the relationships between practitioners and patients. It also applies to practitioners in their interactions with family members and surrogate decision makers. It requires respect for the social, cultural, and religious background of patients, their families, and surrogate decision makers. The principle reminds physicians that medical decisions are often made in the context of family and community background and history.

More specifically, this principle requires good communication skills, including active listening and the willingness to provide information, even when decisions are not being made. According to this principle, when family members and intimate friends accompany and support the patient, their emotions and their relationships with the patient should be acknowledged as valuable contributions to the patient's care. When surrogate decision makers are making decisions about medical treatment for a loved one, they need to receive the information necessary to make an informed decision, as detailed earlier. They should also be treated with the same respect for their emotions, their relationships, and their reasonable goals.

The *Principle of Respect for Dignity* also applies to patients who have not attained, are gradually losing, or have completely lost the capacity to make health care decisions. For example, children, the mentally disabled, and those with advancing Alzheimer's disease will experience emotions, participate in relationships, and have goals for themselves. All of these aspects of their lives should be acknowledged and taken into consideration in every encounter with them and in making treatment decisions. Their privacy and bodily integrity must also be protected to the extent possible, consistent with appropriate medical care and the need for decision making by others.

This principle also applies to those with severe dementia, comatose patients, and even those in a persistent vegetative state. They must always be treated with respect for their privacy and bodily integrity, as far as this is possible. Their inability to make decisions and even their inability to experience emotions and relationships must not allow medical practitioners to ignore their basic dignity as human beings.

*The Principle of Respect for Dignity also requires confidentiality for patients' medical conditions and the treatments they are receiving.*

This is an important element in the maintenance of the patient's privacy. Medical information about a patient must not be revealed to anyone who is not involved in the care of that patient. When patients are incapable of making their own medical decisions, information may be revealed to those who are legally authorized to make these decisions.

Medical practitioners must also preserve their own dignity in their encounters with patients, their families, and surrogate decision makers. They must approach these encounters with an expectation of respect and acknowledgement of their expertise. One of the ways in which this approach can be maintained is for practitioners to offer only those treatments they believe will be effective in meeting reasonable goals for the patient. For example, when family members request or demand that "everything be done," physicians need to be very clear, in their own minds, about what interventions will actually benefit the patient and what interventions will not. They should only offer those interventions they believe will be beneficial and explain why others, requested or demanded by the family, will not offer

any benefit. Professional responsibility requires that physicians practice medicine according to their own judgment based on their training and experience, and not based solely on what family members want for their loved one.

## **The Principle of Veracity**

*The capable patient must be provided with the complete truth about his or her medical condition.*

Capable patients must be provided with the complete truth about their medical conditions, both at the point of diagnosis and as their condition progresses. This is the only way that a patient can make a truly informed decision about accepting or rejecting recommended medical interventions. Patients must also be informed about their conditions in case experimental treatments were to become available. Similarly, surrogate decision makers must be provided with this information so that they can make an informed decision about the incapable patient's treatment.

Controversy arises when no medical treatment is available. Some argue that the diagnosis of a terminal illness or traumatic injury, with no available treatment, should be kept from the patient. Concerns about premature suicide or the loss of hope are often expressed. What is neglected in these arguments is that patients, as persons, have more to worry about than medical treatments. They have to consider their loved ones and what they can do for them now, before they die, and they have numerous other plans to make and see through before the end of their lives. Knowing the truth about what they can expect in terms of their illness or injury allows patients to make plans and live their lives with a purpose they may not have embraced before. Patients and surrogate decision makers also need to know what to expect as a terminal illness progresses so that informed decisions may be made about end-of-life treatment.

Both the *Principle of Respect for Autonomy* and the *Principle of Respect for Dignity* support the need for capable patients to be informed about their conditions, even if they are considered to be terminal, with no effective treatment. This is the only way that patients can make meaningful decisions about their medical treatment, how to respond to their emotions and relationships, meet their reasonable goals, and protect their privacy and bodily integrity as they make decisions about end-of-life care.

## **The Principle of Distributive Justice**

*Health care resources should be distributed in a fair way among the members of society.*

The *Principle of Distributive Justice* is applicable when resources are expensive or scarce and decisions must be made about who will receive these resources.

The controversy with the *Principle of Distributive Justice* concerns what criteria will be used to distribute health care resources, so that the distribution is fair. Different theories of justice recommend different criteria for distribution, including ability to pay, merit, contribution to society, need, and first come, first served.

Our society seems to have adopted a combination of criteria for distributing health care resources. Patients must be treated in an emergency department for an acute illness or trauma. However, they may be released, once they are stabilized, if they do not have insurance or are unable to pay. Similarly, organ recipients must be on a list, using a first come, first served criterion, but must also be able to pay for the procedure and have adequate social support for the recovery process.

The *Principle of Distributive Justice* applies most readily on the governmental and institutional levels, in determining how much of our tax dollars will go to health care and in deciding how an institution's resources will be allocated. Yet, questions about the use of expensive and scarce medical resources may also occur to practitioners as they decide how to treat individual patients. Physicians may consult hospital administrators concerning these questions, but should not refuse medical treatment based on their own determination of the best use of resources.

Most of the principles presented above raise questions as they are applied to individual cases of patient care. Questions of what is harmful and what is beneficial, when harms outweigh benefits, benefits outweigh harms, or certain harms outweigh other harms, who is capable of making medical decisions, and when requested medical interventions are ineffective, must be answered by individual practitioners on a case-by-case basis. The principles may also conflict as they are applied to particular cases. For example, a capable patient may refuse a treatment that a physician judges to be more beneficial than harmful. On the other hand, legally authorized surrogate decision makers may demand medical interventions that physicians believe are ineffective and may even be harmful for the patient at the end of life.

Sometimes, when principles conflict, it is obvious which principle is most important and must take priority. At other times, however, practitioners are faced with an "ethical dilemma" in which the force of the conflicting principles seems to be equal. In these cases, it may be helpful to consult with the hospital ethics committee. This committee will consider the interests of everyone involved in the situation, as well as the relevant ethical principles, and may be able to recommend courses of action aimed at resolving the conflict. When conflicts seem intractable and involve legal concerns – for example, if practitioners are reluctant to provide clearly ineffective interventions demanded by surrogate decision makers – it may be necessary to include hospital administrators, risk management personnel, and hospital legal counsel in these discussions.

## **Annotated References/Further Information**

Beauchamp TL and Childress JF. *Principles of Biomedical Ethics*, Fifth Edition, Oxford University Press, 2001.



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