Foundations of practical ethics

Richard Hain
Toni Saad

Abstract

Principlism remains the dominant framework for addressing ethical quandaries in medical practice. It sets out four principles clinicians should consider that require specification to a particular set of circumstances. There is no hierarchy among the principles; any special prominence given to respect for autonomy is a cultural accretion that is not claimed by the authors of principlism. Principlism does not set out a single consistent or coherent moral theory. Instead, it summarizes for the clinician's convenience the relevant reasoning of more fundamental theories, including those in which the emphasis is on a doctor's intentions (deontological theories), those focussing on the outcome of doctors' actions (consequentialist theories) and those relying on the nature and disposition of the doctor herself (virtue ethics). As sources of guidance in making complex moral decisions in clinical practice, each of these has its attractions and limitations. Principlism does not represent an alternative analytical mechanism, nor is it an exhaustive exposition of those theories. Its strength is that it provides a summary of some of their most important reasoning, in a way that is clear, easy to assimilate and easy to recall at the moment when clinical decisions need to be made in practice.

Keywords Autonomy; ethics; interests; justice

Key points

- Principlism is a practical framework that summarizes ethical reasoning from several moral theories and sets it in the context of practical clinical medicine.
- The summaries are grouped in four themes:
  - beneficence — an obligation to do things that are in the patient's interest
  - non-maleficence — an obligation to avoid doing things that are against the patient's interests
  - respect for autonomy — an obligation to allow patients to make decisions for themselves to the extent that they (1a) are able to do so, and b (2) wish to do so.
  - justice — an obligation to treat patients fairly
- The moral theories that inform principlism include:
  - deontological theories that locate moral value in an agent's commitment to obey a set of rules (duty).
  - consequentialist theories that locate moral value in the result of an agent's actions (outcome).
  - virtue ethics theories that locate moral value in the character of the person making the decision (practical wisdom).
- Respect for autonomy does *not* mean:
  - always obeying a patient's request, even where it is objectively wrong or irrational.
  - insisting that patients make decisions when they prefer not to do so.
  - according less weight to the other three principles in Beauchamp and Childress' principlism.
  - insisting that consent must be exhaustively (rather than adequately) informed.

Introduction

> The first step in the evolution of ethics is an enlargement of the sense of solidarity with other human beings
>
> (Albert Schweitzer, 1965)

Ethics is about the way people live together. Whereas science is about facts — the way the world *is* — ethics is about values, that is, the way the world *ought* to be. Ethics is concerned with careful reasoning and applying such concepts as right, wrong, good and ought. Medical ethics guides one set of people (doctors) in their relationships with another set of people (patients and colleagues).

One reason why communication skills should be treated alongside clinical ethics is that medical ethics codifies an obligation on the part of doctors to behave well to colleagues and patients. At the heart of good communication is a commitment to treating others with kindness and respect. Good communication skills therefore represent and are inseparable from a commitment to the ethical practice of medicine. The converse is also true: because relationships are dependent on the interaction between individuals, medical ethics is reliant on skill in communicating.

In this article, we consider the dominant framework for considering ethics in medicine — principlism — and some of the moral theories that underlie and inform it.

Richard Hain *MB BS MD MSc MSt FRCPE FRCPCH DipPalMed PGCE FHEA is a Clinical Ethicist and Clinical Lead in Paediatric Palliative Care at Noah's Ark Children's Hospital, Cardiff, and Visiting Professor, University of South Wales, UK. Competing interests: none declared.*

Toni Saad *is a Medical Student at Cardiff University School of Medicine, Wales, UK. Competing interests: none declared.*

© 2016 Elsevier Ltd. All rights reserved.

Principlism

Since the American philosophers Tom Beauchamp and James Childress first published *Principles of Biomedical Ethics* in 1977, the four principles approach (principlism) has been the most popular and widely used framework for deliberation in medical ethics (see further reading). It is a practical approach professedly derived from common morality.

The first principle, *respect for autonomy*, is about respecting the patient's right to act and decide in a self-determined way. *Non-maleficence* and *beneficence* respectively refer to avoiding harm and causing good (relieving pain, preventing harm, etc.). *Justice* is a broad principle to do with fairness, for example in the distribution of resources.

Application of the general principles to the individual patient's circumstances constitutes the process of *specification*. For instance, in an otherwise healthy patient who develops pneumonia, the principle of beneficence might militate in favour of inserting an intravenous line to administer antibiotics. In a patient close to inevitable death from advanced cancer, however, the same principle might militate against the same intervention on the grounds that it is invasive and futile.

Principlism sets out to be comprehensive, in that it aims to provide a framework that can be usefully applied to most ethical quandaries a clinician is likely to encounter in practice. But its authors do not claim that principlism is a single coherent moral theory. Rather, it is an attempt to summarize for busy clinicians a number of complex theories that they do not have time to assimilate during training, and that it would be impractical to expect them to apply at the moment a clinical decision is required. Principlism, rather like the *British National Formulary*, represents a compromise between a detailed textbook of theory on the one hand and a list of available practical options on the other.

That has led principlism to be criticized by both those who feel it is too complex and those who feel it is too simple. Muirhead suggests that the complexities of specification, and the resultant failure to yield the sort of rapid and consistent decisions needed in clinical practice, mean that principlism is counterintuitive and impractical for that purpose.[1] Holm, on the other hand, suggests that principlism is not a useful guide of actions in practice because it operates as a mental checklist of considerations with little content.[2]

Autonomy – what it is and what it is not

The principle of respect for autonomy has a laudable motive: attempting to mitigate the sort of paternalism that leads to deception or coercion of the sort that was seen in experimentation during World War II. Of all the principles, it has become perhaps the most widely misunderstood.

Autonomy originated as a description of city–states within nations, whose own system of laws was so good that they were allowed to operate independently of the nation's government. Autonomy describes independence from external constraint, but that independence is not unconditional; it is contingent on a willingness to submit to adequate internal constraints. Applied to individuals, autonomy represents independence, but it is conditional on submission of one's will to what is objectively rational and possible. Autonomy, in other words, does not mean always getting one's own way but being allowed to work out the best solution for oneself rather than being told it by someone else.

Principlism asserts that there is a duty to respect autonomy, an obligation on the part of doctors to respect a patient's wish to make her own autonomous decisions. Over the years, that principle has been widely misunderstood or misapplied in a number of important ways:

- It is often confused with the concept of freedom. Freedom describes the idea that there should be no external restriction on actions, irrespective of whether those actions are rational or right in any objective sense, providing no one else is harmed. A duty to respect freedom would entail the doctor simply obeying the patient's instructions, even if the result would be to cause the patient harm.
- There is often an assumption that respect for autonomy (or even autonomy itself) is the most important of the four principles. Beauchamp and Childress explicitly deny that there is a hierarchy among the principles. They assert that respect for autonomy is no more important than the other principles in principlism and does not automatically 'trump' them. In fact, the dominance given to respect for autonomy in Anglo-Saxon cultures is considered bizarre in other cultures.
- The doctor's duty to respect a patient's autonomy is often confused with the idea that a patient has some duty to be autonomous – that is, the idea that patients may not delegate decision-making to others. That inevitably privileges the moral status of patients who wish, and are able, to make decisions independently of others. It cannot adequately account for and protect many vulnerable patients. Those without autonomy must become 'second-class patients'. So also must those who choose not to make such decisions independently; that conception therefore pathologizes large numbers of perfectly normal people, including children. In any case, individuals do not in reality make decisions in isolation from others; they are inescapably influenced by personal and social factors that depend on others.
- Respect for autonomy is often (correctly) expressed in medical practice by the concept of informed consent to interventions, but it is often assumed that there is a sense in which such consent can be 'fully' informed. Fully informed decisions are inevitably a philosophical fiction.[3] No physician can ever fully inform a patient, and no person – patient or otherwise – can ever understand all the implications of a decision. For a decision to be autonomously made, it is only necessary that an individual be informed to an extent that is adequate for that individual.[4]
- Autonomy is expressed on behalf of oneself, not others. So, for example, a parent's autonomy does not extend to making medical decisions concerning her children in the same way as it can extend to decisions concerning her own body.

Moral theories – deontology, utilitarian consequentialism, virtue ethics

There are three elements to a moral decision: the intention to act, the action itself and the consequences of the action. One way of

© 2016 Elsevier Ltd. All rights reserved.

Download English Version:

https://daneshyari.com/en/article/5681213

Download Persian Version:

https://daneshyari.com/article/5681213

Daneshyari.com