Medical ethics has existed since the time of Hippocrates. The ethics was simplified by lack of successful technology. Basically, doctors were supposed to keep confidences, try to soothe their patients’ suffering, and not overstep their medical abilities. Now we have added to medical ethics surrogate motherhood; allocation of expensive but lifesaving modalities; an emphasis on privacy and autonomy; and an evaluation of the medical system itself.

A set of topics for a course in medical ethics would look something like this: Abortion, Euthanasia, Confidentiality, Truth Telling, Paternalism, Medico-legal Jurisprudence, Allocation, Experimentation, Informed Consent, Genetics and Medicine, the Nature of the Medical Profession, Suffering and Guilt. For each topic, there is a central question.

What justifies an abortion? Should killing or letting die be a part of clinical medicine? When should a confidence be breached? Should a physician always tell the truth to a patient? Should patients be allowed to make all decisions on their own? What are the presuppositions behind the laws of malpractice? How should medical care be distributed? What is a good (scientific and ethical) experiment? What are reasonable criteria for saying that someone understands something? Does the ability to gain control over some aspects of heredity create new responsibilities? What are (and should be) the obligations of the medical profession? How should a physician respond to the patient who asks, “What did I do to deserve this?” These are topics and questions. How and where do they arise?

A 17-year-old young woman asks her family physician to refer her to an abortion clinic. She is about three months pregnant. She is planning on college and a career in business. Her boyfriend is the father but she has no interest in even telling him that she is pregnant, nor does she want her parents to know.
This sort of case is a far cry from the usual sore throats, headaches and backaches seen by most physicians most of the time. In part, its very uniqueness makes it difficult. Of course, there is more to it than just standing out from the rest of the day’s patient load.

Here are some questions that would bother many physicians in this situation—even those who felt that abortion on demand was a woman’s right. Is this a decision that should be made by the young woman alone? Should she at least talk about her feelings with someone experienced with people in this situation? Should the physician make counseling a prerequisite for the referral? Or would this be unjustified paternalistic interference? Should a family physician suggest that she discuss this with her parents? Suppose her parents are also patients of the physician; is there an obligation to tell them about their daughter; or is the prime obligation the keeping of her confidence?

Suppose the doctor does not approve of abortion on demand. How should personal beliefs be reconciled with the needs and desires of patients? Are there professional obligations that should override personal moral beliefs? Finally, what are good reasons for being opposed to abortion on demand? Are they primarily religious in nature; do they turn on a concept of rights; do they depend on some idea of social justice; or do they stem from what the practice of medicine can and should tolerate? Questions proliferate in difficult situations.

Medical ethics as a discipline is an attempt to answer the sorts of questions raised by cases such as the one a have just examined. As answers unfold, the logic of the concepts and how they are connected will become apparent. A picture of the profession will tag along with every consistent look at problems. A view of the nature and importance of suffering and guilt will also be uncovered. Indeed, very little will be left untouched.

Is medical ethics more than just ethics in the hospital or ethics in the doctor’s office? Yes and no. Many of the pressing issues arise here. Many of the decisions have to be made here and made quickly, although often there is even time to call a meeting of a hospital ethics committee. Quite often, the disinterested point of view, touted by some philosophers, seems unrealistic. Can one really be disinterested in a beautiful but possibly battered infant? Can one really be disinterested in the pain and suffering of a severely burned patient who wants to be allowed to die? It is all too easy to point out that “disinterested” does not imply uninterested or uncaring and in doing so forget that doctors almost always have emotional investment in cases such as the ones that present moral quandaries. Perhaps they shouldn’t (that is
another interesting question concerning medical education and human nature, but they do. In real life, these emotional investments cannot (should not?) be overlooked.

Yet for all these complexities, the moral principles involved are very familiar ones. Don’t cause pain unnecessarily. Keep promises and tell the truth, except when obvious harm will result from doing so. Don’t interfere with the lives of people unless they ask for this sort of help. Don’t be so selfish that the good of others is never considered.

Thus, despite all its trappings, the glittering high-technology hospital, the dramatic emergency room, the life-and-death feeling of the intensive care units, the vulnerability often felt in the examining room, medical ethics is still ethics.

Now let us go back to the case of the young woman who wanted a referral for an abortion.

There are psychologists, psychiatrists, and counselors who specialize in abortion counseling. Physicians receive, as a matter of fact, very little training in their medical education in these matters. Yet these sorts of problems crop up all the time. Should physicians be as quick to refer these problems to specialists as they are to refer some rare glandular disorders to endocrinologists? Or should physicians be expected to learn under fire? That, in effect, the way that they get much of their training. Perhaps medical education needs reforming. At least part of what this line of analysis suggests is that the physician in this case may very well be overstepping true expertise in thinking that the woman ought to have counseling. Perhaps she not only does not want counseling, but in fact does not need counseling.

There has been another, even more subtle overstepping of expertise in this case. In asking, “Is this a decision she should make alone?” the physician is raising a moral issue. Clearly this is an important part of what is meant by the question and by the use of the word “should.” Why should the doctor’s medical license also be taken as the license of a moral expert? Even if we were to allow that the physician knew best (whatever that might mean in this case), would it still follow that the physician ought to use his authority to force a course of action on the young woman?

This is the issue of paternalism. More precisely, this is the question of when and how paternalistic actions are justified. What is paternalism? And when is it justified? A detailed analysis of these questions is found in the writings of B. Gert (See B. Gert and C. Culver, “The Justification of Paternalism,” Ethics, 89, 199–210, 1979).
Gert holds that acting paternalistically toward another is best characterized as (a) believing that one is acting for the good of another; (b) believing that one is qualified to act for another; (c) believing that acting for another in a particular case violates a specifiable moral principle, such as those mentioned previously; (d) believing that the good of the person acted for takes precedence over other considerations; (e) believing that the person acted for would believe that generally, no outside help was needed in making decisions aimed at his/her own good.

To justify an act of paternalism, Gert has two requirements. The person acted for would be irrational not to want the action forced because of the evils avoided by so doing. The second requirement is that the one acting be willing to accept as a general rule something like, “In all cases like this, a paternalistic action is allowable.” Getting clear on paternalism is not enough. We have asked another perplexing question. When the physician ponders, “Do I owe it to her parents, who are, also my patients, to tell them?” or when the physician asks, “Does my obligation to her parents justify my making every effort to get her to speak to her parents?” these questions are being posed against the backdrop of professional obligations, a special set of duties only a special sort of professional has. Are there any such obligations? Put in very general terms (within medicine), what exactly is involved in the doctor-patient relation?

This is not to deny that anyone in such a situation might not feel such a tension. But for those of us who are not physicians, it is only a common decency to realize when we have been told something in confidence and to keep that confidence. For a physician, however, literally everything told by the patient must be kept in confidence. This is an obligation that goes back at least as far as the Hippocratic Oath.

Within the confines of the professional obligations, there can be conflicts. In this case, the possible welfare of the patient, which the doctor may think depends on telling her parents, conflicts with the obligation to keep confidences. How are obligations to be ranked? Are there some general guidelines or must each case be treated separately?

Before raising more questions, let us look at some traditional answers to how best to picture the nature of the doctor-patient relationship.

Different models of the doctor-patient relationship have been proposed. On one view, it is very much like a business contract. You give up rights (privacy, for example) and money in return for some service (health care). Obviously, it is the rare doctor-patient relation that has an actual contract. There is
instead an implied promise (Can there be implied promises or must the word “promise” be uttered in the right context?) or contract: the doctor will do everything possible to make you better; you will help the doctor by doing what is prescribed.

There is a variation on this model whereby anything that is not clearly aimed at benefiting the patient directly requires the permission of the patient. A simple example will help. If you have a bacterial infection, the doctor will make every effort to find out which antibiotic will cure you. You have the correlative obligation to take the antibiotic as prescribed. Without the variation, on the first model, the physician would have the right to call your school and suggest that you be excused from gym class. With the variation, the physician would have to be given the right by you, in other words, the doctor would have the obligation to ask you for permission. (Notice that rightstalk has again entered into the discussion. We have been assuming that we have enough of a common sense idea of what a right is so that we are not being led astray.)

On what some consider the engineering model, the doctor is basically a mechanic. Just as you leave your automobile with the auto mechanic after saying what the problem is, the patient tells the mechanic-physician what is wrong and, in effect, goes away. That is, once the physician knows the problem, it is attacked as if the patient were more like an automobile in need of a tuneup and less like a person. Again, there is an implied promise here. The patient gives up the right to be treated like a person in return for the mechanical services of the doctor—with the understanding that these kinds of services are the best route to getting better.

Some see the doctor-patient relationship as one of priest to supplicant. The doctor is privy to all sorts of important information, which the patient is not. Getting better on this model is like having one’s soul saved through a ritual that can be performed only by a special person, a priest. If you want to stay within the folds of the church, you do what the priest says. If you want to get better, you do what the doctor says. A practical consequence of this view would be that self-help programs would be discouraged.

It is often pointed out that what is central to this view is its treatment of the patient as a child, but this is just a function of the lack of knowledge on the part of the patient. Doctors do have special knowledge. Patients should expect to be in the position of taking advice based on special knowledge. What separates this model of the doctor-patient relationship from others is not the need for special knowledge, nor is it the moral dominance of the
physician over the patient. (One assumes that the priest has moral insights lacking in the supplicant.) The essence of the priestly model is that it makes a partnership impossible. One can help a mechanic, “Hand me that screwdriver, will you?” One can bargain on even terms in a business deal. But a supplicant is never even close to being the equal of a priest.

In contrast with the priestly approach, there is the collegial model. It is meant precisely to stress the partnership between the physician and patient. They are partners with a common goal: the health of the patient. On this model, each side trusts the other; each has confidence in the other. The physician suggests treatments the patient agrees or says why not so that a compromise can be reached. Notice that not all conditions lend themselves to this model. For example, the collegial model will not work with babies or in the emergency room where there is a severe, life-threatening condition; or where the patient is unconscious or otherwise incompetent. This model, therefore, requires that there be a way to get a stand-in partner. Put in other terms, this model requires that there be a way to get consent from someone other than the actual patient.

The last model we shall examine is known as the covenant model. It differs from the previous models, all of which are forms of contracts, in that it stresses the dedication of the physician to a higher authority—the goals of medicine. The higher goals are related to eliminating disease and alleviating pain. In this regard, the covenant model pays special attention to the values involved and engendered by the doctor-patient relationship: trust, concern, sympathy. In short, it emphasizes what is often referred to as the caring relationship. To many, it is the appeal to ideals, which characterizes a profession.

These medical models are ambiguous in the following sense. Do they describe actual doctor-patient relationships? Or are they normative, telling us what the doctor-patient relationship ought to be? It is important in ethics to see the distinction between descriptive and normative. In the case of the medical models, there may be no actual examples of some of the models described. Thus, the claim that they are models might be false. On the other hand, just because there are no true covenant relations would not necessarily speak against the possibility that it is the best (from the standpoint of values) model.

In fact, these models are not meant to capture reality in an exact fashion. Rather, each is heuristic, meant to highlight some aspect of doctor-patient relations so that they are easier to study and critique. In a way they are like the concept of ideal gas. There is no real ideal gas; it is just a model of a gas.
The model is used to study real gases. Using the model brings out certain characteristics that otherwise might get lost in the full complexity of the world of gases.

**CONFIDENTIALITY**

Confidentiality goes along with privacy and truth-telling. During the taking of a history, a physician asks all sorts of personal questions from the not-so-personal “When did it start to hurt?” to the considerably more personal, “Are you sexually active?” The doctor depends on truthful answers. What helps to ensure the truthfulness of the answers is the tacit agreement that all of this sort of information is gathered only for the benefit of the patient, that it is necessary, and that it will be kept private.

We have already seen one case where a physician was tempted to violate the canons of confidentiality. The justification for doing so was the doctor’s competing obligation to look out for the well-being of the family unit.

In cases where the clear well-being of a third party (or parties) is put at risk by keeping a confidence, there arises at least the presumption that the confidence can be violated. Infectious diseases are just one kind of example. People who have had seizures are supposed to be reported to their state’s motor vehicle department. Usually, their driver’s licenses are suspended until a physician certifies that they have been seizure-free for at least a year. Drivers of public vehicles (buses, trains, planes) are often suspended because of high blood pressure. Naturally, they would not be suspended if their physicians kept the information confidential. This kind of case brings up a different but related issue.

Should a physician be put in a situation where confidences are likely to be broken? Should a physician choose to be in such a position? What are these positions? Physicians who work for industry or government are often in the situation where they are not expected to keep a confidence; where the kind of physician they are meant to be determines what is or is not a confidence. A doctor doing health exams for an insurance company by the nature of the job cannot keep certain conditions private.

A physician working for a factory is expected to tell of suspected malingering by a worker in order to help the factory cut down on disability payments. Are these violations of confidentiality? Do they undercut the very professionalism of the physician? Of course, a true malingerer hurts everybody by collecting undeserved benefits. But is it the purpose of any physi-
cian to look out for the economic interest of a company and its workers? Isn’t the primary interest of a physician the well-being of specific patients?

Notice here that the question is not purely a factual one. Physicians do work for cigarette companies and other industries. They also work for the armed services and as team physicians in organized sports. Therefore, they can find themselves in the odd situation of “patching” someone up in order to have that person go back into battle only to risk more injury or onto the playing field while still injured. The question is this: Should physicians be asked (ordered) to do this? Are such physicians negating those higher goals implicit in the covenant view of the doctorpatient relationship? Put another way, is the covenant view, even if meant merely as normative, a realistic normative picture, given real life expectations? Asked in its most general way: What is a realistic set of values for the profession of medicine? This is the crux of ethics applied to medicine.

RANKING OBLIGATIONS

What are the prime obligations of physicians? Here is a reasonable list: To help maintain health. To cure disease. To restore to normalcy. To alleviate pain and suffering. Let us look at each of these.

MAINTAINING HEALTH (WELL-BEING)

It would help if we could clearly characterize the concept of health. For our purposes, we can assume that health is a state of body and mind that allows for a sense of well-being (functioning) that is acceptable to reasonable people. It would not be reasonable for me to claim that I am unhealthy because I am not as brilliant as Stephen Hawking or as graceful as Greg Louganis. We each have a baseline beyond which it is not reasonable to strive.

Understanding and rationality, the setting of reasonable expectations, play a role in the concepts of health and well-being. This is what makes them so difficult to characterize. We might say of a thirty-year-old woman who is confined to a wheelchair that she is “otherwise healthy” as a way of pointing out that even if she legitimately feels a great loss of her sense of well-being, there is a sense in which she can overcome this disability. She can find a new sense of well-being based on abilities other than mobility. If my vision begins to fail when I am twenty-five then for my purposes, so does my sense of well-being. But again, I probably would not be considered unhealthy. If at seventy-five I can no longer run a marathon in the same time as I could at twenty-five then this is not a reason to think that my health is failing, nor
should I feel as though my well-being is threatened. The link between a sense of well-being and health is a loose one in part because of the personal values so often involved in the judgment. But to deny the link would be a mistake.

Toothaches, headaches, and backaches are all conditions wish that make everyday life a misery. We normally do not think of a person with a bad toothache as unhealthy. This is because we consider health to be a disposition; a condition over a period of time rather than a short-term state. A person whose teeth are bad may have unhealthy teeth (or gums) but whether such a person would be considered unhealthy is moot. However, if one were to ask a person with bad teeth about their well-being, one would almost certainly get a negative response showing, again, that the concept of health will always have an important personal and value-laden (subjective) side to it.

Quality of life, a variation of what we have called a sense of well-being, need not always be so dramatic as cases of failing hearts and kidneys. When we lose our sense of well-being, we desire relief in order to maintain an equilibrium necessary to get on with our lives. It is reasonable to see a physician’s obligations as well as the obligations of the medical profession as centering around the maintenance of this sort of equilibrium. How is equilibrium maintained?

CURING DISEASE

Diabetes, congestive heart failure, measles, cholera, etc. are classified as diseases. Not classified as diseases are syndromes, such as AIDS, sudden infant death syndrome, and many genetic conditions. We need not discuss the differences between diseases and syndromes. Conditions such as broken bones, headaches, backaches, and colds are neither diseases nor syndromes. But they are deemed worthy of avoiding. What do these states have in common? They all lead to, or increase, the probability of suffering an evil death, pain, or disability. (See C. Culver and B. Gert, Philosophy in Medicine, ch. 5, Oxford University Press, 1982.)

It is easy to see the curing of these states as an important obligation of doctors. Just as we saw that reasonableness was crucial to understanding health, so it is that a general agreement that pain, disability, and death are usually worth avoiding is central to much argumentation in medical ethics. It is easy to understand that when our quality of life has been returned to a reasonable baseline, when we are no longer in danger of suffering an evil, then a physician has discharged an obligation.
RESTORING NORMALCY

RESTORING NORMALCY IS VAGUE

A person’s normal performance (or characteristics) will be a function of age and health. My tennis game is not what it used to be, but still normal for me at age 40. I always play poorly when I have a headache or am worried about exams. This is the best I can do with a sprained ankle. I always put on weight when I have a few beers.

A person’s normal performance can be determined by comparing it to performances (or characteristics) of others like that person, or to the characteristics of the population. Marathon runners tend to have abnormally low pulse rates. Abnormally low? Their pulse rates are low compared to the average population, but not low when compared to other marathoners.

A person’s normal performance can be compared to that person’s felt needs. A budding singer gets compared to a true prima donna. The normal baseline can be what is minimally needed to enjoy life. There are two variations here. (a) “Enjoy” is defined by each individual. (b) “Enjoy” is given a definition that each of us, within limits, has to accept.

Notice that a 6’5” basketball player is not unusually tall for a professional basketball team, but very tall for a philosophy professor, and incredibly tall for a kindergarten student. The philosophy professor might be said to be unusually tall. But the professor would not be called abnormal. The six-foot-five kindergarten student might be considered abnormal because the height in this context is so very unusual that we would be led to expect that a syndrome is responsible. (Illness and abnormal, in this sense, are linked conceptually. Whether they should be is another question.)

Notice also that while too many IQ points may be abnormal in the sense of being statistically rare, it is only too few IQ points that we tend to call a health problem.

We see then that restoring normalcy can mean getting a person back to a condition free of hindrances from disease and/or pain; or helping a person to improve; or helping a person to meet desires. It can also mean getting a person to be like everyone else. For example, a very short child can be given drugs to increase height. In this case, the child has an individual normal baseline; but it is one we override to make that child more like everyone else with respect to height.

The concept of the normal baseline can be used to generate a right to health care. If the normal baseline is seen as the necessary condition for all other
human tasks, for the achievement of human goods, then the restoration and/or maintenance of this normalcy can be seen as a right. Correlatively, the medical profession would have an obligation to provide this sort of care to people.

**Pain and Suffering**

Sometimes, medicine can do no more than alleviate pain. Sometimes, physicians cannot even diagnose the underlying problem. But if they can relieve pain, they have discharged what we might call a minimum obligation. This is the sort of obligation that is captured in the old saying “Above all, do no harm.” This can be taken to mean that at least when it is possible, without danger to the person in pain, try to alleviate or eliminate the pain. It is a pragmatic consequence of the nature of medicine that if a disease condition causing pain cannot be made to go away (an inelegant term meant to cover curing diseases and, for example, suturing a wound), then if it is at all possible, pain ought to be eliminated or alleviated.

**Alleviating Pain and Suffering: Euthanasia**

There is no question but that the alleviation of pain is and should be a goal of medicine and, therefore, of individual physicians. Yet, often to cure a person, short-term pain has to be endured. Injections, surgery, and even some examinations often cause pain and discomfort. They are endured because they bring long-term relief (cure). In these situations, physicians knowingly cause pain and discomfort with the justification that it is in the best interest of the patient.

Sometimes, unfortunately, pain cannot be alleviated without also rendering a patient unconscious. Where pain is caused by a terminal disease, a physician might be asked to help the patient to die. Helping a patient to die can be done in the following ways. (1) The patient can be given a lethal dose of a drug such as morphine. This is traditionally called “active euthanasia.” (2) Life-preserving measures can be withdrawn: A patient can be removed from a respirator. (3) Life-preserving treatment may never be started: A patient may suffer a cardiac arrest and not be given cardiopulmonary resuscitation. Tradition has seen (2) and (3) as passive; or at least more passive than (1).

All three methods can be instituted with or without the patient’s consent. When done with the patient’s consent, helping a patient to die is often referred to as voluntary euthanasia. When done without the patient’s consent, it is referred to as involuntary euthanasia. (Notice that when the patient asks for active euthanasia, we have a case of assisted suicide.)
It seems only rational to prefer death to constant, unremitting pain. Even if it is rational, can a physician let a patient die when the means of keeping that patient alive exist? Can a physician help a patient to die? Can a physician kill a patient under these circumstances (with the permission of the patient)? Sometimes, the pain referred to is not so much the pain of physiology gone awry as it is the emotional distress caused by the loss of quality of life. Getting back to one’s previous baseline is sometimes impossible. To some people, this makes life intolerable. Many of us hold some activity or other so dear that if we were to lose it, death might seem preferable.

Given the discussion of paternalism, it would seem that there is a right to make the decision to die rather than to live a terribly restricted (in our eyes) life. At the very least, no one should be overridden merely for choosing death. There are some who argue that the profession of medicine has no room for intentional killing or letting die—no matter what. The argument need have nothing to do with religion, although it sometimes does. The argument is based on the nature of the medical profession and what the average patient comes to expect from a physician.

Ultimately, the argument goes, letting physicians kill patients (or allowing physicians to let patients die) would undermine the profession of medicine by eroding the trust that patients have in physicians, the trust that nothing will be done to a patient that is not in the best interests of that patient. Once it is known that physicians let some patients die, there will always be a nagging doubt in the minds of some patients.

The profession of medicine is dedicated to life—to preserving it and making it better when possible. Since death is the end of human possibility, at least as we know it, medicine cannot, indeed must not, aim at ending life. Here we have a clash between the right of each person to make a decision and the right of a physician to carry out what many see as the obligations of the profession.

So far, we have examined only confidentiality, paternalism, and euthanasia. We have done so by realizing that the questions associated with these topics dovetail with an understanding of the medical profession. Indeed, our goal has been to see how answers to questions about the medical profession and answers to the more traditional questions of medical ethics go together.
Suggested Further Reading


