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Ethical Principles in Clinical Practice

Each day in every clinical encounter, physicians practice ethics although they may not realize it because they lack the basic vocabulary of ethics. Ethics can be simply defined as the study of and resolution of conflicting principles. This paper will help the physician understand the vocabulary of ethics, which includes the principles of autonomy, beneficence, nonmaleficence, and fidelity and an explanation of surrogacy, capacity, and informed consent. Example cases will be presented showing how these principles sometimes conflict and how such conflicts are resolved.

Ethics permeates all that we do in medicine. Medical training indoctrinates us to practice in ways which have their foundations in historical ethical principles. Although each day we "act ethically," we sometimes don't recognize the ethical aspects of our actions because we are not acquainted with the terminology and methodology of ethics. For instance, the mandate that we "first do no harm," the foundational proscription of our profession, is called in ethics "the principle of nonmaleficence." In recent years, the lay press and medical literature have given increasing prominence to ethical topics, making it important for the practicing physician to understand ethics terminology and principles. This paper will use clinical situations to illustrate and explain important facets of medical ethics.

Principles and Method

Although books are written on the definition of ethics, one useful working definition is that ethics is the study and resolution of conflicting principles. A principle is a basic foundational belief which guides actions. A number of conflicting ethical principles may be relevant and applicable to any difficult medical situation. How patients, physicians, staff and family rank and value these principles and how conflicting rankings are resolved constitutes the main work of clinical ethics.

Autonomy

The principle of autonomy stands for the proposition that an adult with capacity to decide has a full and perfect right to determine what may be done to his body.[1] This is a right recognized in ethics, medical practice, and law.

Justice Cardozo wrote in 1914, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." The Bartling court in California found that "Competent adult patients with serious illnesses which are probably incurable but have not been diagnosed as terminal have the right over the objections of their physicians and the hospital to have life support equipment disconnected despite the fact that withdrawal of such devices will surely hasten death."[2]

Because of autonomy, patients may refuse any proffered procedure, treatment, or even the advice of their physicians. The fact that this refusal is seen as ill-advised or even irrational by the physician does not counter moral, social, and legal norms which hold that competent patients have the right to determine their destinies.

Competence and Capacity

In order to exercise the right of autonomy, a patient must first possess the capacity to make decisions. In day-to-day medical practice, physicians often speak of the "competent" patient. Although this term is commonly understood and is perfectly functional, technically, only a court of law may deem a patient "competent." When speaking of a patient's ability to decide, physicians are actually speaking of a patient's "capacity." A patient who is able to make medical decisions is considered to possess capacity. A patient who is not mentally or psychologically able to make medical decisions is considered to lack capacity.

When assessing a patient's capacity, the physician must evaluate three distinct aspects of decision making ability:

1. Patients must show that they understand the given information about diagnosis and treatment and that they appreciate the significance of the disease and its consequences. In testing for understanding, the physician might ask patients to rephrase the information he has given them.
2. Patients should be able to deliberate in accordance with their own values. Here, the physician might ask patients what is most important to them in making their decision.
3. Patients should demonstrate an ability to communicate consistent choices regarding their decisions. Here the physician might determine patients' choices at different times to test consistency.

Confusion between these two terms, capacity and competence, has sometimes led physicians to believe that there is a requirement that they look to the courts when a patient is, in their opinion, unable to make a medical decision. Almost all courts which have addressed this issue, however, have stated that the courtroom is not the proper place to decide whether a patient is able to make a decision—instead, it is the bedside—

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and that physicians are fully and properly empowered to determine capacity and to base medical decisions on that determination.

Beneficence

The principle of beneficence stands for the proposition that it is the physician's duty to do good for his patient. This is certainly a foundational principle of medical practice finding its roots in Hippocrates. For centuries, beneficence was actualized through the process of the patient presenting himself to the physician for examination and inquiry and then following the advice of the physician. In recent decades, societal needs for self determination have sometimes brought this principle into conflict with autonomy.

Nonmaleficence

Often joined with beneficence is the term, "nonmaleficence," which stands for the Hippocratic duty to "do no harm." One can find conflicts between beneficence and nonmaleficence in almost any clinical situation. The dichotomy between the two principles is the foundation for "risk/benefit" analysis. Using a trivial example, a physician wishes to protect his patient from tetanus by giving an injection of tetanus vaccine (beneficence), but in order to provide this benefit he must breach his duty of nonmaleficence and harm the patient by inserting a needle through the skin, causing pain and the possibility of side effects and infection. In the conflict in this example, beneficence is ranked above nonmaleficence.

Case 1: A 57-year-old man has been diagnosed with inoperable pancreatic cancer. His physician has explained to him the prognosis and the possibility that chemotherapy may yield a palliative effect and extend his life for a few months. In fact, the physician recommends it. After being informed of the potential and likely side effects of chemotherapy, the patient informs his physician that he declines chemotherapy.

The ethical principles in conflict are the patient's right of autonomy versus the physician's interpretation of beneficence. Because, ethically and legally, our society holds autonomy in preeminent regard, the patient's wishes should be followed. This is determinedly true when the primary issue is one of quality of life. Only the informed patient can truly weigh the life-prolonging benefits of chemotherapy versus the pain he might likely suffer.

Case 2: A 59-year-old woman suffers from severe smoking-induced COPD with associated hypoxia and hypercapnia. During a routine office visit, she states that should the need arise, she would refuse intubation and ventilation under any circumstances. Her physician fully explains the fact that patients in her circumstances often benefit from short-term intubation. The patient was twice intubated before, and she was terrified by the discomfort, loss of control, and loss of dignity. Her physician states that he will do all that he can to keep her comfortable and to make sure that the intubation period is as brief as possible. In spite of his assurances, the patient states that she absolutely refuses intubation.

Here again, we have a conflict between the patient's right of autonomy and the physician's duty of beneficence. The conflict in this case is slightly more distressing in that the benefits of short-term intubation are somewhat more apparent and substantial than the benefits of chemotherapy in case 1, yet the guiding principle that a fully informed patient's right of autonomy takes precedence over the physician's duty of beneficence applies.

Case 3: Assume the same facts as those given in Case 2, but add that the patient is brought to the emergency department in respiratory arrest. Emergency department personnel intubate her and connect her to a ventilator.

Her physician is notified and comes to the hospital. He finds his patient ventilator-dependent. None of her indices make it likely that successful weaning is possible. Once again, we have a conflict between the patient's right of autonomy and the physician's duty of beneficence. The conflict in this case may be even more distressing because the physician now faces the reality of withdrawing ventilation, an act which will surely lead to death. Yet again, the patient's right of autonomy provides the guiding principle. The President's Commission in 1982 noted that, "The distinction between failing to initiate and stopping therapy—that is, withholding versus withdrawing treatment—is not itself of moral importance. A justification adequate for not commencing a treatment is also sufficient for ceasing it. Erecting a higher requirement for cessation might unjustifiably discourage vigorous initial attempts that sometimes succeed."[3]

Ethically, ventilation should be withdrawn.

Informed Consent

The principle of informed consent flows from the concept of autonomy. Not only is a patient entitled to decide what may be done to his body, the patient is entitled to receive an adequate amount of information to help him make that decision. Typically, informed consent involves telling the patient of the recommended procedure, its risks, benefits, and alternatives. Ethically, the physician should also make a recommendation and should not simply lay out his collection of medical wares and tell the patient to "pick one."

Naturally, informed consent is closely joined to capacity. For there to be "good"= informed consent, a patient must have the capacity to decide.

Surrogacy

A surrogate is one who stands in the place of another. In medicine, we typically look to surrogates to help us make decisions when our patients lack capacity to decide. The fact that surrogates do make decisions is simply an extension of the principle of autonomy. Patients do not lose the right to make decisions about their health care just because they lose capacity; the mechanism by which that right is expressed changes.

It is sometimes difficult to determine who the "best" surrogate is. Typically it is a person who has the best interest of the patient at heart and who is acquainted with the patient's past expressions, wishes, and values so that the surrogate can make the same decision the patient would make were he able.

There are several methods to determine the surrogate. Usually but not necessarily, the surrogate is a close family member. It is the duty of the physician in consultation with the health care team and other family members to determine the proper surrogate.

Most states recognize a legal document called a Durable Power of Attorney for Health Care wherein the patient, while still having capacity, designates another person, typically called an agent or the attorney in fact, to be his surrogate should he lose capacity to decide.

Patients may sometimes expressly tell the physician their choice of surrogate. In other cases, the patient might communicate through an informal letter or other document.

It is important to distinguish a legal document from one which is legally binding. The Durable Power of Attorney for Health Care is a legal and legally binding document in most states. Just because a document is not legally binding, e.g., a living will or even a handwritten note to the physician of a patient's wishes, it does not make that document illegal. It is up to the physician and those who know the context of the writing to attach the proper probative value to it.

Case 4: A 75-year-old man suffering from multi-infarct dementia suffers a massive stroke. While hospitalized awaiting transfer to a custodial facility, pneumonia develops in the patient. His physician believes that he can treat and control the pneumonia and return the patient to his baseline admitting state, i.e., unconscious and not expected to recover. In fact, the physician feels uncomfortable about not treating an incapacitated patient who is ill with a curable condition.

The patient is a widower but his daughter is well acquainted with the patient, having cared for him in her home for several years preceding the onset of his dementia. She states that the patient was always a strong-minded person and valued his independence. As his dementia worsened, he often seemed depressed and expressed his unhappiness that he'd become a burden to his daughter.

Here we have an extension of the conflicts seen in cases 1 and 2: The physician's duty of beneficence versus the patient's (as expressed through his daughter) autonomy. Although the physician may not agree with the daughter's choice, the choice is not irrational and should be followed, given the patent's past expressed wishes and values. Although one might postulate bad faith in that the daughter acts with some self interest, e.g., she will not have the burden of caring for her father or she might inherit, it is difficult to find a situation where some party does not have some potential self interest in any particular decision.

Fidelity

Fidelity stands for the proposition that physicians keep their patients' interests first in his mind above all others. It requires that they maintain their patient's trust and confidences. It obligates them to carry out their promises to care for patients with faithful attention. Sometimes unfamiliar ethical terminology and perceived legal threats put strain on physicians as they try to carry out their duty of fidelity.

Case 5: A healthy 44-year-old woman executes a Durable Power of Attorney for Health Care naming her roommate as her agent in the event she cannot make decisions for herself. She executes this document after a long discussion with her physician in which she clearly states that should she lose hope of functioning in her position as a college professor, she would want all but comfort care withdrawn.

The patient suffers an unwitnessed, out-of-hospital cardiac arrest and is found unresponsive but recovers a heartbeat and respirations after 45 minutes of resuscitation. After a month, the patient remains deeply comatose with severe anoxic brain injury. A neurologic consultant indicates that the chance for improvement is minimal and that for recovery is nil.

You recommend that all care, including nutrition and hydration, be withdrawn, but the roommate insists that full care be provided and that in her position as agent, she has the right to make that demand.

A Durable Power of Attorney for Health Care does appoint an agent who acts with the authority of the patient, but it does not obliterate all that has gone on in the past. Here the conflict is between the physician's interpretation of his duties of fidelity, to follow the expressed wishes of the patient, and the patient's right of autonomy as expressed by the surrogate.

In the past, some controversy has existed concerning the difference or lack thereof between withdrawing nutrition and hydration versus other modalities of care. In an opinion in the Cruzan case, United

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States Supreme Court Justice O'Connor said, "Artificial feeding cannot readily be distinguished from other forms of medical treatment. The techniques used to pass food and water into the patient's alimentary tract all involve some degree of intrusion and restraint. Requiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity and freedom to determine the course of her own treatment."[4]

In this case, one course of action would be for the physician to tell the agent that he intends to withdraw all but comfort care as expressed in the past by his patient but to agree to do so only after the agent had an opportunity to obtain an ethics consultation or a court hearing to determine the right of the agent.

Summary

Although the example cases present challenging ethical problems, it is likely that in day-to-day clinical practice, much more difficult cases will be encountered. Medical education and the lay press have made physicians more comfortable with basic ethical principles. Decisions involving patient autonomy, beneficence, and nonmaleficence "feel" straightforward in most cases. Cases involving autonomy as expressed through a surrogate are often more difficult, but the ethical approach as explained in this article is still straightforward. Medical advances, economic pressure, and societal demands make it inevitable that even more difficult ethical dilemmas will be seen in the future. Acquaintance with the terminology of ethics will help the physician anticipate and manage these difficult decisions. ❖

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"Companies don't make the most of new opportunities, because they're making the most of old ones."

Roger Martin, "Changing the Mind of the Corporation," Harvard Business Review