

Introduction to Moral Theories and Principles that inform ethical decision making in healthcare

Introduction

If a clinical ethics committee (CEC) is to provide support on ethical issues relating to clinical practice, and to facilitate discussion of the ethical dimension of clinical problems, members of a CEC will require an understanding of the moral theories and ethical frameworks that have informed the development of medical ethics.

In this section we provide a brief introduction to some of the key moral theories and ethical frameworks that have had an important influence on health care practice, particularly in Western medicine.

Ethical Theory

We may feel instinctively that a certain conclusion to a problem is 'fair' or 'unfair', but what criteria do we use to make such judgments? There are different ethical theories that can be applied to a problem to elucidate our thinking, but even so the results may not fit with our moral intuition.

There are several types of normative ethical theory including consequentialism, deontology - such as Kantianism - and virtue ethics. They can be applied in several **procedures** of ethical analysis, such as in analysis of cases (casuistry) and in different **settings** such as in a range of 'communitarian ethics': for example, a feminist approach or a social class based approach.

Moral or ethical theory may consider the application of rules or the consequences of actions.

Deontological theory - what one **MUST** do, based on duties and obligations

Teleological theory - the purpose or consequences of the moral acts

Consequentialist Theory

This is one sub class of teleological moral theory. According to consequentialist accounts of morality the moral value of an act, rule or policy is to be found in its consequences, not in intentions or motives. Utilitarianism is the most influential consequentialist theory. Jeremy Bentham in the late 18th century and John Stuart Mill in the 19th century formulated this way of thinking. Such 'hedonistic' utilitarians argue that the principle to judge our moral thinking is utility, that is, the maximisation of happiness, in the sense of pleasure and the minimisation of suffering, in the sense of pain. In any situation the morally right thing to do is the action that promotes the greatest happiness for the greatest number of people.

However pain and pleasure are not the only criteria that later utilitarians have used to evaluate the consequences of actions, rules or policies. Welfare-utilitarians consider the contribution to, or lessening of, human welfare. Preference-utilitarians seek to establish and satisfy human preferences.

Some key issues:

- Calculate net benefit

The net benefit or dis-benefit is found by balancing the happiness and unhappiness resulting from an act or policy. If one then seeks the greatest happiness of the greatest number that may be taken to justify overriding individual unhappiness in the interests of the happiness of the greatest number.

- Difficulty in calculating consequences

This theory requires that the consequences of acts or policies must be calculated. However in many situations one cannot predict consequences with any certainty and therefore consequentialism is probabilistic, one forecasts the consequences to the best of one's ability. Ethics committees using consequentialist criteria necessarily operate in an area of uncertainty.

- Act and rule utilitarianism

Bentham tended to deal with the consequences of **acts**. However, '**rule** utilitarianism' justifies certain rules on utilitarian grounds. For example, one might justify the general rule 'do not lie' on the utilitarian ground that lying produces more bad consequences than good consequences overall.

In considering what is the right course of action/treatment in any healthcare situation we tend initially to think about the consequences arising from the different options. For example, in deciding whether in particular circumstances a breach of the duty of confidence is justified, we think of the consequences- the harms of breaching the duty and the harms of not warning others of a risk to their health. However, it is often difficult to predict consequences with any certainty.

Deontological Theory

A criticism of consequentialist theory is that it is so concerned with **ends** that it may overlook the moral importance of **means** - the ways in which the ends or goals are achieved. Deontological theory uses rules rather than consequences to justify an action or policy. The best-known deontological theory is that of Immanuel Kant in the 18th century. 'Kantianism' is a modern term, referring to a Kant-like emphasis on duties and rules. Kant defended rules such as 'do not lie', 'keep promises', 'do not kill' on what he claimed were rational grounds. Rules should comply with the *categorical imperative*. The categorical imperative holds that:

- Moral rules should be universalisable i.e. applied to all rational, moral members of the community rather than to just some
- All persons should be treated never simply as means but also always as ends in themselves
- Members of the moral community should take a hand in making the laws as well as living by them

Many modern *Kantians*, as opposed to Kant himself, are not absolutist in their application of moral rules or laws, whilst nevertheless stressing the importance of generally living by moral rules or laws.

The theory is manifested in the idea of a duties owed to a patient – the duty of care and the duty not to harm.

Virtue ethics

Virtue ethics is the name given to a modern revival and revision of Aristotle's ethical thinking. Aristotle's ethics, while not generally thought of as consequentialist, is certainly teleological. For him, the telos, or purpose, of a human life is to live according to reason. This leads to 'happiness' in the sense of human flourishing. This flourishing is achieved by the habitual practice of moral and intellectual excellences, or 'virtues'. For Aristotle, the excellences are of two types. A moral virtue is an excellence of character, a 'mean' between two vices. One of Aristotle's virtues is courage, a mean between recklessness and cowardice, which are vices. Modern virtue ethics sets itself the task of discerning the virtues for our time. In a healthcare setting what virtues would we like doctors, nurses, etc. to possess - self-control, truthfulness, generosity, compassion, discernment, integrity?

Aristotle also identified a second type of excellences, intellectual virtues, which constitute a preference for truth over falsehood and for clarity over muddle, both in pure reason and in practical affairs. Both the moral and intellectual virtues are, for Aristotle, the expression of reason.

Virtue ethics can be seen in the way we feel is the 'right' way to behave towards patients and to colleagues. For example, a virtuous doctor / nurse would take time to explain treatment options to a patient and find out what he/she wants.

Casuistry

Casuistry, or case based reasoning, does not focus on rules and theories but rather on practical decision-making in particular cases based on precedent. So first the particular features of a case would be identified, and then a comparison would be made with other similar cases and prior experiences, attempting to determine not only the similarities but also the differences.

So if a clinical ethics committee were asked to consider whether it was ethical for a clinician to breach his / her duty of confidence, the committee would identify key factors, like the health risks to others if information was not disclosed. It would then make a comparison with other similar cases, identifying the relative risks of non-disclosure. Casuistry should not be divorced from consequentialism, deontology, or virtue ethics but complement them.

A clinical ethics committee can build up useful experience by identifying key factors that informed a decision in one case and comparing and contrasting the application of these

factors in a similar case. This may be particularly useful in a discussion of best interests of a patient. If it was in patient A's best interests to receive treatment, why and how does this differ from an assessment of patient B's best interests in the same circumstances?

The Four Principles

Beauchamp and Childress' Four Principles approach is one of the most widely used frameworks and offers a broad consideration of medical ethics issues generally, not just for use in a clinical setting.

The Four Principles provide a general guide and leave considerable room for judgement in specific cases.

Respect for autonomy: respecting the decision-making capacities of autonomous persons; enabling individuals to make reasoned informed choices.

Beneficence: balancing benefits of treatment against the risks and costs; the healthcare professional should act in a way that benefits the patient.

Non maleficence: avoiding causing harm; the healthcare professional should not harm the patient. Most treatment involves some harm, even if minimal, but the harm should not be disproportionate to the benefits of the treatment.

Justice: respect for justice takes several forms:

- Distribution of a fair share of benefits
- Legal justice - doing what the law says
- Rights based justice, which deals in the language, and perhaps the rhetoric, of claimed human rights, and hence goes beyond, though it includes, legal rights.

These principles are prima facie – that is, each to be followed unless it conflicts with one or more of the others - and non-hierarchical i.e. one is not ranked higher than another. In recent years however, respect for patient autonomy has assumed great significance in the context of patient choice, underpinned by the requirement to provide the patient with sufficient information to put him / her in a position to choose.

The 'Four Principles' are intended as an aid to balance judgement, not a substitute for it.

Taken from: Slowther A, Johnston C, Goodall J, Hope T (2004) A practical guide for clinical ethics support. The Ethox Centre. Section C: Ethical Frameworks.