CHAPTER 3

ROLE OF ETHICS IN PROTECTION OF RIGHTS OF PATIENTS

3.1. INTRODUCTION

Although in the past, it was acceptable for doctors to base their decisions on conscience, intuition, received wisdom, and codes of practice, changes in the nature of the doctor-patient relationship and in the accountability of doctors have demanded a more formal and explicit approach to medical ethics.[1] Doctors are increasingly required to explain and justify their decisions to patients, other health care workers, the media, regulators, and the courts, and to each other. In order to do so they need skills in ethical reasoning combined with an understanding of the law and knowledge of professional guidance. Ethics and law thus have a symbiotic relationship as expressed in this quote by Somerset Maugham[2]: 'conscience is the guardian in the individual of the rules which the community has evolved for its own preservation'.

Ethics has always been a central concern of medicine. The reason may be that much of medicine is about issues of life and death. For example, abortion, infertility treatment, the threat to life through negligent treatment, or insufficiency of health resources, the treatment of the terminally ill and so on. The Hippocratic Oath and its successors have expressed a fundamental medical duty to pursue patients' best medical interests, to avoid harming or exploiting them, and to maintain their confidence. Today we may add to that Hippocratic objective the moral qualifications that we should pursue it in a way that respects people's deliberated choices for themselves and that is just or fair to others whether in the context of distribution of scarce resources, respect for people's rights, or respect for morally acceptable laws.[3]

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1 *Medical Ethics Today The BMA's handbook of ethics and law*, 2nd edition, BMJ Books, London (2004), p.1.

2 W. Somerset Maugham, *The Moon and Sixpence*, Grossett & Dunlap Publishers, New York (1919), p.80.

3 Gillon R., "Patients in the persistent vegetative state: a response to Dr Andrews", 306 *BMJ* 1602 (1993), pp.1602-3.

Most of these issues are not new, and doctors have been responding to ethical challenges for centuries.

3.2. MEDICAL ETHICS

Ethics is the branch of philosophy which deals with moral aspects of human behavior.[4] Ethics deals with the theories and principles of values and the basic perceptions and justifications of values, whereas morals include the customs, and normative behavior of people or societies.[5] Thus ethics in the context of medicine concerns itself with the moral principles that underlie the doctor's obligation to the sick and to society.[6] Medical ethics broadly speaking refers to the medical oaths and codes that prescribe a physician's character, motives and duties which are expected to produce a right conduct and thus guide the members of the medical profession in their dealings with one another, their patients and to society. It portrays the ideal physician devoted to his duties *vis a vis* the welfare of the patient, and the advancement of the medical profession and medical knowledge. Though, it enjoins the physician to show compassion on the patient, it also recognizes and understand the limits of a physician's curative powers.[7] This concept is entrenched in the Hippocratic injunction which states 'strive to help, but above all, do no harm'.

Medical ethics is primarily a field of applied ethics; the study of moral values and judgment as they apply to medicine. Medical ethics encompasses its practical application in clinical setting as well as work on its history, philosophy, theology and sociology. According to British Medical Association medical ethics is the application of ethical reasoning to medical decision-making.[8] Also, medical ethics is a system of moral principles that apply values and judgments to the practice of medicine.[9] But, the question is whether someone can provide an ethically correct answer to morally controversial issues? For example, how can one decide whether an embryo has a right to life? Or whether the withdrawal of life support from an

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4 Avraham Steinberg, Medical Ethics, viewed 14th Dec 2013, http://www.jewishvirtuallibrary.org/jsource/Judaism/MedicalEthics.pdf.

5 Id.

6 Chew Chin Hin, "Medical Ethics and Doctor-Patient Relationship", 34 *SMA* News 6 (2002).

7 Johnson AR, Siegler M, Winslade WJ, *Clinical Ethics: Cases in Medical Ethics*, 2nd ed, Oxford University Press, New York (2001).

8 *Medical Ethics Today The BMA's handbook of ethics and law*, 2nd edition, BMJ Books, London (2004), p. 3.

9 Medical Ethics, viewed 14th Dec 2013, http://en.wikipedia.org/wiki/Medical_ethics.

incompetent patient is ethically right? Hence, Jonathan Herring[10] notes 'it is not for the medical ethicists to provide the right answer but to assist in clear thinking: to set out arguments which are logically coherent and consistent with the facts, and to point out logical or philosophical flaws in the arguments of others'.

Traditionally, medical ethics has focused primarily on the doctor-patient relationship and on the virtues possessed by a good doctor.[11] It has also been very much concerned with relations between colleagues within the profession.[12]The heart of the doctor-patient relationship is that a physician has privilege to touch and even invade the body of another and as a consequence exercises control to a greater or lesser extent over that person, thereby invading his physical integrity.[13] It is good if the likely effect is the cure or amelioration of the patient's condition, and if it is done with the real consent and co-operation of the patient. However, in so far as it can be ascertained, it must be done in the patient's best medical interests. If there is no real consent, or if the treatment is unsuitable or negligently carried out, then it could be regarded as a violation of the patient's physical integrity. Until the middle of the twentieth century, paternalism was the norm and medical ethics was less concerned with respect for patients' autonomy and with justice. The clinical interests of individual patients were the doctor's overriding ethical concern. However, more recently the relationship has changed. As Lord Steyn in *Chester* v *Afshar*[14] declared: 'in medical law paternalism no longer rules'.

3.3. BIOETHICS

Bioethics can be seen as a modern version of a much older field of thought, namely medical ethics.[15]While medical ethics has a long history, bioethics is a much newer discipline.[16] Although moral questions about the ethics of medicine and related areas have been asked for as long as people have asked questions about

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10 Jonathan Herring, *Medical Law and Ethics*, 3rd edn., Oxford University Press, New York (2010), p.18.

11 Helga Kuhse, Peter Singer, "What is Bioethics? A Historical Introduction" in Helga Kuhse and Peter Singer (eds), *A Companion to Bioethics*, Blackwell: Oxford (1998), p.10.

12 Id.

13 Kennedy I, *Treat me Right: Essays in Medical Law and Ethics*, Clarendon Press, Oxford (1991), p.387.

14 [2004] UKHL 41, para 16.

15 Helga Kuhse, Peter Singer, "What is Bioethics? A Historical Introduction" in Helga Kuhse and Peter Singer (eds), *A Companion to Bioethics*, Blackwell: Oxford (1998), p.4.

16 Edward J. Imwinkelried, "Expert Testimony By Ethicists: What Should Be The Norm?", 76 *Temp. L. Rev.* 91 (2003). The term 'bioethics' was coined in 1970 by American cancerologist V.R. Potter.

ethics, the growth of bioethics has stimulated further attention to important moral questions in medicine and biology. 'Bioethics' can be understood both in a broader and in a narrower context. Following the broader context, bioethics includes not only philosophical study of the ethics of medicine, but also such areas as medical law, medical anthropology, medical sociology, health politics, health economics and even some areas of medicine itself.[17] On the narrower context, bioethics is only an area of philosophical inquiry.[18] Hence, bioethics is one branch of practical or applied ethics, which is one branch of ethics, which in turn is one branch of philosophy.

Bioethics emerged in the1960s out of various public concerns. Three factors contributed to this. Firstly, the doctor-patient relationship changed from the paternalistic model to one in which patient autonomy in decision-making is recognized. Secondly, with the introduction of new medical technologies such as assisted reproduction, gene therapy, and life support, doctors were faced with new choices and dilemmas. Finally, the commercialization of medicine and the introduction of managed care and health insurance raised questions about whether the patient's best interest continues to guide doctors in their practice. The origin of modern international bioethics however, has been traced to the brutal abuse of human lives in the Holocaust.[19]

Undoubtedly, bioethics claims medical ethics as part of its province, but in many ways it takes a distinctly different approach. Medical ethics has been concerned with the ethics of good medical practice: that is, with what it means to be a good doctor. Physicians were trained to act paternalistically towards their patients, to treat patients according to the physician's own judgment about what would be best for their patients, with little regard for each patient's own perspectives or preferences.[20]As Emily Jackson[21] strongly argues 'the vantage point was always that of the doctor himself: how the doctor should obtain consent; when a doctor can

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17 D Benatar, "Bioethics and health and human rights: a critical view", 32 *J Med Ethics* 17 (2006).

18 Id.

19 Aurora Plomer, *The Law and Ethics of Medical Research International Bioethics and Human Rights*, Cavendish Publishing, London (2005), p.1.

20 Susan Sherwin, "A Relational Approach to Autonomy in Healthcare", in Francoise Baylis, Marilynne Bell, Maria De Koninck, Jocelyn Downie, Abby Lippman, Margaret Lock, Wendy Mitchinson, Kathryn Pauly Morgan, Janet Mosher, Barbara Parish, *The Politics of Women's Health: Exploring Agency and Autonomy*, Temple University Press, Philadelphia (1998), p.21.

21 Emily Jackson, *Medical Law, Text, Cases and Materials*, Oxford University Press, New York (2010), p.2.

breach his duty of confidentiality; and so on'. However, the goal of bioethics is not the development of, or adherence to, a code or set of precepts, but a better understanding of the ethical issues.[22] It is prepared to ask deep philosophical questions about the nature of ethics, the value of life, what it is to be a person, the significance of being human.[23] Also, it embraces the issues of public policy and the direction and control of science.[24]

Physicians generally consult lawyers to deal with charges of malpractice and negligence. But ethical dilemmas go beyond issues of legality, and doctors need the help of philosophers to make sound, ethical decisions and to justify them to their patients and the public. Moral philosopher provides conceptual and analytic tools and brings in general moral principles to find answers on ethical questions. They can justify or question moral practices using reason and arguments. There is extensive and rich philosophical literature from which medical ethics has borrowed, but four theories are worth noting.

3.4. THEORIES ON MEDICAL ETHICS

3.4.1. Teleological Theory

Teleology comes from the Greek word *telos* (goal) and *logos* (theory). Consequentialism is another name given to this class of theories. Under this theory, every human action has an outcome, and righteousness of a course of action is to be judged by its consequences.[25] A consequentialist philosophy holds that the rightness or wrongness of an action is determined solely by reference to the 'goodness' or 'badness' of the consequences of that action.[26] For example, a consequentialist may weigh up the benefits of telling truth with disadvantages of not telling the truth.[27] For example, to a patient, a doctor may inform the true state of his health, including the consequences of side-effects of medicines on his body in future, assuming that by not disclosing the true facts he may lose the patient's trust and confidence. Such a

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22 Helga Kuhse, Peter Singer, "What is Bioethics? A Historical Introduction" in Helga Kuhse and Peter Singer (eds), *A Companion to Bioethics*, Blackwell: Oxford (1998), p.11.

23 Id.

24 Id.

25 Marc Stauch, Kay Wheat, John Tingle, *Sourcebook on Medical Law*, 2nd edn, Cavendish Publishing, London (2002), p.7.

26 Michael Robertson, Garry Walter, "A Critical Reflection on Utilitarianism as the Basis for Psychiatric Ethics", 2 *Journal of Ethics in Mental Health* 1 (2007).

27 Id.

disclosure may even frighten patients deterring him from undergoing treatment. In choosing between these two alternatives a consequentialist has to choose one which has the best overall consequences.[28] Hence, Consequentialism is based on deciding which result will produce the most 'good'. The problem with consequentialist theory is in deciding what is good?

Utilitarianism is considered as a class of consequentialist theory of whom Jeremy Bentham was one of the earliest exponents.[29] To Bentham, man was at the mercy of the 'pleasures' and it was therefore preferable to be 'a contented pig' than 'unhappy human'.[30] John Stuart Mill, by contrast, argued that cultural, intellectual, and spiritual pleasures are of greater value than the physical pleasures in the eyes of a competent judge.[31]Mill viewed the maximization of some form of eudemonic happiness as the source of the good.[32] As Marc Stauch et al[33]argued 'though, John Stuart Mill referred to the maximizing of pleasure and described utilitarianism as the 'happiness' theory, he was aware that this might be interpreted as pandering to selfish and perhaps, base, tastes'. Mill[34] therefore, distinguished between different kinds of pleasure:

> utilitarian writers in general have placed the superiority of mental over bodily pleasures chiefly in the greater permanency, safety, uncostliness, etc, of the former…that is, in their circumstantial advantages rather than in their intrinsic nature. It is quite compatible with the principle of utility to recognize the fact that some kinds of pleasure are more desirable and more valuable than others. It would be absurd that while, in estimating all other things, quality is considered as well as quantity, the estimation of pleasures should be supposed to depend on quantity alone.

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28 Jonathan Herring, *Medical Law and Ethics*, 3rd edition, Oxford University Press, New York (2010), p.13.

29 Emily Jackson, '*Medical Law, Text, Cases and Materials*, 2nd edn, Oxford University Press (2010), p.10. Utilitarianism emerged as a secular alternative to Christian ethics in the late 18th and early 19th centuries. J S Mill is identified with this theory although Jeremy Bentham was one of the earliest exponents of utilitarian theory.

30 Michael Robertson, Garry Walter, "A Critical Reflection on Utilitarianism as the Basis for Psychiatric Ethics", 2
Journal of Ethics in Mental Health 1 (2007).

31 Mill, J, *Utilitarianism, Liberty, Representative Government*, JM Dent and Sons, London (1968).

32 Michael Robertson, Garry Walter, "A Critical Reflection on Utilitarianism as the Basis for Psychiatric Ethics", 2
Journal of Ethics in Mental Health 1 (2007).

33 Marc Stauch, Kay Wheat, John Tingle, *Sourcebook on Medical Law*, Cavendish Publishing Limited, London (2002), p. 8.

34 Mill JS, *Utilitarianism*, Routledge, London (1863), p.15.

This theory in general states that rightness of a decision is judged by deciding whether it produces, more pleasure than pain.[35] The greatest good for the greatest number is the primary ethical principle of this theory.[36] This theory stresses upon human welfare, as wellbeing of each human being is what matters to the society at large.[37] Whenever there is a conflict between an individual decision and society at large, or duties of professionals, one can find an easy answer by relying on the utilitarian principle. In healthcare, utilitarian thinking would stipulate that whenever there is a choice between different but equally efficacious methods of treatment, patients' benefits should be maximized and the costs and risks minimized.[38] Any other approach would be regarded as an unethical practice.

In utilitarianism all human actions are to be morally assessed in terms of their production of maximal non-moral value.[39] But how are we to determine what value could and should be produced in any given circumstance? Utilitarian's agree that ultimately we ought to look to the production of what is *intrinsically* valuable rather than *extrinsically* valuable.[40] The intrinsic value of something is said to be the value that the thing has 'in itself', or 'in its own right'.[41] It is a value in life that we wish to possess and enjoy just for its own sake and not for something else which it produces. If one is asked what is good about being healthy and he says 'being healthy is just a good way to be', then he is indicating that he takes health to be non-derivatively good in a way that is intrinsically valuable. Apart from health, examples of intrinsic goods include: life, consciousness and activity, pleasures and satisfaction, happiness, beatitude, contentment, understanding, wisdom, beauty, love, friendship, freedom, peace, esteem, etc.[42] Intrinsic value is crucial to a variety of moral judgments. In consequentialism, whether an action is morally right or wrong has to do with whether its consequences are intrinsically better than those of any other action one can perform under the circumstances. Since what one is

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35 David C Thomasma 2004, 'Theories of Medical Ethics: The Philosophical Structure' in Pelegrino, Edmund D, Anthony E. Hartle, Edmund G. Howe , *Military Medical Ethics Vol.1*, TMM Publications, Borden Institute, Washington, (2004), p.28.

36 Id.

37 Id.

38 Peter Mack, "Utilitarian Ethics in Healthcare", 12 *International Journal of the Computer, the Internet and Management* 63 (2004), p.68.

39 Id.

40 Id.

41 Id.

42 Id.

morally responsible for doing is some function of the rightness or wrongness of what one does, then intrinsic value is also relevant to judgments about responsibility. Intrinsic value is also pertinent to judgments about moral justice insofar as it is good that justice is done and bad that justice is denied, in ways that are intimately tied to intrinsic value.[43] Judgments about moral virtue and vice also turn on questions of intrinsic value, inasmuch as virtues are good, and vices bad, again in ways that appear closely connected to such value. For example, undergoing or performing an abortion may not be considered by anyone to be intrinsically good, but many people would occasionally consider it extrinsically valuable as a means to another end, such as the restoration of an ill woman to a state of health. From the utilitarian point of view, this is not what is desired. What we really ought to seek are experiences and conditions in life that are intrinsically good in themselves without reference to their further consequences or extrinsic value.

In making ethical judgments utilitarians may ask which act will most increase the sum of human happiness. A utilitarian is least concerned of whether an act is right or wrong morally.[44] For example, a utilitarian will allow a patient to die peacefully rather than continuing with a painful life. In *Re C*[45] the patient sought a declaration from the court that his foot would not be amputated without his consent, arguing forcefully that he would rather die with two feet than live with one. The court found that, although the prisoner was suffering from schizophrenia, there was nothing to suggest that he did not understand the nature, purpose and effects of treatment; he had understood, and, with full knowledge that death might result from refusing amputation, had clearly made his choice. The court upheld the prisoner's right to refuse treatment and granted an injunction. A utilitarian is interested in the consequences of an action, rather than whether it is intrinsically right or wrong.

Faced with the objection that utilitarianism rides roughshod over widely accepted moral norms and requires endless utility evaluation, another version of utilitarianism known as 'rule utilitarianism' has been developed.[46] It provides a partial solution to some of the defects of utilitarian moral reasoning. A 'rule utilitarian' is

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43 Id.
44 Id.
45 *Re C (Adult: Refusal of medical treatment)* [1994] 1 All ER 819.
46 Jonathan herring, *Medical law and ethics*, Oxford University Press, 3rd edition, (2010), p.14.

least bothered about maximizing the welfare, but rather will focus on which action will lead to best consequences.[47] In other words, rule consequentialism will ask 'which general rules will promote the best consequences in the long term, assuming that everyone accepts and complies with them?[48] For example, it is said that doctors shall keep confidential information given to them by patients. Even though there may be individual cases where it would produce a better outcome to make that information public, the rule of medical confidentiality produces generally good outcomes, in enabling people to be frank with their medical advisers. Therefore, a strict utilitarian would approach the matter case-by-case as to whether the matter may be revealed or not. But, a rule utilitarian will impose a duty on doctors to respect their patients' confidentiality, since this rule will tend to maximize welfare. A utilitarian is interested in the aggregate of wellbeing, not any particular individual's welfare. Accordingly, Utilitarianism is a collection of moral theories holding that one is morally required to seek the best possible balance of utility or disutility.

More recently, preference utilitarianism has come to the fore.[49] Preference utilitarianism requires maximizing the subjective preferences or choices of persons.[50] This form of utilitarianism is most commonly associated with Australian philosopher, Peter Singer. His take on the greatest happiness principle focuses on the impact an action will have on the preferences of those directly affected.[51] Singer recognizes that different people have different preferences and it is best to act in the best of those concerned.[52] In achieving the greatest happiness, Singer argues that we should act in a way that satisfies people's preferences in other words, what people prefer or would most like to happen.[53] As Singer[54] notes:

> Suppose I then begin to think ethically, to the extent of recognizing that my own interests cannot count for more, simply because they are my own, than the interests of others. In place of my own interests, I now have to take account of the interests of all those

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47 Emily Jackson, *Medical Law, Text, Cases and Materials*, 2nd edn., Oxford University Press, New York (2010), p.11.

48 Glannon, W, *Biomedical Ethics*, Oxford University Press, (2005), p.10.

49 Shaun D Pattinson, *Medical Law and Ethics*, 3rd edn., Sweet & Maxwell, UK (2011), p.6. It is associated with R.M.Hare, Peter Singer and Richard Brandt.

50 Id.

51 Singer P, *Practical Ethics*, Cambridge University Press, Cambridge (1979), p.12.

52 Id.

53 Id.

54 Id.

> affected by my decision. This requires me to weigh up all these interests and adopt the course of action most likely to maximize the interests of those affected. Thus I must choose the course of action which has the best consequences, on balance, for all affected.

However, preference utilitarianism fails to deal with the problem of people's unacceptable preferences. For example, Singer's preference utilitarianism is important in considering the practical ethical issues which arise with Voluntary Euthanasia. If doing the right thing is acting in accordance with the individual's preference then keeping someone alive when they would prefer to die is clearly wrong. Preference Utilitarianism, like other forms of utilitarianism is still consequential list and relative. It looks to achieve an outcome that satisfies the preferences of those directly affected and therefore the right action will depend on the circumstances and the preferences of those involved.

There have been a number of criticisms of utilitarianism as a moral philosophy. According to Michael Robertson [55], the negative features of utilitarianism based moral choices are that they involve assessments of preferences which may be biased or flawed; may require abandonment of emotional or filial bonds; potentially involve alienation from moral agency; may involve the active disadvantage or harm of individuals; and, are based on a political and moral philosophy that is arguably anachronistic. With respect to medicine and healthcare delivery, utilitarianism is particularly appealing as it often helps in resolving conflicts between individual and public duties of professionals. [56] But, consequentialism appears to place little weight on the right of autonomy, and would permit a doctor to carry out treatment on a patient without their consent if the overall consequences of the treatment were beneficial.[57]

3.4.2. Deontological Theory

The term deontology comes from the Greek word *deon* which means duty.[58] Deontological theory underlines the importance of one's duties and obligations. The

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55 Michael Robertson, Garry Walter, "A Critical Reflection on Utilitarianism as the Basis for Psychiatric Ethics", 2 *Journal of Ethics in Mental Health* 1 (2007).

56 Id. p.28

57 On the other hand, deontology, by regarding as irrelevant the consequences of actions, ignores the importance medical practice inevitably places on the consequences of alternative forms of medical treatment.

58 Herring, *Medical Law and Ethics*, 3rd edition, Oxford University Press, New York (2010), p.14.

exponent of this theory is Immanuel Kant.[59] The theory holds that certain kinds of actions are good, not because of the consequences they produce, but because they are good and right in themselves.[60]

Deontological theories of medical ethics encompass both religious and non-religious theories. As Gillon[61] notes:

> The great religions typically justify their deontological theories on one or both of two grounds. The first is that God has commanded the people He has created to obey his moral laws and it is their moral duty to obey the creator. The second is that the laws of nature include moral laws that bind everyone, including God.

Currently, neither of the religious perspectives commands a great deal of support from the medical profession. The most important non-religious, deontological theory was developed by Immanuel Kant. Kant believed that a theory of morality had to be constructed without reference to God's existence. This was a necessary outcome of the rational nature of human beings. Kant then went on and used ethical arguments to establish that rational beings recognized themselves to be bound by the 'supreme moral law'. Referring to Kant's theory, Gillon[62] stated:

> This supreme moral law stemmed from the fact that rational agents (or persons) intrinsically possessed an absolute moral value …, which rendered them members of what he called the kingdom of 'ends in themselves'. Not only did all rational agents recognize themselves as ends in themselves but, in so far as they were rational, they also recognized all other rational agents to be ends in themselves, who should be respected as such.

With regard to a person knowing what his or her duty is in a particular situation, Kant says that as human beings are rational creatures they ought to behave in a rational way, i.e. every person ought to behave as if his or her conduct were to become a universal law.[63] This means that every action must be judged in the light of how it would appear if it were to be a universal code of behavior.[64] According to

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59 Id.
60 Id.
61 Raanan Gillon, *Philosophical Medical Ethics*, John Wiley & Sons, Chichester (2003), p.18.
62 Id.
63 Friedrich Heubel, Nikola Biller- Andorno, "The contribution of Kantian moral theory to contemporary medical ethics: A critical analysis", 8 *Medicine, Health Care and Philosophy* 5 (2005), p.7
64 Id.

this theory one must always tell truth not because that makes people happy or gives them pleasure, but because we have a duty to speak truth. Telling lies, even if expedient, could not be accepted as moral under any circumstances because if lying was to be regarded as a universal law to which people ought to conform, morality would be impossible. Take for example, in *Hatcher* v *Black*[65]; a BBC broadcaster went to a physician suffering from a toxic thyroid gland for which an operation was recommended. She asked if it posed any risks to her voice and was reassured. However, as a result of damage to a nerve during the operation she could no longer speak properly. The court went on to hold that the doctor had been reasonable not to warn the patient, given that 'he had done what a wise and good doctor so placed would do'. Lord Denning stated:

> What should the doctor tell his patient? Mr Tuckwell admitted that on the evening before the operation he told the plaintiff that there was no risk to her voice, when he knew that there was some slight risk, but that he did it for her own good because it was of vital importance that she should not worry. In short he told a lie, but he did it because he thought in the circumstances, it was justifiable.

This attitude is derived from the teachings of Hippocrates[66], nearly 2500 years ago which stated:

> . . . perform your medical duties calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and sincerity turning his attention away from what is being done to him; sometimes reprove sharply and sometimes comfort with solicitude and attention revealing nothing of the patient's future or present condition for many patients through this course have taken a turn for the worse.

But, a deontologist would reject the claim of therapeutic privilege or the euphemism for lying as laid down in *Hatcher* v *Black*[67]. Accordingly, for a deontologist the moral action of a doctor in responding to a patient's questioning would be that stated

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65 (1954) Times, 2 July QBD, cited in Bea Teuten, David Taylor, "Don't worry my good man—you won't understand our medical talk": consent to treatment today, 85 *Br J Ophthalmol* 894 (2013).

66 See generally, The Oath of Hippocrates, viewed 16th June 2013, http://classics.mit.edu/Hippocrates/hippooath.html.

67 (1954) Times, 2 July QBD. cited in Bea Teuten, David Taylor, "Don't worry my good man—you won't understand our medical talk": consent to treatment today, 85 *Br J Ophthalmol* 894 (2013).

by Lord Bridge in *Sidaway* v *Bethlem Royal Hospital Governors*[68] where his Lordship said that when questioned by an autonomous patient: '… the doctor's duty must … be to answer both truthfully and as fully as the questioner requires'.

According to Kant no one should be treated merely as a means to an end.[69] Hence, deontologists will never justify the atrocities carried out by Nazi doctors on non-consenting people in the name of scientific research and advancement. Where a person is treated as an end in himself, there is a requirement to respect that person's values.[70] The key to deontological theory is the principle that one cannot justify breach of a deontological principle just by referring to the consequences.[71] Therefore, according to deontologists it is not permissible to kill an innocent person, even if by referring to the consequences. Hence, the centre piece of this theory is the notion of 'personhood'.[72] According to Kant, no decision can be imposed on others against their will, or without their consent. Kant wanted to preserve ethics in an age of rising science by establishing more objective standards for moral conduct, independent of consequences.[73] In effect he wanted ethics to be more scientific and rational.[74] Deontologists often place much weight on duties. They emphasize that the duties parents owe to their children, or physicians to their patients, are overlooked in utilitarian approaches.[75] While making a decision about children, one may take into account the duties one owes to them and not just the consequences for all children.[76] If three people are in danger in a fire, parents are expected to rescue their own child first; even if that means the other two are likely to perish.[77] As Beauchamp and Walters[78] commented on deontological theories as follows:

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68 [1985] 1 All ER 643, 661.

69 Kant I, Robert Paul Wolff 1969, *Foundations of the Metaphysics of Morals*, Indianapolis, Bobbs-Merrill, (1969), p.47.

70 For example, involving people in a risky medical experiment without their knowledge deprives them of their ability to make a rational choice about participation and uses them as a means to some other end. The fact that the knowledge gained from the research might benefit thousands of other people is not relevant.

71 Jonathan herring, *Medical law and ethics*, Oxford University Press, 3rd edition, (2010), p.15.

72 Id.

73 Jonathan herring, *Medical law and ethics*, Oxford University Press, 3rd edition, (2010), p.14

74 Id.

75 Beauchamp, TL, Walters, L, *Contemporary Issues in Bioethics*, Wadsworth Publishing, California (1982), p.19.

76 Id.

77 Id.

78 Beauchamp, TL, Walters, L, *Contemporary Issues in Bioethics*, Wadsworth Publishing, California (1982), p.19.

> Deontologists argue that moral standards exist independently of utilitarian ends and that the moral life should not be conceived in terms of means and ends…An act or rule is right, in the view of a deontologist, in so far as it satisfies the demands of some overriding principles of obligation.
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> Deontologists urge us to consider that actions are morally wrong not because of their consequences but because the action type-the class of which the actions are instances-involves a moral violation. Because of the wide diversity in these theories it is hard to find the unity, but the following two conditions are close to the heart of deontological theories. First, the justification of principles and actions is not entirely by appeal to the consequences of adopting the principles or performing the actions. Second, some principles must be followed or actions performed irrespective of the consequences. Thus, there are not only justificatory grounds of obligation that are independent of the production of good consequences, but these grounds are at least sometimes sufficient to defeat the consequences no matter what the consequences are.

The difficulties facing deontologists particularly relate to how we define the most important obligation. Where two moral people profoundly disagree about what rights or obligations require, it is difficult to resolve the debate. Some of the weaknesses of a strict Kantian perspective are the absence of any guidelines for dealing with the inevitable conflicts between duties and the lack of recognition that emotion and intuition can play a constructive role in ethical decisions.[79] For example, an absolute duty to tell a patient the truth might cause a patient harm in certain circumstances; therefore the duty to always tell the truth conflicts with the duty to avoid needless harm or injury. Kant's theory is a monist theory i.e. it relies or purports to rely on a single moral principle.[80] This gives rise to a major criticism that it does not deal with cases where there is a conflict of duties. So in a situation where truthfully answering a patient's questions would conflict with a doctor's positive duty to prevent harm to that patient (beneficence) an impossible situation arises: the doctor cannot tell the patient the truth and claim that he has done all he can to prevent the patient worrying – which may be necessary for the success of an

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79 Kantian Ethics, *Ethics at a Glance*, Regis University, http://rhchp.regis.edu/HCE/EthicsAtAGlance/KantianEthics/KantianEthics.pdf.

80 Id.

operation, as in *Hatcher* v *Black*[81] , yet according to the Kantian position he should do both. This logical problem that can arise if a theory is both pluralist and absolutist and if its principles conflict is summed up by Gillon[82] who says:

> Suppose, for example, I accept the principles that I should never harm others and that I should never deceive others; if both principles are absolute and I am faced with a situation where somebody would be harmed if I did not deceive him I am logically incapable of acting rightly.

It has been said that Kant's absolute (i.e. unqualified) assertion that, for example, we should never tell lies is unnecessarily restrictive: that moral rules are to be interpreted as generalizations not as categorical propositions to which there are no exceptions.[83] The obligation to tell the truth, for example, only need be adhered to provided that no other overriding factors are present, or provided that all other conditions are equal.[84] So, if a doctor acting from a sense of duty believes that lying to a patient is, ultimately in the patient's best interests then to tell the truth becomes subordinated to the doctor's duty to act in the patient's best interests (beneficence) and *Hatcher* v *Black*[85]may be regarded as 'good law'.

The Kantian concept of autonomy demands too much of patients. The highly rationalistic, individualistic Kantian account appears to assume that all patients are autonomous.[86] However, very few patients could be regarded as autonomous.[87] Majority of the patients are dependent or interdependent, and their decision-making capacity is not always based on reason.[88] However, the deontological theory is seen as an important response to consequentialism. This theory also fits in well with many current concepts of human rights, though Kant placed more emphasis on obligations than on rights.

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81 (1954) Times, 2 July QBD. cited in Bea Teuten, David Taylor, "Don't worry my good man—you won't understand our medical talk": consent to treatment today, 85 *Br J Ophthalmol* 894 (2013).

82 Raanan Gillon, *Philosophical Medical Ethics*, John Wiley & Sons, Chichester (2003), p.18.

83 Bea Teuten, David Taylor, "Don't worry my good man—you won't understand our medical talk": consent to treatment today, 85 *Br J Ophthalmol* 894 (2013), p.897.

84 Id.

85 (1954) Times, 2 July QBD. cited in Bea Teuten, David Taylor, "Don't worry my good man—you won't understand our medical talk": consent to treatment today, 85 *Br J Ophthalmol* 894 (2013).

86 Barbara Secker, "The Appearance of Kant's Deontology in Contemporary Kantianism: Concept of Patient Autonomy in Bioethics", 24 *Journal of Medicine and Philosophy* 43 (1999), p.52.

87 Id.

88 Id.

3.4.3. Virtue Theory

A virtue is 'a trait of character, manifested in habitual action that it is good for a person to have'.[89] According to this approach, if a person has a good character he will behave ethically as a matter of course.[90] Virtue ethics began with the ancient Greek philosophers Socrates, Plato, and Aristotle.[91] It discusses merits of virtue and its importance in living a good human life.[92] According to virtue ethicists, the virtues are those character traits that are necessary for human flourishing: these will be things like honesty, compassion, kindness, justice, and courage.[93] They searched for the elements that made a person good but in so doing they did not look at how a person acted but at what sort of character he had.[94] Virtue theory argues that all human beings have an inborn nature that prompts him to do good but needs proper guidance and training as habits are formed by one's parental and societal training, and also professional or other standards suitable to one's life choices and roles in society.[95] It suggested that a good person who behaves well must develop virtues, which, through habitual use, become part of that person's character. It is difficult to decide exactly what good virtues are. Every social group has a different measure of the balance of virtue in the socially complex mix of personal and community shaping. In one society, eating moderately may be a virtue, for instance, today's society urges everyone to stay in shape, whereas another might stress the pleasures of sampling foods to the point of illness or compulsion. However, certain core

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89 Rachels J. *The elements of moral philosophy*, McGraw-Hill International, London (1999), p.178.

90 Pat Kurtz, Ronald L. Burr, "Ethics and Health", in Karen Saucier Lundy, Sharyn Janes, *Community Health Nursing Caring for the Public's Health*, 2nd edn, Jones and Bartlett Publishers (2009), p.251.

91 Gardiner P, "A virtue ethics approach to moral dilemmas in medicine", 29 *J Med Ethics* 297 (2003).

92 David C Thomasma 2004, 'Theories of Medical Ethics: The Philosophical Structure' in Pelegrino, Edmund D, Anthony E. Hartle, Edmund G. Howe , *Military Medical Ethics Vol.1*, TMM Publications, Borden Institute, Washington,(2004), at p.31.Virtues, are defined as 'good operative habits that intensify the potentialities of human nature from its emotions to its intellect and will toward good actions'

93 Emily Jackson, *Medical Law, Text, Cases and Materials*, 2nd edn., Oxford University Press, New York (2010), p.14.

94 Id.

95 David C Thomasma 2004, "Theories of Medical Ethics: The Philosophical Structure" in Pelegrino, Edmund D, Anthony E. Hartle, Edmund G. Howe , *Military Medical Ethics Vol.1*, TMM Publications, Borden Institute, Washington,(2004), p.31.

virtues are always necessary for any decent society. Physicians need additional virtues, such as humility, compassion, integrity and respect for good science.[96]

Virtue Ethics model takes into account the context and consequences, without reducing ethics to simple matters of promoting pleasure, avoiding pain, or doing one's duty.[97] A virtue ethicist would maintain that people should always try to do the right thing for the right reason.[98]Virtue ethics rejects the idea that patient autonomy is absolute.[99] For example, if a patient wants to opt for euthanasia to end his life, it is not enough that the patient simply argues that death is good for him instead of undergoing medical treatment. Instead, he may prove that his life lacks the most basic human goods.[100]

Virtue theory combines the strength of both teleological and utilitarian theories. For example, Virtue theorists might argue that euthanasia, although performed out of compassion, is morally wrong because it involves killing, itself an evil act. Alternatively, a virtue theorist might argue that providing uncompensated care for the poor is a good human act, even if done for illicit motives such as personal pride, because the act has a quality of goodness independent of the agent. Its basic principle was articulated by Aquinas as; one should 'do good and avoid evil'.[101]

Because of perceived limitations of both teleological and deontological theories, virtue theory has recently received renewed interest within medical ethics.[102] The carrying out of virtues not only requires public consensus about right and good conduct, it also demands a metaphysical agreement about what counts as

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96 Pence GE, *Ethical Options in Medicine*, Medical Economics Company, Oradell, NJ (1980), pp.49-50.

97 Id.

98 Emily Jackson, *Medical Law, Text, Cases and Materials*, 2nd edn., Oxford University Press, New York (2010), p.13.

99 Id.

100 Philippa Foot, "Euthanasia", 6 *Philosophy and Public Affairs* 85, (1977), at pp.89.

101 St. Thomas Aquinas, *Summa Theologica*, Fairweather AM, trans. Philadelphia, Pa: Westminster Press; 1954. Quoted in David C Thomasma 2004, 'Theories of Medical Ethics: The Philosophical Structure' in Pelegrino, Edmund D, Anthony E. Hartle, Edmund G. Howe , *Military Medical Ethics Vol.1*, TMM Publications, Borden Institute, Washington,(2004), p.32.

102 Rebecca L. Walker, "Virtue ethics and medicine", 17 *Medical Ethics* 1, (2010), p.6.

the good.[103] This will require a conceptual link with duties, rules, consequences, and moral psychology, in which the virtue of prudence plays a special role.[104]

3.4.4. Principlism

Beauchamp and Childress [105] recognized the difficulties of attaining agreement on the most fundamental roots of ethics, on the nature of the good, on the ultimate sources of morality, on the limits and validity of moral knowledge, or even on which theory should predominate. To bypass these problems, they opted for *prima facie* principles, that is, principles that should always be respected unless some strong countervailing reason exists that would justify overruling them. Accordingly they formulated four basic principles derived from moral philosophy- autonomy, beneficence, non-maleficence and justice as a framework for ethical conduct in solving the modern ethical problems in medicine and the biological sciences. Modern medicine has to deal with the ethics of abortion, euthanasia, treating the young rather than the old when there is not enough medical care to go around, *in vitro* fertilization, manipulating genes to bring about a better human being or to remove the genes that cause diseases, helping people conceive children, withdrawing life support at the end of life, discussing whether food and water given through tubes can also be withdrawn so a person can die, the limits of a person's freedom to make decisions in a community etc. The four principles formulated by Tom Beauchamp and James Childress provide a simple, accessible, and culturally neutral approach to thinking about these complex ethical issues in health care. They are prima facie based on four moral commitments - respect for autonomy, beneficence, non-maleficence, and justice; plus concern for their scope of application. It offers a common, basic moral analytical framework and a common, basic moral language. Although they do not provide ordered rules, these principles can help doctors and other health care workers to make decisions when reflecting on moral issues that arise at work. The four principles plus the scope of approach claims that whatever one's personal philosophy, politics, religion, moral theory, or life stance, it will not be difficult in committing ourselves to four prima facie moral

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[103] David C Thomasma 2004, "Theories of Medical Ethics: The Philosophical Structure" in Pelegrino, Edmund D, Anthony E. Hartle, Edmund G. Howe , *Military Medical Ethics Vol.1*, TMM Publications, Borden Institute, Washington,(2004), p. 32.

[104] Id.

[105] See generally, Beauchamp TL, Childress JF, *Principles of Biomedical Ethics*, 4th ed, Oxford University Press, New York., (1994).

principles plus a reflective concern about their scope of application. Moreover, these four principles, plus attention to their scope of application, encompass most of the moral issues that arise in health care.[106]

3.4.4.1. *Autonomy*

Literally autonomy is self-governance or self-determination.[107] In other words it means 'right to act on one's own judgment about matters affecting one's life, without interference by others'.[108] According to Devereux[109] 'understanding autonomy is crucial to understanding the realm of health care decision making'. Underpinning this doctrine is a respect for an individual patient's autonomy. It means that patients must be treated with respect, be properly informed, be listened to, give their consent voluntarily and without coercion, and have their confidentiality fully respected. The legal principle of respect for self-determination is applied to questions concerning the physician's responsibility because patients and physicians are unequal in their possession of information and their power to control the circumstances under which they meet. Legal rights are a way of limiting the physician's power and of protecting the patient from unwarranted intrusions such as surgery without consent, public disclosure of information contained in hospital records etc.[110] The choices one has to make within the healthcare context often touches upon the fundamentals of life: refusal of life saving treatment, reproduction, a life free of pain, end of life decisions etc. Therefore, our identity as a person is closely linked to the integrity of our bodies. As Dworkin[111] notes, 'one's body is irreplaceable and inescapable…In addition because my body is me, failure to respect my wishes concerning my body is a particularly insulting denial of autonomy'. The

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106 Gillon, R, "Medical Ethics : four principles plus attention to scope", 309 *BMJ* 184 (1994).

107 Though, originally applied by the ancient Greeks to city-states, philosophers extended the concept to people from the eighteenth century onwards. Individualism has, of course, origins in the humanism of the Renaissance, the rationality of the Enlightenment and the struggle for personal and political freedom out of which our Western democracies sprang. See generally, G M Stirrat, R Gill, "Autonomy in medical ethics after O'Neill", 31 *J Med Ethics* 127 (2005), p.129.

108 Dunstan G, 'Should philosophy and medical ethics be left to the experts?' in Bewley S, Ward RH, eds. *Ethics in Obstetrics & Gynaecology*, RCOG Press, London (1994), p.3.

109 Devereux JA, *Australian Medical Law*, 3rd edn, Cavendish Publishing, London, 2007, p.3.

110 Beauchamp, TL and McCullough, LB, *Medical Ethics*, Prentice Hall, Englewood Cliffs (1984), p.42.

111 Dworkin G, *The Theory and Practice of Autonomy*, Cambridge University Press, Cambridge (1988), p.113.

importance of bodily inviolability is entrenched in by Justice Cardozo in *Schloendorff* v *New York Hospital*[112] in 1914 with his statement:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault.

In common law, judicial statements makes it very clear that every competent adult patient has the *right to refuse* medical treatment, even if his or her reasons are bizarre, irrational, or non-existent, and even if refusal of treatment will result in death.[113]

There are growing indications that a number of bioethicists are becoming less comfortable with this individualism.[114] In healthcare, medical ethics should always be set in the context of relationships and community. If patient's individualistic autonomy is to be the sole criterion for decision making, the patient–doctor relationship is reduced to that of client and technician. Moreover, there has been a change in the interpretation of the term 'autonomy'. Mill laid the foundation for this theory when he proposed the principle of autonomy, on the one hand, and the principle of utility, on the other. According to Mill[115] the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. One cannot be compelled to do or forbear some act simply because in the opinion of others it will be better for him to do so, make him happier and would be wise, or even right. O'Neill[116] believes that autonomy has now become too individualistic. She reminds us that John Stuart Mill hardly ever uses the word, 'autonomy' and when he does so; it refers to States rather than individuals. Mill did not refer to the idea of autonomy directly. He gave emphasis on liberty and according to him each person must be allowed to make free choices provided it does

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112 (1914) 105 NE 92.

113 See, *Airedale NHS Trust* v *Bland*[1993] AC 789; *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.

114 Tauber AI, "Sick autonomy", 46 *Perspect Biol Med* 484 (2003), p.487.

115 Mill, JS, *On Liberty*, Penguin, Harmondsworth, (1982), p.68.

116 O'Neill O., *Autonomy and Trust in Bioethics*, Cambridge University Press, Cambridge (2002), pp. 83–5.

not cause harm to others.[117] Therefore, Mill's version of 'autonomy', 'sees individuals not merely as choosing to implement whatever desires they happen to have at a given moment, but as taking charge of those desires, as reflecting on and selecting among them in distinctive ways'.[118] Similarly 'Kantian autonomy is manifested in a life in which duties are met, in which there is a respect for others and their rights'.[119] Thus in Kant's account of moral autonomy 'there can be no possibility or freedom for any one individual if that person acts without reference to all other moral agents'.[120] According to Jennings[121], Kant and others established that 'morality requires a person to assume responsibility for his or her choices, actions and decisions and to act on the basis of informed reason and autonomously held principled commitments. Others in turn must respect the moral agency and reasonable commitments of the person in this sense'. For example, the most ardent proponent of the principle of autonomy would accept that it would be wrong to deny someone medical treatment because they were incapable of consenting. Similarly in the case of children and adults lacking capacity, the treatment given without their consent cannot be termed as contrary to the principle of autonomy. The doctor's justify such treatment by using the term beneficence.

3.4.4.2. *Beneficence*

The principle of beneficence refers to a moral obligation to act for the benefit of others.[122] This principle dates from the time of the Hippocratic Oath in which the physicians swore, "I will follow that system of regimen which according to my ability and judgement I consider for the benefit of my patients…." According to this principle, the needs and wishes of the patient are the physicians' pre-eminent concern. The physician is meant to relieve suffering, produce beneficial outcomes wherever possible, and enhance patient's quality of life. The source of this additional moral obligation of beneficence taken on by doctors is presumably a certain feeling of benevolence, good will, or sympathy towards the sick.

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117 Mill JS, *On Liberty*, Cambridge University Press, Cambridge (1989), p.13.
118 O'Neill O, *Autonomy and Trust in Bioethics*, Cambridge University Press, Cambridge (2002), pp. 83–5.
119 Id.
120 Campbell AV, *Health as Liberation*, The Pilgrim Press, Cleveland (1995), p.l4.
121 Jennings B, "Good-bye to all that—autonomy", 13 *J Clin Ethics* 67 (2002), p.69.
122 Beauchamp TL, Childress JF, *Principles of Biomedical Ethics*, 5th edn, Oxford University Press, Oxford (2001), p.166.

This principle is apparent in circumstances where the patient lacks competence to make his or her own treatment decisions.[123] In *NHS Trust* v *A (A Child)*[124], the NHS Trust sought a declaration for carrying out a bone marrow transplant on a seven month old child suffering from haemophagocytic lymphohistiocytosis. As there was a chance of child dying during transplant, the parents objected to the treatment. Holman J accepted that the procedure has associated risks but given that a transplant may lead the child to live a full and happy life, the wishes of the parents should be over ridden as judgment must be based on medical evidence and reason.

The principle of beneficence justifies paternalistic decision-making.[125] As mentioned when we discussed the principle of autonomy, the patient is the one who has the right to decide what treatment doctors should provide and the medical professional should respect that choice. So it may be noted that the role of the doctor is to recommend the best treatment, but it can only be given where the patient consents. Non-consensual treatment may amount to degrading treatment but will not do so if it is therapeutically necessary. This principle was established in the 1992 case of *Herczegfalvy* v *Austria*[126], which involved the forced-feeding and restraint of a mental patient. The European Court of Human Rights held that this treatment did not amount to degrading treatment in violation of Article 3 and declared the general rule that 'a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading'.[127] The court emphasized, however, that it must 'satisfy itself that the medical necessity has been convincingly shown to exist'.[128] This reflects the straightforward idea that in deciding what treatment to give a patient, the medical professional should judge as to which will benefit the patient most.

3.4.4.3. *Non-Maleficence*

The principle of non-maleficence refers to the duty to refrain from causing harm. It underlies the medical maxim *Primum non nocere*: 'First, do no harm'.[129]

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123 Elizabeth Wicks, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p. 91.
124 [2007] EWHCA 1696 (Fam).
125 Elizabeth Wicks, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.92.
126 (1992) Series A, No 244.
127 Id. para 82.
128 Id.
129 Beauchamp TL, Childress JF, *Principles of Biomedical Ethics*, 5th edn.,Oxford University Press, Oxford (2001), p.113.

The principle supports a number of more specific moral rules like do not kill, do not cause pain or suffering, do not incapacitate, do not cause offense and do not deprive others of the goods of life.[130] It demands more from the healthcare professional: not merely refraining from causing harm but rather taking positive steps to promote the welfare of the patient.[131] Like Beneficence this principle too can be traced from the time of Hippocratic Oath which states:

> I will follow that system of regimen, which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel.

Physicians' obligation not to harm is reflected in various codes and declarations of medical ethics. In the declaration of Geneva, and as amended in Sydney in 1968, physicians were expected and indeed mandated to:

> ... maintain the utmost respect for human life from the time of conception; even under threat, ... not [to] use medical knowledge contrary to the laws of humanity.

While the International Code of Medical Ethics states that:

> A doctor must always bear in mind the obligation of preserving life.

The duty and obligations of physicians to their patients remain unequivocally that of beneficence and non-maleficene. Harm is justifiable if there is a just, lawful excuse or reason for the act or omission. In real life situations physicians do inflict harm on patients but generally for the purpose of achieving some kind of good. According to Beauchamp and Childress[132], a harm we inflict such as a surgical wound may be negligible or trivial yet necessary to prevent a major harm such as death. The importance of this principle is that it urges against harming one patient to help another.[133] In *McFall* v *Shimp*[134], McFall needed a bone marrow transplant to improve his chances of survival from a serious medical condition. McFall's cousin,

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130 Id. p.117.

131 Beauchamp TL, Childress JF, *Principles of Biomedical Ethics*, 5th edn.,Oxford University Press, Oxford (2001), p.165.

132 Beauchamp T and Childress J. *Principles of Biomedical Ethics.* Oxford: Oxford University Press, 1989; 122

133 Jonathan Herring, *Medical Law and Ethics*, 3rd edition, Oxford University Press, New York (2010), p. 26.

134 10 Pa D & C 3d 90 (1978).

Shimp, was found to be compatible for donation. Shimp, having initially indicated that he would be willing to donate bone marrow, changed his mind and decided against it. McFall sought an order that Shimp had to donate. The court refused and held that it would be wrong to harm Shimp by taking the bone marrow without his consent, even though it would be done for a good motive. The decision could be seen as support for the principle of non-malfeasance. Where the patient consents to the treatment and the doctor provides it, the non-malfeasance principle may not be infringed.

In *Re Y*[135] a 36 year old woman was suffering from non-Hodgkins lymphoma. Her condition was rapidly deteriorating and a bone marrow transplant represented the best hope of saving her life. Her sister, aged 25, was regarded as likely to be the best match for her, but she was mentally and physically disabled and incapable of giving consent. The older sister sought a declaration from the court to permit testing her younger sister and, if the results showed a match, to permit taking bone marrow from her for a transplant. The declaration for testing was granted. The court held that the donation of bone marrow would be a benefit to Y because if the sister died, that would affect Y's mother's state of mind, and she played a major role in the care of Y. It shows how creative reasoning can find a benefit in treatment which might appear to cause only harm. However, the principle of non-maleficence requires that the physician be alert to circumstances in which treatment stops being beneficent and starts constituting malfeasance. Moreover, a strict application of this principle is not practical as medicine often involves doing harm.

3.4.4.4. *Justice*

Justice is often regarded as being synonymous with fairness and can be summarized as the moral obligation to act on the basis of fair settlement between competing claims. According to Aristotle, justice meant equal shares for all.[136] The formal principle of justice or equality attributed to Aristotle is, that equals should be treated equally and unequal's unequally in proportion to the relevant inequalities. [137] The term justice, therefore, means 'freedom from unfair discrimination'. If autonomy dictates that the patient's interests is always foremost

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135 *Re Y (Mental patient: bone marrow donation)* 35 BMLR 111.
136 Gillon, Raanan, "Justice and medical ethics", 291 *British Medical Journal* 201 (1985).
137 Id.

and what is best for the patient should be first in the physician's mind, the principle of justice dictates that the physician must have concern for the fair distribution of the system's resources and for ensuring that they are not distributed in a way that depends on inappropriate discrimination.[138]

Some argue that medical ethics should have no concern with justice in the sense of fair adjudication between competing claims. As role of physician is to follow the Hippocratic principle which is doing the best they can for each patient. The idea that doctors can somehow legitimately evade any need to concern themselves with justice is hardly tenable given that in the course of their practice they are often confronted with conflicting claims on their resources, even from their own patients. For example, the doctor who stays in theatre to finish a long and difficult surgery and consequently misses an outpatient clinic is probably relying implicitly or explicitly on some sort of theory of justice whereby he can fairly decide to override his obligation to his outpatients in favour of his obligation to the patient on the table.[139] Similarly, The Declaration of Tokyo's absolute prohibition of medical involvement in torture affirms a concept of justice based on rights that forbids certain things to be done to other people even if doing them may be of great social benefit. So the idea that justice is a moral issue that doctors can properly ignore is clearly mistaken.

According to Gillon, in health care ethics, justice can be subdivided into three categories: fair distribution of scarce resources, respect for people's rights and respect for morally acceptable laws.[140] This means that patients are entitled to be treated fairly and equally by health professionals. As resources are limited the physicians concern should be for fair distribution of the system's resources and for ensuring that they are not distributed in a way that depends on inappropriate discrimination. In the context of distributing scarce medical resources they take the view that the proper role of doctors is the Hippocratic one of doing the best they can for each patient.[141]

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138 John R Carlisle, "Ethics and Bioethics", in Sandy Sanbar *et al*, *Legal Medicine*, 6th edn, Mosby (2001), p.227.

139 Gillon, Raanan, "Justice and medical ethics", 291 *British Medical Journal* 201 (1985).

140 Gillon, Raanan, *Philosophical Medical Ethics*, John Wiley & Sons, Chichester (2003), p.86.

141 Gillon, Raanan, "Philosophical Medical Ethics", 291 *BMJ* 201 (1985).

All professional practitioners understand that their practice must be as free as possible from inappropriate discrimination and bias, and certainly all are aware of the inappropriateness of discrimination based on race, religion, national origin, gender, sexual orientation, or political opinion.[142] However, there is considerable literature to suggest that the practice of medicine, perhaps without intention, has contained a good deal of bias on some, if not all those grounds, in particular on the basis of age, race, and gender.[143]In the name of the justice principle, bioethics requires each practitioner to search his or her practice and all practice protocols in which he or she is involved for the subtle influence of prejudice and discrimination and to eliminate it whenever and wherever possible.[144]

The four principles framed by Beauchamp and Childress has the advantage of compatibility with deontological and consequentialist theories, and even with some aspects of virtue theory.[145] These principles have been applied widely to the resolution of ethical dilemmas by medical ethicists, and especially by health professionals.

3.5. CONCLUSION

Medical Ethics is considered as one-sided; as it dwells on the ethical obligations of doctors to the exclusion of those of patients. These are just guidelines that are imposed upon the professionals to ensure that their peers and also patients follow appropriate standards of moral decency. Medical ethics, through the ages, has not left contemporary society with a model that can be seen to be effective.[146] Even now the Hippocratic Oath is still considered as an inspiration for the doctors and the benevolent paternalism mentioned in it is accepted and respected by the physicians. But, there are many instances which prove the fact that in the modern day of consumerism, it is difficult to believe and accept the fact that every doctor will treat his patient with benevolence and with good conscience. However, no one can deny

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142 John R Carlisle, "Ethics and Bioethics", in Sandy Sanbar *et al*, *Legal Medicine*, 6th edn, Mosby (2001), p.228.

143 Id. p.228.

144 Id. p.228.

145 David C Thomasma 2004, 'Theories of Medical Ethics: The Philosophical Structure' in Pelegrino, Edmund D, Anthony E. Hartle, Edmund G. Howe, *Military Medical Ethics Vol.1*, TMM Publications, Borden Institute, Washington,(2004), p.36.

146 Jose Miola, *Medical Ethics and Medical Law A Symbiotic Relationship*, Hart Publishing, Oregon, (2007), p.31.

the fact that the basis of ethical codes include: respect for autonomy, beneficence, non maleficence and justice, among others.[147]

Medicine is an ethical profession and a doctor is deeply confronted with complex and sensitive medical issues coupled with the increasing public demand in decision-making process in the modern day advanced technological era. Moreover, healthcare professionals have to balance the needs of the individual patient against the needs of all their patients. Therefore, there is every possibility of a doctor discovering division, opposition, bitterness and confusion among the patients. Medical decisions were regarded as clinical matters best reached by the experts and anyone seeking to challenge a doctor's decision in the court faced an uphill struggle.[148] Doctors too, it appears, seem grateful that courts are willing to resolve cases of ethical complexity. The law sets down minimally acceptable standards, while ethical approaches may include deciding what would be the ideal way for a person to behave. Medical law and medical ethics is closely connected. After all, the courts would be unlikely to make an order which requires a health care professional to act in a way which is unethical. The following chapters discuss these issues and make an attempt to find a balanced decision on moral and ethical issues with the support of healthcare providers, States and courts.

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147 Though balancing patients' autonomy and best interests may be difficult at times, it is interesting to note that the ethical models of the physician-patient relationship all presume that the physician's role is patient-focused. See, e.g., T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 5th ed., Oxford University Press, New York , (2001), pp.312-319.

148 Jonathan Herring, *Medical Law and Ethics*, 3rd edition, Oxford University Press, New York (2010), p.2.