I. Medical Ethics: What is it, and Why Do We Need “Ethical Theory”?  

Bioethics, is, broadly speaking, the branch of philosophy which investigates the rightness or wrongness of actions within the field of medicine. These actions can involve clinical decisions at the bedside, interactions between physicians and their patients, issues relevant to institutional or professional behavior, critical problems in research and development, and social and public policy dilemmas. Medical ethics attempts to discover the answer to normative or “ought”-type questions, rather than to simply describe what is.

Just as the scientific aspect of medicine is fundamentally based on core basic science knowledge, so too, medical ethics is rooted in philosophy. Bioethics, therefore, is not a group of opinions or narratives strung together; rather, it is a discipline with two fundamental purposes:

1. **To teach and reinforce the basic rational tools necessary to understand how to identify values in conflict and to make decisions in an ethical dilemma; this includes understanding the justification of one’s own moral point of view, as well as learning to respect a different view.**

2. **To teach and reinforce virtue and character development, by acting in accord with the ethical principles upheld by reason (“right reason”).**

Thus, ethics is not a “social survey” which seeks to tabulate all opinions on a question and then compromise on all of them. Some values, as difficult and contentious as it may seem, should not be compromised. Some values, after careful and considered judgment, are found to be wrong, and others right. Still, in many situations, a compromise can be reached by carefully evaluating the merits of all reasonable positions.

Anthropology and sociology, on the other hand, are fields of human endeavor that attempt to describe what is—but they are limited, by definition, to answering non-normative questions. Law too, does not really tell us what we ought to do, but rather, what we can (are able to) do in a given society. One of the biggest philosophical mistakes people make is confusing anthropology, sociology, or law, with ethics. Saying, for example, that euthanasia has been practiced since the dawn of civilization (anthropology), or that the legalization of euthanasia in Holland has improved physician attitudes toward pain control (sociology) does not justify euthanasia. There is still an “open question,” namely, “But ought I to perform euthanasia?”

**Ethical Theories** are philosophical theories that seek to provide a rational basis (1) to explain why people act a particular way when faced with a moral dilemma; but, more importantly, (2) to suggest that one particular way of weighing moral decisions might be preferable to another.

Ethical theories allow us to follow consistent principles in making our moral decisions. This aids not only in the formation of conscience and introspection about our own moral character, but it also allows us to understand why people don’t agree with us. By exposing another’s thought process through the
use of ethical theories, we can increase our own understanding of their moral thinking, and, in some
cases, find a way to convince them of our position.

Suppose, for example, you take a moral position that you should never lie, no matter what the
consequences (a “Kantian” position). You are seeing a teenage girl for sexual health counseling in your
office, and an angry father bursts in, demanding to know where his daughter is, and why she is here.
The girl explicitly had asked you for confidentiality. Do you break it? A colleague approaches you and
says, “Listen, I know how you feel about lying...but this girl will be at great risk if her father finds out
she is here. If he thinks she is somewhere else, he will be happier, the girl will be protected, and her
health interests will be protected. So tell a little ‘white lie’ (this is “utilitarian” thinking). So here we
have two competing ethical theories—both initially seem persuasive. Understanding the ins and outs of
these theories (or others) might be helpful as you ponder what to do next...

II. Ethics and the Law

Law represents the codification of an aspect or rule of common morality. Often the construction,
articulation, and enforcement of laws are controversial, because the underlying philosophical
justification of the laws is controversial. Therefore, appealing to the law to help answer the question,
“What ought I to do?” is inadequate. For example, in the 1960s in the American South, racial
discrimination was “the law.” It would not have been an adequate answer to the question of the
rightness of racial segregation to say, “Well, it’s the law, isn’t it?”

Therefore, ethics transcends the law. While we should certainly be mindful of our civic responsibilities
to the law as physicians, we should also always look beyond the law to the reasoning behind it. HIPPA
laws, for example, require health care professionals to keep patient information confidential. But, is
confidentiality important because the law says it is, or is confidentiality important for deeper
philosophical reasons?

III. Moral Relativism vs. Moral Objectivism (Or, Yes, There Is Truth!)

A. Moral Objectivism

People are fond of saying “There is no right answer” to an ethical question. “Who’s to say what’s right
or wrong?” Or, “Everyone is just as right as everyone else.” You may have even been taught such
things in undergraduate philosophy classes! But, as you will see, these platitudes are not only self-
contradicting, they can also undercut the importance of morality itself.

Everyone—liberal or conservative—wants morality to be different from aesthetics or opinion. If I say,
“Racial discrimination is wrong,” I want that to mean something more than simply “I don’t like racial
discrimination.” And, I want it to apply to me and to you, regardless of what you think. Every law we
pass—from traffic laws to anti-terrorist laws—assumes not only that there is a “right” side, but also,
that the law will impose a certain rule on another who disagrees.

If I don’t like heavy metal music—and I don’t—it would be objectively unjust if I were to “impose”
that dislike on you—that is because musical tastes are clearly an aesthetic preference, while racial
discrimination is not. If I find racial discrimination immoral (universally), it would not be unjust to
force you to comply with laws that banned the practice.
What everyone who takes ethics (or pediatric medicine) seriously realizes is that there must be best (though not necessarily perfect) answers to moral questions. There are right answers in bioethics. This does not mean that it will be easy to find true answers or that even in our lifetime we will discover what the right answer to a question is. Alternatively, we could say that there are true answers and false answers to moral questions that are independent of our ability to discover them. This view is called Moral Objectivism.

Morality has objective answers that, often with difficulty, we strive to find, and which apply universally. Still skeptical? Think of something you absolutely oppose—the rape of a child, human slavery or trafficking—and ask yourself: Was there ever a time or place when this was or could be “right”? What if someone opposed me on these issues?

**B. Moral Relativism**

Moral Relativism is the counter-argument, and can take one of three forms:

1. **Cognitive Relativism:** There are no truths at all. What we believe about science, philosophy, history etc. is just what we happen to believe now. Everything is opinion—humans decide what is true or false.

   _Problem: This view is self-referentially incoherent (i.e., contradictory). If I say, “There is no truth,” I expect that statement to be taken as true. So, there is at least one truth, which is that there is no truth—which is logically contradictory._

2. **Cultural Relativism:** Morality differs from society to society; we should be tolerant of all other forms of morality. We cannot say X is wrong, because another culture might perform X, and it is right for them.

   _Problem: If this were true, (1) we could never fight for social change (e.g., against another culture like the segregated South of the 1960s); (2) we could never criticize (or change) the obviously unjust practices of other cultures (e.g., stoning women for adultery; burning widows alive (sati); human slavery). Furthermore, reformers of any kind would always be wrong. This view confuses anthropology with ethics—the fact that cultures vary in ethical belief does not mean that it follows that everyone is right in that belief._

3. **Subjectivism:** This view holds that morality is true for each subject (individual), and that what is actually true (rather than what one perceives as true) varies among individuals. This is common in our culture today. People say, “I don’t believe that X is right, but I wouldn’t want to impose that belief on another.” Or, “People can do what they want, as long as they’re not hurting someone else.”

   _Problem: While both of these statements above have a non-confrontational, emotional appeal, they lack logical substance. The first makes morality into aesthetics—you wouldn’t want to impose a musical preference or a shirt-color preference on another, but what about your belief in just healthcare, in criminal justice for rape victims, in ending poverty? In short, if you really think something is truly wrong—you would want it to apply not just to you, but to others as well, for the same reasons you found it wrong._
The second statement, “People can do what they want, as long as they’re not hurting someone else,” contains within it (underlined statement) a universal claim of morality—of justice. But this is again, a logical contradiction—there are no truths except that people cannot hurt someone else? What is the justification for that claim?

I have spent some time briefly rebutting the claims of moral relativism because it is crucial that we start ethics of any kind believing in the success of the project. We must believe that there is truth which transcends opinion; that we have the ability to choose the good, right answer, however long and imperfect that process might be; and that, in order to change our patients lives, medicine, and society, we can use reason to direct us away from bad choices, and toward good ones.

IV. Principle-Based Ethics

Four dominant principles of biomedical ethics arose to prominence historically from Georgetown University in the 1970s, and have come to be called the “Georgetown mantra.” Principles are used as “weighted tools,” an adjunct to using ethical decision theories. When a dilemma is faced, one can analyze the case by weighing these principles and reexamining the case through the lens of each.

The Four Principles:

1. Autonomy—the duty to respect patient's rights and decisions.

2. Beneficence—the duty to promote patients' welfare (the primary goal of medicine), which may involve a balancing of benefits against harms.

3. Non-maleficence—the duty not to inflict harm.

4. Justice—the duty to be fair on a micro (patient-centered) and macro (systems-centered) level

For example, take the case of whether Johnny’s (a boy with terminal brain cancer) parents should be allowed to forgo a feeding tube for him. We might want to consider both Johnny’s autonomy (represented by his parents) and the physician’s autonomy that they asked to help him. Looking at beneficence: is not starting medically provided nutrition and hydration in the patient’s best interest, or not? Does this act or omission violate the principle to “do no harm?” (non-maleficence) Is it just or fair to allow Johnny’s parents to forgo this intervention only when he is terminal, while other non-terminal patients are denied in the case of pediatric euthanasia? Alternatively, is it just to allow a terminally ill child to “dehydrate,” if it might accelerate the timeline of his death? (justice)

V. The Major Ethical Theories

When human beings do make moral decisions, we hope they will be reasoned, as consistent as possible, and applicable to others beside ourselves. We want to have confidence in both the decision, and in the process by which we come to that decision.

Since the dawn of philosophy itself, moral philosophy has tried to answer the questions of not only why we act as we do, but also, why one way of acting (one process) may be superior to another.
Ethical theories have arisen over time, which helps us to understand how people make moral decisions, and to serve as guides (to ourselves and others) of how to make decisions ourselves. They can also be used to rebut other moral views that are different from ours, or show their weaknesses.

VI. What Makes Pediatric Ethics So Different?

1. **Children are not Competent:** Young children cannot make informed decisions as adults can; they are not considered rational under the law.

2. **Children are Dependent:** Decisions are made by proxy—in the “best interests” of the child, rather than on “substituted judgment,” as is common in adults.

3. **Children are Vulnerable:** Pediatricians have a special responsibility to be advocates for the child, who is physically, socially, economically, and emotionally vulnerable.

4. **Children are Dynamic:** Pediatrician’s should respect the child’s growing autonomy, and dignity through all stages of life—concepts such as autonomy, informed consent, privacy, and confidentiality change as the child grows.


VII. The Five Box Method: Adapted from “The 4 Box Method,” a Practical Method for Clinical Ethics

From *Clinical Ethics, 4th ed.*, By Jonsen, Siegler and Winslade (1998)

“Medicine, even at its most technical and scientific, is an encounter between human beings, and the physician's work of diagnosing disease, offering advice, and providing treatment is embedded in a moral context. Usually, moral values such as mutual respect, honesty, trustworthiness, compassion, and a commitment to pursue shared goals, make a clinical encounter between physician and patient morally unproblematic. Occasionally, physicians and patients may disagree about values or face choices that challenge their values. It is then that ethical problems arise.

Clinical ethics is both about the ethical features that are present in every clinical encounter and about the ethical problems that occasionally arise in those encounters. Clinical ethics relies upon the conviction that, even when perplexity is great and emotions run high, physicians and nurses, patients and families can work constructively to identify, analyze and resolve many of the ethical problems that arise in clinical medicine...

...While we appreciate the importance of principles, we believe that the practitioner approaching a case needs a method that better fits the realities of the clinical setting and the reasoning of the clinician. Clinical situations are complex since they often involve a wide range of medical facts, a multitude of circumstances and a variety of values. Often decisions must be reached quickly...

We suggest that every clinical case, when seen as an ethical problem, should be analyzed by means of four topics. These four topics are:
1. Medical Indications

2. Patient Preferences

3. Quality of Life

4. Contextual Features

...Every case can be viewed in terms of these four topics; no case can be adequately discussed without reference to them. Although the facts of each case differ, these four topics are always relevant. The topics organize the varying facts of the particular case and, at the same time, the topics call attention to the moral principles appropriate to the case. It is our intent to show readers how the topics provide a systematic way to identify, analyze and resolve the ethical problems arising in clinical medicine.

Clinicians will recall the method of case presentation that they learned at the beginning of their professional training. They were taught to "present" a patient by stating in order the patient's history, including the chief complaint, the history of the present illness, past medical history, family and social history, followed by physical findings and laboratory data. These are the topics that an experienced clinician uses to reach a diagnosis and to formulate a case management plan. While the particular details under each of these topics differ from patient to patient; the topics themselves are constant and always relevant to the task of arriving at a case management plan. Sometimes one topic, for example, the patient's family history or the physical examination, may be particularly important or, conversely, may not be relevant to the problem at hand. Still, clinicians are expected to review all topics in every case. Our four topics -- (1) Medical Indications, (2) Patient Preferences, (3) Quality of Life, and (4) Contextual Features--are the ethical equivalents of these familiar clinical topics’

Building off of the work of Jonsen, Siegler, and Winslade, the Bioethics TBL research team at Nationwide Children’s Hospital has modified the “Four Box Method” to include another category by which to measure bioethical dilemmas by. Titled “Empathy and Integrity,” it asks the clinician two questions:

1. How will the decision make the family feel?

2. How will the decision make me feel?

We recognize that a successful approach to addressing bioethical dilemmas in clinical encounters requires not only some grounding in moral philosophy but also a genuine concern for the other; we chose the humanistic values of “empathy” and “integrity” as foremost of importance to consider alongside the existing four categories outlined above.

“Empathy” extends beyond prior categories of “Patient Preference” and “Contextual Features” by addressing the patient in their context of relationships while addressing how clinical decision-making affects the patient-clinician relationship. Thus, it takes into account the emotional interplay that will influence the patient/family’s reaction to the clinical decision and their future interactions with the healthcare team.
The latter aspect, “integrity,” deals with issues of conscience. In section II above, we demonstrated that legal standards do not always align with ethical ones. This can hold true even for professional obligations. When these duties come into conflict with deeply held moral convictions of the clinician, the resulting moral distress of decision-making can result in a sense of loss of integrity for the clinician. Recognizing this aspect of identity when approaching bioethical dilemmas promotes greater self-awareness for the clinician and, hopefully, a better-informed decision. When personal moral convictions about a dilemma come into conflict with the perspectives of others (i.e. patient, family, colleagues, supervisor, etc), or even the obligations of professional or legal bodies, the clinical decision-maker must conscientiously weigh the consequences of their options and make a decision with this in mind.

Below is an example case from “Clinical Ethics” by Jonsen, Siegler, and Winslade, with the relevant aspects of the Four Box Method discussed. Thinking through how the fifth box—questions of empathy and integrity—applies to this case may be a useful exercise. A chart outlining the Five Box Method is included on the following page for your reference.

“In a given case, a patient comes to a physician, complaining of feeling ill. Medical Indications include a clinical picture of polydipsia and polyuria, nausea, fatigue and some mental confusion, with laboratory studies showing hyperglycemia, acidosis and elevated plasma ketone concentrations. A diagnosis of diabetic ketoacidosis is made. Fluids and insulin are indicated in specific doses and volumes. These particulars are the occasion for implementing the moral principle of beneficence, that is, the duty of performing actions that benefit the patient. However, in the same case, the patient may be confused and, after hearing the physician's recommendations, rejects further medical attention: these circumstances, noted under Patient Preferences, raise questions about the principle of autonomy, that is, the duty to respect the patient's wishes. As the case is described, circumstances accumulate under all four of the topics and affect the meaning and relevance of the moral principles. It is advisable to review the entire four topics in order to see how the principles and the circumstances together define the ethical problem in the case and suggest a resolution. It is rare that an ethical problem involves only one ethical principle. Every actual ethical problem is a complex collection of many circumstances. Good ethical judgment consists in appreciating how several ethical principles should be evaluated in the actual situation under consideration. We hope our method helps practitioners to do just that.”
**“The Five Box Method” for Analyzing Bioethical Issues**

<table>
<thead>
<tr>
<th>Medical Indications</th>
<th>Quality of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is patient's medical problem? History? Diagnosis?</td>
<td>1. What are the prospects, with or without treatment, for a return to the patient's baseline state of health?</td>
</tr>
<tr>
<td>3. What are goals of treatment?</td>
<td>3. What physical, mental, and social deficits is the patient likely to experience if treatment succeeds? If it is not started, or if it fails?</td>
</tr>
<tr>
<td>4. What are probabilities of success?</td>
<td>4. Is patient's present or future condition such that continued life might be judged undesirable by them?</td>
</tr>
<tr>
<td>5. What are plans in case of therapeutic failure?</td>
<td>5. Any plan and rationale to forgo treatment?</td>
</tr>
<tr>
<td>6. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?</td>
<td>6. What plans for palliative care?</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Empathy &amp; Intensity</th>
<th>Contextual Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How will the decision make the family feel?</td>
<td>1. Are there family issues that might influence treatment decisions?</td>
</tr>
<tr>
<td>2. How will the decision make me feel?</td>
<td>2. Are there provider (physicians and nurses) issues that might influence treatment decisions?</td>
</tr>
</tbody>
</table>

**Patient Preferences**
1. What has the patient expressed about preferences for treatment?
2. Has patient been informed of benefits and risks, understood, and given consent?
3. Is patient mentally capable and legally competent?
4. Has patient expressed prior preferences?
5. If incapacitated, who is appropriate surrogate? Is surrogate using appropriate standards?
6. Is patient unwilling or unable to cooperate with medical treatment? If so, why?
7. Is sum, is patient’s right to choose a course of action being respected to extent possible in ethics and law?