



Medical Ethics 101

What ethical principles can help us in understanding the tough moral questions arising in contemporary medicine and health care?

Introduction

The complexities of medical care these days can be staggering. And much of the time decisions about medical treatment carry an inescapable sense of urgency. All kinds of potentially troubling situations arise regularly. When facing a potentially lethal illness or injury, should we always leave no stone of treatment unturned? How much detailed information should a patient expect to receive from a physician? How do we decide whether a patient should participate in a medical-research effort? How should we decide who should receive scarce organ transplants? Who should be making decisions about treatment when the patient is elderly and depressed? Who should be making decisions when a baby is born prematurely with severe and multiple defects? The list could go on and on.

Biomedical ethics is a growth industry, riding the coat-tails of astonishing technological advances in medical care. The literature is enormous and growing; no one except a full-time professional in the field can possibly keep up with it. *So what's a thoughtful Christian to do?* How can we sort through difficult ethical decisions about treatment? In times of urgent need, how can we draw upon the moral wisdom needed to help us and those we care about face complex decisions?

Four basic ethical principles have emerged as particularly helpful in understanding the tough moral questions arising in contemporary medicine and health care:

- Autonomy—respect for the patient's right to be part of his or her own care and treatment plan
- Nonmaleficence—the obligation to do no harm to the patient



- Beneficence—the obligation to help the patient
- Justice—fair access to available treatments

Moral discernment is an art as much as a science, but knowing the gist of these principles—their content, their importance, and their limitations from a Christian perspective—can help you know what to listen for when you or those around you are wrestling with the moral aspects of serious injury or illness. Your expertise won't make the necessary decision making simple or free of anguish, but it will give you a way of answering the question, "Am I paying attention to what is morally important in the midst of Carolyn's fearful new reality or Peter's unhappy dilemma?"

Respect for Autonomy

The principle of respect for autonomy stipulates that we not ignore or override a person's autonomous choices or actions—even if we think their judgments are mistaken—unless they harm other persons or the society. In medical contexts, respect for autonomy most often has to do with ensuring free and informed consent for medical treatment or research. That consent entails four elements.

AUTONOMY

To be *autonomous* is to be one's own person, free to follow a course of action chosen by oneself. The autonomous person must have the capacity to deliberate rationally about his or her choices, goals, and actions. He or she must have the ability to understand the situation that is the context for deciding or acting. That includes the ability to understand likely outcomes and risks. And the autonomous person must be free from control by others' coercion, intimidation, or deception.

First, *disclosure of information*. The patient has a right to be told about the nature of proposed treatment, its level of risk and probable benefits, and alternative treatments.

Second, *comprehension of information*. Disclosure means nothing unless the information is communicated in a way that makes sense to the patient and his or her family. Written explanations may be helpful but typically need to be supplemented by careful verbal explanation.

It is important to make sure that patients and their families understand what is going on. Concerned Christians who are not themselves medical professionals ordinarily can't provide expert knowledge, but we can make sure it is forthcoming and can sometimes serve as the needed interpreter. Informed Christians, both lay and clergy, can be a sounding board for the patient and family, allowing them to rehearse the options and decide what the patient really wants.

Third, *voluntary consent*. Consent for a course of treatment must be secured without coercion, intimidation, or deception. Here again, concerned and informed Christians can be helpful as a kind of watchdog. Has the patient's consent genuinely been freely given? If not, someone nearby may need to intervene.

Fourth, *competence*. For consent to be free and informed, the patient must be able to understand his or her situation and the proposed treatment. He or she must be able to weigh the probable risks and benefits. Some basic level of rational capacity, psychological stability, and maturity is required.

A distinctively Christian perspective offers both qualified support for and a critical perspective on the prin-

ciple of respect for autonomy. On the one hand, we believe people are made in God's image. God has given us minds in order to think and make responsible choices. We need to protect each person's autonomy in this sense, respecting her or his God-given ability to make decisions.

On the other hand, Christians recognize that autonomy is not absolute. We are interdependent creatures. We are never wholly separated or isolated from one another and from God. At times we need to accept help, and at times we need to bear one another's burdens. Christians understand our lives as gifts from God, not merely our own possession or property. So, ultimately, we are stewards of our lives, not sovereign owners. Christians properly regard the respect for autonomy as a high value but not as absolute.

Nonmaleficence

The principle of nonmaleficence has all sorts of practical implications. For instance, caregivers ought not to perform harmful or unnecessary procedures. The principle prohibits "harvesting" an organ by hastening the death of a person who is a potential organ donor. Nonmaleficence prohibits research methods that harm human subjects or place them at high risk.

NONMALEFICENCE—DO NO HARM

The heart of the principle of *nonmaleficence* is expressed in the maxim from the Hippocratic tradition: "First of all, do no harm." The basic idea is that if we are unable to help someone, then at least we should not do that person harm. The obligation not to harm is usually regarded as more stringent than the obligation to help or rescue others. The principle of nonmaleficence refers to the duty (1) not to harm others intentionally or directly and (2) not to expose others to the risk of harm. This prohibits treatment procedures in which the harm suffered is not outweighed by the avoidance of a greater harm or the provision of a greater benefit. Risking harm may be allowed in some instances but only so long as the goals of the action or procedure are sufficiently important. Nonmaleficence also requires that caregivers be thoughtful and act prudently. Negligence is a violation of this principle.

The duty not to harm can be grounded in any number of basic Christian affirmations. Some of these are as follows:

- Each person is created by God in the divine image and therefore worthy of the highest respect (Gen. 1:26–27).
- Christ died for every person, meaning each person is valuable (Rom. 4:23–25).
- We may encounter Christ in every person (Matt. 25:31–46).
- We should love our neighbors as ourselves (Mark 12:28–31; Luke 10:25–37).

All of these lead Christians to guard against deliberate or careless harm of persons. The special duties of a caregiver in a medical context are even stronger. As patients and caregivers, we are participants in a covenantal relationship that prohibits deliberate harm and prescribes the exercise of professional skill and diligence.

But Christian convictions also provide a critical perspective, particularly on what counts as benefits and harm. Physical suffering and death are seen as terrible and genuine evils to be avoided when possible—but not ultimate evils to be avoided at all costs. Sometimes patients and their families need to be reminded and reassured that suffering, in some situations, can be endured and even transformed or redeemed. Christians may sometimes need to remind ourselves and to remind patients' families that we can entrust ourselves to God's loving care in life and in death.



BENEFICENCE

Whereas nonmaleficence refers to harm that we are restricted from inflicting, *beneficence* has to do with positive obligation to help others. The principle of beneficence usually carries the proviso that we are obliged to help only when we can do so without excessive cost or risk to ourselves. In a medical context, beneficence refers to positive efforts on the part of the caregiver to improve a patient's health.

Beneficence

The principle of beneficence is based on a sense of reciprocity and fair play. Beneficence is a way of passing along to others the beneficial assistance we have received in the past. This surely makes sense to Christians, who see gratitude for the goodness in our lives as directed not only to other people but to God. Christians may have reason, similarly, to strengthen and extend the duty of beneficence. Christians often recognize a claim upon themselves to love their neighbor even when it is costly or risky.

The principle of beneficence can be and often is in tension with the principle of autonomy. The conflict between these two duties raises the issue of *paternalism*. Paternalism refers to actions in which a medical practitioner overrides the patient's autonomy, either by coercion or deception, precisely for the sake of helping the patient in some way.

There is widespread agreement that in some cases (as when dealing with young children, severely retarded persons, clinically depressed persons, and so on) it is necessary for someone else to make decisions in the patient's best interest. Much more problematic is paternalism in the case of a generally competent patient. For example, should an elderly or terminally ill person be able to reject treatment and be allowed to die?

Justice

Justice has to do with sharing the benefits and burdens, goods and services of society among its members according to some standard of fairness. But what should that standard be? There's the rub!

CAN WE DECEIVE PATIENTS?

Is it ever justifiable to deceive a patient about his or her situation because the caregiver or the family feels that the information would shock or discourage or frighten the patient? Perhaps so, but surely only in the most extreme circumstances. Withholding crucial information, after all, prevents the patient from exercising any control over his or her course of action in the face of illness or injury. Pastors as well as laypersons have an important role here in helping family members and patients themselves cope with unsettling news.

On what criteria do we or should we distribute access to medical care? Sometimes we use a method of allocation that begins with formal equality but shifts to equality of opportunity. Hence, first-come, first-served approaches and lotteries use randomness to approximate equal opportunity. Sometimes we use merit as the relevant factor, interpreted as medical fitness to be a candidate for treatment or medical likelihood of long-term benefit.

More problematic, at least from a Christian perspective, is the primary distribution of health care access according to ability to pay. The implicit assumption is that ability to pay is a reflection of societal contribution or individual effort. That may or may not be a defensible assumption, but in any case, it is in some tension with a Christian perspective that measures justice in terms of whether the needs of the weakest members of society are met. Since worth of persons is a matter of divine grace more than human performance, distribution according to need would seem to be most compatible with Christian convictions.

MEDICAL JUSTICE

Common to all theories of justice is a *minimal* (or *formal*) principle traditionally attributed to Aristotle: "Equals ought to be treated equally and unequals unequally." But who is equal and who is unequal? What are the relevant factors? Answering those questions drives us to search for *material* principles of justice, which try to give some content to the formal principle. There are at least five major options for what counts as the relevant factor:

1. to each person an equal share;
2. to each person according to individual need;
3. to each person according to individual effort;
4. to each person according to societal contribution;
and
5. to each person according to merit.

Conclusion

These four ethical principles and the concepts they entail are tools for the thoughtful Christian—but they are only tools. They don't by themselves provide answers so much as a checklist of questions to be asked in situations where tough decisions about medical care must be made.

About the Writer

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