



CHAPTER 2

Principles of Healthcare Ethics

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► Introduction

The chapter “Theory of Healthcare Ethics” of *Health Care Ethics: Critical Issues for the 21st Century* provided an overview of the major ethics theories and gave examples of how these theories apply to the practice of health care. In the changing Patient Protection and Affordable Care Act of 2010 (ACA 2010) era, knowledge of theories of ethics is especially important for appropriate patient and organizational decision-making. However, a foundation in ethics theory is not sufficient for day-to-day practice. Theories form the basis of the principles of ethics that provide a rationale for action in healthcare practice. This chapter includes the most commonly used principles (justice, autonomy, nonmaleficence, and beneficence) and presents information about their application. In addition, the chapter presents a model for decision-making that applies knowledge of both theories and principles of ethics.

► Nonmaleficence

If we go back to the basic understanding of the Hippocratic ethical teaching, we arrive at the dictum of “First do no harm, benefit only.” The principle of *nonmaleficence* relates to the first part of this teaching and means “to do no harm.” In healthcare ethics, there is no debate over whether we want to avoid doing harm to patients, professional staff, or the community. However, the debate occurs when we consider the meaning of the word *harm*. The following ethics theories come into play here:

- A consequentialist would say that harm is that which prevents the good or leads to less good or utility than other choices.
- A natural law ethicist would say that harm is that which is opposed to our rational natures, that which circumscribes or limits our potential.

- A deontologist would say that harm is that which prevents us from carrying out our duty or that which is opposed to the formal conditions of the moral law.
- A virtue ethicist, a person of practical wisdom, would find that harm is that which is immoderate, that which leads us away from manifesting our proper ends as humans.
- An ethical egoist would define harm as that which was opposed to his or her self-interest.

What Is Harm in the Clinical Setting?

In the clinical setting, harm is that which worsens the condition of the patient. However, deciding what *harm* or *worsen* means is no simple matter. Much of health care involves pain, discomfort, inconvenience, expense, and perhaps even disfigurement and disability. Using the natural law theory of double effect, we justify harm to patients because there is a greater good. A consequentialist would say that the greater good, the greater utility, occurs from accepting the pain or dismemberment as part of the cost to get the benefit the healthcare procedures promise. The due care standard to provide the most appropriate treatment with the least pain and suffering sounds almost like a deontological principle.¹

Most healthcare professionals consider harm to mean physical harm because the long history of healing has focused primarily on overcoming bodily disorders. However, harm can occur in other ways. For example, healthcare managers can cause harm by failing to supervise effectively. The result may be inadequate staff or a lack of equipment that is maintained or kept up to date. Either of these can lead to adverse patient outcomes. Harm also comes from strategic decisions that lead to major financial losses and jeopardize the ability of the organization to continue. From a community standpoint, making a decision to dispose of hazardous materials without taking

proper precautions puts the community at risk. In another example, healthcare policy makers can cause harm to the community by changing eligibility requirements that lead to patient populations being unable to afford or access the care they need. The ways in which harm can occur are infinite.

Harm as Negligence

Given the vast number of ways in which harm can occur, healthcare professionals have developed numerous protocols to protect patients, families, the organizations, the community, and themselves. Failure to engage in these protocols is an act of omission as opposed to directly doing harm, which is an act of commission. A substantial body of law and ethical understanding supports the view that such a failure is *negligence* (omission). Negligence occurs when the person has not exercised the due diligence expected of someone in his or her role and level of responsibility.

Healthcare financial managers, other administrators, and clinicians also face a number of laws to ensure that they are not engaging in fraud and abuse, which also cause harm. For example, failure to follow the expectations of good financial management is essentially *malfeasance*. This term is close to *maleficence* and represents neglect of fiscal responsibility and actions that conflict with policy or the law. Medical professionals are subject to a similar concept called *malpractice*. Part of the education of all healthcare professionals concerns what it takes to avoid doing harm in avoiding malpractice. To ensure the best patient care with the least amount of harm, the practice of due diligence is included in the education and practice of healthcare professionals.

Part of the education and development of a healthcare professional is the creation of persons of integrity who consider it a violation of self to put those who trust in them at risk. These professionals work to avoid this violation and are persons of practical wisdom. They

have achieved *eudaimonia* in their professions and in their lives. They also have the ability to meet with other health professionals and discuss the action needed in a complex ethical situation. It is an understanding of the health-care community that persons who assume the role of healthcare professionals share a common understanding of the mission, vision, and values of health care. They are also able to reason together, even if they arrive at their conclusions by different ethics theories and principles. This shared value of “First do no harm, benefit only” provides a foundation that is often lacking in ethical disputes outside of health care.

Harm as a Violation of Autonomy

An exceedingly large number of issues come to the surface as soon as you begin to address, in a thoughtful way, the issue of what harm is. For example, quality-of-life issues come into play. If a person elects not to receive a treatment because of a loss of life quality, then many people believe that imposing the treatment on that person is wrong. This would violate the principle of autonomy and evidence paternalism. In contrast, think of the situation in which a healthcare professional does not fully educate a patient about treatment options or dissuades the patient from using a certain treatment because of cost or a lack of insurance. While this action may save money for the insurance company or the facility, it does not respect the full autonomy of the patient. Regardless of circumstances, if one applies the principle of autonomy, persons own their lives.

Autonomy is also an issue if the person is incompetent. In this situation, the ethical approach is to determine whether one knows the person's wishes from the time when he or she was competent and, if so, follows them. This practice is termed *substituted judgment*. If the person's wishes are unknown, then the healthcare professional uses an approach called the *best interest* or *reasonable person decision*. The basis for this approach is the assumption

that a reasonable person would choose what is in his or her best interest.

► Beneficence

The other part of the Hippocratic ethical dictum is “benefit only.” The principle of beneficence addresses this dictum. The *bene* is the Latin term for “well” or “good.”

Beneficence and a Higher Moral Burden

Beneficence involves more than just avoiding doing harm. It represents a level of altruism that is absent from simply refraining from harm. The ethics principle of having to engage in altruistic or beneficent acts means that we are morally obligated to take positive and direct steps to help others. Relative to the ethics theories, the underlying principle of consequentialism, the greatest good for the greatest number, is itself a statement of beneficence.² Early writers in the consequentialist tradition argued for the theory because of their belief that human nature was benevolent.³

Because beneficence is a fundamental principle of healthcare ethics, ethical egoism (i.e., the belief that our primary obligation is to ourselves and that selfishness is a virtue) is not logically connected to health care. This is true because the motivation for most people who want to be healthcare professionals is helping people. Health care also is different in terms of common morality. In the larger society, people are not seen as negligent or deficient when they fail to perform beneficent acts. However, in health care, everyone involved in the provision of care, including clinicians, administrators, and support personnel, are expected to act with beneficence.

For example, acts of kindness and courtesy not expected by typical strangers are required of healthcare workers. For example, failure to

open a door to help someone in a wheelchair may be discourteous in most settings or perhaps even rude. However, if healthcare personnel take this action, it is unprofessional and may result in disciplinary action. Acting with kindness, compassion, and understanding, even under extremely stressful circumstances, is part of the description of professionalism in health care. In addition, active beneficence requires the ability to see every patient as a unique person who has worth. It also requires a balance between beneficence and clinical decision-making for the best patient care. Such a balance is often difficult, especially in times of great change and challenge.⁴ Despite its challenges, beneficence is part of the common morality of health care.

Nonmaleficence and Beneficence Are Insufficient Principles

Historically, the main problem that emerged from emphasis on nonmaleficence and beneficence is that in most healthcare situations, the physician was the person who defined “harm” and “good.” Historically, most people were ignorant of what the physician was doing or talking about or why he or she prescribed certain treatments. Thus, the physician defined the patient’s self-interest and carried it out. When the person who is receiving a benefit or avoiding harm has little or no say in the matter, that person receives paternalistic treatment. The term *paternalism* comes from the Latin *pater*, which means “father.” Paternalism, by definition, means that one treats the patient as one would treat a child.⁵ While the concept of paternalism is still part of health care today, changes such as the ACA 2010 and Internet access to healthcare information affect the patient–provider relationship. Patients increasingly assert their desire to make decisions for themselves and see themselves as partners in their own care. Thus, we have to move beyond nonmaleficence and beneficence to include the principle of autonomy.

► Autonomy

If a health professional makes a decision for a patient from the “First do no harm, benefit only” perspective without involving the patient in the decision, then the patient’s autonomy has been violated. Even if the professional’s entire intent is to put the patient’s interests before his or her own, leaving the patient out of decisions violates the patient’s “self.” While the motivation may be beneficence, the patient may not experience this action as one of kindness or compassion. Taking the appropriate action for patient decision-making requires an understanding of the principle of autonomy and its application in clinical and administrative decisions.

Autonomy and the Kantian Deontological Tradition

Autonomy as a concept means that the person is self-ruling. The term *auto* is from Greek and means “self.” The rest of the term comes from the Greek *nomos*, which means “rule” or “law.” Thus, one can understand autonomy as self-rule.⁶ Underlying the concept of autonomy is the idea that we are to respect others for who they are. This view is honored in the medical tradition as far back as the Hippocratic writings. Therefore, the duty of the physician is to treat people’s illnesses, not to judge them for why they are ill. It might be necessary for the physician to try to get patients to change what they are doing or who they are, but that is part of the treatment, not a character judgment.

Autonomy in Health Care

In the healthcare setting, it is often unclear whether the patient does or does not possess the conditions required for autonomy. Two important conditions must be met for autonomy:

- Are patients competent to make decisions for themselves?
- Are patients free of coercion in making decisions?

These questions reflect the idea that autonomy implies the freedom to choose. Typically, people have an understanding of what it means to be competent and be able to make choices on their own behalf. However, that is not all there is to competence and autonomy.

A competent person also needs to be free of coercion. Coercion could mean he or she is trying to please someone—parents, children, or care providers—and thus is hiding his or her real choices. In health care, coercion that might prevent free choice occurs in many ways. Providers often encounter patients whose choices are compromised or coerced. For example, an abused spouse may not feel free to discuss the causes of injuries. A raped daughter may avoid discussion of a sexually transmitted disease. Drug abusers may hide their condition for fear of job loss.

An interesting approach to competence is the idea of specific competence as opposed to general competence.⁷ Competence can be understood as the ability to complete a task. This may mean you are able to do and understand some things but not others. For example, a person with a transient ischemic attack might be unable to balance a checkbook. However, that same person might be able to understand the consequences of medical procedures and thus might assent to them or might not. This is an example of specific competence. A person may be intermittently competent because of his or her medical condition. Thus, the person is competent to assent to treatment right now but was not so 2 hours previously and might be unable to do so 2 hours in the future. Given the complexity of defining competence and the need to respect the autonomy of patients, clinicians must serve as gatekeepers for decision-making based on their ability to determine a patient's competence for decision-making. Fortunately, there are tools and standards to assist with this gate-keeping role.⁸

At this point, we have examined the importance of nonmaleficence, beneficence, and autonomy as principles of healthcare ethics. Application of these principles is essential

to providing high standards of patient care and to the function of mission-based healthcare organizations. The community assumes that these three principles are a given in all healthcare organizations. However, consistently practicing them is often challenging, especially in a complex, ever-changing healthcare environment.

The last of the four principles of ethics, justice, often tests the healthcare system in both patient and organizational ways. This last section examines the theory and application principle of justice in today's healthcare environment. It provides a foundation for understanding the need to practice justice and the difficulties in defining and practicing this principle.

► Theories of Justice

In general, to know something is unjust is to have a good reason to think it is morally wrong. However, we must be able to decide whether that action is truly morally wrong. Therefore, we can ask questions like “What kinds of facts make an act unjust rather than simply wrong in general?”

People use the term *injustice* to mean that they are unfairly treated. Injustice in this sense occurs when patients with similar cases do not receive similar treatment. Following Aristotle, many believe that healthcare professionals are required, as a formal principle of justice, to treat similar cases alike except where there is some relevant or material difference in the cases. The equity requirement in this 2400-year-old principle is critical.

Justice usually comes in two major categories, procedural and distributive. *Procedural justice* asks, “Were fair procedures in place, and were those procedures followed?” *Distributive justice* is concerned with the allocation of resources. In some cases, both of these justice issues will be in play at the same time. Both of these justice principles start from the idea that in the distribution of burdens and benefits,

the allocation should be equal unless there is a material reason to discriminate.

Procedural Justice

Procedural justice can be defined as *due process*. For example, in the legal system, we speak of being equal before the law as part of procedural justice. In the legal sense, then, procedural justice or due process means that when you get your turn, you receive the same treatment as everyone else. One can apply this concept to health care. For example, when you were waiting to see your primary care physician, did you receive the same attention care as the person who preceded you? Or as procedural injustice, were others seen before you without any clear medical reason?

Procedural injustices occur in patient care, but they are more common when dealing with healthcare employees. For example, if a healthcare administrator has to terminate a few employees because of economic considerations, are the procedures for determining who will go applied without bias? In such cases, the issue is not so much whether what happened was in itself just or fair but whether the method used followed the stated procedures. No one would claim that it is fair to terminate good employees with long careers of service who have done nothing wrong. However, if economic circumstances dictate that employees must be terminated, the procedural justice question of whether there were standards and procedures for making the selections and whether the decision maker followed those standards and procedures correctly emerges.

Failures of due process or procedural justice can also occur in the health policy arena, and policy makers should carefully watch for these failures. For example, at a public hearing concerning a health program that is controversial within the community it is attempting to serve, the chair allows each speaker 3 minutes to present his or her comments. You will not think it justice if some speakers are allowed 10 minutes, whereas others are constrained to 3 or told to sit

down after only 1 minute. You would also not think it just to only allow speakers who agree with the committee to have a voice.

The concept of distributive justice is also important for maintaining an ethics-based healthcare system. Because of its importance, it merits its own section and a discussion of principles and issues. This information should assist healthcare professionals and others in the difficult task of providing justice related to resources.

Distributive Justice

The concept of distributive justice relates to determining what is fair when decision makers are determining how to divide burdens and benefits.⁹ The Kaiser Family Foundation data suggest that there are distributive justice issues related to the extent of the resource allocation disparity in healthcare demand and spending.¹⁰ For example, in the United States, the average cost of health care in 2010 was \$8402 per person and totaled over \$2.6 trillion dollars. The United States also spends more money on health care than any other developed nation. In addition, an estimated 20% of the total healthcare costs expenditures are caused by waste and fraud. Is this fair?

When it comes to distributive justice on the national level, many questions emerge: Why is health care so expensive in the United States as opposed to other countries? Does the amount of expenditure mean that Americans are healthier than anyone else on earth? Are there less expensive ways to achieve healthcare goals? Will the changes created in the changing ACA era provide better health care for more people and reduce the cost of care overall? Such questions continue to be debated. However, for our discussion, the point is to understand the difficulty of distributing the burdens of healthcare costs, while seeking the holy grail of affordability, availability, and quality all at the same time.

To understand distributive justice, you must first understand that resource allocation

issues occur at all levels. For example, a physician has to decide how much time to spend with each patient. Busy nurses have to decide how quickly to respond to a call button relative to the task in which they are currently engaged. Nurse managers have to effectively allocate too few nurses to too many patients.

Justice issues also exist for health administrators whose duties include hiring employees. In trying to be just in providing compensation, they must decide the best method to use to increase salaries. Should the increase be across the board or by merit or seniority? If by merit, then who decides which employees deserve a pay raise, and is the method fair? The latter question is one of procedural justice.

In the bigger picture, organizational leaders have to decide whether to spend scarce money on capital improvements on buildings and equipment, new employees, current employees, new services, or advertising or whether to save the money. In health care, allocation of scarce resources can be a matter of life and death. Those who must allocate funds often face difficult decisions related to distribution. For example, in Texas, persons with acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection pleaded at a Texas Department of Health public hearing that funding not be cut. On the line was a drug assistance program facing budget cuts. At that time, the drugs for treating AIDS and HIV cost \$12,000 per year, and the state was considering only allowing coverage if income levels did not exceed \$12,400. If a person with AIDS or HIV made \$13,000 a year, he or she would have only \$1000 on which to live. In addressing this issue, patients with HIV or AIDS told the panel members to look them in the eye so they would know who they were killing. Hearing attendees promised “not to slip quietly into their graves.”¹¹

Regardless of the outcome of that policy decision, the emotional consequences, coupled with necessary fiscal decisions, highlight the need for the reflective equilibrium in making

decisions about distributive justice. Reflective equilibrium is discussed later in this chapter. To be knowledgeable about why decisions are made with respect to distributive justice, one must explore issues related to these types of decisions.

Material Reasons to Discriminate

The basic principle of distributive justice is that each person should get an equal share of the burdens and benefits unless there is a material reason to discriminate. What are the reasons to discriminate?¹² One can summarize the multiple reasons to discriminate for material reasons in two different concepts: the person deserves it or the person needs it. Society believes that those who work hard and do well deserve their success. That is the common moral thinking in the United States. In contrast, a person who breaks the law and hurts people deserves punishment. This common moral thinking is often held by healthcare professionals and organizations. However, it also includes a more complex element—need. The following list includes the most common candidates for material reasons for health care to discriminate, all of which are subsets of need or being deserving:

- Deserving or worthy of merit includes one’s contribution or results and effort.
- It also includes the needs of individuals or groups, such as the following:
 - Circumstances characterized as misfortune
 - Disabilities of a physical or mental nature or, more generally, unequal natural endowments
 - A person’s special talents or abilities
 - The opportunities a person might have or might lose
 - Past discrimination against a group that is perceived as having negative effects in the present
 - Structural social problems perceived as restricting opportunity or even motivation.

In the larger society, there is also a need to discriminate on the basis of material need. One of society's views of distributive justice is that you get what you deserve or merit. Your results or contributions are what count the most in getting what you deserve. The most common form of getting what you deserve comes from the market. Therefore, if you are good at what you do, the market rewards you. If you are not, the market does not reward you, or even punishes you. For example, a physician who sees the most patients should be the one with the higher income. In addition, healthcare administrators who meet revenue or productivity goals should get higher pay than their peers who fail to do so.

In the larger society, effort matters, too. Many people seek rewards based on their effort, and often, this effort is rewarded by our institutions or culture. In some cases, we cannot determine whether the results that did or did not occur were within the person's control. However, we can observe their effort, and it translates into rewards. Thus, the healthcare administrator, who supervises the more complex healthcare system, receives more pay than a department manager. Researchers in biomedicine might work long and hard without necessarily getting the results they seek, yet they receive compensation for their expertise and labor.

Many people are willing to assist a person whom they perceive as putting forth effort and give up on a person who is not. This applies to healthcare treatments as well. For example, patients who follow "doctor's orders" and do not ask too many questions are viewed as working hard to solve their health problems. They will likely elicit more support and effort from the clinical team. These situations are common in the management of chronic diseases and in behavioral health. What of the reasons to discriminate on the basis of need?

Discrimination on the Basis of Need

It is exceedingly difficult to put an upper limit on the concept of need. For example, the

classic World Health Organization (WHO) definition of *health* is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."¹³ This definition sets up a model of need that is theoretically impossible to meet. However, some approaches are more useful than others. These include the following:

Need based on misfortune. In health care, the common morality is to discriminate for or against patients on the basis of their need for care. For example, persons with emergencies are treated first, no matter how long one has waited in line. Persons in accidents, regardless of whose fault it is, are seen as having experienced a misfortune. Victims of natural disasters generally are perceived the same way. However, many of the conditions we treat in healthcare organizations are not owing to an infection, a bad series of decisions, or a natural disaster. People may suffer from genetic defects that vastly restrict their functioning. Others have reduced abilities in physical or mental capacity. One can consider these conditions a form of misfortune.

Even in the healthy population, significant disparities exist between people as to physical and mental ability, including factors such as motivation. For example, one could consider a person's special talents or abilities as a potential area for discrimination. Although we normally do not think of discriminating in favor of someone because of special talents or abilities, it does occur. In health care, the clinical team may make more efforts to help someone with a special talent. For example, each Olympic athlete competing in Rio, Brazil, had a primary physician, who worked with the athlete during his or her preparation for the games. In addition, the U.S. Olympic Committee had 80 medical professionals to care for the athletes. There was also a full-service clinic to address the

needs of athletes' coaches and staff. The average American certainly does not have this type of access to care. However, it was determined that the abilities of these elite athletes and their representation of the United States merit discrimination based on their special talents.¹⁴

From a healthcare organization's viewpoint, administrators make hiring and promotion decisions on perceived ability, speculating that past performance will be a guide to future performance. In that sense, the criteria for hiring are a mix of something the candidate for employment has done and a gamble that he or she will continue to perform well. Policy decisions sometimes are made this way as well, such as when awarding a contract or a grant or funding a program. Decisions on rewards or funding are based on the appearance that those involved have the ability to accomplish necessary goals of the policy makers or organizations.

Children and the elderly also receive special consideration based on abilities or talents. For example, the argument for spending money on children's health care ties into the idea of their future abilities. This echoes the natural law argument to maximize potential. Many clinical workers will go to great lengths to help a child become whole because the child has so much life yet to live. Advocates for the disabled and the elderly also are concerned with ability. They worry that the reduced potential and ability of the elderly can lead to discrimination and thus loss of opportunity.¹⁵

Need based on past discrimination. Other forms of need might include redress of past injustices to social groups, which overlaps with the need to provide opportunities and prevent the loss of ability.

In the United States, this thinking led to the Civil Rights Act of 1965 and affirmative action laws. It could also be argued

that past discrimination means that the protected groups deserve special dispensations. Clearly, the opportunities of many persons in those groups were restricted. Many special talents went undeveloped because the conditions included in discrimination. In health care, we have seen the nation respond to special groups and their needs by the development of entire healthcare systems for them. For example, the creation of the Veterans Health Administration was in response to the needs of those who served the country. In addition, the Indian Health Service was created to provide care to a limited and specific group that experienced discrimination on many levels.

For some disadvantaged groups, the effects of adverse discrimination have led to access and structural problems that prevent some of the members from taking advantage of available opportunities. These burdens, such as poverty, poor educational and housing systems, and poor transportation systems, often contribute to the difficulties experienced by some individuals. Regardless of the root cause of problems, one knows that structural burdens have adverse health consequences.

Many people who claim to have a need also say they have a right to our services. The debate about whether health care is a right or a privilege is still part of the national discussion today. Let us look at the concept of rights, because they are intertwined with the concept of justice.

Distributive Justice and Rights

The efforts toward addressing changes in the ACA 2010 and other healthcare reforms continue the debate over whether access to health care is a right or a purchased commodity. Much of the language in the debate is confusing because there are many types of rights. One thing is clear: to claim a right means that a person believes there is some legal reason

that he or she is entitled to something or that there is at the least a moral claim supported by ethics principles and theories. Categories of rights range from ideal rights to legal rights. When a person claims that something is a right, the typical reaction of the other party is to consider the basis of the claim. Is it a legal one? Is it moral? Alternatively, is it not a right but simply a wish or a statement of a preference?

Ways of Categorizing Rights

FIGURE 2.1 provides a visual reference for the types of rights and their relationships. One can find all the rights within the circle of ideal rights, which are rights we wish we had. All of the rights within the larger circle are subsets of the ideal right. Rights that are partially within one or more other circles are rights that share common characteristics with their shared circles. For example, natural rights include elements of substance rights and negative rights. Some of the substance rights and negative rights have become legal rights. A positive right is a certain type of thing or social good to which you have a legal right. All positive rights are a subset of legal rights.

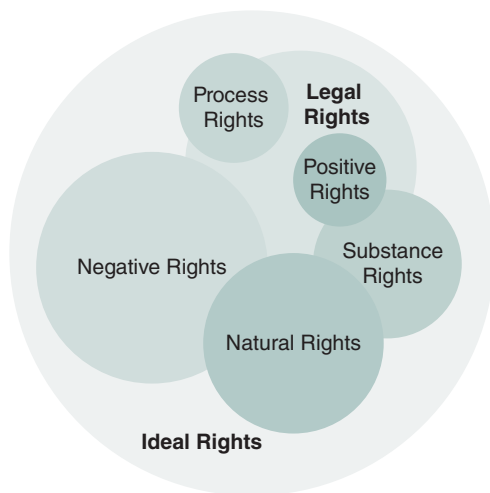


FIGURE 2.1 Types of rights and their relationships.

The size of the circle also indicates the relative importance of each type of right within the common morality of the United States. For example, in the United States, the common morality puts more emphasis on negative rights than on substance rights. Some other nations place a greater emphasis on collective welfare as opposed to individual opportunity. In these cases, the substance rights category would be larger, and more of it would fit inside the legal rights circle.

The list of rights here is by no means exhaustive. The following discussion of the types of rights in Figure 2.1 provides a synopsis of the issues involved.

Major literature exists on the topic of rights and includes others that are not part of Figure 2.1.¹⁶ The best of all rights, from the point of view of the claimant, are enforceable and legal rights.

Legal and Positive Rights

Margaret Mahoney notes that positive rights used to be called “social goods,” which society may or may not provide. The change to calling them “rights” was part of a rhetorical technique to give them a greater sense of legitimacy for the public.¹⁷ A *legal right* means that someone has a legal obligation to fulfill your right, whatever it happens to be. A *positive right* is a narrow example of a legal right, because it is a specific social good. For this reason, it is shown in Figure 2.1 as a circle completely within the set of legal rights. These rights are written into law and are described as *entitlements*. However, a legal right can include more than simply entitlements. For example, the legal system protects the right to due process, but it is not the provision of a good. One could say the same of the legal right to privacy under the Health Insurance Portability and Accountability Act (HIPAA). Thus, like due process, a right to privacy is not a positive right, even though it is a legal right.

When rights are under pressure because of budget shortfalls, political pressure to cap

government spending, or the like, the real meaning of a legal right is that you can go to court to get it enforced. Legal rights are not as strong as they were once thought to be in protecting the person with the right. For example, you may have a legal right to abortion or to Medicare and Medicaid, but if no one is providing it, your right has little value. Apparently, even the strongest version of a right does not mean that you will be able to exercise whatever rights you have.

Substance Rights

Substance rights may or may not be legal rights. They are rights to a particular thing, such as health care, housing, a minimum wage, welfare, food stamps, safe streets, a clean environment, and the like. In this sense, they are similar to positive rights but not necessarily legal, as with an entitlement. This is somewhat of a nuanced difference, because a substance right might imply that it is a right to something basic needed to maintain life. Nations, such as those in Europe, can be concerned with substance rights and attempt to guarantee an outcome or a basic minimum for their citizens. In those nations, the substance rights became legal rights. The positive legal rights noted earlier for health care also are substance rights, as would be the right in the United States to get treatment at an emergency department regardless of the ability to pay.

Negative Rights

In Figure 2.1, depending on the common morality of the United States, the circle for negative rights is relatively large and extends into the legal rights domain. The terminology used for negative rights comes from the British tradition and essentially means that you have the right to be left alone. You have the right to do anything not strictly forbidden by the law.

Negative rights are clear and enshrine liberty. For example, the Bill of Rights is primarily

a list of negative rights, for example, speech and assembly will not be restricted. The Bill of Rights also includes the idea that a state will not enforce a religion. It also reinforces the negative right that allows individuals to have weapons because “a well-regulated militia, being necessary to the security of a free state, [means] the right of the people to keep and bear arms shall not be infringed.”¹⁸

In the realm of health care, one major negative right is that we have the freedom to pursue our lives as we see fit. For example, motorcyclists claim they have a negative right to be free from having to wear protective helmets. Another negative right enshrined in law in some places is the right not to have smokers in your workplace, eating area, or public areas generally. Smokers maintain this is a major affront to their freedom. One person's negative right to be free of smoke is the cancellation of another person's negative right to be free to smoke. Therefore, there are often conflicts about how individuals view these rights and their effect on others.

Other legal protections that ensure you are left alone involve the protections against sexual harassment and hostile work environments. The privacy protections in HIPAA are yet one more legal negative right. An individual's medical information cannot be accessed unless he or she authorizes it or unless there are medically necessary reasons related to his or her care. As in the case of positive substance rights, the costs for those who must honor these rights and take responsibility for ensuring that individuals are free of these hazards can be large.

Process Rights

Given the Bill of Rights, many laws relate to ensuring that due process is followed, at least for most people. As noted in the discussion of the layout of the diagram in Figure 2.1, process rights do overlap with natural rights. In the United States and in most developed nations, process rights also are legal rights.

Natural Rights

Natural rights have a long history. The concept of a natural right means that we should respect attributes that humans have by nature.¹⁹ For Aristotle and St. Thomas Aquinas, these features would be those that best support the achievement of our highest good. The appeals to natural rights within our common morality that are most well-known go back to the Founding Fathers. Drawing heavily on John Locke, Thomas Jefferson proclaimed in the Declaration of Independence, “We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty, and the pursuit of Happiness.”²⁰

One practical advantage of the natural rights approach to determining a person's rights is that people from very different perspectives use the same language. Thus, even if their views are philosophically inconsistent, they can agree that someone has a natural right. For example, many will say that there exists a natural right to that which is necessary to move toward one's full potential, and health is important to this. To the extent that health care is related to health, one should be able to sustain the argument that morally one has a right to health care. Note that the philosophical reasons for why anyone should be able to develop his or her potential are manifold. However, people of differing religious and philosophic views could agree about having a natural right to develop potential without having to even acknowledge their underlying philosophical differences. Thus, simply as a matter of rhetoric, the language of natural rights plays an important role in making right claims within our common morality.

Ideal Rights

An *ideal right* is a statement of a right that is meant to be motivational, a goal to seek. WHO's definition of health and its subsequent claim that everyone has a right to the highest-attainable health falls into this category. Ideal rights serve to guide organizations, communities, and nations

to go beyond the minimum concept of human rights and seek to provide higher standards for their patients or constituents.

Reflections on Rights

One element of the reflective equilibrium model (discussed later in this chapter) that comes into play is the weighting of rights. The fact that we have a right seldom means that it trumps all other considerations. Consider the issue of conflicting rights at the policy-making level. Assume there are rights to national security, education for the young, transportation, protection of property rights, and health care. Is one right more important than the others at all times? Probably not, even though sometimes people think that their claim of a right should more important than all the others. In a healthcare example, do the healthcare needs of the old deserve more attention and financial support than those of the young?

What Does Having a Right Mean?

The U.S. Supreme Court has noted that you have no rights unless they are legal rights backed by statute. The fact that a strong moral case can be made is not sufficient. This applies directly to the example healthcare case that follows. Recruiters for the military sold military service to World War II and Korean War veterans by stating that if they put in 20 years or more of service, they could obtain free medical care at Veterans Affairs (VA) hospitals. However, the Pentagon ended those benefits for veterans over age 65 in 1995 because they were eligible for Medicare. However, Medicare is not a complete healthcare system, and it is not free. Further, some veterans over age 65 say they cannot afford the premiums, deductibles, and copayments of supplemental programs.

When the veterans filed suit to stay in the VA program, they learned that a promise by a recruiter does not equal a law on the books. Thus, in one sense, they had a right to something because they were promised it. However, in the

strictest sense of the word, they had no rights if a law did not compel their treatment. A review of the laws dating from just after the Civil War found that the Department of Veterans Affairs was treating people without statutory authorization. The Supreme Court ruled 5–4 that although the recruiters had made promises in good faith, there was no contractual obligation. Thus, the federal government had no contractual obligation to the veterans.²¹ This ruling is significant because it enshrines the idea that the only rights you have are strictly legal ones. As the nation and the world struggle increasingly with resource allocation issues, concerns about rights and distributive justice will become ever more common.

► Reflective Equilibrium as a Decision-Making Model

FIGURE 2.2 depicts the reflective equilibrium model. The middle of the figure shows the basic facts of the situation for a healthcare issue in which there is a need for a decision. In discussions of ethics, those making decisions about who must decide what to do use what are called *considered judgments* as

decision-making guides.²² Another term for such considered judgments is *ethical intuitions*, although the terms are not exactly the same.

A considered judgment implies that a degree of thinking and reasoning occurs before making a decision. To many people, an intuition is simply a feeling, but to ethicists, a moral intuition includes an element of reasoning. In moral reasoning, we test our considered judgments against our feelings, and vice versa. Clearly, the common morality will have a considerable influence on these judgments and intuitions as well.

Intuitions or considered judgments, as understood by ethicists, are essentially moral attitudes or judgments that we feel sure are correct.²³ These are of two types:

- Intuitions or considered judgments about particular cases. For example, letting people stay in the New Orleans Superdome during the Hurricane Katrina incident without doing anything to supply or protect them adequately was not a decent thing to do.
- Judgments regarding general moral rules. For example, people whose lives or property are threatened by a natural disaster should be helped.

Many such considered judgments exist in health care. For example, a person with a

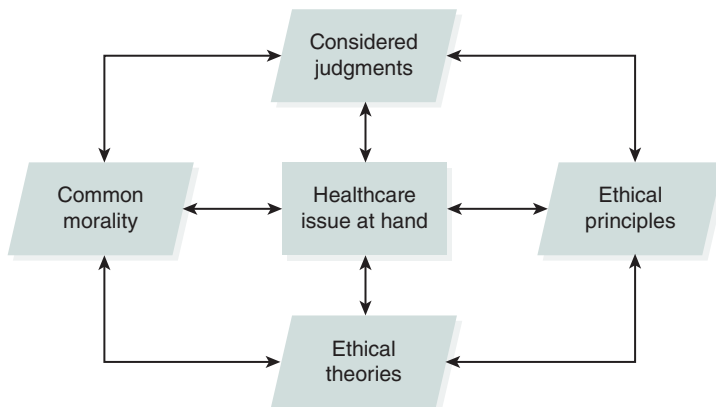


FIGURE 2.2 Reflective equilibrium at work.

medical emergency should receive treatment regardless of his or her ability to pay.

Ethics theory comes into play in examining people's motivations. Some people may believe they act because they have a duty to help others. Others may believe that assisting in a decrease of suffering of others is appropriate and that the more people their decisions can help, the better. Still others might appeal to our basic inclinations as humans to do the right thing or suggest that God or some deity guides our behavior in addressing the problem. When asked to justify their actions and decisions, these same persons might rely on their personal explanations or they might also rely on ethics principles.

As discussed earlier, ethics principles include the advancement of liberty, respect for autonomy, and actions taken out of beneficence to advance welfare. They also include ensuring that following the principle of non-maleficence, we do nothing to cause harm. We try to do this all fairly by upholding principles of justice. The typical portrayal of the healing ethic, "First do no harm, benefit only," captures at least two of these principles, non-maleficence and beneficence. The questions become just what to do. In the midst of all the decision-making, the people involved are unlikely to consciously draw on ethics theories or principles. They have internalized these ethical foundations for making decisions and simply make a decision. This is what it means to be a person of practical wisdom, a person exhibiting *eudaimonia*, as described in the chapter "Theory of Healthcare Ethics."

The term *reflective equilibrium* describes this back-and-forth process of coming to a coherent solution. John Rawls described this method,²⁴ and its hallmark is its lack of dogmatism. The person involved in making the decision revises the decision as new information becomes available. The person may choose to draw on one principle or ethics theory more heavily than he or she did in previous decisions.

Such movement back and forth among competing ethics theories and the quick reweighing of the importance of ethics theories

and principles can sometimes look like incoherence or arbitrariness. However, people making healthcare decisions are not as troubled by the requirements of doctrinal purity as they are by the need to come to a decision. They need to have a sound ethical basis to explain the decision, get action on that decision, and get on to the next task. Ethics theories and principles can help them reach those decisions, explain them, and motivate others to act decisively, urgently, or passionately on them.

With this foundation, the outcome is better, assuming the decision was sound. If not, the reflective equilibrium begins again. For this reason, the author chose the toolbox approach to better equip healthcare decision makers with an understanding of the principles and theories of ethics so that they can better decide, better explain, and better motivate. As Beauchamp and Childress put it, disunity, conflict, and moral ambiguity are pervasive features of moral life. Thus, it should be no surprise that untidiness, complexity, and conflict should be part of the process, too.²⁵

► Summary

The principles of healthcare ethics complete the elements necessary for reflective equilibrium. The primary principles of healthcare ethics are autonomy, beneficence, nonmaleficence, and justice. Justice is, by far, the most complex principle because it includes various conceptions of rights and there is greater dispute about what justice is and how to achieve it. Understanding the various nuances of rights and justice is of considerable importance in making resource allocations at the patient bedside, at the organizational level, or at the health policy level of government.

In using the reflective equilibrium model, a person will have to use reason to pick from among the principles, theories, the common morality, and his or her considered judgments to apply them to the issue at hand. In healthcare, we have a great advantage over most

organizational approaches to dealing with ethical issues. Given the tradition of ethics committees and consultants, a group of persons skilled and experienced in applying the reflective equilibrium is more likely to reach a decision that is reasonable than is a single person. This process will be messy; it will be error-prone. That is the human condition, and there seems to be no way around it.

Ethics is a complex field. Even after thousands of years, humans have yet to develop an ethics theory that will satisfactorily handle all the issues. Nonetheless, some approaches have proven more satisfactory than others and have led to the development of principles. You might ask, “Now what?” Are there any final answers for healthcare issues now and in the future? The answer is no. However, the important role of the study of ethics and ethical issues and the use of the reflective equilibrium model is to keep the inquiry going. The process matters as much, or even more, than the products. Given the current state of profound change within the healthcare system and the need to make changes that are ethically sound, the application of ethics theories and principles is ever more important. Let us hope the changes we face and must make will result in an improvement of our lives and an increase in the good. It is the job of each of us to keep the process going.

► Questions for Discussion

1. Why should clinicians have a thorough understanding of the principles of ethics?
2. It is said that you can hire those who will not participate in nonmaleficence, but it is more difficult to ensure beneficence. Why is it difficult to hire for beneficence?
3. Given the changes that are occurring with the ACA 2010, technology, and

other aspects of health care, why will respect for autonomy be more challenging in our future?

4. Justice in health care is more than doing what is fair. What aspects of justice are particularly challenging in healthcare environments?
5. How can you use the reflective equilibrium model to make practical decisions on ethical issues in your practice of health care?

► Notes

1. See E. E. Morrison, *Ethics in Health Administration*, 3rd ed. (Burlington, MA: Jones & Bartlett Learning, 2016), 55.
2. J. J. C. Smart, “Distributive Justice and Utilitarianism,” in *Justice and Economic Distribution*, eds. J. Arthur and W. Shaw (Englewood Cliffs, NJ: Prentice Hall, 1979), 103–15, esp. 103. In contrast, Richard Hare, also a consequentialist, specifically disavows that intuitions are a sufficient base for an ethics theory; R. M. Hare, “Justice and Equality,” in *Justice and Economic Distribution*, eds. J. Arthur and W. Shaw, 116–31, esp. 117.
3. D. Goleman, “The Roots of Compassion,” *New York Times*, December 19, 2006, <http://happydays.blogs.nytimes.com/2006/12/19/the-roots-of-compassion/?ty&emc=ty>. The author of the article surveys brain research and finds that humans may be hard-wired to have empathy, compassion, and thus beneficence. T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 7th ed. (New York: Oxford University Press, 2013), point out compassion as a focal virtue in health care on pages 37–39.
4. See Morrison, *Ethics in Health Administration*, 3rd ed., 60.
5. For an insightful discussion of the concept of paternalism, including its effect

- on policy and practice, see Beauchamp and Childress, *Principles of Biomedical Ethics*, 7th ed., 214–23.
6. See R. E. Ashcroft et al., eds., *Principles of Health Care Ethics*, 2nd ed. (West Sussex, England: John Wiley & Sons), 12–13.
 7. This approach was pioneered by Beauchamp and Childress, *Principles of Biomedical Ethics*, 7th ed., who point out this history on pages 114–20.
 8. See Beauchamp and Childress, *Principles of Biomedical Ethics*, 7th ed., 117–20, for examples of standards and tests for incompetence.
 9. Robert Nozick, in *Anarchy, State, and Utopia* (New York: Basic Books, 1974), 149–50, argues that the very language of “distribution” implies a central organization deciding who gets what and why. To him this improperly frames the discussion to imply a state and its attendant mechanisms when the problem is the state itself and its inevitable oppression.
 10. Kaiser Family Foundation, “Health Care Cost: A Primer 2012 Report,” May 2012, <http://kff.org/report-section/health-care-costs-a-primer-2012-report/>.
 11. M. A. Roser, “Don’t Cut State Drug Funds, AIDS, HIV Patients Plead,” *Austin-American Statesman*, January 17, 2003, B1, B6.
 12. J. Arthur and W. Shaw, eds., *Justice and Economic Distribution*, 2nd ed. (New York: Pearson, 1991), were helpful here.
 13. World Health Organization, “About WHO,” <http://www.who.int/about/en/index.html>.
 14. K. Fiore, “Olympic Doctors Ready to Treat Team USA,” *MedPage Today* (July 24, 2012), <http://www.mepagetoday.com/orthopedics/sportsmedicine/33890>.
 15. For a sampling of complaints, see K. Hausman, “Mentally Ill Workers Rarely Prevail in ADA Discrimination Claims, Survey Finds,” *Psychiatric News* 37, no. 16 (2002): 6. See also M. Weiss, “Study Finds Discrimination against Disabled Patients,” *ABCNewsHealth.com*, <http://abcnews.go.com/Health/story?id=2633167&page=1&CMP=OTC-RSSFeeds0312>. See also R. Longley, “Disabled Face Discrimination in Rental Attempts,” *About.com*, <http://usgovinfo.about.com/od/rightsandfreedom/a/disablerents.htm>.
 16. See L. Wenar, “Rights,” *Stanford Encyclopedia of Philosophy*, 2015, <http://plato.stanford.edu/entries/rights/>.
 17. M. E. Mahoney, “Medical Rights and the Public Welfare,” *Proceedings of the American Philosophical Society* 135, no. 1 (1991): 22–29, especially 23.
 18. Second Amendment of the United States Constitution, Legal Information Institute, https://www.law.cornell.edu/wex/second_amendment.
 19. Wenar, “Rights,” was helpful here. See, especially, section 6.1 on status rights, <http://plato.stanford.edu/entries/rights/>.
 20. Declaration of Independence. See paragraph 2, <http://www.ushistory.org/declaration/document/>.
 21. Associated Press, “Veterans Lose Health Care Suit against Pentagon,” *Washington Post*, November 20, 2002, www.americanveterans.org/news/112002.html. For a sample of unhappy commentaries, see M. Marquez, “Government Must Honor Promises from the Past,” *Austin-American Statesman*, January 21, 2003: A11.
 22. J. Rawls, *A Theory of Justice* (Cambridge, MA: Harvard University Press, 1971), 47–48.
 23. Arthur and Shaw, eds., *Justice and Economic Distribution*, 14.
 24. Rawls, *Theory of Justice*, esp. 20–21, 48–51.
 25. Beauchamp and Childress, *Principles of Biomedical Ethics*, 7th ed., Chap. 10, especially 404–10.