

Principles of Healthcare Ethics

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INTRODUCTION

Chapter 1 of *Health Care Ethics: Critical Issues for the 21st Century* presented the major ethical theories and their application in health care as part of a foundation for the study of ethics. This chapter extends that foundation by showing how those theories inform the principles used in health care and apply to the issues in that field. The principles commonly used in healthcare ethics—justice, autonomy, nonmaleficence, and beneficence—provide you with an additional foundation and tools to use in making ethical decisions. Each of these principles is reviewed here. The concept of justice is presented last because it is the most complex. In addition, this chapter presents a model for decision making that uses your knowledge of the theory 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 bad or harm. However, the debate occurs when we consider the meaning of the word *harm*. The following ethical 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 seeking *eudaimonia*, 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 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 workers 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. At a different level of harm, making the decision to dispose of hazardous materials without taking proper precautions puts the community at risk. In another example, healthcare policy makers can cause harm by changing eligibility requirements that lead to patient populations being unable to afford or to 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 workers have developed numerous protocols to protect patients, families, 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). The person has not exercised the due diligence expected of someone in his or her role.

Healthcare financial managers 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 very close to *maleficence* and represents neglect of fiscal responsibility. Medical professionals find a similar term with *malpractice*. Part of the education of all healthcare professionals concerns what it takes to avoid doing harm, to ensure that due diligence is followed.

Part of the development of a healthcare professional is to create a person of integrity who would consider it a violation of self to put those who trust in him or her at risk. Persons who avoid this violation are persons of practical wisdom. They have achieved *eudaimonia* in their professions and in their lives. They can sit down together and discuss what they should do in a complex ethical situation. In the healthcare community, we believe that persons working within the healthcare ethic share a common understanding of the mission, vision, and values of health care. They are able to reason together, even if they get to their conclusions by different ethical theories and principles. The shared values of “first do no harm, benefit only” provide a foundation that is often lacking in ethical disputes outside of health care.

Harm as Violations of Autonomy

An exceedingly large number of issues come to the surface as soon as you begin to address the issue of what harm is in a thoughtful way. 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. Using the principle of autonomy, persons own their lives.

However, if the person is incompetent, the ethical approach is to determine if one knows the person's wishes from the time when he or she was competent, and, if known, to follow them. This practice is termed *substituted judgment*. If the person's wishes are unknown, then the usual approach is called, the *best interests* or *reasonable person decision*. The assumption is that the reasonable person would choose what is in his or her best interest.

BENEFACTENCE

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

Beneficence and a Higher Moral Burden

Beneficence implies more than just avoiding doing harm. It suggests a level of altruism that is absent from simply refraining from harm. The ethical 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 ethical 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 disconnected from health care. This is true because most people enter health care as a profession because they want to help people. Health care also is different in terms of the common morality. The larger society does not necessarily hold people as negligent or deficient for failure to perform beneficent acts. However, in health care the professional roles carry that expectation.

Acts of kindness and courtesy not expected by typical strangers are expected of healthcare workers. Failure to open a door to help someone in a wheelchair may be discourteous in most settings or perhaps even rude. However, it is unprofessional if you are a healthcare worker. Beneficence is part of the common morality of health care.

Nonmaleficence and Beneficence Are Insufficient Principles

Historically, the main problem that has 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 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. However, one of the major developments in health care over the last several decades has been patients' assertion of their desire to make decisions for themselves. Thus, we have to move beyond nonmaleficence and beneficence to include the principle of autonomy.

AUTONOMY

If you make a decision for me from the "first do no harm, benefit only" perspective without involving me in the decision, then my autonomy has been violated. Even if your entire intent is to put my interests before your own, leaving me out of decisions about myself violates my "self." Your intention to execute an act of beneficence does not mean I experience it as such an act.

Autonomy and the Kantian Deontological Tradition

Autonomy as a concept means that the person is self-ruling. The term *auto* is from the Greek and means "self." The rest of the term comes from the Greek *nomos*, which means "rule" or "law." The derivation of terms such as *normative* comes from this Greek word. Thus, one can understand autonomy as self-rule. 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 a 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 the decision? 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.

The competent person also needs to be free of coercion. Coercion could mean they are trying to please someone—their parents, their children, or the providers—and thus are hiding their "real" choices. Forms of coercion that might prevent free choice in health care are myriad. Providers often encounter patients whose choices are compromised or coerced. For example, an abused spouse may not feel free to discuss the causes of bruises. 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.⁴ 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 assent to them or not. This is an example of specific competence. A person may be intermittently competent owing to his or her medical condition. Thus, the person is competent to assent to treatment right now, but was not two hours previously, and might be unable to do so two hours in the future.

At this point, we have seen the importance of nonmaleficence, beneficence, and autonomy as principles of healthcare ethics. Now we move to the last of the four principles of healthcare ethics: justice.

THEORIES OF JUSTICE

In general, to know something is unjust is to have a good reason to think it is morally wrong. We can ask, “What sorts of facts make an act unjust rather than simply wrong in general?” Several reasons are available.

People use the term *injustice* to mean unfairness in treatment. Injustice in this sense occurs when similar cases do not receive similar treatment. Following Aristotle, many believe that we are required, as a formal principle of justice, to treat similar cases alike except where there is some relevant or material difference. The equity requirement in this 2,400-year-old principle is critical. Now I shall break down the concept of justice into its components.

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 issues will be in play at the same time. Both 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 a 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, if you are waiting to see your primary care physician, did others get to go ahead of you without any clear medical reason?

Procedural injustices occur in health care, but they are more common when dealing with employees. For example, if a healthcare manager has to terminate employees due to 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 there must be terminations of employees, the procedural justice question emerges as to whether there were standards and procedures for making the selection and whether they were followed.

Failures of due process can also occur in the health policy arena, and those participating in policy making carefully watch for these failures. For example, suppose that at a public hearing, the time limit for speaking is 3 minutes. You will not think justice is done if some are allowed to speak 10 minutes, whereas others are constrained to 3, or perhaps told to sit down after only 1 minute.

We now turn to a review of the principles of distributive justice.

Distributive Justice

The concept of distributive justice relates to determining what is fair when decision makers are determining how to divide burdens and benefits.⁵ Kaiser Family Foundation data suggest the extent of the resource allocation disparity in healthcare demand and spending.⁶ One percent of the U.S. population consumes 23.7% of healthcare resources. Half the U.S. population consumes only 3.4% of healthcare resources. The other half consumes 96.6% of healthcare resources. This is an extraordinary mismatch in the use of healthcare resources. Is it fair?

When it comes to distributive justice, several questions can emerge. Why are so many using so little? Are they healthy or simply unable to access the system? Are we seeing an improvement in the lives of that 1% who are taking up nearly 25% of the spending, whether measured by the patients or by the medical community? Are there less expensive ways to achieve healthcare goals? Do the healthcare goals, whatever they are, make sense relative to the world in which we find ourselves? Such questions are debated endlessly; however, they will not sidetrack us here. The point is to see the difficulty of the task 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 they are engaged in when it sounds. Nurse managers have to allocate too few nurses to too many patients. Healthcare managers hire employees. If they are going to increase pay, they must decide what method to use. Should the increase be across the board or by merit or seniority? If by merit, then who decides whether employees deserve it, and is the method fair? The latter question is one of procedural justice. This is an example in which the two types of justice often occur together.

Organizational leaders have to decide whether to spend scarce money on capital improvements on buildings and equipment, new employees, more money for the 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. For example, in Texas, persons with AIDS and 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. The drugs for this treatment cost \$12,000 per year, and the state was considering only allowing coverage if income levels were not in excess of \$12,400. If a person made \$13,000 a year, he or she would have only \$1,000 on which to live. Desperation prevailed, as people told the panel to look them in the eye so they would know who they were killing. Attendees promised “not to slip quietly into their graves.”⁷

Regardless of the outcome of that policy decision, in the midst of such emotions the need for the reflective equilibrium (discussed later in this chapter) is high. Decisions are difficult when you are facing people who claim they are in such a crisis. One can explore many related issues to understand why decisions are made with regard to distributive justice.

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?⁸ The multiple reasons to discriminate typically boil down to two different concepts: that 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 morality in the United States. In contrast, a person who breaks the law and hurts people deserves prison. Health care shares this common morality but also includes a more complex element—need. The following list includes the most common candidates for material reasons to discriminate, all of which are subsets of need or being deserving.

1. Being deserving or worthy of merit includes one’s contribution or results and effort.
2. 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 based on material need. One of society’s views of distributive justice is that you get what you deserve or merit. Your results or contribution is what counts the most in getting what you deserve. The most common form of getting what you deserve in the larger society 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, the physician who sees the most patients is sometimes the one with the higher income. Healthcare managers 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 want rewards based on effort, and often this effort is what our culture and our institutions reward. Kant, for example, thought we should be praised or blamed for actions within our control, which includes our willing, not our achieving. 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 as reward. Thus, the healthcare manager who supervises the more complex healthcare system receives more pay than a department manager does. Researchers in biomedicine might work long and hard without necessarily getting the results they seek, yet they are compensated for their expertise and their labor.

Many of us are willing to help a person whom we perceive as putting forth effort and will give up on the one who is not. This applies to healthcare treatments as well. For example, patients who follow "doctor's orders" to the letter and are clearly working hard to solve their health problems 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. Now let us take up the reasons to discriminate based on need.

Discrimination Based on Need

It is exceedingly difficult to put an upper limit on the concept of need. For example, the World Health Organization (WHO) defines *health* as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."⁹ 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 based on 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 owing to 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, during cancer treatment, Lance Armstrong, who later was a seven-time Tour de France bike race winner, was administered a different chemotherapy than the protocol to protect his aerobic capacity.¹⁰ Although that may not sound significant, it is a special treatment.

Healthcare managers make hiring and promotion decisions on perceived ability, speculating that past performance will be a guide to future performance. In that sense, the criteria are a mix of something you have done and a gamble that you will continue to perform. Policy decisions sometimes are made this way as well, such as when awarding a contract or grant, or funding a program. It appears that those involved have the ability to accomplish the goals of the policy makers.

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.¹¹

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 opportunity and prevent the loss of ability. Such thinking led to the Civil Rights Act of 1965 and affirmative action. 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.

In the United States, health care long ago gave up the institutionalization of segregation by race or gender. Nonetheless, in health care we have seen the nation respond to special groups and their needs by development of entire healthcare systems for them. For example, the Veterans Administration system is the largest healthcare system in the world. In addition, the design of the Indian Health Service is to provide care to a very limited and specific group.

For some disadvantaged groups, the effects of adverse discrimination have led to structural problems that prevent some of the members from taking advantage of available opportunities. These structural burdens, such as poverty, poor educational and housing systems, and even poor transportation systems, often receive blame for the difficulties experienced by some. Regardless of what led to the 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. Let us look at the concept of rights, because they are intertwined with the concept of justice.

Distributive Justice and Rights

In the United States, debate continues over whether access to health care is a right or a purchased commodity. Much of the language is confusing, because there are many types of rights. One thing is clear: to claim a right means that you believe there is some legal reason you are entitled to something or that there is at the least a moral claim that your right is supported by ethical principles and theories. Rights range from ideal rights to

legal rights. When someone makes a claim 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 simply a wish or a statement of a preference?

Ways of Categorizing Rights

The diagram in **Figure 2-1** shows 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. Rights that are within another circle are subsets of that 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.

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 our common morality puts more emphasis on negative rights than on substance rights. Some other nations place a greater emphasis on the 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.

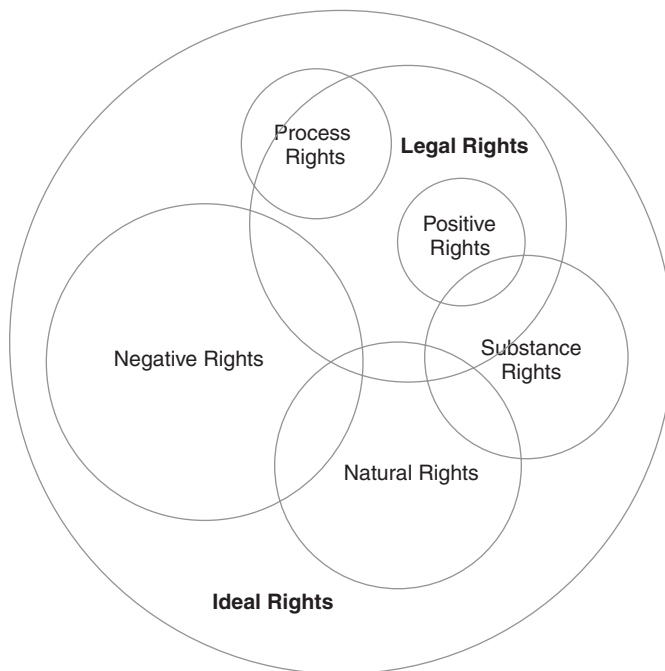


Figure 2-1 Types of rights and their relationships.

Major literature exists on the topic of rights and includes others that are not part of Figure 2–1.¹² 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 to the public.¹³ 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 the diagram in Figure 2–1 as a circle completely within the set of legal rights. These rights are written into the 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 HIPAA (Health Insurance Portability and Accountability Act) laws. 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 can be legal rights or not. 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, or at least be stabilized, at an emergency department regardless of ability to pay.

Negative Rights

In Figure 2–1, based 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, such as that 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 people 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.”

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.

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. Your medical information cannot be accessed unless you authorize it or for medically necessary reasons related to your care. As in the case of positive substance rights, the costs on the part of those who must honor or take responsibility for ensuring you 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.¹⁴ For Aristotle and St. Thomas Aquinas, these features would be those that best support our 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.”

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 argue or 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. The WHO definition of health and its subsequent claim that everyone has a right to the highest attainable health care falls into this category.

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 at the policy-making level. Assume there are rights to national security, education for the young, transportation, protection of property rights, and health care. Does one right trump the others at all times? Probably not, even though sometimes people think that their right claim should trump all the others. Even within health care, do the healthcare needs of the old trump 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 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 co-payments 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, but 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 VA was treating people without statutory authorization. The Supreme Court ruled 5–4 that although the recruiters had made the promises in good faith, there was no contractual obligation. Thus, the federal government had no contractual obligation to the veterans.¹⁵ This ruling is very 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 Figure 2-2 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 what to do use what are called *considered judgments* as decision-making guides.¹⁶ 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.¹⁷ These are of two types: (1) intuitions or considered judgments about particular cases (e.g., 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 good thing) or (2) regarding general moral rules (e.g., 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 medical emergency should receive treatment regardless of his or her ability to pay.

Ethical theory comes into play in examining people's motivations. Some people may believe they should do something because they have a duty to help others. Others may believe that assisting in a decrease of suffering is appropriate, and that the more people our 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 or deities want us to fix the problem. When asked to justify their actions and decisions, these same persons might rely on these explanations or they might rely on ethical principles.

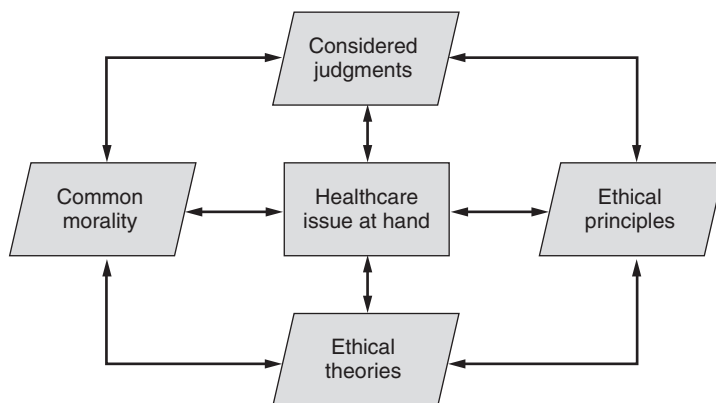


Figure 2-2 Reflective equilibrium at work.

As discussed earlier, ethical principles include advancement of liberty, respect for autonomy, and acting out of beneficence to advance welfare. They also include ensuring that we do nothing to cause harm by following the principle of nonmaleficence. 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: nonmaleficence 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 ethical theories or principles. They have internalized these foundations for making decisions and simply do so. This is what it means to be a person of practical wisdom, a person exhibiting *eudaimonia* as described in Chapter 1.

The term *reflective equilibrium* describes this back-and-forth process of coming to a coherent solution. John Rawls has described this method,¹⁸ 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 ethical theory more heavily than he or she did in previous decisions.

Such movement back and forth among competing ethical theories and the quick reweighing of the importance of ethical 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 that decision, get action on that decision, and get on to the next task. Ethical theories and ethical principles can help them to 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 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.¹⁹

SUMMARY

The principles of healthcare ethics complete the elements necessary for the 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 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, the theories, the common morality, and the considered judgments to apply them to the issue at hand. In health care,

we have a great advantage over most organizational approaches to dealing with ethical issues. Given the tradition of ethics committees and consults, a group of persons who are 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. Over thousands of years, humans have yet to develop an ethical 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. Although there was acceptance of certain beliefs for relatively long periods, the process eventually leads to a change. Let us hope the changes will result in improvement to 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. What do you think is the most important principle for clinical healthcare professionals? Explain.
2. Why is beneficence a more complex principle than nonmaleficence?
3. Why is respecting autonomy so important to the future of health care?
4. Why is justice in health care more complicated than just doing what is fair?
5. How can the reflective equilibrium model assist you in making practical ethical decisions in the future?

FOOD FOR THOUGHT

Today's healthcare system presents and will continue to present ethical challenges. Consider what Summers teaches us about the principles of ethics. How can you make these principles part of your day-to-day practice of medicine? Will you have to make some difficult choices to remain an ethics-based practitioner?

NOTES

1. See E. E. Morrison, *Ethics in Health Administration*, 2nd ed. (Sudbury, MA: Jones and Bartlett, 2011), 48.
2. J. J. C. Smart, "Distributive Justice and Utilitarianism," in *Justice and Economic Distribution*, ed. J. Arthur and W. Shaw (Englewood Cliffs, NJ: Prentice Hall, 1979), 103–115, esp. 103. In contrast, Richard Hare, also a consequentialist, specifically disavows that intuitions are

- a sufficient base for an ethical theory; R. M. Hare, "Justice and Equality," in *Justice and Economic Distribution*, ed. Arthur and Shaw, 116–131, esp. 117.
3. D. Goleman, "The Roots of Compassion," *New York Times*, December 19, 2006. Retrieved from <http://happydays.blogs.nytimes.com/2006/12/19/the-roots-of-compassion/?8ty&emc=ty>. Accessed November 29, 2011. 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*, 5th ed. (New York: Oxford University Press, 2001) point out this early history on page 166.
 4. This approach was pioneered by Beauchamp and Childress, *Principles of Biomedical Ethics*, 5th ed., who point out this history on pages 70–72.
 5. Robert Nozick, in *Anarchy, State, and Utopia* (New York: Basic Books, 1974), 149–150, 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.
 6. Kaiser Family Foundation, "Illustrating the Potential Impacts of Adverse Selection on Health Insurance Costs in Consumer Choice Models," November 2006. Retrieved from <http://www.kff.org/insurance/snapshot/chcm111006oth2.cfm>. Accessed November 29, 2011.
 7. M. A. Roser, "Don't Cut State Drug Funds, AIDS, HIV Patients Plead," *Austin-American Statesman*, January 17, 2003, B1, B6.
 8. Arthur and Shaw, eds., *Justice and Economic Distribution*, 1–11 was helpful here.
 9. World Health Organization, "About WHO." Retrieved from <http://www.who.int/about/en/index.html>. Accessed November 29, 2011.
 10. L. Armstrong, *It's Not About the Bike* (New York: G.P. Putnam's Sons, 2000), 108–109.
 11. 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. Retrieved from <http://abcnews.go.com/Health/story?id=2633167&page=1&CMP=OTC-RSSFeeds0312>. Accessed November 29, 2011. See also R. Longley, "Disabled Face Discrimination in Rental Attempts," About.com. Retrieved from <http://usgovinfo.about.com/od/rightsandfreedom/a/disablerents.htm>. Accessed November 29, 2011.
 12. See L. Wenar, "Rights," Stanford Encyclopedia of Philosophy, 2011. Retrieved from <http://plato.stanford.edu/entries/rights/>. Accessed November 29, 2011.
 13. M. E. Mahoney, "Medical Rights and the Public Welfare," *Proceedings of the American Philosophical Society* 135, no. 1 (1991): 22–29, especially 23.
 14. Wenar, "Rights," was helpful here. See especially section 6.1 on status rights. Retrieved from <http://plato.stanford.edu/archives/fall2006/entries/rights/>. Accessed November 29, 2011.
 15. Associated Press, "Veterans Lose Health Care Suit Against Pentagon," *Washington Post*, November 20, 2002. Retrieved from www.americasveterans.org/news/112002.html. Accessed November 29, 2011. For a sample of unhappy commentary, see M. Marquez, "Government Must Honor Promises from the Past," *Austin-American Statesman*, January 21, 2003: A11.
 16. J. Rawls, *A Theory of Justice* (Cambridge, MA: Harvard University Press, 1971), 47–48.
 17. Arthur and Shaw, eds., *Justice and Economic Distribution*, 10.
 18. Rawls, *Theory of Justice*, esp. 20–21, 48–51.
 19. Beauchamp and Childress, *Principles of Biomedical Ethics*, 5th ed., Chap. 9, especially 389–390.

