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ETHICS

What Would a Good Doctor Do? Reflections on the Ethics of Medicine

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Abstract Ethical challenges are prevalent in modern-day medicine. Whether arising in the daily practice of medicine, in the conduct of research, or in our educational practices, physicians need to understand the relevance ethics plays in our professional lives. This paper examines the ethical foundations of medical ethics, suggests qualities that define optimal professionalism, and frames the discussion employing two hypothetic case presentations.

Keywords medical professionalism · ethics · altruism · obligation

Introduction

Challenges of an ethical nature abound in modern-day medicine. Patients, their families, those who provide medical care, and the institutions where this care is conducted face difficult choices almost as a matter of routine. In addition to those arising in clinical practice, important and controversial ethical concerns also arise in the arena of clinical research and in our educational practices. No domain of modern medicine is untouched. In particular, the problem of conflict of interest has become an issue especially relevant in our time.

Amongst the classical disciplines, ethics provides us a method for identifying, confronting, and resolving the moral and professional questions arising in clinical medicine. Whether the problem arises at the beginning as in the neonatal intensive care unit, at the end of life as in caring for patients with terminal cancer or Alzheimer's disease, or somewhere in between, grounding in the principles of ethics should be of considerable interest and value to all who provide patient care.

In order to better understand the relevance of and role played by ethics in our daily activity, we can learn by going back to the original meaning of the word. The ancient Greek words *ethos* and its root *ethica* are important for understanding the meaning of right and wrong. Originally a reference to one's place of dwelling or abode, during the time of Aristotle, *ethos* came to mean a person's interior dwelling place, a reference to what a person carries within themselves: their attitudes, orientations, and disposition to those with whom they interact, indeed with the world around them [1]. As such, *ethos*, in the sense of a person's inner being, is essentially the core of all of one's acts. While contemporary medicine, particularly the examination of the ethics of medicine, has been more concerned with acts or decisions, it is this deeper, historical derivation of what ethics means that lies closer to what it means to be a *professional* in the context of medical practice [2].

Foundational theories

The discipline of philosophy has played a vital role in the development of modern ethical discourse and certain foundational elements continue to provide a framework upon which ethical concepts are formulated and discussed. Broadly speaking, contemporary ethics is seen from two contrasting viewpoints: *consequentialism* with its focus on consequences and the *nonconsequentialist* beliefs which derive guidance from rule-based (deontological) approaches [3, 4]. The consequentialist believes that human beings ought to behave (and make decisions) in ways that result in the greatest good. Their most dominant philosophical tradition is that of *utilitarianism*. Based on the writings of Bentham and Mill, utilitarianism derives its name from

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utility, a reference to "usefulness." Therefore, a utilitarian believes that "everyone should perform that act or follow that moral rule that will bring about the greatest good (or happiness) for everyone concerned" [5].

In contrast, the *nonconsequetialists* claim that consequences do not, in fact should not, enter into judging the actions of others. Relying on "higher" standards of morality (for instance, God), actions (and people) are to be judged solely on whether they are right. Nonconsequentialism is premised on a belief that rules of a moral nature exist and that such rules can be employed to guide appropriate decision-making. Kant and his categorical imperative are derived from this philosophical school.

However, there is a third approach, more ancient in its origins, which seems a better fit in terms of helping us understand our ethical responsibilities. That is the school of *virtue* ethics [6]. Perhaps because of its attention to a real role model performing the action who actually embodies virtue (i.e., the doctor), as opposed to just following abstract principles which make certain actions right or wrong, virtue ethics has an intuitive appeal in the discourse pertaining to medical ethics and particularly to physicians concerned about how they can become good medical professionals. Virtue ethics considers the kind of person the physician should be, and as such, is a good fit when matters related to professional obligation and standards are at the core of consideration. For contemporary medical professionals, questions arise when we as a profession ask, what are the virtues that help us define the good physician. Let me clarify this point a bit further.

Modern medical ethics

Historically, the tenant of Western medical ethics may be traced to beliefs relating to the duty of physicians such as the Hippocratic Oath and other early rabbinic and Christian teachings. In modern times, particularly the 1960–1970s, a core set of values or principles have come to dominate the landscape of ethical discourse. In the collective, they constitute a kind of "repository of wisdom" that serves to help us answer a—perhaps *the*—question that sums up what lies at the core of our professional ethics …

What would a good person (doctor) do in this situation?

In attempting to answer this question, I offer two qualities central to the notion of good doctoring and professionalism that I believe, if routinely employed, would solve many of our difficulties. These are the notions of *altruism* and *obligation*. Altruism speaks to the idea of the physician working primarily for the best interest of others, specifically their patients. As a behavior, it connotes an attitude or disposition of the physician to act for the benefit of others; as a principle, it becomes morally compulsory. When a patient entrusts him/herself to the care of a physician, certain ethical *obligations* are immediately implied. Of these, perhaps the most important is the *fiduciary* duty; that is, the relationship of confidence or trust that develops between the patient and their doctor. The word comes from the Latin *fides* (faith) and *fiducia* (trust). A fiduciary is someone who has undertaken to act for and on behalf of another in a particular matter in circumstances which give rise to a relationship of trust and confidence. Such duties require the highest standard of care and maintenance as well as extreme loyalty. The fiduciary responsibility that accompanies the role of a professional is the principal difference between working in an occupation and practicing a profession.

So how does a practicing physician develop an understanding and a practical approach to these responsibilities? Let me emphasize, the challenge before us is, Aristotle would say, practical in nature, not theoretical. That is, our challenge is not just a matter of understanding professional virtues but rather becoming a certain kind of physician and in so doing exemplifying those virtues in our everyday practice. Two case examples that raise professional challenges will help to illustrate this point. The first is a somewhat ordinary case though common dilemma, and a second that is more a product of our times and technology.

Case 1 You are referred an 85-year-old woman with incapacitating low back pain due to severe spinal stenosis. Her medical history is significant for chronic congestive heart failure, currently well managed though she has been hospitalized twice in the last year for episodes of decompensation. She is frail and has been physically limited for several years. She lives independently though her daughter, the only living family member, has wanted her to move into a nursing home for many years, mainly for her mother's safety. The patient has refused. Her mental capacity is intact though she has experienced a few, transient episodes of confusion in the setting of urinary tract infections in the recent past. She goes out only on Sundays to the home of her daughter. The patient is very desirous of undergoing surgery, mainly because she believes it will allow her to maintain her independent living status.

Should you operate on this patient?

Case 2 It has been known for some time (some would say since *time immemorial*) that the female knee has unique physical characteristics. Narrower, thinner, and with a more natural tracking mechanism than the male counterpart, these physical characteristics have been incorporated into the design of a new "gender-specific" knee replacement that better approximates these unique anatomic features of the female knee. Because it is similar in design to existing knee prostheses currently approved and on the market, the Food and Drug Administration has approved this new design under a 510K exemption. As such, the new prosthesis has not undergone clinical trials.

As a respected and influential arthroplasty surgeon, you have been approached by the company about your potential interest in using their new prosthesis in your female patients. The company is new; indeed, this is their first

product. The research and development that have resulted in this exciting product is viewed as justifying its costs, twice that of the current standard prosthesis of the company's competitors (who too are working on their own versions). In the companies overture to you, you are offered a week-long training course in an animal laboratory at their expense in California. In addition, you are being presented with an opportunity to purchase a 1% equity interest in the company and, once you are using the device, you will be paid a $1,000 per patient fee in order to facilitate the gathering of information on the postmarketing experience with the device.

Should you accept this offer?

How does one approach these situations? What is a good physician in these two cases? Here are four guiding principles of contemporary medical ethics: *beneficence*, *nonmaleficence*, *autonomy*, and *justice* that can be employed to help guide our deliberations.

The oldest of these tenants are those of *beneficence*, that is, a practitioner should always act in the best interest of the patient, and *nonmaleficence*, the dictum of "do no harm" (*primum non noncere*). Their ancient origins underscore their enduring relevance to the practice of medicine. *Beneficence* not only connotes acts of mercy, kindness, and charity, it goes beyond, subsuming all forms of action done to benefit others (patient). Conceptually, it differs from benevolence, a term that references the character trait of being disposed to act for the benefit of others. As a term, beneficence covers beneficent actions in general; as a principle, it refers to one's moral obligation to act for the benefit of others. In contrast, the principle of *nonmaleficence* imposes an obligation not to inflict injury on others and, as such, introduces the notion of harm [7]. These principles have particular relevance to the first case where balancing these competing motives may be particularly at odds. As patients get older and less robust and as they acquire comorbidities, it becomes more difficult to know when you are doing good (by performing surgery) versus when conditions should be pushing you the other way. How risky is this surgery in this 85-year-old woman? Indeed, should her age be a consideration at all? Even if successful, how much and for how long will she benefit from it? Could a surgical procedure of lesser magnitude (and lesser risk) accomplish most of the goals (i.e., Going for a home run when a first base hit wins the game?) What are her motives, pain relief or the avoidance of institutionalization? Are the surgeon's goals congruent with the patients? While you may not think of them in this way, these are everyday ethical and practical challenges for the practicing surgeon.

In the case of the female knee replacement, issues pertaining to beneficence also arise. Does the experience with this device suggest at least equivalency of outcome to the traditional prosthesis or could the patients do worse—recalling the "do no harm" dictum. There is also the fiduciary responsibility. Does a recommendation to use the new device adhere to this principle? What would the good surgeon do?

The concepts of *autonomy* and *justice* have emerged much more recently [8]. Indeed, the notion of the respect for autonomy of the patient has come to lie at the heart of Western medical practice and its ethics, replacing the legacy of medical paternalism of the physician. This principle, once unfamiliar to physicians, has lead to a major reformulation of the practice of medicine allowing patients the right to chose and refuse treatment, altering medical research, and changing practice with respect to such matters as truth-telling. The latter had important implications both in clinical medicine, especially in the setting of terminal malignancy where the paternalistic physician of a now bygone era might withhold difficult but vital diagnostic and prognostic information. The resultant notions of autonomy and justice were subsequently instrumental in the development of the concept of *informed consent*. In the context of ethics and professionalism, the notion of *informed consent* has broader implications than the routine consent procedure prior to surgery.

In both clinical scenarios, it is the physician's responsibility to inform patients of what they should expect, both in terms of nature of the perioperative experience and with respect to the anticipated outcomes. In the elderly woman with spinal stenosis, not only should she be informed about her outcome with respect to pain, her likelihood of independent living after recovery from surgery needs to be discussed. One does not necessarily follow the other. In the use of the gender knee, its rationale, the application of that rationale to the patient contemplating surgery, the relatively small accrued experience with the device, and the surgeon's financial interest in the company [9] are just some of the issues relevant to ethically informed consent. The good surgeon would demonstrate a critical understanding of these concerns.

Lastly, the work of Wennberg [10] during the past two decades concerning unexplained geographic variation in medical practice and the even more disturbing observations concerning racial disparities in health care have further promoted the ascendance of *just allocation of expensive resources* as a central principle of medical ethics [11]. Indeed, given the dramatic and uncontrolled problem of health care costs, autonomy, as a central ethical principle, may loose ground to notions of justice in an ever financially constrained medical system. Health care costs and how to provide efficient and equitable care to all patients will increasingly influence our professional sense of justice. If the new "female" knee is truly an advance in total joint arthroplasty, who will or should have access to this technology? Are the long-term functional outcomes sufficiently superior with this device when compared to the standard, nongender models? If not, why are we spending time and resources developing and marketing them? Wouldn't justice considerations suggest we should go the other way, that is, cheaper, more generic models that give patients almost everything most will ever need? Again how would the good physician and surgeon understand his/her responsibilities in this setting? Specifically, what would the just physician be inclined to do?

In closing, ethics is important simply because it is an essential dimension of our work as physicians. We rely, often without knowing it, on its principles to formulate judgments and to make decisions on behalf of our patients. Given the

complexity of modern medicine, physicians, indeed anyone working in the current medical environment, needs a framework upon which approaches to these challenges can be formulated. Ethics and its philosophical foundations, along with our ongoing critical input as a profession, provide us the tools. But ultimately, our challenge is for our profession and for each of us individually to critically explore the age old question: what does it mean to be a good doctor?

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