

Bioethics: Medical

Rui Nunes*

Faculty of Medicine, University Porto, Porto, Portugal

Abstract

In a plural and secular society, bioethics may be related to basic human rights that, in all modern and civilized societies, evolved to the point of giving an almost unlimited respect to the human being. This idea is clearly expressed in the Universal Declaration of Human Rights, a statement that is crucial in all ethical reflection on medicine. It is generally accepted, at least in societies influenced by modern culture, that some basic rights are inherent to all human individuals, regardless of race, gender, sexual orientation, and political or religious convictions. And medical ethics could not escape this influence of bioethics: the right of every citizen to his or her freedom of self-determination. The Nuremberg Code, in particular, refers to this issue concerning the ethical imperative of obtaining informed consent. Thus, there was no need to create a new medical ethics but reformulate it in the light of new paradigms.

Bioethics then settled as a new global field, although of multi- and transdisciplinary nature. Global bioethics means not only the adoption of a unique universal ethics but also the inclusion of all matters that relate to the life sciences. In a broad sense, to this concept is also associated an essential dimension of the practice of medicine and biomedicine that is a set of duties inherent in any healthcare profession.

Keywords

Bioethics; Medical ethics; Principles of biomedical ethics

Introduction

When, in 1970, Van Potter introduced the term “bioethics” in the international scientific literature, perhaps, he was not aware of the impact of this area in the evolution of contemporary society (Potter 1970). Today, bioethics has reached maturity as a scientific, academic, and social intervention area, which incessantly seeks the ideals of justice, equality, and personal self-fulfillment. In fact bioethics erupted, nearly four decades ago, as a wake-up call vibrated by physicians and biologists, given the incredible possibilities of new technologies in medicine, biology, and genetics. Faced with the new powers that science gives men about life and about himself or herself, it is imperative that society becomes aware of all its long-term consequences and, in a cross-disciplinary and pluralistic dialogue, open to an increasingly informed public, taking all necessary decisions to promote a sustainable development.

Medicine and science could not escape this challenge, i.e., in a plural and interdisciplinary perspective, they question the scope and the limits of biomedical technology in humans, question

*Email: ruinunes@med.up.pt

under principles that should, beyond identifying the nuclear issue, analyze it in terms of the values defended by the most representative currents of the human thought. This methodology is somewhat unique, since if it is certain that the segmented knowledge, specific to each area, is, in essence, limiting because it reflects the paradigm of that scientific reality, the search for an interdisciplinary alternative can, and must, reveal itself as intrinsically cross-disciplinary.

Even if bioethics had originally a broader meaning, particularly related to the preservation of the biosphere, it quickly came to look into the ethical issues placed by the provision of healthcare and biomedical sciences. And, although the term is new, bioethics can be seen somehow as an evolution of an ancient field of reflection, medical ethics.

History and Development: Background

Professional ethics has its roots in the Hippocratic tradition of medical practice. The text which supports the Hippocratic Oath is seminal and decisively influenced medical practice. The *Ius Iurandum*, known as Hippocratic Oath, was not occasional. Indeed, Hippocrates through his extraordinary talent learned that medicine was more than the strange, unproductive, and harmful mixture of beliefs and superstitious practices. And a landmark of his philosophic humanism was the compassion for the man in suffering systematically transmitted in the Hippocratic message. This professional ethics survived, this way, two and a half millenniums, having successively embodied various codes of professional ethics and the oaths which intend to honor it.

In addition to the aforementioned Hippocratic Oath, the Aesculapius Advices, the Oath of Asaph, the Prayer of Maimonides, the Geneva Declaration (1948, revised in 1968 and 1983), and the International Code of Medical Ethics of the World Medical Association (1948, revised in 1968, 1983 and 2006) should be noted. All these documents have in common, the assignment of a central role to the physician in the practice of medicine, exhorting certain ethical principles that, regardless of culture from whence they sprang, aimed the promotion of personal virtues and honor of the medical profession. It is the realization that, then as now, from birth to death, passing through disease, the life of a person inevitably relates to the practice of medicine. This is the assumption that medical ethics, although referring to standards of conduct that are specific to a profession, concerns all citizens. And statutory codes allow the better understanding of the values of the society in which we are inserted.

Indeed, any profession imposes certain duties to those who exercise it. The more this profession is organized, the most likely it is to assume a coded status where professional duties emanating from official bodies of the profession are well defined, duties and sometimes certain associated rights. In some countries that follow the Romano-Germanic legal tradition, such as France or Germany, professional ethics was incorporated in juridical norms. That is, from a moral code of professional rules and from a process of self-regulation, deontology gave birth to a juridical norm. Thus, professional ethics ensures good professional practice, basing it, on one hand, on the purity of ethical principles and, on the other, in its regulations.

In other countries, like the United Kingdom or the United States of America, medical ethics and professional ethics are so interdependent that the need to resort to the legal formulation of the guiding principles and professional rules is not felt, opting instead for self-regulation and the creation of sanctions of disciplinary nature. The professional self-regulation arises from the acceptance by the medical profession of a certain standard of competence and conduct and is periodically revised by professional associations. For example, in the United Kingdom, a country of Anglo-American legal tradition (*common law*), it is the responsibility of the professional associations – the *General Medical Council* and *British Medical Association* – to perform the task

of disseminating the principles of good medical practice that actually serve more as a guideline than as formal rules of conduct. In countries with this tradition, which emerged from the work of Thomas Percival *Medical Ethics: A Code of Ethics and Institutes Adopted to the Professions for Physic and Surgery*, the intrinsic responsibility of the profession is believed to be more reliable than the imposition of a set of encoded and normative rules (Reich 1999). Also in the United States of America and given the conjunction of the development of Anglo-American medical ethics, the *American Medical Association*, through its code of ethics (1847, revised in 1903, 1912, 1957, and 1980), gave expression to the common sense of physicians and surgeons that medicine should be a self-regulated profession.

In many countries, medical ethics is the guiding foundation of professional conduct at all levels of expertise and determines for physicians a set of ethical standards of behavior, and it should also serve as a guideline in the different aspects of the human relationship established in the course of professional practice. The physician must be guided by ethical principles pertaining to the tradition of medicine, substantiated in its ethical code, respecting the dignity of the human person.

However, an accurate analysis of the evolution of medical oaths and codes reveals that after the universal acceptance of the basic human rights, something had to change in the ethical standards of the medical profession, not because they were wrong, or even outdated, but because the citizens' rights came gradually to occupy a prominent place in plural and secular societies. The Belmont Report is an example of this. This report was one of the first ethical instruments of international relevance, by appealing to the principle of respect for individual autonomy within human research. It was an important document that decisively influenced the ethical standards in clinical trials and other types of research (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research 1978). After the Nuremberg trial, the international community was obliged to regulate the practice of medicine and experimentation on human beings, particularly with regard to obtaining informed consent. At stake was the profound violation of certain fundamental rights, placing the question in the very essence of human dignity. Similarly, the emergence of new technologies and the perception of failure of traditional ethical frameworks contributed decisively to the emergence of bioethics.

And medical ethics could not escape this influence of bioethics: the right of every citizen to his or her freedom of self-determination. The Nuremberg Code, in particular, refers to this issue concerning the ethical imperative of obtaining informed consent. Thus, there was no need to create a new medical ethics but reformulate it in the light of new global paradigms. One of these paradigms is the principle of respect for individual autonomy.

Conceptual Clarification/Definition

In a pluralistic and secular society, bioethics may be related to the basic human rights that, in all modern and civilized societies, evolved to the point of giving an almost unlimited respect to the human being. This idea is clearly expressed in the Universal Declaration of Human Rights, a statement that is crucial in all ethical reflection on life sciences. It is generally accepted, at least in societies influenced by the Western culture, that some basic rights are inherent to all human individuals, regardless of race, gender, sexual orientation, and political or religious convictions. It is not intended to claim that all human beings are equal in the strict meaning of the term. In fact, we are all different in the biological and intellectual levels. Moreover, a true social equality is perhaps unattainable. The concept of equality refers to the inclusion in a group that gives equal rights to all its members, at least, regarding certain fundamental rights.

This perspective does not imply any kind of behavioral standardization. Uniformity is opposed to the very essence of human nature, given that intellectual creativity is a factor that contributes to the existence of the moral community. For this reason, there will always be differences between people, regardless of the similarity of their moral status. The inalienable rights to life, food, family, and basic healthcare do not imply that people are all alike or that they aim the same life projects. It implies that whatever their intellectual skills are (and hence its ability to flourish in society), a minimum level of social conditions is guaranteed in conformity with the dignity of the human person.

But for solving the ethical problems of everyday life, we must find plausible arguments to justify the correct approach to follow. That is, determine the basis, the reference point of the values that, as a community, we believe are essential. This foundation can be found in what is understood and known as human dignity and its impact on fundamental human rights. These rights, which are irrevocable, as well as the ethics associated with them, have the necessary features to expand transculturally and reach full universality. It is in this plural and multicultural context that bioethics has developed, having as background a paternalistic perspective of medical practice. But one may ask in a global world where healthcare professionals and patients frequently find themselves as moral strangers how people can live peacefully and reach common endeavors. In a transcultural society where there is no unanimous view of what should be the proper foundation of ethics and moral life and where there is increased accessibility to information, patients are more critical in relation to the decisions and attitudes of healthcare professionals.

As Western societies are crossroads of cultures, religions, and unrelated beliefs, it becomes difficult to define which values prevail in a given society. Tristram Engelhardt Jr. recognizes this difficulty by trying to demonstrate the existence of a secular ethics, entirely uncommitted with the Judeo-Christian tradition which prevailed in the past or any other type of orthodoxy culturally imposed (Engelhardt 1996). By allowing a wide, if not total, scope of action to self-determination and individual self-fulfillment, society ultimately consents all or nearly all manifestations of personal will, even when contrary to the widespread moral intuition. The lack of rational arguments that prove that a particular action is incorrect originates, inevitably, a decline in the moral force that compels a certain prohibition.

Ethical Dimension

Bioethics and Medical Practice

The existence of a cross-cultural consensus implies that medicine should always improve the conditions of human existence, respecting the identity of the subject and the species to which it belongs. However, the exercise of individual freedom and the consequent existence of cultural pluralism implied the need to find a common platform for the resolution of certain conflicts in the area of bioethics, particularly in the context of medicine and other healthcare professions. A way of achieving this consensus might well be, in practical terms, the elaboration of a set of guiding principles, of systematic application, in clinical practice and in human research. These principles of biomedical ethics (Kennedy Institute of Ethics principlism) would be midway between the fundamental ethical theory – integrated body of rules and principles – and rules of conduct, which, by definition, are restricted to certain contexts and necessarily more limited in scope.

As formulated by Beauchamp and Childress, the principles of biomedical ethics – autonomy, beneficence, non-maleficence, and justice – reflect the characteristic secularization of Western societies that confer some equidistance between individual self-determination and other fundamental human values, such as social responsibility or human solidarity (Beauchamp and Childress

2013). This human solidarity identifies interpersonal duties that are evident, for example, on human research or on organ donation for transplantation.

The application of these principles has generated some controversy because, when in the presence of complex ethical dilemmas of difficult resolution, several principles conflict, prevailing the one which is internalized and recognized as crucial by the moral agent. In making critical decisions, most people have a natural tendency not to focus specifically on any of these principles, reflecting a moral stance subject to some fluctuation, sometimes even a certain degree of inconsistency. The decisive factor, in solving a real ethical dilemma, may be the level of individual integrity of the agent. The practical application of the underlying ethical principles is dependent to a large extent on the presence or absence of these virtues. Still, the language of principles is instrumental to modern bioethics, particularly with regard to respect for autonomy, beneficence, non-maleficence, and justice.

The ethical framework that relies to the use of principles is called principlism. Whatever the formulated principles are, the heart of the matter lies in the circumstance that these meet halfway between conventional ethical theories and mere rules of conduct. The most common criticism of principlism is that it is not an integrated body of ethical rules – of an ethical theory in the classical sense of the term – nor it provides a consistent method of articulating the principles. Moreover, the use of principles does not escape the hypothesis of, sometimes, when they come into conflict there is no possible resolution to the moral dilemma. However, the formulation of principles intended to meet the plural diversity of modern societies and the ethical minimum that cuts across the different cultures of humanity. One speaks, then, when formulating the principles of construction and ethical reflection, of the concept of “common morality” and not of a systematized ethical theory. It is a less ambitious goal than the one intended in the past but more in line with the construction of a plural society.

This proposal of principles of practical application, even if based on the humanism of Western culture, is more concerned in originating actions easily understood as fair, as well as the definition of moral obligations attached to them, and less in finding values that may or may not justify these moral obligations. It is, perhaps, a pragmatic approach, since it makes it easier to reach a consensus on general principles to adopt than on the values that can support these principles. This pragmatism also reflects the fact that secular ethics is disconnected of a cultural tradition with deep social roots.

Modern society does not adopt a uniform ethical posture, opting for the plurality of beliefs and opinions. The underlying values and virtues to this moral heterogeneity are subject to a transforming constant tension by the current dominant culture. This culture is guided by a scientific-technological imperative that penetrates decisively within traditional cultures. In the beginning of the millennium, medical ethics could not escape this change. There is the need for a consensus on fundamental ethical principles at a cross-cultural level. Within each culture, it should be extended across all segments of the population, not being limited to the developed social strata. This was, perhaps, the great cultural transformation of medical ethics: its evolution for a bioethics focused on the dignity of the person and their right to freedom of self-determination. And the relationship with the patient should increasingly be considered as a partnership, in which doctor and patient are active agents in decisions involving values and ethical dilemmas. In other words, it is a true therapeutic alliance.

Bioethics and Medical Research

Biomedical research involving human subjects is a common practice all over the world. However, this practice still provokes some anxiety among the public. To overcome this problem, ethics committees are a well-accepted institution for the empowerment of the public in the control of clinical research. More than a development of the traditional Hippocratic medicine, the ethics

committee is a direct consequence of liberal democratic societies. In some countries, like the United States of America, ethics committees for research (institutional review boards (IRBs)) deal specifically with the ethical review of research protocols on human beings. However, in many European countries as elsewhere, ethics committees have a dual role. Although clinical trials on human beings are a specific task of these committees, they also deal with clinical issues, namely, with regard to common situations such as abortion, human reproduction, and end-of-life decisions.

Since the late 1960s, individual physicians were unable to cope with some ethical dilemmas in research involving human subjects. Therefore, stringent guidelines were proposed to regulate different types of human research, namely, by the Council for International Organizations of Medical Sciences (CIOMS 2002). A possible solution to cope with these dilemmas was to seek ethics advice by an independent ethical review committee with authority to give a definitive recommendation. This professional ethical responsibility was perhaps the greatest force propelling ethics committees. Professional malpractice and the fear of judicial litigation were also influential in the development of ethics committees. But, the main reason why ethics committees do exist is that in a pluralistic, democratic society, people often meet as moral strangers. Pluralism of ethical beliefs leads to a practice where patients/subjects and physicians have different sets of values. More than finding common ethical values, the search for procedural norms that protect the human being has been the goal of ethics committees. As an example, it is frequently argued that specific legislation should exist to protect incompetent human subjects in accordance with accepted guidelines and recommendations. These guidelines have been followed for some time all over the world.

A binding principle is respect for personal autonomy and informed consent. The ethical and legal doctrine of informed expressed consent is a means to give the individual patient respectability and to enforce the bioethical principles of autonomy and beneficence. Written consent (documented consent) is usually needed and ethics committees are empowered to control this consent over time. Specific legislation should exist to protect both competent and incompetent human patients in accordance with accepted guidelines and recommendations, namely, the Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine (Council of Europe 1996). Issues like stem cell and embryo research, eugenic abortion, synthetic biology, and human gene therapy need also careful thought from international regulatory bodies so that ethics committees are aware of legitimate patterns of behavior.

Also, research on children is put into question because valid consent is impossible and the child is seen as one of the most innocent human beings. However, if medicine is to progress, pediatric research must be carried out. As long as parental consent is obtained (the long-standing principle of familial autonomy), most people feel that research can and should be performed. However, more stringent guidelines are required. One of these guidelines refers to the distinction between therapeutic and nontherapeutic clinical trials. Any child has at least the right to his or her autonomy. And society should provide the means to fulfill the right to an open future. The existence of this right was first proposed by Joel Feinberg referring to the concept of “rights in trust,” that is, rights that are to be “saved for the child until he is an adult.” Those rights must be protected in the present to be exercised later in life. This general category of rights holds that parents do not own their children but are only guardians on their behalf. It follows that a child’s scope of future choices must be protected (Feinberg 1980).

Both on the clinical setting and in research, the principles involved in the ethical reasoning are associated to common beliefs of democratic processes. These principles are mainly procedural, notwithstanding the fact that different ethical backgrounds are involved in its foundation. They can be summarized as follows:

- (a) Respect for persons and the need for free, informed consent
- (b) Protection of incompetent persons, namely, children and psychiatric patients (surrogate decision-making, proxy consent, living will, and so on)
- (c) The ethical imperative to maximize benefits and minimize harms (beneficence and non-maleficence)
- (d) Privacy rights and confidentiality
- (e) Justice in the access to healthcare and to the benefits of science
- (f) Accountability of healthcare professionals and institutions delivering healthcare
- (g) Responsibilities of physicians and other healthcare professionals

Conclusion

The recent evolution of bioethics in medicine is an evolution in a double sense: its globalization and its concrete operability. The doctor and other healthcare professionals who practice medicine or investigate in a laboratory should be fully aware that human nature is the accepted foundation of medical practice. Indeed, bioethics had an enormous influence on the recent evolution of traditional medical ethics. Values such as personal integrity, privacy, and self-determination are considered as fundamental aspects of human life and represent an intimate sphere that cannot be manipulated or coercively undermined. It is the proper foundation of the human person, rooted in its convictions about what is most valuable in life.

But the influence of bioethics happened as well in the relationship between the physician and society. Maintaining the principle that the main focus of attention is the patient, the ethical principle of justice also implies that choices are made according to the criteria of transparency, i.e., according to the principle of public *accountability*. There are several competing theories of justice that are regarded as the foundation of fairness in social relationships. Specifically John Rawls' difference principle argues that not only liberty but also fair equality of opportunity should be considered. Some social and economic inequalities are permitted as long as the greatest benefit of the least advantaged is pursued (Rawls 1971). This egalitarian theory of justice implies that no citizen should be excluded from the health system due to a lack of financial resources. The full achievement of ethical freedom implies equal access to certain key positions that, in turn, cannot be obtained without a minimum of physical, psychological, and social conditions. Nevertheless, in this view, specific modalities of treatment can be excluded from the basic package due to economical restrictions of the system (Nunes and Rego 2014).

Bioethics then settled as a new global field, although of multi- and transdisciplinary nature. Global bioethics means not only the adoption of a unique universal ethics but also the inclusion of all matters that relate to the life sciences. In a broad sense, to this concept is also associated an essential dimension of the practice of medicine and biomedicine that is a set of duties inherent in any healthcare profession.

Cross-References

- [Advance Care Planning](#)
- [Advance Directive](#)
- [Animal Ethics](#)
- [Artificial Nutrition and Hydration](#)

- ▶ [Assisted Suicide](#)
- ▶ [Autonomy](#)
- ▶ [Benefit and Harm](#)
- ▶ [Bioethics: Clinical](#)
- ▶ [Bioethics: Education](#)
- ▶ [Bioethics: Environmental](#)
- ▶ [Bioethics: Founders](#)
- ▶ [Bioethics: Global](#)
- ▶ [Biolaw](#)
- ▶ [Biopolitics](#)
- ▶ [Children and Ethics](#)
- ▶ [Children: Research](#)
- ▶ [Children's Rights](#)
- ▶ [Chronic Illness and Care](#)
- ▶ [Clinical Ethics: Teaching](#)
- ▶ [Codes of Conduct](#)
- ▶ [Committees: Clinical Ethics Committees](#)
- ▶ [Committees: International Ethics Committees](#)
- ▶ [Committees: National Bioethics Committees](#)
- ▶ [Committees: Research Ethics Committees](#)
- ▶ [Conscientious Objection](#)
- ▶ [Consent: Informed](#)
- ▶ [Death: Good Death](#)
- ▶ [Discrimination: Concept of](#)
- ▶ [Donation: Organs](#)
- ▶ [Ecocentrism](#)
- ▶ [Egalitarianism](#)
- ▶ [Embryo](#)
- ▶ [Enhancement](#)
- ▶ [Environmental Ethics](#)
- ▶ [Equality and Equity](#)
- ▶ [Ethicist](#)
- ▶ [Ethics](#)
- ▶ [Euthanasia: Active](#)
- ▶ [Euthanasia: International Debate](#)
- ▶ [Euthanasia: Passive](#)
- ▶ [Feminist Ethics](#)
- ▶ [Freedom and Free Will](#)
- ▶ [Freedom of Treatment](#)
- ▶ [Futility](#)
- ▶ [Honor Codes](#)
- ▶ [Human Dignity](#)
- ▶ [Human Nature](#)
- ▶ [Human Rights](#)
- ▶ [Integrity: Concept of](#)
- ▶ [Integrity: Personal](#)
- ▶ [Integrity: Professional](#)

- ▶ Integrity: Research
- ▶ Justice: Global
- ▶ Justice: Theories of
- ▶ Life: Definitions
- ▶ Medicine and Ethics
- ▶ Medicine: Philosophy of
- ▶ Moral Theories
- ▶ Nursing Ethics
- ▶ Oath
- ▶ Organ Transplantation
- ▶ Palliative Care
- ▶ Palliative Sedation
- ▶ Paternalism
- ▶ Patient Rights
- ▶ Pediatrics
- ▶ Persistent Vegetative State
- ▶ Person
- ▶ Personalism
- ▶ Principlism
- ▶ Professional Ethics
- ▶ Professional-patient Relationship
- ▶ Religion and Global Bioethics
- ▶ Reproductive Ethics
- ▶ Research: Clinical
- ▶ Research: Ethics Committees
- ▶ Research: Human Subjects
- ▶ Respect for Autonomy
- ▶ Right to Die
- ▶ Right to Health
- ▶ Science Ethics
- ▶ Sexual Ethics
- ▶ Solidarity
- ▶ Suicide
- ▶ Truth-telling
- ▶ Utilitarianism
- ▶ Values
- ▶ Virtue Ethics

References

- Beauchamp, T., & Childress, J. (2013). *Principles of biomedical ethics* (7th ed.). New York: Oxford University Press.
- CIOMS. (2002). *International ethical guidelines for biomedical research involving human subjects*. Prepared by the Council for International Organizations of Medical Sciences (CIOMS) in collaboration with the World Health Organization (WHO). Geneva: CIOMS.

- Council of Europe. (1996). *Convention for the protection of human rights and dignity of the human being with regard to the application of biology and medicine: Convention on human rights and biomedicine*. Strasbourg: Council of Europe.
- Engelhardt, H. T. (1996). *The foundations of bioethics* (2nd ed.). New York: Oxford University Press.
- Feinberg, J. (1980). The child's right to an open future. In W. Aiken & H. LaFollette (Eds.), *Whose child? Children's rights, parental authority and state power* (pp. 124–153). Totowa: Littlefield, Adams.
- National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research. (1978). *The Belmont report: Ethical principles and guidelines for the protection of human subjects of research*. Washington, DC: US Government Printing Office.
- Nunes, R., & Rego, G. (2014). Priority setting in health care: A complementary approach. *Health Care Analysis*, 22, 292–303.
- Potter, V. (1970). *Bioethics, the science of survival* (pp. 127–153). Autumn: Perspectives in Biology and Medicine.
- Rawls, J. (1971). *A theory of justice*. New York: Harvard University Press.
- Reich, W. T. (1999). *Encyclopedia of bioethics*. London: Simon & Schuster/Prentice Hall International.

Further Readings

- British Medical Association. (2007). *Medical ethics today. Its practice and philosophy* (2nd ed.). London: BMJ Publishing Group.
- Daniels, N., & Sabin, J. (2002). *Setting limits fairly*. New York: Oxford University Press.
- Jonsen, A. (2000). *A short history of medical ethics*. New York: Oxford University Press.