A doctor's conscience: Conventional and reflective morality in clinical decision making

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A Doctor's Conscience: Conventional and Reflective Morality
in Clinical Decision Making

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ABSTRACT

A Doctor's Conscience: Conventional and Reflective Morality in Clinical Decision Making

by

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This work examines ethical theories of deontology, teleology, internal and external morality as applied in conventional and reflective moral methods towards equilibrium among eight normative values for healthcare including: autonomy, beneficence, nonmaleficence, justice, privacy, confidentiality, veracity and fidelity. Upon critical analysis of conventional and reflective moral praxis's both are found to be insufficient in accommodating value pluralism. This work concludes by outlining a hybrid model for ethical decision making complementing both theories by bringing together conventions and reflection to more effectively guide professional medical practice toward the teleological aim of medicine.
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CHAPTER 1

INTRODUCTION

In 2004 healthcare expenditures accounted for 16% of the Gross Domestic Product (GDP) for the United States economy, amounting to $1.9 trillion. This figure represents a near doubling of healthcare GDP since 1980 when expenditures accounted for 9% of GDP. Growth in healthcare expenditures outpaced total economic growth from 1980 to 2004. Five percent (5%) of the total population of the United States consumed 49% of the healthcare dollar treating five chronic conditions including diabetes, mood disorders, heart disease, hypertension, and asthma. Most of those with these conditions are Medicare and or Medicaid beneficiaries (Stanton 2006, 1-7).

These figures illustrate a number of important considerations. First, healthcare is an important policy issue because of its high cost and broad effect. Public expenditures on healthcare through Medicare and Medicaid accounted for 85% of total spending on these five most chronic conditions (Stanton 2006, 7). Regardless of whether or not one has health insurance or not, a substantial amount of public money is spent on healthcare. This fact alone makes healthcare relevant to all individuals in the United States not only as consumers or potential consumers but also as taxpayers.

Second, each person will have some encounter with the healthcare system. Individuals may seek treatment from a physician, may aid a friend or loved one in
seeking treatment. Even if an individual does not see a physician or have any direct involvement with healthcare, he is likely paying for it for others. Therefore, each person has some interest in healthcare whether he realizes it or not.

Healthcare is delivered by a system comprised of governmental entities, insurance companies, hospitals, pharmaceutical companies, physicians, patients, et cetera. Each entity has the theoretical end of achieving health for patients. But this phenomenon is most apparent in the clinical encounter between the physician and the patient.

The relationship between physician and patient is among the most intimate relationships between human beings. A physician may be privileged to information about his patient that no partner, parent, or friend would be privy to. Pellegrino describes the clinical encounter between a physician and a patient as, “The confrontation of doctors and patients whose lived worlds intersect in the moment of clinical truth. This is the omega point upon which the actions of individual doctors as well as the whole healthcare system converge” (Pellegrino 2001, 560). In the clinical encounter the physician is in part a gate keeper to the vast resources of the healthcare system. He decides what tests and treatments to prescribe. An individual patient is not sufficiently authorized to order his own tests or write his own prescriptions. Therefore, it is critically important to evaluate how physicians make clinical decisions within such a vast system. This is the subject of inquiry for this thesis.

We seek to identify the precise point where the physician and the patient meet and make decisions to achieve the good end of health for the patient. This point is the clinical encounter and within the clinical encounter a physician is called to make critical ethical decisions that will have great bearing on his patient’s goal of attaining health.
Additionally, the decisions made in the clinical encounter may affect other entities as part of the systematic delivery of healthcare.

Throughout this work differing ethical theories for how doctors should best achieve the good end of their practice are considered. Some argue that despite the magnitude and influence of the healthcare system, these influences are external and should be set aside while doctors and patients resolve ethical conundrums arising from the clinical encounter. Others argue that external influences are important to the clinical encounter but should be treated in a way that minimizes their influence on the clinical encounter if considering external forces biases the physician or the patient toward making ethically sound medical decisions inconsistent with the ultimate good end of achieving health.

This work is most concerned with how physicians make ethical decisions in the clinical setting. How do they identify what is ethically relevant and what is not? How well do they ascertain what is important for their patient and what may be misguidance? For the physician, the nature of good practice in medicine is important to our inquiry into the ethics of clinical decision making. The physician acts as an artist in the application of his knowledge to the current state of affairs including identifying all relevant particulars to each case. Good practice, then, should be considered in a range from excellent to bad. The spectrum would include medical practice that is bad, shoddy, mediocre, good, and excellent.

For Aristotle, the hope for the professions or the artisans would be those who are excellent in their practice of their art. Excellence in artful practice encompasses the application of theoretical wisdom to a particular case using practical wisdom well. The
nature of theoretical wisdom is its value neutrality. Theoretical wisdom is concerned with what is true and false in the world, what is natural, universal, and unchangeable. This realm of knowledge includes science and math. But what theoretical wisdom lacks, practical wisdom will complement and guide the medical practitioner toward the artful activity of healing. Although medicine is chiefly influenced by science as theoretical wisdom, practical wisdom is necessary to know when and how to use medical knowledge and skill. Considering practical wisdom requires knowledge of what the good aim or telos of the activity is.

Theoretical wisdom is concerned with what is and is not, while practical wisdom is concerned with what should and should not be done in relation to the good aim of the activity. Practical wisdom is the artful application of theoretical wisdom to novel or unique circumstances. The application of practical wisdom is the true test of the excellent practitioner. Each particular case presents a new set of circumstances that will vary in some degree from a “textbook” case. In these instances the practitioner is charged with creatively and artfully applying his knowledge to this case.

Imagine a physician and a musician, specifically a flute player. Both the physician and the flute player possess theoretical wisdom inherent with their activities of healing or flute playing. The physician knows the physical nature of the human body and what are necessary physical preconditions for the body to work well. The flutist also knows the physical nature of his flute and what necessary preconditions must be present in order for his flute to play. The flutist knows that the flute is a tube with holes covered by keys and that by blowing into the flute and holding certain keys different sounds are
made, just as the physician knows that the body is a complex network of interconnected biological systems yielding overall function of the body.

Both the physician and the flutist know what is fundamentally true theoretically. Now they can apply their aptitude and skill to their respective activities. For the flutist to be excellent he must not only know how the flute works, but must also know how to make certain notes in certain sequences to make music that is excellent, rather than an unpleasant screeching sound. The spectrum of good work applies to the flutist as it does to the physician. A novice flutist may play badly, but with practice get better. However, some flutists will become excellent and innovative in their flute playing because they have a natural aptitude towards excellence in their art. The same holds true for physicians.

Mastery of the knowledge of medicine is only one part of the puzzle necessary to practice well in medicine. Situations will arise where the physician is at a loss for how to apply his theoretical wisdom well. He strives for excellence, but may be at a loss as to how to achieve the good aim of his activity when all the additional theoretical wisdom in the world is not going to guide him.

For physicians and practitioners of an art, standards are articulated to evaluate how good their work is.

The activities of chess players, physicians, and navigators are evaluated by standards that reflect the nature of their activity and the state of knowledge of the activity at the time. Such standards are by no means independent of the activities they govern. Practice in these areas is known to be imperfect in certain ways, yet the standards governing the practices function as standards. They are authoritative even though they are recognized as changeable and improvable. It is not true in general that effective standards by which activities are evaluated must be independent of those activities (Wallace 1996, 64).
Standards of practice surround each activity in which we are engaged. As Wallace points out, evaluating good practice is not independent of the activity itself, but considered in relation to the activity and toward the aim of the activity. The question is how to apply the standards and rules, and when are we justified in breaking them or deviating from them?

This work evaluates how the physician functions in accord with the standards of his profession in working towards a good ultimate goal for his patient. It is necessary to state essential principles that often come into conflict in resolving real ethical problems in medicine. Beauchamp articulated four principles for the physician in the clinical encounter: veracity, privacy, confidentiality, fidelity. Applying these principles to the clinical encounter often elucidates other values or principles including autonomy, nonmaleficence, beneficence, and justice.

It is appropriate to separate out these two sets of principles. The first set is of most importance to the physician in informing his clinical judgment. Secondly, the larger values apply to the system as a whole. For purposes of this evaluation, we are focused on the physician. However, we will also consider the influence of ethical principles brought to the clinical encounter by the patient and the system.

This thesis employs a qualitative approach to addressing the question of how physicians make ethical decisions in the clinical setting. The first chapter introduces us to medical morality generally describing deontology, teleology, internal and external morality and how each of these concepts weighs in on the physician's moral practice. The second and third chapters describe conventional and reflective morality using case examples from clinical medicine where each approach can be used in resolving
conundrums. The thesis will end with a conclusion elucidating the strengths and weaknesses of both conventional and reflective morality. From this evaluation a hybrid approach incorporating both schemes is articulated.

Of note, throughout the work, the words “dilemma” and “conundrum” will be used somewhat interchangeably favoring conundrum as the more appropriate word to describe a situation where a moral decision needs to be made. This distinction is important as the word “dilemma” implies two options, usually a right and wrong option. While “conundrum” is more appropriate in most cases as many situations in medical ethics do not have a clearly right or wrong approach. Rather whatever decision is evaluated based on a pluralistic application of certain principles that are relatively important to a particular case.
CHAPTER 2

MEDICAL MORALITY: ETHICAL PRINCIPLES OF HEALTHCARE, INTERNAL AND EXTERNAL MORALITY

In this chapter we outline the foundation for this discussion on ethics concerned with physicians making clinical decisions. The first idea we must consider is the very notion of health, what it is, and how a physician helps a patient act toward the good end of health. Next, we will briefly consider the Aristotelian notion of good work in a profession and how this notion is integrated into the physician’s practice. Building on that we then will review physician ethics, and conclude with an introduction to a couple of moral schemes in clinical decision making: internal and external morality.

Health as the Good End of Medicine

Of most concern to physicians is the notion of health, ensuring it, restoring it, and working towards it. Therefore a discussion of what constitutes health will enlighten us as we consider the activities of physicians and patients toward the end of health.

Health is accepted as the end of the activity of the physician’s practice of medicine. This end is accepted as a good and universal end, good in that health is sought so that the body and soul may experience rational being and life, and universal in scope as all humans and animals experience a relative state of health.

Health is the state of being whereby a person is able to function to the best of his natural abilities. A state of health is recognizable by others and attainable in the sense
that medicine, nutrition, exercise, behavioral changes, et cetera, may restore a state of health from an unhealthy state. Leon Kass writes,

Health is a natural standard or norm – not a moral norm, not a value as opposed to a fact, not an obligation, but a state of being that reveals itself in activity as a standard of bodily excellence or fitness, relative to each species and to some extent to individuals, recognizable if not definable, and to some extent attainable (Kass 1975, 30).

Considering Kass, health is a relative state of optimal being recognizable to oneself and to others. Kass furthers his definition by establishing that the true opposite of health is "unhealth" rather than disease (Kass 1975, 20-21). Having a disease does not make one unhealthy per se. Health is not established by the absence of ailment or disease, because it is indeed possible for a person to be unhealthy absent physical ailment. Conversely, it is certainly possible that a person may be afflicted with a disease and still meet the optimum of their natural tendencies apparently unencumbered by a disease. This can be seen with certain HIV-positive patients or cancer patients in the early stages of their disease. Not only do they not appear to be unhealthy to others, they may not feel unhealthy and may continue to function to the optimum of their potential.

It is the patient, not medicine or the physician, who ultimately realizes whether he are healthy or not. Lack of medical justification for an individual’s claim that he is unhealthy is insufficient to render the patient’s claim false. There could be a number of different influences affecting a patient’s perception of health yielding a feeling of unhealth that is not measurable, and consequently may not be alleviated by any external actor.

It is important to establish that health is relative and only fully experienced by patients. Physicians should have primary concern over the necessary preconditions that
must be present in the body and mind to promote the realization of health in the patient. In addition to strong technical knowledge of the physical processes of the body they also must apply their knowledge and skill in an artful manner.

Excellence in Clinical Medicine: Medicine as Healing Art

The end of the medical activity is the health of the patient. Ultimately actions working towards health result from an internal morality concerned with the activity toward the good. Internal morality occurs whenever an individual makes a moral decision to act. The sphere of internal morality expands as the moral agent invites friends or counsel (such as a physician) into the internal moral praxis. Those parties to the internal activity are the physician and the patient, but this fact does not exclude external norms from informing the activity toward the good end of health.

The physician's profession is healing. Healing is an artful activity as it incorporates not only theoretical wisdom (knowledge of universal and unchanging information) but techné (skill, art, craft). Theoretical wisdom is taught, while techné is acquired through practice. A good physician is one who has an aptitude to acquire knowledge and the skill of medicine and uses these in an artful manner. Deciding how to use this knowledge and skill is where healing becomes artful and actions by physicians become ethical. Beyond diagnosis and treatment is the question of a practical nature on how to use knowledge in particular cases. This is the point where physicians must be informed by ethics in making clinical decisions.

Despite the acquisition of medical knowledge and skill, the physician by himself is still not able to restore health to a sick person. The patient must work toward the good of health too. In many cases, the physician becomes a teacher or a coach, and the patient
a student. The physician possesses the knowledge of what needs to be done to maintain or restore health, but the patient must take learned advice in order to realize the good of health. The ultimate experience of the good of health rests with the patient, while the physician merely helps the patient along toward achieving that good. This truth refutes those who would purport that health is the sole concern of the physician. Certainly, restoring health in others is the goal of any good physician, but the physician cannot instill health in others without their participation, consent, and desire.

There are two critical elements to the physician’s ability to practice medicine: knowledge and skill. There must be a range of competence or excellence in the use of the physician’s practice as well. A physician’s work may be evaluated on a range beginning with what constitutes bad or shoddy work, competence, good work, and ending in excellence. Determining where a physician falls in this range is a matter of assessing how well the physician applied his knowledge and skill to any particular case.

Medicine, including knowledge of the physical preconditions necessary for a body to work well, is a matter of science or theoretical wisdom. This form of knowledge is generally universal in that the normal function of cells, organs, and bodily systems is essentially the same in all humans. The physician in training first devotes his study to how the body works, or should work. Then he begins to explore different diseases and how the body can fail to work. Through this process he learns how to affect the systems to restore natural functioning of the body. However, limitless knowledge about how the body works does not inform how the physician may change the body’s processes to restore health; this consideration is within the realm of skill.
The skillful use of medical knowledge will result in knowing what is wrong and what can or should be done to restore health. The looming question of what should be done remains beyond the scope of theoretical wisdom or skill, and lies in ethics. To answer these questions, a physician must rely on something beyond evidence-based medicine. What lies in this realm beyond technical knowledge is practical knowledge and ethics. Physicians, like members of any profession, acquire habits of practice while in training and in practice. The concern for ethics is that these habits be aimed toward the good. A physician may be considered ethically sound if he practices in a manner that is consistent with working toward the good. Further, a good physician with good ethical habits may make predictable actions consistent with working toward the good aim of medical practice.

Physician Ethics

As a practitioner of the healing art, a physician is charged with determining how his knowledge and skill can be used to help others restore, attain, or maintain health. Additionally, physicians as members of the profession of medicine are bound to the ethical rules governing their profession. They are also bound by societal norms as members of the community where they live and work.

Professional ethics, applicable to all professionals including physicians, are categorized in two main themes: deontology and teleology. Deontology is a moral theory concerned with duty whereby actions are deemed right or wrong without appeal to their consequences; some acts are right regardless of their results. Immanuel Kant's theory of the categorical imperative and maximizing good ends is a deontological theory. Ends in this context are not contingent on inclination; rather they are absolute, objective, and
universal. For Kant autonomy and respect for others, or more specifically respect for
others’ rights are paramount (Arrington 1998, 226, 292, 380). Therefore, any act that
works against the rights of others is morally impermissible. Since right and wrong acts
are absolute, the empirical consequences of action become irrelevant in evaluating the act
for moral soundness in accord with dutiful action.

Teleology is the theory attributed to Aristotle where activity aims at some
ultimate end or good, the telos. “Every art or applied science [techne] and every
systematic investigation, and similarly every action and choice [proairesis], seem to aim
at some good” (NE 1094a1). Aristotle’s theory invites that human behavior is aimed at
achieving some good or ultimate end. Aristotle outlined health as an intrinsic good
desirable for its own sake. Additionally, activity towards the good of health, surgery for
example, is an instrumental good as surgery is a means to the good of health. Plato
further considered health itself as an instrumental good as it was a necessary precondition
to other ends including love, pleasure, or anything desired because of its own qualities

The employment of these two themes is decided through a moral thought process
classified as either conventional or reflective considering both internal and external
values applicable to the situation. Conventional morality is the general term applied to
professional deliberation where the professional contemplates how the normative values
or rules of his profession apply to the case at hand. For instance, a physician may
consider the rule of confidentiality as elemental and may never breach it under any
circumstances. In this case the physician is more concerned with adhering to the rule,
despite the good or bad results from pedantically following the rule.
Reflective morality considers first the relevant particulars of any given situation where action is called for. After assessing the particulars then the decision maker will look to normative values for guidance in resolving the moral conundrum. This form of morality is also referred to as "reflective equilibrium," attributed to John Rawls. The term reflective equilibrium suggests that numerous values, beliefs, moral principles, and theoretical postulates exist and will come into conflict in particular cases. The better moral decision will strive for balance or equilibrium among the applicable values toward the most coherent justification for any moral act (Beauchamp 2001a, 398).

Internal morality is the term used to describe the moral actions or decisions used in certain activities. For example, although two parties are present during the clinical encounter (patient and physician), the act at hand is the act of healing and the practice of medicine. This activity carries with it notions of morality internal to the concern of the purpose of the activity (teleology). Teleological considerations are those concerned with the ultimate end or good of any particular activity. In medicine, the act of healing or the act of practicing medicine constitutes the techné or the artful application of knowledge and skill towards a good end. "Since there are many activities, arts, and sciences, the number of ends is correspondingly large: of medicine the end is health..." (NE 1094a7-8). The practice of medicine is not an intrinsic good, its aims are good. The good end for medicine is health and health is the telos of medical practice. Treatment and surgery are intermediate goods in that they are a means to a greater good.

Internal morality is concerned with the moral agent achieving the good he is striving for. Often is the case that an individual seeks counsel with others, either friends or someone considered wise or knowledgeable. With the addition of advice from others
the deliberation remains internal because both actors are seeking the same good. For example, the physician-patient relationship constitutes an internal moral praxis because both parties seek the good end (health) regardless of approaching any moral conundrum from different perspectives. The action of both the physician and patient is aimed at the good. The relevant values in internal morality include those constituting considered judgments brought to the contemplation by either the physician or the patient or both.

External morality considers the effect of normative values outside of the internal moral praxis or outside the practice of medicine. Examples include the values of the community, churches, hospitals, families, the government and anything outside of the individuals' moral sphere. In a physician-patient relationship where external morality played an influential role, both the physician and the patient would heavily consider the imposition of external will on their decisions regarding healthcare. For example, a poor man on Medicaid who needs a heart transplant in the state of Nevada will be denied access to such a procedure because (1) heart transplants are not performed in the state of Nevada, and such a procedure would have to be undergone out-of-state and out-of-network; (2) Medicaid will not cover out-of-state or out-of-network treatment. Since Medicaid refuses to pay for a heart transplant out of network and the patient is too poor to pay for the procedure himself, the patient has been denied access to care based on values external to the physician and the patient.¹

Ethics uses these concepts to both describe and prescribe moral decisions and deliberation that physicians face pursuant to their role as professionals. Morality enters into any professional-client relationship when all of the technical information the professional possesses has been accessed, and a choice must be made in what to do for

¹ This case adapted from the case of Troy Shaw reported in the Las Vegas Sun on October 24, 2006.
professional possesses has been accessed, and a choice must be made in what to do for
the patient or client. Often a physician becomes frustrated when choices on how to treat
a particular patient cannot be easily explained without additional knowledge of the
subject. Instead, the physician is forced to make a judgment considering other factors
outside the science of medicine, but squarely in the practice of medicine. This situation
constitutes the art of healing, or the artful application of knowledge to different cases.

An example of the point where excellence requires art over technique lies with the
flute player. At some point a flute player will not become better at playing the flute by
amassing more knowledge about how the flute actually works. Knowing how to play the
flute and playing the flute well require something more than mere knowledge of how a
flute works.

The same is true for physicians. Physicians are endowed with vast knowledge
about how the human body works. Physicians are also trained in methods for restoring
the body to a state of optimal functionality when health is compromised. How a
physician goes about diagnosing and treating patients requires *techné* or the artful
application of scientific knowledge. How the physician applies his knowledge and skill
is what separates a competent physician from an excellent physician. With the excellent
flute player, additional theoretical wisdom will not increase his ability to play the flute.
What is required to complement the theoretically wise physician is practical wisdom,
wisdom in understanding how to artfully apply his knowledge and skill to novel cases.

Doctors are faced with decisions that are not medical as much as they are ethical.
When no more data will make a difference in whatever choices are available, and a
choice must be made, the decision is ethical. In clinical medicine, physicians then must
draw from the body of values and norms applicable to medicine, society, and the particular patient in the particular circumstances. Once the physician has gathered these factors then he may work to resolve whatever ethical conflicts have arisen.

Consider the following case example as illustrative of the moral conundrums physicians face:

A 5-year old girl had been a patient in a medical center for three years because of progressive glomerulonephritis. She had been on chronic renal dialysis, and the possibility of a renal transplantation was considered. The effectiveness of this procedure in her case was questionable. On the other hand, it was the feeling of the professional staff that there was a clear possibility that a transplanted kidney would not undergo the same disease process. After discussion with the parents, it was decided to proceed with plans for transplantation. Tissue typing was performed on the patient; it was noted that she would be difficult to match. Two siblings, age 2 and 4, were thought to be too young to serve as donors. The girl’s mother turned out not to be histocompatible. The father, however, was found to be quite compatible with his daughter. He underwent an arteriogram, and it was discovered that he had anatomically favorable circulation for transplantation. The nephrologists met alone with the father and gave him these results. He informed the father that the prognosis for his daughter was quite uncertain. After some thought, the girl’s father decided that he did not wish to donate a kidney to his daughter. He admitted that he did not have the courage, and that particularly in view of the uncertain prognosis, the very slight possibility of a cadaver kidney, and the degree of suffering his daughter had already sustained, he would prefer not to donate. The father asked the physician to tell everyone else in the family that he was not histocompatible. He was afraid that if they knew the truth, they would accuse him of allowing his daughter to die. He felt that this would ‘wreck the family.’ The physician felt very uncomfortable about this. However, he agreed to tell the man’s wife that “for medical reasons” the father should not donate a kidney (Levine et al 1977 4).

This case illustrates a multifaceted moral conundrum that medical knowledge cannot address. The relevant scientific or medical facts have been fully vetted. The decisions elucidated in this case are not matters of medical science, but of morality.

All principles of medical ethics come into play here. Values and principles for healthcare generally include the notions of autonomy, beneficence, nonmaleficence, and
justice. For the physician as practitioner, the professional values of veracity, privacy, confidentiality, and fidelity to his patients critically collide in this case. Addressing each of the values shows us the moral tension that any case in medicine may bring. And as we will see, the mere knowledge of the values does not inform how they should be applied in particular cases.

From a deontological perspective, the above case would be ethically evaluated by carefully considering the general duties of the physician. The physician then would be well versed in his duties as a physician and seek how to meet those obligations given these circumstances.

Alternatively, or in many cases interchangeably, the case may be evaluated from a teleological perspective, whereby the chief concern is activity toward a good end. Health is the good end of the activity of medicine, so in evaluating a clinical case teleologically, whatever action would bring the patient closest to health would be the right course of action.

Considering a clinical case either deontologically or teleologically brings our focus to what would dictate a certain action over another. What would be more appropriate at this point would be a discussion of how each principle is evoked by this case. At other points in this work, we will analyze different methods for moral deliberation in clinical ethics. In the meantime, however, let us consider first the general principles applicable to healthcare, then those applicable to the physician’s particular decision.

Autonomy is the principle that applies almost universally in healthcare. In this case, the autonomy of this minor patient is absent as law has decided that she is not
decisions and obligations for her well being fall to her legal surrogates, her parents. What is evoked in this case is the autonomous choice of the father. He does not have to give up his kidney to his daughter, and she cannot make a legal claim on it either. No one can force the father to give up his kidney; this is his choice and his autonomy is intact.

Beneficence applies to healthcare generally as a quality that seeks to help in healing. Despite motivations for profit by some healthcare entities, the basic mission is to work in healing. More broadly construed, however, beneficence is the charitable act of helping. In professional settings where physicians are paid for their services, the charitable nature of their service is not as applicable. Regardless, though, physician knowledge and skill are considered not to be proprietary as they were acquired through public sacrifice through public subsidy of medical training programs, state-sanctioned monopoly on the practice of medicine through medical licensing, and the mere submission of patients for the physician to train on. All of these indicate a public interest in training physicians; therefore those who receive the training are not allowed to use it only for their own enrichment (Pellegrino 1993, 45).

In this case, the physician is adhering to beneficence, but the father is not. The father is not willing to give up a kidney for his daughter’s sake. Strict utilitarian consideration of this case would conclude that the father’s reluctance and the physician’s secrecy are morally permissible. Utilitarianism demands the most benefit for the greatest number involved. Since the father is unwilling, it would not be to his benefit to donate the kidney (Beauchamp 2001a, 342).
But we must consider the effect of unrealized potential benefit. If the father did donate the kidney the daughter would surely benefit. In time the father may realize that the sacrifice of his kidney to save his daughter’s life will benefit him in the future. Such may be the case and should be included in a thorough discussion with the father regarding the full impact of his decision. Regardless, if the father remains unwilling to donate as he lacks courage to undergo the operation, he may eventually feel a tremendous amount of regret. If this is likely then the father will experience personal shame and harm. If all other conditions of the physician-patient relationship are intact with the father, then the physician has an obligation to not cause harm to the father as well.

In this case the notion of nonmaleficence is present as well. To do no harm is the physician’s mantra and has been since Hippocrates. The harm in this case comes from the consequences if the physician violates the father’s claim to confidentiality. As the father asserts, the family could be severely harmed if they knew of the father’s favorable donor status. But is it not reasonable to argue that the long-term guilt the father may experience would be harmful to him as well? As asserted in the previous paragraph, there could be yet unrealized harm to the family or the father following the inevitable outcome of his decision not to donate. To make this determination, though, the physician would have to ascribe certain values to the father that the father may not have. For instance, it would seem reasonable that most fathers would be willing to give up a kidney to save their child. But is it not also possible that a reasonable father would be as reticent as this father is? After all, the father asserts that donating the kidney is not to his benefit, so for the family or the physician to try to force it out of him would constitute harm.
Another point, however, is that the physician is now party to a conspiracy in lying to the mother about the father’s donor status. As the mother of the minor patient, as surrogate, she has a right to know the status of her daughter’s health. But the mother does not have a right to know about the status of her husband’s health. For the physician to intercede in this relationship could wreak harm on the family.

Justice is a principle in healthcare according to which those who need care should be able to get it. Justice is concerned with notions of fairness and equity in healthcare delivery. In this case, the daughter needs a kidney, the father is a suitable donor, yet he is unwilling to donate. This seems unfair and unjust. The patient has been receiving care, and the system is doing everything it can to try to alleviate her disease. It is still possible for a kidney to come available from a source other than the father. However, it must be considered in this case that it would also be unjust to manipulate or coerce the father to donate his kidney.

In addition to the application of more universal healthcare principles generally, the physician must also answer to a number of values applicable to his profession and his role in this patient’s care. In this case the physician’s duty to veracity is the most pressing moral question. Veracity dictates that a physician must be honest and forthright regarding the true status of a patient’s condition. Additionally, the physician must explore and explain all treatment options known to him, even those he cannot himself provide (Beauchamp and Childress 2001a, 283-292). This principle requires that the physician make true and accurate statements about a patient’s health, diagnosis, prognosis, and treatment.
In this case, the physician is being asked to withhold information critical to the care of his patient. It can be argued that the father is not the patient in this case. However, the physician is privy to confidential medical information and would be the one performing the transplants should that happen, thereby establishing a physician-patient relationship with the father. Since the physician-patient relationship applies, the physician is bound by the other principles of confidentiality, privacy, and fidelity to the father as well as to the daughter.

It would be considered coercive and deceptive for the physician to breach the father’s confidentiality, in this case thus violating veracity. Again, the physician cannot force the kidney out of the father. The physician, though, can discuss at length with the father the consequences of his decision, and would indeed seem to have an obligation under the notion of veracity and fidelity to make certain that the father fully understands the ramifications of his decision, including consideration of the potential long-term damage to his own conscience and to his family. But even if, after this full disclosure of the risks and benefits, the father remains unwilling, then the physician is not justified in violating this principle in this case.

Our discussion on veracity plays well into the other principles for this physician to consider in this case, including privacy and confidentiality. It would seem that privacy and confidentiality are the same thing, but there are sufficient distinctions that warrant treating these two values separately.

Privacy is considered an inherent right of any patient that should be respected and protected by the physician. Privacy is breached with the consent of the patient in allowing the physician to engage in an exam and investigation of the patient’s condition of health.
Through this examination and inquiry, information is gathered that is then considered confidential and may be released only with the consent of the patient. Here lies the critical distinction. Privacy is inherent, while confidentiality is protected by law and permission to share private information is granted by the patient. So, confidentiality is a right asserted, rather than retained inherently.

In this case the father’s privacy and confidentiality are of central concern to the physician. The father could have decided not to have been tested for histocompatibility with his daughter, but since he was, the information is now available to the doctor. Then the father asserts his right to keep the information confidential. The physician then must ascertain whether he is allowed to share this information without the patient’s consent, and in this case, there is no justification to breach the confidentiality.

It would have to be the case that breaching the father’s confidentiality would have a net benefit to the daughter. There would be no way for the physician to be able to assess whether or not releasing the father’s information to the mother would in some way influence the father to donate. Even if this is what the physician thought might happen, releasing the information would likely be used coercively against the father. Under a coercive circumstance, the father is still not a willing donor and his autonomy is not maintained.

It is often the case while considering norms of veracity, privacy, and confidentiality, that precedents are set when the system or a physician violates these principles. In a more global sense, would potential donors be less willing to submit to compatibility testing if they knew their status would be disclosed against their will? Suppose that a family member was not histocompatible with the daughter, but by virtue
of the testing was determined to be a good candidate for kidney donation for another person in the facility. The potential donor relaxed his right to privacy for a specific purpose. It would be inappropriate to think that anyone submitting to compatibility testing would then be offering up their kidney to any person who may need it. If the physician disclosed a donor’s status to other potential recipients, would this breach have a chilling effect on people’s submitting for compatibility testing? Even if the possibility that it would were remote, any precedent that dissuaded potential donors from being tested would have far-reaching impact on the system of organ procurement and transplantation.

Maintaining confidentiality in the physician-patient relationship is critically important to the success of any physician-patient relationship. If there is a sense that physicians cannot be trusted, then physicians will not be able to put the benefit of their knowledge and skill into full and good use for any single patient or the greater community. In addition to protecting their patient’s trust by protecting their privacy, physicians are also obligated to remain loyal to their patients. Thus enters the value of fidelity.

Fidelity is the notion of loyalty of the physician to the patient. In practice adherence to this notion requires that the physician place the best interests of his patient above self-interest and above the interests of others. Fidelity is closely linked with beneficence for the loyalty in question is to the patient’s best interests including the good end of medical practice, the benefit of attaining health.

Clearly in this case, the physician’s loyalties are divided between treating the daughter and accommodating the father’s confidentiality claim. The physician is
obligated to treat the daughter and remain loyal to her best interests. What frustrates this situation is that her best treatment is a transplant and a good donor is the father; everything the physician needs to treat this patient well is present, except that the donor is reluctant. The physician must maintain loyalty to his patient and to the father’s right to confidentiality. To violate the father’s confidentiality would be disloyal to the father and would not benefit the patient.

Of importance in applying this principle to this case is the fact that the physician is not being disloyal to the daughter by not sharing the father’s donor status with the rest of the family. His fidelity is maintained since he has been fully honest with the family about the daughter’s condition. He is not shirking his loyalty to her by keeping her father’s secret. He would violate fidelity only if he put another’s interests above that of the patient. In this case the father is putting his own interests above that of his daughter. If fidelity has been violated it has been violated by the father against his daughter. It could be said that the physician is a party to this, but in this instance the more pressing moral agent is the father. The daughter cannot do anything to affect her own realization of the benefit of health. The daughter is without autonomy and subjugated to the moral acts of her parents and therefore has no status as a moral agent except that she would benefit from her father’s kidney donation.

Although the physician acts as a moral agent in any clinical encounter, he is only bound by the morality of his profession as a physician and values of the community where he practices. The physician has met his moral obligation to this patient and this family in this case.
The only fact that would have made a difference is whether or not the physician knew with some degree of certainty that violating the father’s right to confidentiality would have made the difference in convincing him to become a willing donor. It is important that the father would have to come around on his own accord and not as the result of coercion. The physician, then, should strive toward a middle ground persuasion fully discussing the consequences of the father’s act.

In any case the physician must have justification for violating a principle of medical ethics. In all cases, the physician must ascertain to what extent each principle applies and must order the principles to balance with the limits of the medical profession and the normative values of the patient. In each case the patient is a unique moral being whom the physician must accommodate. Conversely, the physician has obligations to his profession and community as well. This is the omega point for healthcare, and these decisions are not medical; they are ethical.

This single case has elucidated the values and principles of the healthcare system, the medical profession, and the patients. Additionally, this case has shown how clinical decisions in medicine are ethically complicated. As is often the case, critical questions in medical ethics have life-and-death effects. Because the stakes are so high in many of these cases, critical inquiry into the methods for resolving medical-ethical dilemmas becomes important.

Through the rest of this work, we will explore different approaches towards reconciling the ethical with the medical. Chiefly, we will evaluate notions of conventional and reflective morality.
Morality in Medicine: Internalism and Externalism

Internal morality pertaining to physicians can be described as follows, “Clinical medicine is a professional practice governed by a moral framework consisting of goals proper to medicine, role specific duties, and clinical virtues. We call this framework the IMM [Internal Morality of Medicine]. The professional integrity of physicians is constituted by loyalty and adherence to the IMM” (Miller and Brody 2001, 588).

External morality considers norms and values outside the immediate clinical encounter. “Public opinion, law, religious institutions, and philosophical ethics have all served as sources of external morality. When applied to biomedicine, appeals to external morality usually reflect social concerns about moral failures and abuses” (Beauchamp 2001b, 607).

Most medical ethicists fall into three seemingly natural camps in terms of prevailing moral theories: essentialist-internalists, externalist-value pluralists, and hybrid theories. The first theory we will consider is internal morality.

Internal Morality

Internal morality of medicine can be categorized into four accounts: essentialist, practical precondition, historical professionalism, and an evolutionary perspective.

The essentialist account most appropriately includes Pellegrino’s philosophy of medicine existing as a phenomenon known to man extending beyond man’s ability to control. In other words, medicine has a nature that is discovered by man, and is defined by its ends and purposes. An internal morality following from Pellegrino’s essentialist argument would be realized by medicine’s practitioners upon reflection on the “proper” nature, goals, and ends of medicine (Arras 2001, 645).
“Essentialism claims, in brief, that careful reflection on the very nature of medicine as a practice, including reflection on its ends or goals, can yield a serviceable medical ethic” (Arras 2001, 645). From this reflection, physicians would tackle some practical problems in medicine and would likely realize the fundamental tenets of medical ethics, including fulfilling the duty of the healer; resisting influences from external sources (i.e., managed care organizations, hospitals, and society at large) affecting the physician’s autonomy or judgment, only engaging in those activities as physicians with the purpose of healing or alleviating suffering. Conversely physicians should not use medical knowledge or skill in activities not aimed at the ultimate good of health (some cosmetic surgery, some abortions, and lethal injections, et cetera) (Arras 2001, 645).

In the essentialist account the notion of the professional plays a central role. Because of an inherent asymmetry of power between the physician and the patient, the physician has a higher moral responsibility to act as a good custodian of the medical power and remain judicious in its use.

Fundamental to this account is heavy reliance on the moral character of the individual physician. The physician is charged as a moral agent whose purpose is to act towards the good of health in all cases. Therefore, essentialist internal morality requires that the physician develop sound habituation toward the end of the medical activity. Such habituation is inherent in the moral character of the physician, and developed in training and practice.

Another account of internal morality is the practical precondition account for what is necessary to constitute the practice of medicine. For example, a practical
precondition would include something foundational to the physician-patient relationship absolutely necessary in order for the relationship to succeed. Arras presents the example of a physician who evidences scrupulous adherence to the duty of confidentiality as a precondition of a physician-patient relationship (Arras, 2001, 646). His reasoning is that without trust between the physician and the patient the physician cannot properly execute her role as physician without the faith and trust of the patient. If a patient is not honest with his physician she will be hindered in providing the best care possible and ultimately working toward the health of the patient. If the patient cannot trust that what he tells his physician is held in the strictest confidence, and confidentiality is something he desires, then his health will be diminished. So the physician must maintain absolute confidentiality of the patient in order to preserve an effective physician-patient relationship. Thus, confidentiality is a practical precondition to the therapeutic relationship.

Internal morality in some forms comes about considering the history of the profession. Historical professionalism is best described as doctors making the morality for other doctors. Physicians establish the acceptable norms for the profession, deriving their duties not from higher virtues but from norms acceptable to the profession. What follows then is a body of professional values constituting an agreement among the members of the profession on what the profession will and will not do. A prime example of this is the *Code of Medical Ethics* authored by the American Medical Association.

This type of internal morality would entertain only external values or virtues that members of the profession itself thought were relevant to their professional roles (Arras 2001, 648). The authority for these rules is derived from membership in the profession.
This type of internal morality would square with deontology, whereby the physician follows the rules of the profession with limited consideration of the nature, origin, or moral authority of the rules themselves.

Finally, internal morality is seen to expand and evolve to accommodate modern values. The evolutionary perspective for internal morality brings together a “conversation” within the profession of medicine and the larger society. The evolutionary perspective would reject the core ethic that medicine exists eternally; rather, the values applicable to medicine exist in the current time and place as the result of a dialectical conversation between the medical profession and society.

The evolutionary perspective may take a tenet such as a duty to treat the sick as a coalescence of the expectation of society that physicians heal the sick. This obligation to society is strengthened by the fact that physicians are licensed and given an exclusive state-protected monopoly to the practice of medicine. By virtue of the privilege of licensure, the profession owes its services to the society that is protecting its profession from incompetent intrusion (Arras 2001, 649-650).

Additionally, the evolutionary perspective would allow limited intrusion of external values and norms into the essentialist internal moral deliberation. However, in sharp defense of internal morality, Edmund Pellegrino defends his essentialist account in terms of appeal to higher virtues evidenced through the very nature of medicine.

External Morality

External morality, in contrast to internal morality, considers what other values or norms may intercede during the clinical encounter. External morality may be useful in more richly informing internal morality. Examples include religious values, laws, and
ethical theory itself. In opposition to internal morality, which would assert that external factors should not influence the clinical encounter, externalists invite consideration of outside factors as weighing on the clinical encounter.

Ethical theory is an interesting external imposition to the clinical encounter. “Many moral philosophers continue to think that if we could find a correct theory, we could modify or construct medical ethics to conform. Ideally, a theory would be powerful enough to justify the entire institution of medical morality” (Beauchamp 2001b, 607). This statement challenges some notions of internal morality including essentialism and historical professionalism, but falls in line with the evolutionary perspective of internal morality.

A good ethical theory for medical ethics would, “Alert attentive persons to concrete issues, identify the morally relevant features of circumstances, determine the difference between morally acceptable and unacceptable solutions to problems, and show which conditions are necessary and sufficient to justify the violation of a moral rule” (Beauchamp 2001b, 607-8). Unlike internalist morality, the concern is applying the rules, and not breaking them. As postulated here, an ethical theory must have a mechanism to justify breaches in the rules.

The problem with ethical theory as an informative external moral factor is that theory construction itself is suspect because it runs the risk of excluding potentially relevant practical considerations. Beauchamp opines that no generally valid theory is currently available. Beauchamp is more concerned with universality of moral codes for medical practice. Rather Beauchamp suggests that a method for justifying certain acts under certain circumstances is the more pressing ethical inquiry. Beauchamp further
states that a sound ethical theory informing clinical ethics would include what he calls a "coherent justified specification". In this theory what is important is evaluating the justifications for acting one way or another for coherence. Coherent justifications would constitute a valid specification to any ethical rule or principle (Beauchamp and Childress 2001a, 399-406).

Further, theory and practice often collide in unproductive ways. Philosophers use theory to explain and justify morality and to clarify moral concepts. The goal of moral philosophers is not to solve practical problems. Many theories address philosophical problems, not practical ones. Beauchamp asserts that the solution to this problem is not to toss out philosophers and replace them with practitioners, rather, to bring the two together to articulate a theory that can accommodate both internal and external values applicable to medical practice (Beauchamp 2001b, 609).

External morality is more accommodating to communities and cultures with different social values. Internalism appeals to universal goods and ends, but individual communities where doctors practice may not accept the universal goods and ends in the same way. Internalism cannot accommodate morally reasonable variances among different groups of people. Consider here the difference between moral strangers and moral friends. Moral strangers are those who interact in a way that is not informed with a common morality learned from similar social experiences. Moral friends, conversely, share common experiences forming their common values and are better situated to resolve moral conflicts as they arise.

Communities will weigh values differently considering medical topics including blood transfusion, organ transplantation, use of herbal and holistic medicine, and spiritual
healing. There is no way to justly reject differences in moral commitments to different concepts of healing. "These norms have moral authority if and only if they are accepted as authoritative by members of a community" (Beauchamp 2001b, 610). Without justification, it is impermissible to impose a universal medical ethic that transcends culture and history when culture and history are different among different communities.

However, excessive ethical pluralism may render medical ethics useless without any single grounding principle. For example, if a community adopts a law absolutely forbidding a physician to treat a patient without explicit consent, then the physician would be proscribed from treating an unconscious patient in an emergency. This seems counterintuitive to the value of beneficence. Excessive value pluralism in this regard would seem to overemphasize autonomy at the expense of life saving.

Regardless of the relative values of each community, there are some features of human beings that are indeed universal. This universality is the starting point for external authority in medical ethics and "appeals to universal moral principles that are valid independent of the perspective of particular communities and traditions of medical practice and ethics" (Beauchamp 2001b, 612). Included in this idea are those elements common to the human experience. All humans everywhere experience life, varying degrees of liberty, and relative pursuit of happiness. Life is experienced without the consent of the person. In other words, no one asked to be born; it just happened and the act of living is experienced on an individual basis. Moral communities place varying degrees of importance on life. Some communities apply a utilitarian ethic on life, while others engage in extraordinary efforts to maintain life. Liberty is closely related to freedom of conscience. Many civil societies limit expressions of liberty. Happiness is
highly relativistic depending on the normative values of any given moral community. Each of these elements of life is common to the human experience. How different moral communities respect these elements elucidates the moral values held by any particular moral community. These are the features that the essentialists rely upon to justify their universal precepts of the ends of medicine. The distinction here is that different communities will weigh the importance of certain values differently.

Internal moralities are community-specific, but rely on universal precepts for their justification. The important distinction here is justification. A moral precept is justified if it is accepted; therefore the community must accept the precept, not because the profession says so, but because the community accepts it as so. These moral precepts become the considered moral judgments embodying basic ethical beliefs. Whatever a community considers as its particular ethical principles proves valid for the community that originates these precepts and agrees to follow them. It could be the case that normative values violate higher virtues. Therefore, constant questioning of the precepts and their justification is warranted rather than deontological acquiescence to practical codes if a moral community desires to be more civil and just.

External morality requires a mechanism for specifying which moral norms have been justified. “Specification is not a process of producing general norms; it assumes that they are already available. It is the process of making these norms concrete so that they can meaningfully guide conduct” (Beauchamp 2001b, 614). External morality does not reject internal morality; instead it requires the application of internal morality to meet the particular case and allows for justified specifications to accommodate attainment of the goals of the professional practice. In this way external morality complements internal
morality because ultimately the result of an internal moral praxis will determine the action to be taken. Specification is essential to using abstract principles. For example, "a physician must never violate patient confidentiality". As courts have ruled, in certain circumstances, psychiatrists are obligated to report potential harm to other persons if they become aware that a valid threat is mentioned by a patient within the confines of the physician-patient relationship. Hard and fast adherence to the rule is usurped by third-party safety, and considering this as a valid specification supports the need for flexibility in moral reasoning that is available in external morality more so than internal morality alone. Specification must always retain the original norm but add particulars.

As the authority of internalist moral norms must be justified, so must the specifications for each norm. Morally sound persons will disagree on the application of moral rules in particular cases. "We cannot hold persons to a higher standard than to make judgments conscientiously in light of the relevant basic and specified norms and the available evidence" (Beauchamp 2001b, 616). In these instances the judgment must be made assessing all relevant facts and whatever justification for the specification must be coherent.

Conclusion/Summary

Application of these moral schemes occurs through conventional and reflective moral deliberation. However, doctors do not identify themselves as members of one scheme or another. Most often, doctors resolve ethical conundrums relying on their own experience as physicians and as members of a community. Ethicists use these various theories to both describe and prescribe types of moral deliberation.
CHAPTER 3

CONVENTIONAL MORALITY IN CLINICAL MEDICINE

As was outlined in the preceding chapter, ethical norms – including autonomy, nonmaleficence, beneficence, and justice – apply to healthcare overall. More specific ethical norms – including veracity, privacy, confidentiality, and fidelity – additionally apply to the physician in his role as physician.

Further, we outlined the features and differences of internal and external morality in medicine, but left to this chapter to discuss manners in which we see these moral methods applied. In practice, internal and external moral deliberations are considered both in conventional and reflective ways. In this chapter we will explore internal and external ethical reasoning applied in a conventional method.

Conventional Morality

Conventional morality is the application of normative values or principles and rules to particular cases where some sort of ethical conundrum is present. “To follow a conventional morality is simply to be directed by traditional or customary rules or practices without stopping to examine or criticize those rules or practices or customs” (Callahan 1988, 20). The rhetorical question for the professional in conventional morality is “how do I apply the rules of professional conduct to this case”. This accepts the idea that there are commonly articulated rules that pertain to this practice, and this
practice's ends (*telos*). The important feature of conventional morality is the absence of critical reflection on the desirable ends the rules seek to attain.

Conventional moralists are considered deontologists even if their theories include some consideration of the consequences as instructive to the decision to act. However, strict adherence to the application of ethical rules to particular cases constitutes deontological conventional morality. Such a conventional morality is not as concerned with the consequence of the moral act, as it is with adhering to the duty of the profession in following the rules. “Thus the moral worth of an action does not lie in the effect expected from it nor in any principle of action that needs to borrow its motive from this expected effect” (Kant 1993, 401). This makes conventional morality more deontological than teleological, because in pure teleology the good end is the goal, and how to get there is the conundrum.

Deontological considerations should take place irrespective of the consequences; an example would include Kant's categorical imperative (Callahan 1988, 22). When a deontologist holds an act impermissible, the reasons to not perform the act are that it is unjust, fraudulent, or otherwise wrong. In other words, the reason not to act is not relevant to the ends or consequences of the act; rather it is that the act itself is not in accord with the rules.

Conventions

Having established that health is the end of medicine, relative norms and values are articulated to inform the activity toward that end – the conventions of medical practice. To contemplate conventional morality we must accept the conventions or normative values being considered. We have already stated what the conventions for
healthcare ethics are: autonomy, nonmaleficence, beneficence, and justice. Additionally, ethical principles for physicians include veracity, privacy, confidentiality, fidelity. These abstract notions provide the grounding for medical ethics, but how to incorporate these values into clinical practice requires further explanation.

Doctors, like any other professionals acquire ethical habits primarily through learning and practicing their art. Through the evolution of the practice of medicine, the profession itself has articulated its principles, and society has articulated what it expects of medical professionals. The dynamic nature of medicine makes inquiry into the ethics of medicine acutely relevant to life in modern society. The expanding power of the medical art forces society to react to new techniques and procedures. The role of the physician in society has changed, and what society expects from its doctors has changed along with it.

This dynamism has incited learned debate on the proper role for physicians. As a function of historical professionalism, physicians continue to articulate the values for their own profession. The *Code of Medical Ethics* authored by the American Medical Association represents the codification of normative values for physician practice.

Most professions have codes of ethics. The purposes of these codes are several. First, they legitimize the professionals *qua* professional. By adhering to the code, the professional can authoritatively state his claim on his professional status. Secondly, codes offer a written escape route should professionals be asked to do something they find

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2 Consideration of any one of these principles would provide ample fodder for thesis. For our purposes, I accept these principles as "the" norms for clinical medicine. Any one of them could be removed from any paradigm by academic argument, but if such was the case, our discussion on ethical methodology would not change. I adopted these principles chiefly from *Principles of Biomedical Ethics: 5th Edition* by T. L. Beauchamp. In other research that I have done, I have not seen these principles refuted; rather the manner in which they are applied is the subject of debate among scholars in this field. Consequently, I find the debate on the use of these principles more interesting.
unethical. Codes are most often produced by the profession itself, so they are more centered on internal morality for the practice of their profession. Sometimes codes may be used to accommodate expansions in the profession’s practice.

Code of Medical Ethics

The code is published every two years with whatever additions or subtractions have been articulated by the Council on Ethical and Judicial Affairs and adopted by the AMA’s House of Delegates. The Council on Ethical and Judicial Affairs of the AMA is comprised of eight physicians and one non-physician, serving single-year terms, supported by an expert staff. The council drafts the code of medical ethics and the final code is approved by the House of Delegates of the American Medical Association.

The code’s preface includes the following qualifier outlining the scope and purpose of the use of the code,

Medical ethics involve the professional responsibilities and obligations of physicians. Behavior relating to medical etiquette or custom is not addressed in the Code. The opinions which follow are intended as guides to responsible professional behavior. No one Principle of Medical Ethics can stand alone or be individually applied to a situation. In all instances, it is the overall intent and influence of the Principles of Medical Ethics which shall measure ethical behavior for the physician. Council opinions are issued under its authority to interpret the Principles of Medical Ethics and to investigate general ethical conditions and all matters pertaining to the relations of physicians to one another and to the public (AMA 2002, viii).

Here the AMA is outlining the proper use of its code. Of interest, the AMA does not suggest that this code should be binding on the physician, merely guiding. Further, the AMA states that no single principle can stand alone.

The code lists nine principles of physician conduct:

1. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
2. A physician shall uphold the standards of professionalism, be honest in all professional interaction, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

4. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

5. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultations, and use the talents of other health professionals when indicated.

6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

7. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

8. A physician shall, while caring for a patient, regard responsibility to the patients as paramount.


We can consider these nine principles as conventions of medical practice articulated by the profession itself. Within these statements, we see most of the principles of healthcare previously outlined incorporated.

What is absent from the code is a mechanism for enforcement. The preamble asserts that the code should stand as instructive, but limits itself as something not to be taken too literally or applied universally. This would seem to suggest accommodation of physicians relying more on their own judgment in novel cases rather than the code, leaning toward reflective morality. But to invoke the code, and to follow the code, are to use conventional morality, as the code constitutes norms for the profession.

Summarizing our conventions, we include the normative values applicable to healthcare and physicians. Applying these conventions is a practice of the physician through internal or external moralities, or both. Regardless of the form of the morality
(internal or external) contemplating ethical questions in terms of how one follows the rules results in a conventional moral praxis.

Applying Conventional Morality

Conventional morality does not exclude either internal or external morality. Internal morality is concerned with decisions toward the good. For medicine, internal morality is the deliberation between the physician and the patient about what medicine can and cannot do toward the end of health. This practice would inherently consider the conventions outlined here.

Although the physician is considering the normative values applicable to his profession, he is not divorcing himself from the ethical rules. Therefore, when the physician contemplates the values of the profession, although seeming to be external to the clinical encounter, he is fulfilling his role as physician to this patient in this case. Although the physician is considering moral rules for medicine that are extrinsically as well as intrinsically applicable to the relationship, this contemplation does not count as external morality.

External Proscription Against Abortion

A pregnant woman is admitted due to complications early in her pregnancy at a non-profit hospital associated with the Catholic Church. She is less than twenty-two weeks along in her pregnancy but has developed a life-threatening condition caused by her pregnancy where she is at a high risk for death. Substantial medical evidence indicates that a baby born at twenty-two weeks or less has a very low survival rate and a very high rate of severe long term developmental problems both physically and mentally if the baby does survive such a premature birth.
In this case, the physicians determine that for the sake of the mother, the pregnancy must be terminated. However, because of the hospital’s association with the Catholic Church, an abortion is not an option pursuant to part four, directive forty-five of the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs)\(^3\) which strictly forbids abortion under any circumstances.

The relevant medical facts in this case are that the mother is almost certain to die or undergo severe suffering if she continues to be pregnant. The baby at this point is not sufficiently developed to survive on its own without enormous hardship. Trying to sustain the mother while pregnant to try to give the unborn baby more gestational time to mature would negatively affect the health of both the mother and unborn baby.

The relevant ethical concerns include the physician’s fidelity to treat the mother and the concern for the health of the unborn child. Further, the ERDs constitute a new set of conventions applicable to all healthcare services provided by institutions or persons associated with the Catholic Church.

From an internal moral standpoint, there is justification to terminate the pregnancy to save the mother. However, because of where the patient is located, anything considered an abortion would be prohibited. The proscription against abortion is an excellent example of an external moral value affecting this clinical decision in this

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\(^3\) The Ethical and Religious Directives for Catholic Healthcare Services (“ERDs”) are the official Catholic Church’s directives for all health care providers associated with the church in the United States. The directives are authored by the United States Conference of Catholic Bishops and are approved by the Pope. The directives are binding to any hospital associated with the church and any provider with privileges to practice at that hospital. Part four, directive 45 reads, “Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.”
Following this rule is a matter of conventional moral deliberation because the concern is to treat the patient well, while still following the applicable norms or conventions.

Regardless of whether or not the mother is Catholic, or has similar feelings against abortion, she is an in-patient of a Catholic hospital, so abortion is out. Further, any physician treating her in this hospital has agreed to abide by the ERDs and has a duty to follow the rules. It is reasonable to state that the physician’s duty is conflicted between his fidelity to his patient and fidelity to the hospital and the rules governing their practice.

What is ultimately decided by the ad hoc ethics committee dealing with this case is to induce labor and accept the risks to the premature baby. For the mother’s health, the pregnancy must end, somehow. Abortion is not an option, but inducement of labor is not proscribed by the ERDs. After inducing labor, the mother’s health is slowly restored after delivering a very premature baby. The baby does not survive.

This case illustrates the potential influence of external values. Additionally, the deliberation on what to do in this case is constrained by obligations to comply with the conventions of the facility.

Further reading of the relevant directive includes the statement, “Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion” (ERD, part four directive 45). It would seem that this directive would proscribe the act of inducing labor prior to viability as it constitutes an abortion. Despite the significant body of evidence supporting that a baby born after only twenty-two weeks gestation would likely perish, there is also a possibility that the baby would survive,
although likely with severe complications. In light of this later part of the directive, if the “sole” intent were to terminate the pregnancy, the physician would be acting unethically according to the directive. If the pregnancy were allowed to continue, though, the mother would likely die, killing the unborn child as well. But this situation illustrates the ethical tension in this case between the mother’s health, and the convention.

If the mother desired the abortion, she would have to go to another facility and find another doctor. In this case, her condition was unstable, so a transfer was not considered safe. Did the mother suffer more enduring labor than she would have enduring an abortion? The intent of inducing labor was to save the mother. The baby might have lived.

Some ethicists have promulgated formulaic approaches to resolving clinical ethical issues. Doctors are trained to make diagnoses and consider treatment options using “evidence-based medicine”. Physicians use scientific approaches in diagnosing, so it would seem to follow that resolving ethical issues in medicine should be done in a similar, formulaic approach. To this end, Albert Jonsen, Mark Siegler, and William Winslade proffer the “Four Topics Method” as a rubric for assessing ethical considerations in clinical medicine.

The physician or whoever is charged with making the ethical decision in the clinical encounter is tasked with identifying the relevant features of the case at hand addressing four specific areas: medical indications, patient preferences, quality of life, and contextual features. This method incorporates the general healthcare values of autonomy, beneficence, nonmaleficence, and justice, placing them by reference under different subheadings.
For example, beneficence and nonmaleficence are listed under the "medical indications" and "quality of life" assessments. Autonomy is listed under "patient preferences", and justice and fidelity are listed under "contextual features".

The first step in this method or any clinical encounter is to fully assess the patient's medical condition, or state of health. Essentially the question asks what the medical condition is and how the patient will benefit from medical care.

"Patient preferences" asks the method to assess "Is the patient's right to choose being respected to the extent possible in ethics and law" (Jonsen, Siegler, and Winslade 2002, 12). "Quality of life", asks to further explore the practicality of medical intervention in terms of short-and-long-term. Under the heading of "contextual features", the method asks for consideration of external factors that may affect the clinical decision, including law, resource availability, and conflicts of interest.

Although providing a formulaic consideration of the relevant facts affecting the clinical encounter, a mechanism for ordering the importance of these facts is not present in the method. Jonsen, Siegler, and Winslade, "The authors believe that clinicians need a straightforward method of sorting out the pertinent facts and values of any case into an orderly pattern that facilitates the discussion and resolution of ethical problems" (Jonsen, Siegler, and Winslade 2002, 2). However, the method itself does not present a way to rank the importance of its findings. The difference here is that assessing the relevant facts does not inform how to resolve the issues. But the authors of the four-topic approach believe that a systematic way of listing the ethical issues affecting care will help guide the discussion; "good ethical judgment consists in appreciating how ethical principles should be interpreted in the actual situation under consideration" (Jonsen,
Certainly assessing the relevant issues is an important and necessary first step. But how is the physician to make a decision based on the facts? This is the critical point where a physician’s knowledge and skill will no longer inform his decision; here he must make a decision more in accord with the art of healing than with the science of medicine.

Tarasoff Case: Psychiatric Confidentiality

Consider the four topic method and its application to the Tarasoff case, an actual case where the central issue is whether or not to breach confidentiality. Ethical decisions in medicine are not always limited to questions about whether or not to employ medical treatment. Sometimes, however, actions in accord with the patient’s health are not a matter for medicine, but a matter of law. Physicians have a certain legal status and enforceable power in determining competency of other persons. Physicians are cloaked in certain legal obligations in certain cases. As we will see in this case, obligations to the patient and obligations to society can often come into conflict, and the physician must rely on sound judgment in determining a course of action.

Prosenjit Poddar was a voluntary outpatient receiving psychological therapy at Cowell Memorial Hospital, affiliated with the University of California at Berkeley. During a regular treatment session in August, Poddar informed Dr. Lawrence Moore, his therapist that he was going to kill an unnamed girl, readily identifiable as Tatiana Tarasoff, when she returned home from spending the summer in Brazil. Moore, with the concurrence of Dr. Gold, who had initially examined Poddar, and Dr. Yandell, assistant to the director of the department of psychiatry, decided that Poddar should be committed.

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4 This case example is extrapolated from Tarasoff v. Regents of the University of California, 17 Cal.3d 425 (1976); 131 California Reporter 14 (July 1, 1976). This case was cited in Principles of Biomedical Ethics: Fifth Edition by T. L. Beauchamp, Ph.D. et al.
to a mental hospital for observation. Dr. Moore first orally notified campus police that he would request commitment. Later, Moore sent a letter to the Campus Police chief requesting assistance in securing Poddar for involuntary confinement.

Two officers took Poddar into custody, but, satisfied that he was rational, released him with the promise that he stay away from Tatiana. Dr. Powelson, director of the department of psychiatry and Dr. Moore's supervisor, then requested the return of Moore's letter, and ordered that all documentation relating to the request for seventy-two hour confinement be destroyed.

Poddar persuaded Tatiana's brother to share an apartment with him near Tatiana's residence. Shortly after Tatiana's return from Brazil, in October, Poddar went to her residence and murdered Tatiana.

This case requires the physicians to weigh maintenance of patient confidentiality against the protection of a third person from violence. Deontological internal morality would suggest that the possibility of the effect on a third person of the patient's action is irrelevant to the process of treating and healing the patient. Considering Kant, the physician's duty is to maintain confidentiality. Confidentiality is essential to a therapeutic relationship so it could be said that maintaining confidentiality is a Kantian maxim as it should be maintained in all clinical cases everywhere. To deny this as a duty to uphold would require that we consider the consequences of violating the confidentiality, namely the harm to the third person. Such consequentialist contemplation removes the praxis as deontological and brings it toward Mill utilitarianism. For deontology to work in this case, the duty would have to be defined in favor of society over the patient. If this were the case, the maxim would lie with benefiting society over
the patient. But this is not the case, confidentiality for the individual patient remains the
duty and therefore, deontological conventional morality would not allow breaching
patient confidentiality despite the consequences.

It is reasonable that the murdering of another person would have negative effects
on Poddar's mental health. If the physician does not stop Poddar from committing the
murder is he allowing harm to occur? Although the physician is not inflicting the harm,
he could prevent it by confining the patient. But the physician cannot do this without
violating his duty to confidentiality. So it would have to be the case that if a physician
foresees his patient engaging in conduct detrimental to his health he should do something
about it. The physician cannot forcibly stop a patient from engaging in conduct
detrimental to his own health without violating autonomy. In this case using internal
morality in a deontological conventional sense, the physician cannot consider the
consequences of Poddar's actions as far as justifying violating the patient's autonomy or
confidentiality. What the physician is resigned to do, then, is to fully address the
underlying causes for Poddar's desire to kill Tarasoff and attempt to convince Poddar of
the profound effect murdering another person will have on his own health.

What is more important is why this patient has this desire to harm someone else,
and getting to the impetus of this desire should be the sole concern of the physician.
However, it seems untenable that a person who has credible knowledge that another
person may be harmed should ignore that information and not act on it as a member of a
civil society. But this is a physician-patient relationship, and to appeal to obligations to
society or third parties invites an external morality. Even if the intrusion of external
values is found to be morally sound, the decision then goes to whether or not the therapist
is justified in violating the internal obligation to his patient in lieu of compliance with an 
external duty.

Poddar was a voluntary patient of this therapist and therefore waived none of his 
rights to confidentiality. Trust and full disclosure in a psychiatric case are more essential 
than in other forms of physician-patient relationships for the simple reason that the 
psychiatrist's ability to determine state of mind is more subjective than other medical 
disciplines that can rely more on empirical testing. What constitutes a physician-patient 
relationship is the use of medical knowledge or skill to benefit the patient with the 
patient's consent. A psychiatrist is a physician, and Poddar is a voluntary patient in this 
case.

Applying the four topic method to this case would yield the following relevant 
facts. First, assessing the medical indications yields little information regarding the 
nature of the condition or the treatment. The extent of the effect of this mental health 
condition is for the therapist to determine. The medical indication in this case is not so 
much about further diagnosis, but what measures available to medicine should be used in 
this case. One of those powers of medicine is the ability to involuntarily confine a patient 
to a mental hospital for a limited amount of time. Commitment to a mental hospital is 
chiefly for the patient's benefit, but it is reasoned that when a patient poses a threat to 
others, confinement is also justified. Therefore, the clinical question here is whether or 
not to invoke that power in this case. The therapist here felt that Poddar’s intent was at 
least credible or he would not have had grounds for ordering involuntary confinement.

Secondly, under the patient preference heading of the four topics method, 
competency of the patient is considered. It is important to assess the competency of the
patient in order to determine whether he is able to make decisions in accord with his own best interests, and, whether or not this patient can or will comply with whatever treatment is prescribed. In this case, again, the therapist feels that Poddar's threat is credible, and initiates the necessary steps to prevent harm to others. However, Dr. Moore's attempts at confinement are thwarted by the officers who determine Poddar to be rational, and Dr. Moore's superior, who does not support Dr. Moore's decision. However, do these external influences change Dr. Moore's assessment? The case suggests that they do not, but Dr. Moore does not aggressively pursue confinement, indicating that he is not confident in his assessment of the patient, despite concurrence of two other colleagues familiar with the case.

Third, quality of life in the four topic method discusses what mental, physical, or social deficits the patient may suffer without treatment. In this case, converting the patient from out-patient to an in-patient would need to have clinical benefit for the patient in both treating his underlying condition, and preventing further harm. This assumes that committing murder would have negative effects on this patient's mental health. If this is the case then confinement would be justified. However, it could be the case that for the patient, murdering Tarasoff could be cathartic and restore Poddar to good mental health. This is an untenable moral position because one's sanity is not worth another's death from an external normative value perspective. However, internal morality focuses on the activity to treat the individual patient while rejecting or limiting external moral influences. This example illustrates the danger of blindly following certain moral rules in the name of duty without the capacity to accept circumstances that would justify breaking the rule.
Finally, a contextual feature of the four topic method incorporates contemplation of the relevant external factors affecting the clinical relationship. It is at this point in the four topic approach where relevant laws and larger obligations would be considered. At this point in this case, a number of external forces are at work; including reluctance of the police to assist and confine the patient, Dr. Moore's superior overriding his confinement decision, the patient's unwillingness to cooperate by voluntarily committing himself; and the duty to protect the patient's confidentiality. Of critical consideration here is to what extent the physician obligated to the potential victim. What is the physician's obligation to society? The four box method invites these questions, but relies on the clinician and whomever he consults to weigh the assessed facts.

This case serves as a good example of the failure of the four topic method to resolve ethical issues. This case is a true clinical case, and assessing the relevant factors in the four topic method does not help the therapist resolve the ethical issue (whether or not to breach confidentiality). Knowledge of the medical indications, patient preferences, patient's quality of life, and the contextual features merely serves as a systematic way to list the relevant particulars, but gives little guidance on how the clinician should proceed after listing these particulars.

From a conventional perspective, the duty at question here is whether or not to violate the patient's right to confidentiality. Confidentiality is essential to preserve trust in a therapeutic relationship, especially in psychiatry. Violating confidentiality may destroy necessary therapeutic trust.

The Tarasoff case resulted in litigation where the family of the victim, Tatiana Tarasoff, sued the therapist and the University of California Board of Regents for
negligence in not meeting their duty to protect the public from violent assaults. The case wound up before the California Supreme Court which held the therapist negligent in failing to execute his proper duty to protect Tatiana.

In their defense the respondents argued that to breach Poddar’s confidentiality would have violated the Code of Medical Ethics of the American Medical Association. The majority of the court rejected this argument, asserting that the determination to maintain confidentiality must be weighed against the general public interest. In this case the general public interest is to be reasonably free from assault, especially assault that could be prevented. Further, the majority stated, “Weighing the uncertain and conjectural character of the alleged damage done the patient by such a warning against the peril to the victim’s life, we conclude that professional inaccuracy in predicting violence cannot negate the therapist’s duty to protect the threatened victim” (Beauchamp and Childress 2001a, 417). The defendants also argued that they could not be certain that Poddar’s threat was credible. However, the court ruled that “professional inaccuracy” does not relieve them of an obligation to the wider public.

By this decision, the courts are establishing the precedent that in cases such as these, the clinician has a legal obligation to protect the public or the intended victims even if doing so undermines a sacred trust of the patient-physician relationship. Further, the court finds that therapists have an obligation to society. Here the court is imposing societal norms upon the clinician.

If person X learns that person Y is intending to kill person Z, person X, in the court’s opinion, has an obligation to do something to protect person Z as part of being a member of civil society. However, interpersonal communications are not privileged, but
physician patient relations are. Trust and confidentiality are critical, especially in a psychiatric case. The psychiatrist, though, came about Poddar’s threat through their professional relationship, so the rules of the professional relationship apply. The physicians defended not breaching confidentiality in this case, but the court held that the therapist had a supererogatory obligation to the public over the patient.

The dissenting opinion of the court supported conventional morality in the Tarasoff case. The minority supported the absolute importance of maintaining confidentiality – especially in psychiatric relationships – despite the consequences. This conclusion could also be considered deontological: the duty is to the confidentiality as it is fundamental to the success of the healing relationship. Despite the consequences as evidenced in the Tarasoff case, the minority still held that confidentiality is absolute in the clinical relationship. “Given the importance of confidentiality to the practice of psychiatry, it becomes clear the duty to warn imposed by the majority will cripple the use and effectiveness of psychiatry” (Beauchamp and Childress 2001a, 418).

Additionally, the dissenting opinion raised the critical concern that violence would increase because those who have violent thoughts will not express them because the instances of confinement will go up out of abundance of caution by the clinician. “Many people, potentially violent – yet susceptible to treatment – will be deterred from seeking it; those seeking it will be inhibited from making revelations necessary to effective treatment” (Beauchamp and Childress 2001a, 418). The minority opines that the bulk of violent threats expressed to therapists are not credible, but this valuation of the threat is based on the subjective experience of the therapist.
Summing up Conventional Morality

Principles and values are going to apply to any clinical relationship. In conventional morality the principles are accepted and following the principles supersedes the ends the rules exist to meet. The rationality behind the principles winds up not being of primary concern for the clinician; rather, the application of the principles in particular cases results from the conventional moral praxis.

We saw in the case of the proscription of abortion that the external principle for Catholic healthcare directly informed the ultimate treatment decision. Deliberation on how to best treat the patient was confined by the rules binding on the facility, physician, and patient. Such contemplation excluded other possibilities that may have been more in accord with preserving health for the mother. If it were the case that the mother would have suffered less by having an abortion instead of induced labor, then the decision to induce departed from the principle of alleviating suffering and restoring health.

In the Tarasoff case, we saw the clinicians respect and protect confidentiality despite the bad outcome for a third person. Not considering the consequences of violating confidentiality lies squarely with a conventional morality in accord with confidentiality. Additionally, the fidelity to the patient would have been breached if the confidentiality were violated for the sake of an external person, not party to the relationship, and not a patient. However, the courts concluded that this case constituted a situation providing justification for breaching the relevant ethical principles. In doing so, the court imposed an external morality, whereby the physicians have a duty to other potentially affected persons. The court’s action in this case constituted a departure from conventional morality and an introduction to reflective morality.
In contrast to conventional morality we consider reflective morality. Reflective morality is a moral praxis whereby the basic values of the clinical relationship are considered, but their application to particular cases is different. In the next chapter we will evaluate how reflective morality differs and how reflective moral praxis may have resolved these cases differently.
CHAPTER 4

REFLECTIVE MORALITY IN CLINICAL MEDICINE

In the previous chapter we discussed conventional morality and how it is used to deliberate towards clinical ends in medicine. Here we will focus on reflective morality and how it uses both internal and external moral modalities in clinical decision making differently from conventional morality. The goals of clinical medicine remain the same, but evaluating conventional and reflective moral methods will elucidate how those goals may be obtained.

Reflective Morality

Reflective morality in contrast with conventional morality is more concerned with achieving certain goals while conventional morality is more concerned with adhering to rules that when followed should achieve the same good end. "Reflective morality arises when an individual begins to reflect on what principles will govern his or her actions, particularly when those actions involve the rights and interests of other persons (or other sentient beings) or the integrity of the agent" (Callahan 1988, 10). As Callahan sees it, the first order of business is to identify what principles apply to the activity. Secondly, a moral agent would then assess different options consistent with adhering to the relevant principles of an activity considering the particular circumstances of the case. Principles considered relevant to the case at hand would be those consistent with the aim or telos of the activity. In this sense reflective morality is teleological.
Teleological thinking informs actions in accord with desirable goods or ends, the *telos*. Callahan opines, “In practice, the temptation is often to function teleologically, that is, to attempt to produce good results without considering seriously enough what moral values might be sacrificed in the process” (Callahan 1988, 19). Callahan here elucidates the notion that teleological reasoning is consequentialist. A consequentialist theory stands in strong contrast to a deontological theory which directs the moral agents reasoning toward following the principles for the principles’ sake despite the consequences.

For example, a physician may consider his actions in accord with the principles of good professional conduct when dealing with conflicts among different values. Consider the importance of truth telling in the clinical setting Wallace writes,

One has a fuller or lesser knowledge and understanding of truth-telling as a practical consideration depending upon the extent of one’s understanding of the importance of truth in various areas of life, why it is important, and how it is to be compared in importance with other considerations that pertain in these areas” (Wallace 1996, 20-21).

Here Wallace asserts that mere knowing that truth-telling is important and should be done is insufficient in determining whether or not one should tell the truth. To take a deontological approach to truth – telling rejects that other values may usurp the need to tell the truth in the case at hand. But if one understands the purpose of truth-telling, one is better equipped to meet that purpose.

This is an example to prove the point that mere knowledge of the goods is insufficient for working toward them. There must be many different ways of resolving moral conundrums outside of strict adherence to the rules. In medicine, for example, there are instances where full disclosure of the truth would have a deleterious effect on
the patient, so much so that sound clinical judgment would justify not telling the whole truth. These sorts of novel cases are what trap the deontologist. If a physician believes in telling the whole truth all of the time and in one case the patient is harmed by the truth, then the physician has met his duty to the rule, but failed to achieve the overriding good aim of his clinical practice.

Reflective morality vets relevant values applicable to the decision at hand, and seeks to meet the good aim of the activity. In this praxis, full understanding of the relevant technical matters is of primary importance. In medicine, what is this patient’s condition of health and what treatments are available? Then, after the physician has assessed all reasonable technical features of the case, normative values are considered in the deliberative process. The normative values would include what have previously been established as the values applicable to healthcare and physicians: autonomy, beneficence, nonmaleficence, justice, privacy, confidentiality, veracity, and fidelity. In addition to these “core” values, whatever particular normative values are of concern to the physician, patient, or external sources, will be given consideration.

Whenever a clinical relationship exists, the core values are present. However, reflective morality is relativistic and value pluralistic, inviting both the physician and the patient to consider whatever particular values each of them brings to the clinical encounter. Value pluralism inherent in the reflective moral praxis does not exclude the core values. Rather, it provides for varying degrees of weight of each value and invites valid external concerns into the clinical decision making process. Whatever is important to the patient and the physician in the case at hand is fair game in reflective morality. This praxis invites more values into play.
The ultimate end of a moral praxis is a decision to act or not act. From a reflective standpoint the desired end and the action towards that end are coherently justified. Coherence, in this sense, is argued to stem from a form of reflective equilibrium⁵, where balance among prior “considered [moral] judgments” is achieved. Considered judgments are “the moral convictions in which we have the highest confidence and believe to have the lowest level of bias” (Beauchamp and Childress 2001a, 398). These considered judgments would be our current state of beliefs about what one should morally do in a case based on reasoned or historical experience with the situation.

Conundrums appear in reflective equilibrium. “Whenever some feature in a moral theory that we hold conflicts with one or more of our considered judgments, we must modify one or the other in order to achieve equilibrium” (Beauchamp and Childress 2001a, 398). This is the essence of the reflective moral praxis: to apply prior beliefs to novel cases. It is often the case that different actions will pit certain beliefs against others, and what is required is to justify treating one belief differently from the other.

This coherence approach may help limit excessive pluralism, except that in practice not all considered judgments may be considered in full force each time. What constitutes a considered judgment remains non-universal and pluralistic. Our considered judgments constitute the core values of healthcare: autonomy, beneficence, nonmaleficence, justice, privacy, confidentiality, veracity, and fidelity. The challenge in reflective equilibrium is achieving balance among each of the valid prior moral commitments.

⁵ Beauchamp credits the term “reflective equilibrium” to John Rawls.
Physician’s ad Jehovah’s Witness

It could be the case that the physician is a Jehovah’s Witness and does not believe in blood transfusions for himself and will not order or perform them in his practice of medicine. Although he is a competent physician, fully aware of the medical conditions warranting treatment with a blood transfusion, he may interpret the use of blood transfusions as a malicious act devastating to the patient’s soul, constituting malfeasance. The physician has limited his own practice of medicine based on his personal values. A patient would need to be aware of this if the patient is not a Jehovah’s Witness and does not accept the same values. This notion illustrates how a physician and a patient may be moral strangers, which may affect the clinical relationship.

Whether or not the physician and the patient are moral strangers versus moral friends will have an effect on the clinical encounter. In the above example, the physician is interpreting the principle of nonmaleficence as a proscription of transfusing blood. However, his proscription against blood transfusions places his duty to veracity and fidelity at odds. If the patient is also a Jehovah’s Witness (moral friend), then he will understand the physician’s stance and accept it. However, if the patient is not a Jehovah’s Witness (moral stranger), then he should be made aware of the physician’s moral position. If the physician failed to notify his patient of his beliefs, then the physician would be failing in veracity, fidelity, and autonomy.6

6 There is no duty to inform a patient of a physician’s religious belief. However, if those beliefs limit the use of otherwise valid and accepted medical treatments that the patient may not object to using, then the physician is obligated to inform the patient that he is unwilling to do certain procedures. This would hold true if the physician were Catholic or held any religious beliefs that would limit access to medical care of his patient. The most pressing issue is whether or not a physician would remain objective in exploring diagnostic and treatment options based on his personal beliefs despite a personal proscription against them.
However, the physician retains autonomy in practicing medicine in a manner consistent with his own personal values. Forcing a physician to perform procedures contrary to his personal beliefs is an unfair restriction on the physician’s judgment of good practice. However, if this physician worked in a trauma center where blood transfusions are routine, it would be morally impermissible for him to not order them when needed because the patient may not be in a position to advocate for his own care.

Reflective morality will incorporate pertinent values from both the physician and the patient. If it is the case that a physician is unwilling to engage in certain treatments on moral grounds, this should be accommodated for the physician retains a degree of autonomy in his practice. A physician’s autonomy is important in order to secure the most objective diagnosis and treatment plan from the physician. It is not fair to say that a physician should violate his own moral code just because he is a physician. To suggest such would require that the core values of the clinical encounter have such moral force as to disqualify an otherwise technically competent physician from the profession because he or she will not perform or order certain procedures. But such accommodation of the physician’s beliefs challenges external notions of what can be expected from the clinical relationship. A patient may validly expect that a physician will use all the tools of medicine to help heal the patient. But if a physician does not adhere to this external expectation, is he less of a physician?

Additionally, the patient may impose moral values on the internal activity of medicine that force the physician into creative alternative treatments. If a patient is a Jehovah’s Witness and refuses blood transfusions, the physician may have to work harder to restore health to the patient. Further, if the patient were going into surgery and refused
a blood transfusion should one become necessary, the surgeon would be incurring additional legal liability should anything go wrong. In these cases it would be customary for a physician to secure additional liability waivers should complications not be treated by a necessary blood transfusion.

Medical Licensing: Monopoly on Medical Practice

Physicians hold a state sanctioned monopoly over the practice of medicine through medical licensing. The common mission of state medical boards is to protect the public at large by ensuring that only licensed physicians practice medicine and that those licensed meet minimum competency standards. The state will actively restrict those not meeting these standards from practicing medicine as such practice is harmful to the public.

Through each state’s “Medical Practice Act” or similar chapter of state law, the state outlines what constitutes the practice of medicine and the duty and obligations of physicians practicing under the licensing authority. The compelling state interest for state intervention in medical licensing is to provide both positive and negative standards for medical practice. Positive standards would describe what a physician can and is obligated to do as holder of a medical license. Negative standards would outline physician conduct that would be grounds for sanctioning a licensee.

Most medical practice acts do not require that doctors perform or offer certain treatments. The purpose of licensing physicians is to ensure that the public has access to competent doctors, not particular treatments. In Nevada, chapter 453A of the Nevada Revised Statutes (NRS) allows for licensed physicians to prescribe marijuana for
treatment of certain chronic medical conditions. Nevada's medical licensing chapters, 630 and 633 of the NRS state that a physician cannot be disciplined for prescribing medical marijuana under the provisions of chapter 453A. This is an example of ensuring that the public has access to a certain treatment but does not require the physician to provide the treatment. Considering these two chapters of law, 453A provides for medical marijuana and authorizes only a licensed physician to write the prescription. Chapter 630 and 633 insulate a licensed physician from discipline for writing for medical marijuana, but does not require a licensee to do so.

A physician's election not to participate in a treatment must be respected to protect the physician's autonomy. If a physician is required to perform certain procedures by law, the state is stripping a level of autonomous professional judgment from the physician. The state must balance this need for professional autonomy against ensuring that patients seeking or requiring certain treatments, although controversial, may get them if it will work to the patient's best interest.

In controversial cases such as the use of medical marijuana, abortions, treatment of intractable pain, and administering lethal injections to condemned prisoners, the state

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7 NRS 453A.030 “Attending physician” defined. “Attending physician” means a physician who:
1. Is licensed to practice:
   (a) Medicine pursuant to the provisions of chapter 630 of NRS; or
   (b) Osteopathic medicine pursuant to the provisions of chapter 633 of NRS; and
2. Has responsibility for the care and treatment of a person diagnosed with a chronic or debilitating medical condition.
(Added to NRS by 2001, 3054; A 2003, 1180, 14301

NRS 453A.120 “Medical use of marijuana” defined. “Medical use of marijuana” means:
1. The possession, delivery, production or use of marijuana;
2. The possession, delivery or use of paraphernalia used to administer marijuana; or
3. Any combination of the acts described in subsections 1 and 2, as necessary for the exclusive benefit of a person to mitigate the symptoms or effects of his chronic or debilitating medical condition.
(Added to NRS by 2001, 3055)

8 Both NRS 630.3066 and NRS 633.521 respectively
does not require the physician to provide certain procedures. Instead the state accommodates certain practices within certain guidelines. The law requires licensees to adhere to good medical practice, but does not require the physician to perform controversial procedures, accommodating some autonomy for the healthcare professional. If a state began requiring doctors to perform abortions or administer lethal injections, the state would essentially begin practicing medicine, depriving physicians of independent judgment. Respective medical practice acts constitute conventions required to hold medical licenses. Most medical practice acts have vague definitions of malpractice or professional misconduct to allow for more discretion of the licensee in his or her practice as well as to allow the adjudicating board more discretion in enforcing standards of practice. The regulatory scheme for medical licensing is a good example of a reflective moral praxis as medical boards evaluate individual cases of physician conduct much in the same way as courts apply general laws to specific cases.

Internal and External Morality in Reflective Morality

Reflective morality incorporates internal and external morality in different ways. The essentialist-internalists such as Pellegrino believe that the good of medicine, health, and the activity towards it exist outside physician-patient preferences. “The moral authority of an internal morality of medicine is independent of whether or not physicians accept or reject it….the authority arises from an objective order of morality that transcends the self-defined goals of a profession” (Pellegrino 2001, 564-565). Here, Pellegrino rejects the validity of historical professionalism whereby physicians through precedent and history articulate the realm of medical practice. Instead, Pellegrino opines that the “order of morality” is objective, implying that it exists outside both the physician
and the patient, but must be of concern to both the physician and the patient during the clinical encounter. Pellegrino would suggest that internal morality is all that is necessary as the physician and the patient strive for the good. The parties to the internal morality are the physician and the patient, and the good is achieved through their work. The main point Pellegrino wants to make is that the good of health itself exists beyond the practice. In other words, the good of health exists whether or not the physician or patient is aware of it; therefore the practice of healing or working towards this good is a higher order practice transcendent of human influence. In this sense, health exists as a universal good that the patient and the physician are working toward they cannot create nor can they destroy it. This point, in Pellegrino's view, is essential to the practice of medicine, and holding this position would favor the internal morality approach over others because it is concerned with higher order goods that cannot be made, changed, or destroyed.

Pellegrino rejects notions that medical ethics should be used to accommodate changes in external social mores. "An ethics thus conceived is an ethic external to medicine. It denies that there is something essentially in the nature of medicine as a kind of human activity which determines its ends and its ethics internally" (Pellegrino 2001, 560). Pellegrino works to identify something essential to clinical medicine that is beyond the physician and the patient. By doing so he invokes classical arguments from Aristotle and Plato asserting the teleological end of medicine as the ultimate ruling principle. By doing this he invites ancient philosophical arguments on how one may work toward the good.

In Pellegrino's view, the character of the physician plays a central role in accessing knowledge of the good and working toward it. "The untrustworthy
professional could exploit the patient's vulnerability for personal power, profit, or
prestige. In each case, the character of the professional is the final safeguard. In each
case, the end of professional activity is the good of the person in need of help”
(Pellegrino 2001, 573). Pellegrino asserts the potential harm when a physician places
self-interest over that of the patient. But Pellegrino offers only the character of the
physician as a safeguard against this harm. This is a major problem because all the cards
are in the physician's deck. It is the patient who is seeking health as he writes; the
physician is intended to help the patient seek that end.

We can accept Pellegrino's theory that the practice of medicine is good work
toward a good end in the Aristotelian sense. But we cannot build a paradigm for good
clinical practice on that notion alone. In the first case, health is relative in each person
who experiences it. Health is universal in that it is experienced to some degree in every
person, but to some degree is individualistically relative. Therefore, it is difficult to
develop a coherent ethical theory around such a broad and abstract notion. To restate the
good end as “health relative to this patient” does not remedy the problem because we are
still at a loss for how to act towards this good.

Additionally, knowledge of what health is as a virtue and as a homeostatic state in
the human body remains insufficient for informing actions toward the good. The ability
to work toward health will be limited by facts, cultural expectations, and different
weighing of the values by the patient (Beauchamp and Childress 2001a, 398). It is too
simply stated that the physician should be concerned only with working toward the good
of health.

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It is the purpose of the healing arts to attain the good of health, but to limit attaining this good to only an internal moral praxis is to exclude important elements of the activity toward the good. Pellegrino agrees with these core values of healthcare: autonomy, beneficence, nonmaleficence, and justice. He adds four areas of focus for the physician in attaining the good: the medical good, the patient's perception of the good, the good for humans, and the spiritual good. These four features rest exclusively in the internal morality of medicine whereby only the physician and the patient are involved in making decisions in these areas toward the good of health. Addressing these four areas and adhering to the four general principles for healthcare prove impossible in a pure internal moral sense.

Through these four features Pellegrino might be trying to give us a formula for assessing the values relevant to the clinical encounter. Using this formula we would then know what the issues are, but we would not know how to resolve them. Although he tries to argue that an internal morality is properly informed when it considers individual consequences within each of these four areas, in practice each area invites internal moral deliberation considering external values as instructive to the internal moral discussion. Additionally, considering actions under his four principles of internal morality inherently has external effects to the degree where the effect of the internal praxis would dissuade action because of the external consequences.

Achieving equilibrium among Pellegrino's four features is not possible using a purely internal moral praxis. Internal morality in medicine limits the scope of the deliberation to the physician and the patient. The physician and the patient bring the
relevant values applicable to the clinical encounter. These values are inherently external derived from both the patient’s and physician’s expectations and experiences.

To simultaneously consider the medical good, patient’s perception of the good, good for humans, and the spiritual good requires consideration of the consequences of any particular act. These consequences will affect others external to the clinical relationship. And to consider these consequences biases the internal moral praxis toward teleology over deontology which is Pellegrino’s aim. However, to achieve balance among his four features requires that both the physician and the patient consider the influences and effects of whatever actions are taken based on the clinical encounter. This is paradoxical because to consider the consequences of an act on humans generally and the good of medicine, for example, implies that the actions in this particular set of circumstances will have some effect on others. If a clinical decision is arrived at from considering the decisions effect on others, then it cannot be the case that what is purely in the best interests of this patient under these particular circumstances is purely internal.

Of Pellegrino’s four features none can exist in isolation from external factors. Contemplating the medical good requires considering what technical features of medical practice can do for this patient in terms of treatment options. However, it also has consequences, for if the powers of medicine are abused or, in Pellegrino’s sense, not used toward the expressed aim of attaining health, then what medicine is and what it means to society change. A good example is the abuse of medical knowledge or skill in administering lethal injections. Whether the intent is to execute a condemned prisoner or to assist a patient in desired suicide, both would constitute an act contrary to the medical good because the aim is not to restore health.
Reflecting on Proscribed Abortion

Reconsidering the cases outlined in the preceding chapter, let us articulate how reflective morality may have handled the cases differently. Regarding the Catholic Church’s proscription against abortion a reflective moral praxis would have considered the relevant medical indications differently.

First, in either reflective or conventional morality the medical indications for the case must be fully addressed. The only medical concern that should be weighed more heavily under the reflective moral praxis is whether or not the mother suffered more from the premature delivery than she would have had she had an abortion. Whether or not an abortion would have been easier on the mother’s failing health is important in considering the best benefit for the patient. However, because of the ERD treatment options were limited in that because of the directive abortion was not an option. So if the mother would have suffered less undergoing an abortion, then following the rule prohibiting abortion placed the mother in more risk. The treatment options were limited by conventional morality whereby they would not be so limited under reflective morality. This exemplifies how a reflective morality may consider the medical indications and treatment options of the patient differently. Additionally, this case illustrates how the full effect of the medical condition and possible treatments is more thoroughly considered in reflective morality.

If it was the patient’s desire to have an abortion in lieu of induced premature labor, this would be an important piece of information affecting how this patient is treated. If it was the case that the patient preferred the abortion, and this valid treatment option was not offered to her or even considered because of the institutional proscription
against that treatment option, then the physician failed in both veracity and fidelity by not informing the patient that a potentially safer treatment option was available to her even though the physician and the hospital were unwilling to perform the procedure. Without maintaining veracity it is difficult to accept that the patient’s decision to undergo a certain course of treatment is fully informed and in accord with the patient’s best interests.

The important distinction here is that under a reflective moral praxis it is more likely that the patient would have full access to all the available treatment options. In this case, instead of even considering an abortion, the hospital and the physician had to work around the proscription.

The patient’s personal moral position on abortion is irrelevant under conventional morality. It seems untenable that the patient’s moral position concerning certain treatment options could ever be irrelevant. “The patient wants to, and should, be able to rest assured that the doctor or nurse only looks at what is best for the patient. One should, for example, not have to worry about whether the doctor first and foremost will subordinate herself to a politically controlled or ‘correct’ [sic] health care” (Nordin 1999, 118). Under conventional morality, this is what happens. The physician and the hospital were more concerned with whether or not they would violate the ERDs than with what may have been a better treatment option.

Further, this distinction highlights how reflective morality requires that veracity and fidelity have been fully exercised by the physician as both are essential to obtaining proper informed consent from the patient. Consent is essential to the notion of autonomy, a right that cannot be rejected without substantial justification that the patient is not
competent to make a decision in accord with prior considered judgments of well being\(^9\). Additionally, if a physician engages in treatment of a patient without reasonable tacit or explicit consent, the physician is committing battery against the patient. In most cases, however, the patient may not understand his own rights in the clinical encounter with regard to consent.

In the proscribed abortion scenario, the chief difference between conventional and reflective moralities is whether or not a controversial treatment common in some parts of medicine and strictly forbidden in others would be considered in the clinical encounter. If the patient desired an abortion and was denied the option, and then veracity was not met by the physician. The physician has a duty to inform the patient of all available treatment options, even those the physician cannot or will not do. A simple example includes that an internist or family practitioner must know the limits of medical knowledge and when his patient needs to see a specialist.

Ultimately a reflective moral praxis in this case would have accommodated the patient’s desire for an abortion if she so desired. Under reflection, the medical condition is more fully explored and all treatment options are made available. In this case, the medical condition could not have been fully explored because one major treatment option was eliminated by an external value. Externality may validly affect the clinical relationship, and this is why internal morality practiced in a conventional way will more

\(^9\) Informed consent is a complex notion in medical ethics. The question surrounds how much information the patient needs to make an informed decision. Additionally, can the patient understand the medical information provided? It is unreasonable to expect a patient to understand specifically what will be done during a surgical procedure or the precise biochemical mechanisms of one medication over another. So, it is accepted that the patient must be adequately informed in order to consent to treatment. A thorough discussion of informed consent cannot be undertaken here.
likely miss assessing the full moral picture. Consider the external values imposed on physicians following the Tarasoff case.

Tarasoff Reconsidered Reflectively

In the Tarasoff case the chief concern was maintenance of confidentiality of medical information obtained during a clinical encounter. The information at hand, if considered credible, would have severe negative effects on a third party (i.e., her possible murder). The physicians decided that maintaining confidentiality was more important than the possible harm to the third party. The case resulted in litigation whereby the Supreme Court of California ruled that the physicians in the case had an overriding duty to the greater public, and that such greater duty constituted sound justification for the breach of confidentiality.

The physician in the case and the dissenting opinion of the court in Tarasoff are good examples of conventional morality in action. Both the physicians and the dissenting justices felt that their duty was to confidentiality despite the potential consequences. Such a conclusion is deontological whereby the duty to the principle supersedes the possible effects of the action. This decision is purely deontological because the rule of confidentiality is sacred under these terms and such a position excludes any imaginable circumstance where the rule should be broken.

How would reflective morality have considered the case differently? The court’s ruling is a good example of reflective morality. The court essentially ruled that the physician has a greater duty to protect society from harm and that this duty supersedes the physician’s duty to the patient. The physicians had reasonable belief that the patient’s
threat was credible and because they had this knowledge had a supererogatory duty beyond protecting the confidentiality of this patient under these circumstances.

A reflective moral praxis would take into account the effect of adhering to the duty and its consequences. Generally conventional morality considers the application of the rule over the end or purpose the rule exists to meet. This process of considering when a rule should not be fully complied with is inherently reflective, and a process that courts often engage in. The decision making process courts routinely undergo is very similar to what physicians are asked to do when making clinical judgments.

The role of the judiciary in American democratic government is to determine the intent of the laws made by the legislative branch and executed by the executive branches and how they are applied to particular cases at hand. The legislature cannot be expected to make laws that are clearly relevant to each and every case; the medical profession cannot promulgate a body of norms that are clearly relevant in all cases. In law and medicine, novel cases will arise, and both judges and physicians must decide how the rules apply to this particular case.

An example from law includes Ronald Dworkin’s discussion of the decision in the nineteenth-century case of *Riggs v. Palmer*. In that case, a grandson murdered his grandfather, and following his conviction, claimed the part of the estate the grandfather left to this grandson vis-à-vis his will. At the time there was no law preventing a legatee from inheriting after murdering the testator. This case advanced to the Supreme Court of New York where one lone justice argued that to deny the legatee the right of inheritance, which was clearly the intent of the grandfather as expressed through his will, would constitute precedent that would invalidate the underlying intent of wills.

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10 *Riggs v. Palmer* 22 N.E. 188 (1889) Court of Appeals of New York

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Despite clear law informing this particular case, the court relied upon an underlying legal principle that a criminal should not profit from his crimes. Writing for the court Justice Earl stated, “If there arise out of them [legal statutes] collaterally an absurd consequences manifestly contradictory to common reason, they are with regard to those collateral consequences void” (Johnson 1993, 119). In this case, the murderer clearly would profit, and the court opined that it would not have been the intention of the legislature to have the laws governing wills abused in this way. “In other words, judges should understand and apply the law of wills independently of the rest of the law” (Wallace 1996, 77-78). “This is an application of the general point that reasonableness in following any norm is a matter of observing the norm in conjunction with other norms that pertain in the pursuit of one or more activities” (Wallace 1996, 79). Wallace’s point is that it is not desirable to consider laws in isolation, but to consider law making and law abiding as an important social activity. Then consider the intended purposes of the activity to make better moral decisions about how to engage in such an activity.

Each professional activity is part of a greater social activity. Each social activity is experienced in a community and that community determines how the activity should occur. “An account of the good is at once local and particular – partially defined by the characteristics of the polis” (MacIntyre 1984, 148). MacIntyre discussed the common history of each person in his family and community, and that each of these common histories form the moral fabric of normative values. Further, a community could come together to achieve a common moral project. For this to be successful all would have to agree on what constitutes a virtue and a vice (MacIntyre 1984, 151).
This illustration translates well into the work of physicians as their professional practice constitutes a social activity with clear ends and means. Their practice involves effect on their patients and on society as a whole. Good practice in this sense then requires consideration of the larger consequences of a physician’s work. To this end good practice would be enhanced when acts of the practice are considered in conjunction with the higher purposes of the activity. For physicians, the higher purpose is the health of their patient. And like judges, physicians must understand the “laws” of medicine, and identify how to best apply them in the case of their individual patient. To do so well invites reflection on the ends and purposes of the rules more than the rules themselves.

In the Riggs case, if the court ruled in a conventional deontological fashion, then the murderer would have received the inheritance. But to do so was a morally tenuous position whereby reflection on the use of the practice, the use (or abuse) of the law, would have negative effects and evidenced poor jurisprudence.

On the other hand, allowing judges to supplement the law seems to overstep the role of the legislature. However, in this case, the court didn’t invent a baseless ruling; rather it supported its conclusion not based on the absence of laws governing murdering testators, but rather on the intention and purpose of the law governing wills. The intent of wills is to ensure that one’s wishes are carried out after one has died. In order for the court to honor the terms of the will, the court would need to be convinced that under the circumstances, the grandfather would have still intended for his grandson to inherit part of his estate. Additionally, if the court had been so tightly bound by the strict letter of the law, “the law would be a stupid thing” (Wallace 1996, 79 quoting H.L.A. Hart from The Concept of Law 1961 Oxford University Press). Courts and doctors need to be able to
think out of the box and not be too tightly bound by rules and principles, but instead be free to make reasoned judgments in the best interest of the activity of their profession.

Conclusion on Reflective Morality

We want our doctors to think in terms of our own health first and foremost. We do not like thinking that our doctors are even considering what effect the outside world may have on our own personal health. We want our doctors to follow the rules, all of the time. And all of those rules should point toward our individual health. This is essentially what medicine should be about; this is why we have doctors. But this is not how the system works in the real world and this is our system that we created.

Long ago are the days when doctors were just doctors and they could do everything. Now medicine is highly specialized and very expensive. Medicine is as complicated as our own society. We live in a culturally pluralistic society with only a few common values necessary to maintain a civil state. Yet, when it comes to medicine, there are fewer absolutes since there are different cultures.

If medicine’s end is health relative to the individual, then medicine must take into account what constitutes health for any particular patient. It is hard to hold to absolute values of medicine, but easier to hold to professional standards of practice that transcend any professional. Medicine is a professional art and like any art its end is excellence in practice. For medicine excellence is achieved through health realized by the patient. To achieve this good end of professional practice the practitioner must be free to consider whatever factors make a difference in restoring or maintaining health for this patient. Therefore a moral practice that is accommodating of a pluralistic culture will have more
success in achieving the good end of health than a deontological conventional moral practice.

Reflective morality in medicine allows for more values to be considered without rejecting values altogether. We saw that reflective morality considers numerous values, excluding only those not relevant to the good end of the practice. Conventional morality, on the other hand, will exclude contemplation of certain values that may threaten theoretical moral compliance with the principles of the practice and the goals it is trying to meet. Reflective morality tries to restore balance or equilibrium in moral decision making. This moral theory is more in line with the purpose of medicine and healing in the first place, to restore balance and equilibrium to the body so it may realize health as good.
CHAPTER 5

CONCLUSION

Throughout this work we have identified six concepts woven through the web of ethical decision making in clinical medicine. These concepts include: deontology, teleology, internal and external morality, conventional and reflective morality. These moral schemes employ eight notions of normative values in medicine including: autonomy, beneficence, nonmaleficence, justice, privacy, confidentiality, veracity, and fidelity.

Ethical decisions in medicine are a matter of internal moral praxis. The physician and the patient decide what is in the best interest of the patient as they strive toward the good of health. This internal contemplation is influenced by external values informing the internal decision making process by prescribing some values and proscribing others. The product of internal moral decision making is achieved in part by contemplating conventions or reflecting on the ends of the activity. In some cases, a clinical decision is derived from a true conventional moral praxis, while others are purely reflective. In other cases, however, the result of a decision could be said to come from a combination of both conventional and reflective moralities. And this leads us to the ultimate challenge in medical-ethical decision making: How best to act toward the good of health?

This thesis does not advocate that one moral scheme is better than another for the following reasons. First, the author rejects that ethical naturalism exists. Knowledge of
right and wrong does not present itself like scientific knowledge. Science is well grounded by empirical evidence where the laws of science are discovered rather than made. Perhaps it is the case that there are universal virtues and the knowledge of those virtues comes about through reason. As Kant suggests, pure practical reason is how we understand what the good is. The question lies in what we do with that knowledge once we have attained it. But like science, ethics requires consensus among the learned to accept conclusions as valid. Therefore, our understanding of virtues comes about through an epistemic consensus informed by practice in working through moral conundrums.

Second, ethics is concerned with habit towards good activity. An individual strives toward the goods and may employ learned counsel toward that end. Counselors include moral friends, like-minded individuals with whom to share ethical concerns. In instances where the concern is spiritual, legal, or medical, a person may consult a professional concerned with the activity. Here is the omega point for the practice of any profession and, of particular concern with this work, the practice of medicine. When a person consults a physician that physician must have both theoretical wisdom of how to directly advise or help the patient attain the good end of health and the practical wisdom to deliberate well on the good use of his knowledge toward his patient's realization of the good as the patient desires.

Third, the author accepts a qualified liberal pluralistic notion of good ethics. Each person represents an individual moral agent with varying degrees of understanding of what constitutes a good and how to work toward it. Each physician will have individualized notions of good practice for his profession. Where the physician and the patient meet may invite different concepts of what the good is and how to get there.
However, excessive pluralism in its most pure form is problematic because it challenges the notions of some fundamental grounding principles. The qualification for excessive pluralism is that there are or need to be some basic universal notions consistent with activity toward health and the practice of medicine. Whether these notions exist in a universal sense or are the result of considered prior judgments on the good is fodder for a robust debate among ethicists.

Fourth, what matters most in our discussion is not whether or not normative values in clinical medicine are in the form of virtue or universal principles but how we achieve the good end of health from the activity working towards it. Consensus on some very basic ethical principles concerned with the practice of medicine is necessary if one seeks to act well toward achieving a good end. Some knowledge of the good is essential before working toward it. But how each person achieves the good is relative as each person’s state of health varies. Therefore, a moral scheme most attuned with achieving the good on a case-by-case basis must be able to include the notions of the good but apply them in a manner to promote equilibrium in the practical activity.

This leads us to conclude that a hybrid of conventional and reflective morality is the better approach to clinical decision making. Grounding morality in basic ethical principles while remaining open to their relative bearing on the clinical encounter is more likely to result in excellent medical practice achieving the good of health for patients.

Strengths of Conventional Morality

The most attractive features of a conventional moral praxis are that it is well rooted in normative principles laden with deontological duty to adhere to these principles. The principles are presumed to be the result of reason and in accord with the good
requiring no further critique. A dutiful physician will follow the rules accepting that to
do so will yield good work toward the good aim of his professional practice. Grounding
the practice in solid rules provides a good predicate for the practice of medicine by
members of the profession and understanding of good professional practice from the
perspective of lay society.

Theoretically this scheme should work well but requires a number of
presuppositions. First, the principles of practice must be so well attuned with the good
end of the practice that they are immune from critical reflection. Normative values for
physician practice stem from obligations to an internal morality for the activity of
practicing medicine and are categorized as essentialist, practical precondition, historical-
professionalism, and evolutionary as outlined in the first chapter. Through these various
accounts, normative values have formed outlining what principles a physician should
adhere to in the internal moral praxis. Internal morality in a conventional praxis is aimed
at dutiful adherence to the principles. Thus this moral scheme is deontological and non-
consequentialist. This scheme prescribes and universalizes the ethical precepts for
medical practice.

Outlining the principles for physician conduct and considering those principles
uncritically standardizes the practice of medicine. Standardizing medical practice may
promote trust in the profession as a whole. It may also have the effect of promoting a
contractual nature to the physician-patient relationship where the patient expects the
physician to provide certain goods and services (Geller 2006, 82-85).

Physicians adhering to conventional morality are unfettered by accommodating
excessive value pluralism. The physician is focused on how to mold the activity of any

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clinical encounter into accord with the rules of the profession and the practice. The contemplation for the physician under this moral scheme is how to fit the current state of affairs encumbering this patient into the standard model for good ethical practice of the healing art.

A conventional moral approach is more accessible to a physician because contemplation in applying this scheme is similar to how physicians conduct investigations into medical problems. Physicians are scientifically trained and approach their patients in a pragmatic critical manner consistent with diagnosing disease. This approach is well articulated by Ladd as he outlined the “problems approach” a physician undertakes in evaluating a patient.

When a patient sees a physician the patient expresses feeling ill. The patient does not know exactly why he feels ill but wants to feel well. The physician is now charged with conducting an investigation into the patient’s symptoms to identify the source of the patient’s ailment. The physician takes a history, performs an exam, may order radiological and/or laboratory tests in an effort to accumulate evidence to use to make a diagnosis. The physician then interprets this evidence to make an educated guess on a diagnosis and will suggest treatment accordingly. If the treatment works, the patient feels well and the physician has done his job.

In this example, though, the patient and the physician approach the same problem in different ways. Both the patient and the physician are concerned with resolving the patient’s ailment and restoring health. But the patient just knows that he feels sick, while the physician wants to know why the patient feels sick. For example, the patient feels pain in the right lower quadrant of his abdomen. The physician begins a systematic
investigation of possible sources for the pain. Here the physician is ruling out a number of possible causes of the abdominal pain: appendicitis, diverticulitis, irritable bowel syndrome, Crohn’s disease, or any number of other ailments that may lead to this patient’s feeling ill.

For Ladd, the physician and the patient are approaching the problem from different perspectives. The physician is trying to solve the medical mystery causing the patient’s pain and the patient just wants to feel better. Both are concerned with the ailment and alleviating the pain, but from largely different perspectives. From this, Ladd suggests that the investigation of the same set of circumstances is different warranting different considerations of the good of health. This dichotomy illustrates that both the physician and the patient are operating from different value systems and therefore should consider medical ethics differently (Ladd 1983, 223).

This example shows that in practice the physician uses a programmatic inquiry into resolving the medical mystery. He is trying to identify how this patient’s condition is most similar to other conditions resulting in the same set of symptoms increasing the probability that one diagnosis is correct over another. In other words, the physician is trying to see how this case fits with other similar cases using a standard method of inquiry. Such a method of inquiry is ingrained in a physician’s training as the proper approach to evaluating any patient. Since physicians are well trained in this methodological approach to diagnosis and treatment and conventional morality mirrors this process, physicians would be more likely to accept a conventional approach.

This point was illustrated in our discussion of the “Four Topics Method” where there was a systematic way of assessing the relevant particulars of any given case in an
effort to resolve ethical conundrums. The authors of the “Four Topic Method” promoted their method as accessible to physicians because of the way physicians are otherwise trained to address problems.

But it is not necessarily the case that a method more accessible to physicians is a better method for meeting the ends of the professional practice. It may be the case that physicians need to think beyond their habit of medical inquiry to properly address ethical issues in medicine.

Weaknesses of Conventional Morality

Conventional morality’s chief failure is its deontological bend. The praxis of deciding how to comply with ethical principles places allegiance to the principle above the aim of the activity. Considering the principle of confidentiality, if a physician is more concerned with the duty to preserve confidentiality, he may be closed to considering situations where violating confidentiality is more in line with the greater purpose of achieving the end. This point was well illustrated in the Tarasoff case where a murder could have been prevented if the physician had not pedantically adhered to the notion of confidentiality. In this case the duty to the principle outweighed the greater civic duty of the physician to prevent harm to others.

Conventional morality does not handle ethical pluralism well. Some ethical precepts are important, but with each patient any number of external or internal values brought to the encounter by the patient may complicate an encounter with a strict conventional physician.

Pellegrino and others lament the departure from an essentialist view for physician conduct as physicians. Pellegrino asserts that since the aim of the physician’s practice is
health the physician will know better how to attain health for his patient. Following this notion eliminates the patient from expecting his physician from acting on the patient’s moral preferences. It could be the case that the patient does not know what is necessary for his own health and the physician should coach them toward activity in accord with the good.

The presupposition invites medical paternalism which lays the moral responsibility on the physician. To give the physician exalted moral agent status requires an elemental trust of the physician’s moral judgment. Pellegrino asserts that physician character traits lend themselves competent to make such moral deliberations.

It seems untenable to defer moral decision making as it pertains to medicine to physicians alone, especially in light of the fact that it is the patient who desires the good of health and the physician is there merely to help. Medicine has evolved into a more contractual-commercial enterprise where patients dissatisfied with a physician’s advice or unwillingness to perform certain procedures results in a patient finding another doctor who will. This trend does not make the patient more right than the physician, but a common ground must be met. This sort of shift in the relative importance of the physician increases the notion of ethical pluralism.

Conventional morality does not accommodate ethical pluralism, limiting its usefulness and universal application. Conventional morality is either too abstract or too conservative to be helpful in resolving practical ethical problems in clinical medicine. If the ultimate end is health and only health, this notion does not help us to determine how to work toward that in novel cases. If the rules of physician conduct are deontological,
then we cannot handle situations where acting in accord with the duties conflicts with other moral principles.

Conventional morality relies on the unquestioned acceptance of the normative values of medicine. These moral values have evolved over time. But how can conventional morality advance to accommodate advances in medical science without critical contemplation of the values? Theoretical wisdom advances and practical wisdom follows. First, we must understand the theoretical then through practical wisdom understand what the theoretical means and how to use it. Conventional morality does not encourage advances in practical wisdom.

Strengths of Reflective Morality

Reflective morality focuses on fully assessing the case at hand and considering all applicable ethical principles and preferences to the contemplated activity. Reflective morality does not reject out of hand certain principles. The grounding central principles of autonomy, beneficence, nonmaleficence, and justice remain. The chief difference is that reflective morality accommodates specifications accommodating breaching these ethical principles when the consequences of such a breach are more in line with the teleological end of the activity. More open consideration of normative values invites more ethical pluralism, making this theory more applicable to more cases.

In contrast to conventional morality, reflective morality is more focused on the ends of the activity over the duty to adhere to ethical principles. This theory is consequentialist in nature as the full effect of the action is considered when deliberating toward the action. Consequentialism stands in contrast to deontology whereby the consequences of the act are irrelevant because such considerations would hinder acting in
accord with duty, again considered to be unquestioned. As a consequentialist theory focused more on achieving a good end of the activity, reflective morality is also a teleological theory.

Health as the relative state of optimal functioning for each individual invites each individual to bring his own normative values to the clinical encounter. The act of working towards health is the *telos* of the physician’s work. Essentialist-internalists such as Pellegrino argue that their theory is more in line with the good end of medicine (*telos*). However, reflective morality holds the *telos* as central while deontological conventional morality holds the norms central. Because of reflective moralities more broad consideration of any and all relevant principles to achieving the good end, this theory is more in line with the ultimate good of medicine than deontological conventional morality.

Through reflective morality, a physician is better able to accommodate his patient’s ethical preferences or influences. This is ethical pluralism and each clinical encounter is going to consider ethical principles differently.

In some cases spiritual influences of the patient will bear heavily on the clinical encounter. For example, Jehovah’s Witnesses proscribe blood transfusions, so a physician must honor that preference and work around it.

Reflective morality is definitively consequentialist as it centrally considers the effect of the action on achievement of the good. This invites ethical pluralism as well as numerous treatment options into the clinical encounter because everything is accessible in reflective morality. The method for removing treatment options is based on whatever relevant values apply to this particular case. Through deliberation the physician and the
patient may achieve an ethical equilibrium among the various ethical principles applicable to the clinical encounter.

Because reflective morality is far more pluralistic than conventional morality the method for identifying specifications to ethical practices is paramount. Beauchamp’s justified specification account works well in identifying which circumstances warrant breaching ethical rules or principles.

As we saw in the Tarasoff case, reflective morality would have accepted the conclusion that breaching Poddar’s confidentiality was in the best interests of the community and the intended victim. This set of circumstances warrants a justified specification to the confidentiality rule. Reflective morality challenges the moral agents to analyze the consequences of their actions to see if they are in accord with the aim of the activity. Actions taken by the physician and the patient will have consequences on the realization of the good of health.

Weaknesses of Reflective Morality

Reflective morality is a far more liberal approach to ethical decision making where elemental standards for conduct may be treated differently. Although physicians in reflective morality abide by the basic principles for healthcare, this moral praxis accommodates situations where these principles may be violated when the circumstances are such that the greater aim of the activity would be achieved.

It is harder to take a liberal approach to ethics because foundations are few and far between and there is more room for consideration than in applying conventions to a moral deliberation. Accepting a more liberal view of morality widens the field of valid normative values. Such a liberal approach leads to excessive relativism of normative
values. For example, a physician asked to perform a lethal injection of a condemned prisoner may have a hard time rejecting such a task under a reflective moral praxis. Physicians as the custodians of knowledge and skill of medicine should not be required to use it in any manner requested of them. If a physician objects to using his skill to execute a condemned prisoner, his position should not be challenged. This leads to the general principle that a physician may decline to participate in treating a patient. In other cases, a physician may be asked to perform an abortion or prescribe a medication that would inhibit conception. If the physician disagrees with using medical skill in this way, he should have the ability to object.

These examples illustrate that physicians do have knowledge of the good of health and how to work towards it. They offer their professional services to patients who seek the good of health. Excessive relativism, however, abandons grounding principles whereby the fanciful preferences of a community or a patient may not be in accord with the good end of health. Consider a patient seeking a prescription for narcotic pain medication, not because he has chronic pain or injury, but because he just wants the euphoric effects of the drug. This is a misuse of the medication and an abuse of the physician’s authority to write prescriptions for narcotics. Because the patient believes that taking these drugs will have a transient benefit, the physician knows that abuse of these drugs would have long term damaging physical effects. The prudent action for the physician is to coach the patient on the dangers of narcotic abuse including the negative physical effects of long term use including dependence and bodily harm. Here the physician must see the long term benefit of denying the patient the narcotic prescription without a valid medical justification.
Reflective morality may invite ethical relativism and pluralism in excess. As the above examples show, sometimes the desires of the patient are not in line with the ultimate health of the patient. In these instances, a physician is better served adhering to medical principles over accommodation of the patient's preferences.

A Hybrid Theory of Medical Morality

Neither a purely conventional nor a reflective morality is better than the other. Both have attractive features and undesirable weaknesses. In lieu of this certainly a hybrid theory with the best features of both is most instructive to resolving ethical problems in clinical medicine.

We return to what is basic about the physician-patient relationship. A patient seeks the advice and help of a physician when the patient is ill. This is the clinical encounter and the omega point for clinical ethics and the entire healthcare system. The physician holds the key to the vast resources of healthcare whose purpose is to restore health to the sick. The physician is the custodian of the medical art and is committed to his profession to help those in their desire to achieve the good of health. Which resources to use are at the physician’s discretion, but his decision is not absolute; it is influenced by patient preferences and often external factors.

What is ideal in a clinical relationship is that the relative state of health can be achieved for the patient to restore him to his optimal functioning. To that end the clinical encounter should be grounded in some ethical principles with the ability to fully assess the particulars of the situation to tailor activity toward the best achievement of the good of health. Conventional morality is focused on applying the principles while reflective morality could be too broadly construed to include excessive relativism and pluralism.
Ideally, then, we would seek an ethical paradigm that grounds the encounter as purposeful toward a good end while also remaining open to divergent moral values brought to the encounter.

The clinical encounter is always the result of an internal morality between the physician and the patient. As we have explored in this work there are instances where external moral factors have influenced either the patient or the physician, or both. Regardless of these influences, however, the decision ultimately lies with the doctor and the patient. So then, the doctor and the patient have the option of choosing whether or not to accept the external influences on the clinical encounter.

The hybrid model for medical morality applied to the father-daughter kidney case discussed earlier in this work would allow for additional options beyond the justified conclusion from the conventional-deontological approach. The hybrid approach limits the scope of the consequences of the physician’s moral act while maintaining allegiance to the normative values.

The physician’s conundrum is two fold. First, he is asked to maintain the father’s medical confidentiality. Secondly, he is asked to lie to the wife/mother about the father’s donor status. He can rationalize his decision as consistent with his duty to confidentiality. But this case presents a situation where he would be justified under a reflective praxis to breach the confidentiality if and only if breaching this confidentiality would have reasonable benefit to the patients. Such is not the case here. It is not certain that violating the father’s confidentiality will have a good outcome. But further, the physician should not lie to the wife. His only recourse is to not say anything about the father’s histocompatibility to the wife. His unwillingness to disclose this information has
the likely effect of the wife's confronting her husband, but whatever ensues from that
encounter is between them.

The physician does not have to become part of the conspiracy to lie to the
wife/mother about his favorable donor status. The physician has the option of not
disclosing the results of the histocompatibility test to the wife suggesting that she ask him
what his status is. The physician can breach confidentiality only with consent of the
patient. In this case the father has not consented to this disclosure and has further asked
the physician to conceal the truth from his wife. The physician is not authorized to
release medical information on the father in this case. Additionally, he is not required to
say anything one way or the other about the father's histocompatibility. Saying nothing of
the father's histocompatibility would relieve the physician of the burden of lying and
maintain a higher standard of confidentiality than saying to the wife that the father is not
a good match, "for medical reasons."

The physician in this case justifies his lie as a supererogatory act trying to protect
the family from further emotional trauma. But the circumstances do not justify the
physician's lie. Whatever results from the mother and father's discussion on this topic is
for them to decide. The detriment to this relationship will occur now or later whether or
not the wife/mother discovers through her husband that he is histocompatible yet
unwilling to donate sooner rather than later. It could be reasonably argued that
maintaining the deception in the long term could be even more detrimental. But the
dynamics of this family and their relationship are not the primary concern of the
physician. Whatever complicates this relationship is well beyond the scope of this
clinical encounter and not the responsibility of the physician to mollify.
Deontological and conventional morality denies considering the consequences of any moral act. Reflective morality invites numerous considerations of the consequences for any moral act. In this case reflective morality takes consequentialism beyond what is necessary for the physician to practice well in this case. The physician in this case interprets his duty to maintain confidentiality as paramount but extends his act to deception of the wife/mother through rationalizing mitigating undue harm to the family. It is not the physician's responsibility in this case to maintain the family; his responsibility is to treat this child without unduly harming others. Whether or not the family falls apart because of the father's decision is not relevant to the doctor's job here.

Reconsidering this case using the hybrid model elucidates how deontological-conventional morality limits the physician's options. Further, reconsideration under a reflective praxis introduces a moral obligation of the physician to consider numerous external values or consequences of his action beyond what is reasonable to apply to a physician in the clinical encounter. What the hybrid approach does is limit the scope of the physician's moral consideration of his actions to what is relevant to the case at hand without holding him morally responsible for broad or far-reaching moral consequences or accommodating excessive external values. In this case the reflective morality is better at helping the physician and the patient sort out what external norms are relevant to his clinical decision.

The deontological conventional approach appears to be academically sound but also has an air of righteousness. Presuming that the values for a profession are unquestionable and to dutifully follow the rules hinders the ability to handle novel cases.
Conventional morality accommodated the father from withholding his favorable donor status from his family and denied his daughter her life because he did not want to donate his kidney. Conventional morality properly applied to this case accommodates both the doctor's and the father's decisions. Only with a reflective moral praxis can we press the physician to consider breaching the father's confidentiality if there is a reasonable intuition that doing so would benefit the daughter. Reflective morality brings that possibility to the table while conventional morality holds that confidentiality sacred and despite the circumstances must be maintained.

Conventional morality provides what reflective morality underemphasizes and that is grounding and universal principles. Through conventional morality the rules are followed and this stabilizes the system of healthcare by articulating the role and conduct of physicians and providing society with expectations of what physicians can and will do. However, it does not accommodate novel or complex cases as well as reflective morality does.

In both schemes the starting point is the principles of healthcare and physician conduct. But only in reflective morality can the principles be violated when good cause is present to show that the ultimate good end would be more fully achieved by breaching the rules. This presents an irony for proponents of conventional morality.

While the essentialist-internalists opine that their more strict approach to apply healthcare principles facilitates the attainment of the good, this scheme in practice does not contemplate working toward the good. Applying a strict conventional moral praxis favors adherence to the principles with the side benefit being achievement of the good of health. Although the essentialist-internalist asserts that the telos of medical practice is the
good of health, conventional moral praxis considers only duty to the principles and does not consider the consequences of deontological application of the rules. The irony comes about when considering reflective morality that is more focused on the consequence of the moral act itself and its accord with achieving the good end of medicine.

Medical science is a dynamic and rapidly changing subject. Modern patients are more informed and more critical of physicians. Also, modern patients are less loyal to their physicians and will likely change doctors in response to changes in their insurance plans (provided that they are insured). This is not to say that physicians should pander to transient desires of their patients. But the moral authority for the practice of medicine does not lie with the physicians alone. Physicians are hard pressed to stay abreast to rapidly changing treatments in medical science. Physicians are highly trained in diagnosis and treatment with little formal training in ethics. Most ethics training of physicians comes about through years of practice. It seems unfair to lay the moral responsibility for medical activity on the physician alone. The physician is part of a system with numerous external pressures affecting practice.

The patient is the person who realizes the good of health with the aid and advice of the physician. But it is ultimately the patient who is the moral agent desirous of the good of health. The physician works with the patient to achieve that end. The physician cannot be said to achieve the end alone. The physician’s work should be aimed at achieving the benefit of health for others.

An ideal paradigm would include basic grounding principles to the practice of medicine including knowledge of – and adherence to – the principles of autonomy, beneficence, nonmaleficence, and justice. For the physician’s practice adhering to – and
knowledge of – the principles of privacy, confidentiality, fidelity, and veracity. Accepting these basic principles predicates a starting point for both the physician and the patient in the clinical encounter. Then the physician and the patient may begin their work aiming toward health for the patient in terms of achieving equilibrium among each of these principles.

We conclude with this, that the good aim of health is best realized when the clinical encounter is grounded in some ethical principles, but both the physician and the patient are not excessively encumbered by external values unfairly influencing their activity toward the good end of health. Therefore, a reflective moral praxis grounded in consideration of conventions is the most accommodating paradigm for clinical decision making.

A good physician practices well when he can bring the best of his theoretical knowledge to the clinical encounter and is able to think about the practical use of his knowledge. Textbooks may not help a physician resolve whether or not a patient should receive one treatment over another. But his patient’s preferences and other external values may inform the decision. The days of “doctor knows best” are past, now the “doctor and the patient” know best and both medicine and society must prepare for more robust ethical dialogue concerning the telos of the healing arts.
REFERENCES


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