ETHICAL ISSUES IN HEALTH

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Summary

Medical ethics have been studied for thousands of years, but a multidisciplinary approach has recently emerged through bioethics. Bioethical reflection accepts diversity and is secular, allowing proponents of different views to explain themselves to each other through shared concepts. Ethical orientations include those historically directed by strict ideas of duty (deontology), and directed by a search for fair solutions to immediate problems (consequentialism or utilitarianism). Modern alternatives include orientations intended to redress the ancient exclusion of women's voices and experiences from ethical analysis (feminism).

Attempts to reconcile differences among orientations have identified a few key principles on which adherents to different orientations agree. They rank equally with each other, and are ordered according to analysis of particular issues. They are the duty to respect persons by deferring to the autonomy of persons capable of self-determination, and protecting those who are not. Others are the duty to do and maximize good (beneficence), and the duty to avoid or minimize harm (non-maleficence). The principle of justice centers on fair allocations of limited resources (distributive justice).

Different levels of ethical analysis are the interpersonal (microethics), the social (macroethics), the administrative (mesoethics) and the trans- and inter-national (megaethics). Two significant areas where ethical thinking is developed and can be illustrated are reproductive and sexual health, and research involving human subjects. Both ethics and law are directed to control of personal and social behavior, and they often coincide. They may also differ, however, and even conflict.

Lawful conduct may be unethical, and ethical options may be legally prohibited. The modern international human rights movement is a reaction particularly to mid-twentieth century ethical abuses by governments using the power of law. Many ethical principles are now reflected in modern human rights principles, and many of these principles are contained in laws.

1. Introduction

In its widest sense, the word “ethic” refers to a custom among a group of people, and to an individual person’s disposition or character. For instance, a person who has a “work ethic” is disposed and accustomed to work diligently. Ethics also refer to behaving properly and to pursuing right conduct, so that improper or wrong conduct is described as being unethical. Medical ethics are the rules that define the duties of medical practitioners in regard to the practice of their profession. A fundamental historic medical ethic is to “Do No Harm,” which is sometimes described as the first ethic of health care in general and of medicine in particular. The principles urged by a celebrated physician in Classical Greece, Hippocrates, who was born about 460 years before the beginning of the Christian era, are the foundation of what is still revered in westernized medical training and practice as the Hippocratic Oath. The particular details of the Oath have evolved considerably over the centuries, but the Oath remains the basis of a covenant by which those who render professional health care services claim to be bound to those they treat.

As a branch of debate and training in moral philosophy, ethics can be traced back to other thinkers of Classical Greece such as Plato and Aristotle, but more recent health care ethics have been developed in association with religious traditions. In the Christian tradition, providing conscientious care for the sick through medical, nursing and related services has long been mandated. Many westernized hospitals bear the names of Christian saints. In the Islamic tradition, a central component of the orthodox Islamic university founded in the year 972 (A.D.) in Cairo, associated with the Mosque of Al Azhar, remains its hospital and medical school. Similarly, the twelfth century Jewish rabbi, physician and philosopher Maimonides (Moses ben Maimon) advanced scholarship in medical ethics based on traditional Jewish law.

In both Hippocratic and religious medical traditions, ethical codes tend to prescribe solutions to dilemmas, rather than provide principles of which practitioners must take account in reaching their own decisions to resolve conflicting duties or loyalties. In practice, however, codes often must be regarded as stating principles that must be weighed against other considerations and each other. For instance, the historic oath included, and modern variants retain, a general prohibition on violation of patients’ confidentiality, but the principle omits reference to its limits, where information patients provide in confidence should or may be disclosed to others. Dilemmas arise, for instance, when patients’ infections may be spread to others such as fellow-patients who cannot protect themselves if uninformed of the risk to exposure. Preservation of confidentiality may violate the historic injunction to do no harm.

Modern medical developments have raised many new dilemmas in health care ethics. In the Islamic tradition, for instance, the rearing of children is an important duty and value, and so is preservation of the integrity of lines of genetic parentage, or family lineage. Women bearing children outside lawful marriage is not tolerated, and married women who bear children that are not their husbands’ are considered guilty of adultery. The new reproductive technologies facilitate third-party sperm, ovum and embryo donation to infertile couples, and to couples at high risk of conceiving genetically impaired children. Because sperm and embryo donations violate the certainty of family lineage, however, such donation is considered a form of adultery, and is therefore not permitted. At one end of the spectrum of human life are the new reproductive technologies, and at the other end are techniques that postpone death. Blending these technologies are such processes as recovery of sperm from the bodies of recently deceased men for artificial insemination of their widows, leading to birth of their posthumously-conceived children. Ethical opinions vary on the permissibility of these processes. The postponement of death of individuals capable of enjoying years of life following, for instance, resuscitation when their hearts stop beating, seems uncontroversial. Ethical concerns arise, however, at resuscitation of patients who have for some time been unconscious in a persistent vegetative state from which no resumption of consciousness is possible due to brain damage, and of elderly patients who have recently been resuscitated several times.

Organ recovery from bodies of recently deceased persons for transplantation also enhances recipients' lives, but the scarcity of the supply of transplantable human organs and the growing demand for them from patients at risk of premature death due to organ failure raises difficult ethical questions of the just allocation of this scarce, life-prolonging resource among competing groups of patients. The gap between the demand for organs and the supply raises further ethical concerns regarding alternatives to the recovery of organs from dead bodies, including donations of their organs by suitable related or unrelated living donors, development of artificial organs such as mechanical devices capable of simulating the functions of natural human organs, and development of genetically modified, or transgenic animals such as pigs, whose organs can be removed and transplanted into human recipients in the process described as xenotransplantation. The occurrence of so-called "Mad Cow Disease" shows the capacity of some animal pathogens to cross the physiological barrier between species to affect humans, so that xenotransplantation raises ethical concerns about the transgenic and other preparation of animals for recovery of their transplantable organs, the willingness of patients to receive them, and public health risks from implanting animal organs into human populations.

2. The Rise of Bioethics

The word "bioethics" is a combination of "bio," representing biological knowledge or the science of living systems, and "ethics," which refers to knowledge of human value systems. The word appeared in the 1960s, and is popularly attributed to Van Rensselaer Potter, an American medical researcher at the University of Wisconsin, who used it to describe the range of ethical issues associated with developments in human biology. The first institutional use of the word occurred in 1971, when what is now known simply as the Kennedy Institute of Ethics was founded at Georgetown University in Washington, D.C. as the Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics.

It has been seen that the value systems that assess developments in human medicine and biology, and their ethical implications, have ancient and historical roots, and fit within frameworks of religious traditions. However, bioethics arose out of historical religious morality as a reaction against religious conservatism, particularly concerning developments in human reproduction biology. It is significant that the Kennedy

Institute, founded at Georgetown University, a Roman Catholic institution, associated bioethics with human reproduction, since commentators have observed that fertility control more than any other single issue provided the major impetus that created bioethics. In the early1960s the Vatican convened a panel of Roman Catholic theologians, moral philosophers, scientists and others to consider Catholic teaching on artificial birth control, which the Church traditionally condemned. The panel stimulated rich interdisciplinary debates, involving ethical, religious, scientific, legal and social controversy on levels of social policy as well as personal ethics and ecclesiastical authority. The outcome was an enlightened recommendation for the liberalization of Church doctrine and teaching that took account of developments in scientific knowledge and concepts regarding human biology. However, in 1968 the Vatican rejected the recommended reforms, and reasserted the authority of prevailing Church teaching, in defense of the doctrine of Papal Infallibility.

Participants in and observers of this experience lost confidence that the conservative Catholic Church could offer ethical leadership and guidance in the light of evolving biological and other scientific understanding. Many turned from the increasingly futile Church debates on fertility control to focus the great intellectual energy and vision that their earlier debates had generated into the new area of bioethics. This field of debate is multidisciplinary, pluralistic, non-doctrinaire and inclusive of women's voices and experiences as enjoying the same authority and legitimacy as those of men. Freed from doctrinal orthodoxy and authority, participants in bioethics could address new developments on their merits, and disagree with each other in respectful debate without seeming to defy hierarchies or institutions that claimed a monopoly on truth. Roman Catholics joined with non-Catholics, and philosophers and theologians joined with non-philosophers and non-theologians, to advance the common pursuit of the new multidisciplinary, secular venture of bioethics.

Because of its origins emerging out of western religion and largely western intellectual disciplines and sensitivities, a question has been raised concerning whether bioethics are only western in character, and alien to non-western, non-westernized cultures and societies. A prevailing North American emphasis on personal autonomy rather than social duty has added to doubts concerning whether bioethics are universal. However, the underlying principles of bioethics, particularly respect for persons, including protection of vulnerable individuals, the duty to do good and avoid or limit harm, and justice, are common to many if not all cultures, and bioethics does not claim to prescribe universal solutions to problems. Its pluralistic character is more concerned with the integrity of processes of bioethical judgment than with compliance with particular outcomes and, unlike some religious institutions, it does not require obedience to authoritatively pronounced prescriptions. Through international associations, literature and debates, bioethics is expanding beyond its North American origins and is increasingly providing a *lingua franca* or common language of ethical discourse on developments in human biology and health. The 1996 Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine, sponsored by the Council of Europe and, for instance, the Universal Declaration on the Human Genome and Human Rights, sponsored by UNESCO in 1997, indicate the spread of bioethical analysis beyond its historical origins.

3. The Role of (Bio)Ethics

Religiously inspired caregivers to the sick provide services in accordance with their religious beliefs and sacred teachings, and those inspired by humanistic and other moral philosophies may invoke their philosophical convictions to explain the duties they undertake to deliver compassionate care to sick and suffering individuals. Both now often tend to describe themselves, and to be described by others, as bioethicists, but modern bioethics are essentially secular, pluralistic and multidisciplinary. Some leaders in bioethics come from religious or philosophical traditions, but many others are primarily physicians, nurses, biologists, social workers, lawyers and, for instance, historians or anthropologists. Bioethicists are interested in working with others outside their own disciplines to determine the values that should underlie the provision of medical care in particular and health care in general. They make assessments not simply on the basis of religious authority or philosophical claims, but through scientific knowledge and disciplinary interactions.

Ethics and particularly bioethics have been recognized to address two fundamental questions -- namely, what individuals and human communities should do, permit, tolerate or prohibit in biology, particularly affecting existing and future human beings, and how decisions should be made to determine what conduct is mandatory, permissible, tolerable or prohibited. Bioethics addresses basic issues in the human, institutional and social management of human birth, sickness and death, but has come to popular attention through technological developments. These have concerned techniques for biologically or medically assisted conception or assisted reproduction to overcome infertility, effective means to limit or remedy unplanned and undesired conception, mechanical means to assist or replace organ functions, tissue and organ acquisition for transplantation to prolong or enhance life, and, for instance, medical and health care management of people approaching and reaching the end of their lives.

Bioethicists determine information from a range of scientific, non-scientific and social fields of knowledge, following the maxim that good bioethics depend on good facts, and propose appropriate conduct in medical care and provision of health services. They often work in and through committees in hospitals and other health care facilities or medical research institutes, as members of or consultants to committees. Governmental and other public-sector agencies, and also private-sector bodies, are increasingly creating ethics committees that make or recommend decisions on issues of bioethical concern.

Ethics in general and modern bioethics in particular present language and concepts in which to express ideas about right conduct in medical care and health policy, and in which to dissent from others' views and preferences. Bioethics differs from several traditions of religious ethics, because the latter may be based on hierarchies of authority dissent from whose pronouncements is considered to be defiance and heresy. In contrast, bioethical opinions often differ, reflecting different approaches and prioritizations of values. In offering language of respectful difference and criticism, bioethics also offers language of explanation and justification. The different orientations, prioritized principles and levels of bioethical analysis outlined below, when taken together, often lead to no self-evident conclusions, but they equip commentators and decision-makers in medical care and health policy to anticipate how others may think, to explain and defend their own conclusions, and to disagree with those of others. Concepts of bioethics empower individuals and institutions to react to others' conduct and observations in a common language, and to invite and engage in comprehensible, civil discussion about ends and means in medicine and health care. Adversaries may recognize each other as following different ethical reasoning, rather than as being unethical because their views diverge.

4. Ethical Orientations

Several different ethical orientations guide ethical and bioethical conclusions. Historical orientations continue in effect today, reflecting the philosophical and religious origins of bioethics. These orientations have been the subject of profound scholarship and debate. Approaches to the ethics of health care continue to evolve, some as variants of earlier thinking and others more novel. Of modern significance are feminist approaches, which address the contribution of women's experiences to ethical perceptions and the impact of ethical reasoning on women's lives. Historical sources of ethical reasoning and pronouncements, namely institutions of academic philosophy, religious hierarchies, professional associations, legislatures and judges in law courts, did not include women, and some still deliberately exclude women from authoritative positions. Women's experiences and perceptions are significant in bioethics, however, not only because women are more immediately affected than men by means of fertility control and promotion, but also because in many societies women are the primary caregivers to the young, the elderly and the ailing.

5. Duty-Based (or Deontological) Ethics

This orientation invokes a concept of natural reason or natural law, and distinguishes vice from virtue as a matter of the inherent quality of an act or proposal. Natural law, propounded for instance by Aristotle, was incorporated into the doctrine of the Roman Catholic Church in the thirteenth century by St. Thomas Aquinas to harmonize reason and faith as divine gifts. An exponent of secular duty-based ethics was the late eighteenth century German philosopher, Immanuel Kant, who taught that humans are always to be treated as ends in themselves, never only as objects or means towards ends, and that any ethical principle must be capable of a universal, exceptionless application. Duty-based bioethics tends to be absolutist, unaccommodating of ethical relativity and pluralism. The Roman Catholic Church, for instance, once prohibited adherents to the Roman Catholic faith from reading Kant's writings, because they challenged the teaching authority of the Church and were considered heretical.

Duty-based ethicists believe that good cannot come from evil, and that wrongful means cannot be justified by results that are desirable in themselves. That is, they deny that the end can justify the means. For instance, Roman Catholic ethicists believe that artificial contraception such as by use of contraceptive drugs and condoms is wrong. They have therefore opposed condom distribution programs that are intended to contain sexually-transmitted HIV-infection. They also oppose abortion, which is often a result of unplanned pregnancy that would be prevented by use of artificial contraception, but do not accept that the desirable result of reducing the number of abortions can be ethically achieved by use of prohibited means of contraception. Similarly, Kantians may be troubled by a couple's decision to continue conception and births of daughters until they conceive a son who will marry and bring a wife to the family's home to care for the couple in their old age, for fear that the son, and later his wife, would be regarded only as a means to serve the couple's ends of securing shelter and care.

In the former case, preventable HIV infection and pregnancies that result in abortion might occur because condoms are unavailable, and in the latter, if the son were not conceived, the elderly widowed wife might face poverty and homelessness in old age, due to her daughters' lack of inheritance rights to family land and economic rights. However, duty-based ethicists feel no liability for contributing to human suffering, since they consider that a beneficial end does not justify unethical means, and that unethical means cannot produce an ethically virtuous or good result. In pursuing principles of virtue and inherent rights, they explain away harms associated with their practices as requiring remedies that do not compromise their principles.

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Bibliography

Beauchamp T.L. and Childress J.F. (4th ed., 1994). *Principles of Biomedical Ethics*, 546 pp. New York, Oxford: Oxford University Press. [This foundational text presents an introductory overview of bioethical thinking as it has evolved over three decades.]

Bennett R. and Erin C.A. (eds.) (1999). *HIV and AIDS: Testing, Screening and Confidentiality*, 285 pp. Oxford, New York: Oxford University Press. [Ethical analyses of central issues in mismanagement of HIV/AIDS patients from international perspectives.]

British Medical Association (1992). *Medicine Betrayed: The Participation of Doctors in Human Rights Abuses*, 234 pp. London: Zed Books. [An international review of ethical misconduct regarding torture, psychiatric abuse, threats and capital and corporal punishment.]

Brody B. (1988). *Life and Death Decision Making*, 250 pp. New York, Oxford: Oxford University Press. [Theory and case studies on ethical issues concerning end-of-life management of competent and incompetent adults and of children.]

Buchanan A.E. and Brock D.W. (1989). *Deciding For Others: The Ethics of Surrogate Decision Making*, 422 pp. Cambridge, New York, Melbourne, Sydney: Cambridge University Press. [A comprehensive analysis of ethical decision-making affecting people incompetent to decide for themselves.]

Bulger R.E., Heitman E. and Reiser S.J. (eds.) (1993). *Ethical Dimensions of the Biological Sciences*, 294 pp. Cambridge: Cambridge University Press. [A variety of essays and reflective studies by multidisciplinary biological investigators, and significant policy statements.]

Cohen-Almagor R. (ed.) (2000). *Medical Ethics at the Dawn of the 21st Century*, 265 pp. New York:

Annals of the New York Academy of Sciences, Vol. 913. [A review of ethical issues in health care resource allocation, the beginning and end of life and developments in biotechnology.]

Ethics, Science and Information Division, British Medical Association. (1993). *Medical Ethics Today: Its Practice and Philosophy*, 374 pp. London: BMJ Publishing Group. [Answers to a wide range of ethical questions that arise in medical practice by the BMA Medical Ethics Committee.]

European Network of Social Co-operation on Medicine and Human Rights. (1998). *The Human Rights, Ethical and Moral Dimensions of Health Care*, 481 pp. Strasbourg; Council of Europe Publishing. [One hundred and twenty cases in health care examined according to law, international and European ethical perspectives and a range of religious and agnostic convictions.]

Gillon R. (ed.) (1994). *Principles of Health Care Ethics*, 1118 pp. Chichester, New York, Brisbane, Toronto, Singapore: John Wiley & Sons. [The 90 chapters present different disciplinary religious and cultural approaches to many complex ethical issues in modern medicine and health care, providing an analytical framework for ethical reflection.]

Harris J. and Holm S. (eds.) (1998). *The Future of Human Reproduction: Ethics, Choice and Regulation*, 254 pp. Oxford: Clarendon Press. [International contributions to ethical and related thinking on recent advances in reproductive technology.]

Jayasuriya D.C. (ed.) (1995). *HIV Law, Ethics and Human Rights*, 420 pp. New Delhi: United Nations Development Programme. [Essays by leading commentators on ethical and related dimensions of the HIV pandemic.]

Keown, J. (ed.) (1995). *Euthanasia Examined: Ethical Clinical and Legal Perspectives*, 340 pp. Cambridge: Cambridge University Press. [A vigorous debate between advocates of opposing views on the ethics of euthanasia.]

Levine R.J. (2nd ed. 1986). *Ethics and Regulation of Clinical Research*, 452 pp. Baltimore, Munich: Urban & Schwarzenberg. [A comprehensive survey of the ethical duties of clinical investigators, based on requirements of U.S. federal regulations.]

Mason J.K. and Laurie G (ed.) (7th ed. 2006), Law and Medical Ethics 820 pp. Oxford: Oxford University Press [A wide-ranging review of legal and ethical issues arising from medicine and healthcare practice reflecting perceptions in English-speaking countries.]

Purdy L.M. (1996). *Reproducing Persons: Issues in Feminist Bioethics*, 257 pp. Ithaca, London: Cornell University Press. [Feminist approaches to bioethical controversies regarding control and promotion of human reproduction.]

Robertson J.A. (1994). *Children of Choice: Freedom and the New Reproductive Technologies*, 281 pp. Princeton: Princeton University Press. [An analysis of implications of resort to new reproductive technologies, and ethical arguments for their responsible use.]

Sherwin S. (1992). *No Longer Patient: Feminist Ethics and Health Care*, 286 pp. New York, Oxford: Oxford University Press. [An overview of feminist approaches to health care ethics.]

Steinbock B. (1992). *Life Before Birth: The Moral and Legal Status of Embryos and Fetuses*, 256 pp. New York, Oxford: Oxford University Press. [An evaluation of ethical claims to rights regarding pregnancy and unborn human life.]

Wolf S.M. (ed.) (1996). *Feminism and Bioethics: Beyond Reproduction*, 398 pp. New York, Oxford: Oxford University Press. [Leading feminist commentators address a wide spectrum of perspectives on bioethical concerns.]

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