Review Article

Ethics in acute medicine

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Abstract
Clinical ethics is a core part of the decision-making process. Whilst often reduced to the four principles approach, the situation is more complex. Teaching of ethics frequently focuses on quandary issues, such as assisted-suicide, but there is an ethical component to every clinical encounter. Where differences of opinion arise it is important to understand one's own perspective and that of others. Compassion is an important starting point.

Keywords
clinical ethics, clinical decision-making, compassion

Ethics – a core component of clinical decision-making

In a previous article I have discussed they process of clinical reasoning as applied to acute medicine.[1] I had situated the discussion in the context of the clinical encounter as described by Pellegrino and Thomasma.[2] In this encounter three questions are asked: First - what is the problem? The topic of diagnostic reasoning was the focus of the previous paper. Second – what *can* be done? That is, what are possible therapeutic options? And lastly – what *should* be done? What is the best solution for this patient? In this paper we will consider this question, focusing not on the biomedical but on the ethical aspects.

Ethics –Not just 4 principles

I find it somewhat surprising that much that is published about medical ethics comes from outside the profession. I think that in order to understand the challenges clinicians face it is helpful to have "skin in the game". Taleb argues that appreciation and understanding of the risk involved in any endeavour can only be by those sharing in the risk.[3] In the case of medicine, this means there is a need for involvement of doctors and patients when ethical issues are under discussion. This is a crucial part of the part profession of medicine. That said, I also find it surprising that many clinicians are satisfied with a superficial understanding of the issues. We like to think we know about ethics; we like to think we know how to *do* ethics. In the English-speaking world the whole subject is frequently reduced to the four principles of Beauchamp and Childress.[4] These are:

Respect for autonomy,
beneficence,
non-maleficence, and
justice.

And of these principles, autonomy had come to be viewed as paramount. Then came COVID. The autonomous decision of those who chose not to be vaccinated was viewed with suspicion and even hate. Justice, as demonstrated in the fair allocation of occasion of resource, such as priority for critical care beds, came to be an important factor in public debate. Beneficence and nonmaleficence seemed hard to define, with ill patients being denied visitors in their time of distress and even in their last days and hours. Clearly there is more to ethics than this.

It may come as a surprise to learn that the four principles were developed in response to a specific need and in fact arose out of the scientific committees which had been established to look at the ethics of genetic engineering.[5] Earlier, broader debates had included the views of philosophers and theologians and considered the proper ends (goals) as well as the means required to achieve them. Later debates focused simply on the correct application of means to achieve the agreed ends and the four principles provided a simple framework for such debates. Since that time, the four principles have become synonymous with clinical ethics in a broader setting and, although they provide useful pegs upon which to hang discussion, they do not present a deeper understanding of the moral landscape.

So then, how are we to approach the subject? From an academic perspective ethics, along with aesthetics, is a branch of philosophy that considers value judgments. Whereas aesthetics considers what is beautiful, ethics considers what is good. As in aesthetics, so in ethics, easy judgments are easy: one can look at a mountain landscape and rubbish dump and quickly decide which is beautiful and which is ugly. Whereas our response to other images may reveal a difference in taste, for example the art of Picasso versus that of Rembrandt. Such differences may be accounted for by our experience and upbringing. In the ethical realm there are some

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Box 1. Self-evident moral principles (after W.D. Ross)

Self-evident ethical principles
Respect for persons (including oneself)
Fidelity & Honesty
Justice
Reparation
Beneficence
Non-maleficence
Compassion

things that all would agree are wrong: cruelty, dishonesty, malice. And other things we view as laudable: kindness: honesty generosity. Again, there are grey areas that require further thought. When considering the subject of medical ethics, it is usual to discuss difficult situations where dilemmas most commonly arise, for example, neonatal care, end of life issues, evolving technologies such as genetic engineering and transplantation. However, I feel it would be a mistake to launch into such quandary ethics without first considering more quotidian or everyday ethics for, as noted, every clinical encounter has an ethical component. (Indeed, every interpersonal encounter can be viewed as having an ethical component.) How then should we behave?

What do you mean by good?

We could begin by considering what we mean by the word good. For G.E. Moore, "good is a simple notion, just as "yellow" is a simple notion; that, just as you cannot, by any manner of means, explain to anyone who does not already know it, what yellow is, so you cannot explain what good is."[6] Whilst this may explain good as a value, it is not sufficient to consider its application as applied to medical practise. W.D. Ross described a number of what he termed "self-evident ethical principles". These were: respect for persons (including oneself); fidelity and honesty; justice; reparation; beneficence; and non-maleficence.[7] To these I would add another: compassion. (Box 1) Focusing on developing these in our daily lives and professional practice would be a good discipline. I am sure that we could all think back over the past week and recall instances when we have failed to demonstrate these in our interactions with patients and colleagues – not to say family and friends! What about when we consider our actions to be "for the good of the patient"? Pellegrino and Thomasma identify four components of the patient's good:

- The patient's concept of ultimate good – that which constitutes the patient's ultimate standard for their life choices, and which holds the highest meaning for them.
- The biomedical good – that which can be achieved by medical interventions into a particular disease state.

Box 2. Levels of moral discourse (after Aiken)

Particular Judgements
1. No reasons are given for the moral judgement.
2. The moral judgement applies to one particular case
Rules
1. The rule applies not just to one immediate case but to all similar cases
2. The rule tells us directly what to do or not to do
Principles
1. A principle supports rules – or criticises them
2. A principle is more general than a rule; it does not tell us directly and concretely what to do.
Basic Convictions
1. A basic conviction is the basis for our principles, rules and overall ethical reasoning
2. You can't go deeper than basic convictions

- The patient's concept of their own good at the particular time and circumstances of the clinical decision.
- The good of the patient as a human person capable of reasoned choices.[8]

Levels of moral discourse

In addition to the patient's views, we also bring our own perceptions and those of our culture and society to the question of the good. Aiken describes ethical responses as occurring on four levels (Box 2): first the expressive-evocative level. Here, no reasons are given for the moral judgement and the judgement applies only to the particular case at hand. (This is analogous to the type 1 processes described in the previous paper.) The second level is that of rules. Rules apply not just to one case but to all similar cases. Rules tell us directly what to do or not to do. Examples at this level would include the law and professional codes of conduct. At the next level, underpinning the rules are principles. Principles support the rules or criticise them. A principle is more general than a rule and does not tell us directly and concretely what to do. Finally, at what Aiken described as the post-ethical level, and underpinning all of the above, are the individual's basic convictions, their core personal beliefs and worldview.[9] From this it can be seen that to truly understand one's own ethical perspective, and the views of others, time must be taken to explore the underlying principles and basic core beliefs involved. Let us unpick this a bit further using the example of euthanasia / physician-assisted suicide. This is a topical issue – at the time of writing a consultation on euthanasia is underway in Jersey and assisted-suicide is to be considered by the Scottish Parliament. It is also a topic upon which people have strongly held and opposing views. Hence the evocative-emotive

response is going to be a polarised one of support or horror. However, without further debate, this is as useful as "Boo!" or "Harrah!" We can turn to the next level, that of the rules. Aiken notes that most ethical deliberation does not go beyond this level, but on this occasion the rules will not help us, as it is the validity of the rules (as in the law) that is being questioned. We must therefore go on to the next level and consider the principles upon which rules are based. Here we get into more complex matters. Whilst principles include autonomy, beneficence, and justice, others must also be considered, such as, dignity, sanctity of life, and truthfulness. In considering these it must be noted that the weight and priority which an individual gives to any one principle will depend on something else, their core convictions and worldview. This fourth and final level is the most basic. In contemporary terms, it could be viewed as those things which form an individual's identity. Someone whose core identity is that of a freely autonomous being, for whom the highest priority is the right to choose, will have a different perspective to that of someone whose core identity is as a follower of a particular faith or membership of a particular community. It may be seen that the individual's evocative-emotive response is often reflection of their core convictions and beliefs. Is discussion therefore pointless? No; sometimes opinions may change, sometimes not. Whilst it is unlikely that there will be a shift in an individual's core beliefs, there may be some appreciation of the facts of a particular case and how principles should be balanced. And at least those with opposing views will be able to better understand each other. There is a need to do ethics ethically![10,11]

Moral distress, injury, and organisational ethics

In considering our day-to-day behaviours we need to remember that we do not practise in isolation. We are part of a team, a community of practice, an organisational culture. Teams, organisations, and cultures can exert enormous influence on those within them. The team spirit or organisational ethos can set the pattern for our behaviour – sometimes for good, sometime for ill, sometimes intentionally, and sometimes without thought to the outworking of its plans.[12]

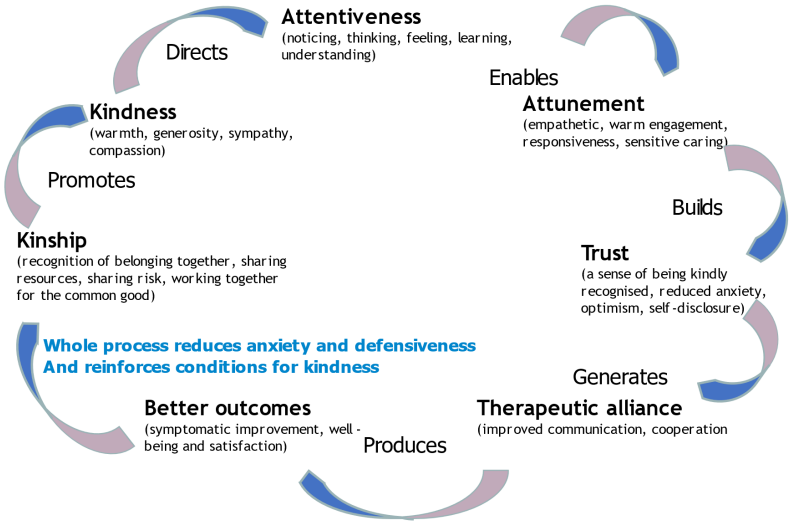
It is often easiest to go with the flow but if an individual finds that the system drives them to act against their conscience then they can face *moral dilemmas,* leading to *moral distress* This arises when a person is clear about the ethical course of action but institutional constraints make it difficult to implement.[13] In extreme cases *moral injury* may occur.[14] It is pertinent to think about the moral and psychological impact of clinicians attempting to make ethical decisions, to do the *right thing* for patients at such a time of unprecedented pressure in healthcare. Those in positions of leadership must bring an ethical awareness to this part of their work. When considering the concept of moral distress it is perhaps a good time to ask about the individual's conscience. This moral gut feeling is important because, as with an individual's evocative-emotive response, it links to their core values. It is an interesting observation that more analytical approaches seem to favour utilitarian outcomes when compared with personalising the decision.[15] As with diagnostic reasoning, the Type 1 response is often the right one.

Teaching ethics

So then, what about ethics in education? There will always be a need for ethical and professional development. It is part of the role of the teacher to encourage students to ask the right questions and in doing so help them to seek the truth. Education, particularly medical education, must be less about imparting information and more about character formation. This occurs not just in the taught class but in our everyday practice, be it in the surgery, the clinic, or on the wards. Teaching has been described as a subversive activity with the culture of the classroom contributing as much if not more than the curricular content.[16] The day-to-day lives of our teams and units provide many opportunities for all of us to participate in the professional and moral formation of our students and trainees. James K.A. Smith describes such day-to-day routines as cultural liturgies[17] and, just as religious liturgy shapes the life of the believer, even such secular liturgies impact the mind and behaviour of these who practise them. In the words of the late Roger Scruton, "culture counts".[18]

Intelligent kindness

In a book written in the wake of the uncovered failings of the Mid-Staffordshire NHS Foundation Trust, Ballat and Campling suggest the need for a culture of "intelligent kindness" in healthcare.[19] In their book of the same name, they explore the meaning of kindness – moving past any vague, fuzzy notion of "kindliness", to consider its derivation from the Middle English word *kinde* meaning family, from which we also get kin. Real kindness then is based on a sense of connectedness leading to sympathy and compassion. Kindness is described as "kinship felt". They suggest a "virtuous circle" whereby kindness can be developed. Kindness directs attentiveness, which enable attunement, which builds trust, which generates a therapeutic alliance, which produces



Kindness - a virtuous circle (after Ballat, *Intelligent Kindness*)

Figure 1.

better outcome, enabling a sense of kinship, which in turn promotes kindness. (Figure 1)

Concluding Unscientific Postscript

Søren Kierkegaard (1813 1855) was a Danish philosopher, poet, social critic, and theologian, He is widely considered to be the first existentialist philosopher. In addition to his many philosophical works he also wrote about spiritual matters. In his book *Works of Love*[20] he looks closely at Biblical command to "Love your neighbour as yourself" as illustrated by Jesus' parable of the Good Samaritan. Some of you will know the story, but for many the term "good Samaritan" means nothing more than a charitable or helpful person. However, the story is more nuanced than this. It can be found in chapter 10 of the Gospel of Luke. The setting is a conversation between Jesus and one of his hearers.

On one occasion an expert in the law stood up to test Jesus. 'Teacher,' he asked, 'what must I do to inherit eternal life?'

'What is written in the Law?' he replied. 'How do you read it?'

He answered, "'Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind" and, "Love your neighbour as yourself.'"

'You have answered correctly,' Jesus replied. 'Do this and you will live.'

But he wanted to justify himself, so he asked Jesus, 'And who is my neighbour?'[21]

This question, "who is my neighbour?", is of relevance for us today. Jesus answers his questioner with a story. It is worth reading this in full. In the story Jesus tells, the man who helps is not the one who his listeners would have expected to do so. The relationship between the first century Jews and their Samaritan neighbours was as fraught as that between residents of Israel and the West Bank today. They would have not immediately recognised each other as kin. The challenge as presented is to reach out and show compassion to all – including those with whom we do not identify. We need to examine our prejudices, recognise the points of tension and, whilst we may not agree with individuals, treat them with kindness. This may include patients, colleagues, and management. I would here refer back to W.D. Ross's self-evident principles. It is also worth reflecting on the matter of worldview and basic convictions, as the first part of the answer by Jesus' questioner provides the context for the subsequent command to love one's neighbour.

So then, ethics is about doing the right thing. We can attempt to analyse situations but ultimately, we are seeking the patient's good. Good is frequently self-evident but sometimes seeking the good takes time, effort, and motivation. I conclude with a quotation from a lecture entitled "The secret of medical practice" given to students at Harvard by a former Professor of Medicine, Francis Peabody. Again, the address is worth reading in full.

"One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."[22]

Declaration of Interest

The author is a Lay Reader in the Church of Ireland.

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