Medical Ethics

Avraham Steinberg, MD

A. Definition of the Term

Ethics is the branch of philosophy which deals with moral aspects of human behavior.

Some differentiate between ethics and morals. Ethics[1] deals with the theories and principles of values and the basic perceptions and justifications of values, whereas morals[2] includes the customs, and normative behavior of people or societies. Nevertheless, these terms are often used interchangeably, their meanings now overlap and they are becoming virtually synonymous.

Medical ethics in the narrow historical sense refers to a group of guidelines, such as the Oath of Hippocrates, generally written by physicians, about the physician's ideal relationship to his peers and to his patients. Medical ethics in the modern sense refers to the application of general and fundamental ethical principles to clinical practice situations, including medical research. Individuals from various disciplines may author these principles. In recent years, the term has been modified to biomedical ethics which includes ethical principles relating to all branches of knowledge about life and health. Thus, fields not directly related to the practice of medicine are included, such as nursing, pharmacy, genetics, social work, psychology, physiotherapy, occupational therapy, speech therapy, and the like. In addition, bioethics addresses issues of medical administration, medical economics, industrial medicine, epidemiology, legal medicine, treatment of animals, as well as environmental issues.

This section discusses general ethical principles, developments of basic principles of medical ethics, and ethics teaching in medical schools. The practical applications of these principles in specific medical situations are found in different sections of the medical halachic encyclopedia.[3]

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1. The Greek word *ethike* means habit, action, character.
2. The Latin word *mos* means habit or custom.
3. This is taken from the *Medical Halachic Encyclopedia* by Prof. A. Steinberg. This section discusses secular ethical-philosophical issues. Medical ethical principles are found in many religions, some of which are discussed in BA Brody *et al.* (eds): *Bioethics Yearbook*, Vol. I. Theological developments in Bioethics, 1988-1990,

B. Historical Background

Since the beginning of human history, concern for medical ethics has been expressed in the form of laws, decrees, assumptions and "oaths" prepared for or by physicians. Among the oldest of these are the Code of Hammurabi in Babylonia (approximately 1750 BCE), Egyptian papyri, Indian and Chinese writings, and early Greek writers, most notably Hippocrates (lived between 460 and 377 BCE).

Early medical ethical codes were written by individuals or by small groups of people, usually physicians. The Oath of Hippocrates is considered historically to be the first such code written in an organized and logical way which describes the proper relationships between physician and patient. During the Middle Ages, other medical codes were written. In recent times, Thomas Precival's writings, disseminated in 1803, represent one of the first ethical codes in the United States and the Western world.[4]

Beginning in the second half of the nineteenth century medical organizations began writing codes of medical ethics. The first ethics code of the American Medical Association (AMA) was published in 1847.[5] This was the first ethical code of a professional organization which outlined the rights of patients and caregivers. Over the years many revisions and additions to this original code have been made. The latest edition of the AMA Code of Medical Ethics (1997) contains four parts, which include general principles, opinions on specific issues and special reports. The AMA established the Council on Ethical and Judicial Affairs to advise it on legal and ethical issues and to prepare position papers on these issues for the AMA. The British Medical Association published its first code of Medical Conduct of Physicians in 1858. The code has subsequently undergone numerous changes.[6] The World Health Organization (WHO) issued the Declaration of Geneva in 1948. This is the first worldwide medical ethical code and is modeled after the Oath of

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Kluwer Acad Pub, 1991; B.A. Lustig *et al.* (eds): *Bioethics Yearbook*, Vol. 2, 1990-1992, Kluwer Acad Pub, 1993; E.D. Pellegrino *et al.* (eds): *Transcultural Dimensions in Medical Ethics*, 1992. Specifically for Islam, see AA Nanji, *J Med Philos* 13:257, 1988 and *J Med Ethics* 15: 203, 1989. For Buddhism, see P. Ratanakul, *J Med Philos* 13:301, 1988. For Confucianism, see R. Z. Qiu, *J Med. Philos* 13:277, 1988.

4. See C. B. Chapman, *N Engl J Med* 301:630, 1979.
5. See R. Baker, *JAMA* 278:163, 1997.
6. From time to time, the British Medical Association's view is summarized. See British Medical Association: *Handbook of Medical Ethics,* BMA, London, 1981

Hippocrates. Many other medical organizations throughout the world, including those in Israel, have issued medical ethical codes.

Modern medical ethics as a separate field began to develop in the 1950's. One of the major innovations of modern Western medical ethics involves the physician-patient relationship with the dramatic change from paternalism to autonomy and its resultant requirement for informing the patient, obtaining informed consent, and relating to the patient as an active partner in decision-making.[7]

C. General Ethical Principles and Theories

The study of ethical theories provides a logical framework for the understanding of the ethical dimensions of human conduct, helps one to recognize ethical dilemmas and provides tools for their resolution. Ethics examines and measures human conduct. Accepted practices of human conduct in a given country are termed normative behavior. Ethical standards are used to evaluate and ensure the appropriateness and desirability of such practices.

A value usually denotes the good, the beneficial in ethics, the truth in cognition, and the holy in religion. A value is not determined objectively. It is not a scientific term and cannot be scientifically defined. Therefore, science is neutral with respect to most bioethical values. A value represents a subjective assessment and may be measured by what a person is willing to sacrifice for it and not by what it gives to him.

Ethical dilemmas are created only in relation to human beings, within the framework of relations between one human being and another. They arise when two or more alternative actions, each of which is inherently good, yield conflicting outcomes. Or an action that benefits one person may cause harm to another. In such situations, one must find the ethical justification for each course of action and have a system of prioritization to select the most appropriate one. Ethics asks what should be done, not what one ordinarily does and not what one could do.

The two central questions in ethical theories are:

- What is the good for which we strive or should strive, and what is the evil that we would like to or must avoid?

7. Concerning the historical development of medical ethical views in different countries, see *Encyclopedia of Bioethics*, s. v. Medical ethics, History.

- What is the proper or desired course of action, and what is the inappropriate or forbidden course of action?

Some people believe the two questions are interrelated and debate which comes first and which is the corollary. Others totally separate the two questions.

Sometimes the dilemma is factual and not one of values. In such cases, debates and discussions may result from imprecise knowledge about the facts related to the dilemma either due to lack of actual information or lack of clarity or understanding of positions and views about the issues. Often mere clarification of the facts may resolve the ethical question. Good ethics starts with the correct facts. A decision is inherently unethical if it is based on erroneous or incomplete data. Therefore, the first step in adjucating a concrete medical ethical issue is to gather the pertinent facts. Proper clarification of the facts often avoids futile ethical debates. Sometimes debates result from differences in the fundamental positions of the people involved. Even in such cases, a clear and precise presentation of the various positions may achieve mutual respect, precision of ethical focus, and sometimes even resolution of the ethical dilemma, even if a consensus is not reached.

Ethical dilemmas would not exist if ethical principles were like parallel lines which never intersect. However, in reality values do not function in that way. Rather they go in different directions and involve situations where values conflict with each other. Then, one must choose between good and bad values or between values of greater or lesser utility. Sometimes, resolution of an ethical problem is easy with a single, unanimous agreed upon course of action. At other times, the resolution is a compromise between opposing interests, with no one totally satisfied.

Theoretically, ethics should decide between good and bad, between proper and improper, between correct and incorrect. But the proverb says: A wise person is not the one who knows how to choose good from bad, but he who chooses the lesser of two evils.

Ethical acts can be evaluated on four planes:

- the desire, intent or motivation
- the ethical principle, theory or value
- the method
- the consequences.

Various ethical teachings emphasize one or more of these planes, and some utilize all four. At times one needs to consider specific circumstances, which may be temporary or changing, or one needs to find a middle path between opposing and contradictory values.

Ethics differs from precise science in several ways:

- One cannot readily subject ethical questions to controlled experimentation and study and one cannot separate purely ethical considerations from personal-subjective influences which are affected also by cultural and historical backgrounds. Since ethical decisions are influenced by historical, philosophical, socio-cultural and religious attitudes, each with strong subjective components, there are few universal objective truths. The most widely used terms in ethics are "good or bad," "proper or improper," and "correct or incorrect." In contrast, in the physical and natural sciences, we arrive at specific conclusions based on objective observations or experiments with minimal human biases. Therefore, the terms used in science are "true and false."
- Science arrives at conclusions whereas the ethics provides decisions or recommendations. A conclusion is the obligatory acceptance of the facts whereas a decision or recommendation is a voluntary choice among various options.[8] Furthermore, a scientific conclusion is based on the past, i.e. previous studies which lead to present conclusions. Ethics, on the other hand, is future oriented, that is to say a present choice is based on a future desire, intent or consequence. Thus the word "cause" is a scientific term which explains a current situation based on earlier data whereas the words "reason" and "argument" are value terms which attempt to justify current action based on desires or motives.[8]
- If an error is discovered in scientific knowledge, the scientist can correct it by explaining the facts differently without requiring him to change his personal conduct. By contrast, if an error is discovered in a value judgement or ethical conduct, "repentance" is required with a change in

8. See Y. Leibowitz: *Sichot Al Madda VeArachim*, 1987.

> the person's behavior.[8] In science only success of the effort is considered significant whereas in ethics the effort itself in trying to resolve the dilemma is considered worthwhile. Many scholars in ethics and religion believe that the attainment of perfection should not be the ultimate goal. Rather, the goal should be the effort to gain perfection since its actual attainment is all but an impossibility for a human being. This is also true from a religious point of view – it is erroneous to believe that a person is obligated to recognize the truth; rather, one must seek the truth since absolute truth is only with God.

Ethics also differs from laws and religion in that the latter two provide definitive and absolute rulings. By contrast, ethics in general does not decide absolutely, but rather focuses and clarifies questions and issues and presents options and alternatives for dilemma resolution.

There have always existed various ethical schools of thought with significant differences between them. They differ in the principal justifications and validity of the various ethical theories as well as in the terminologies, the specific principles and rules, the relative relationship between them and in their practical application.

One of the basic ethical questions is the source and validity of values. Ancient Greek philosophers debated this issue. Plato and the Stoics argued that the validity of moral cognition is absolute and objective and that universal ethical laws and principles apply to all people in all places and at all times. By contrast, the sophist and skeptic philosophers argued that one cannot prove or justify a universal ethical law or value, and they believed that ethical principles are relative, and dependent on the place, the time, and the circumstances. An intermediate view was that of Pythagoras and his followers who said that certain values and norms exist for certain populations but may vary in different cultures and be influenced by external circumstances.[9]

These basic differences of opinion remain even in modern times. Some philosophers view most or even all values merely as subjective recommendations which differ from society to society and from era to era and, according to the circumstances, even from

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9. See N. Spiegel: *Toldot Haetika Haatika*, Jerusalem, Magnes, 1985, pp 12-30.

person to person. This view is based on the observation that various actions are perceived differently by various societies. According to this view, ethical values are not innate but must be acquired and hence are influenced by forces which determine various types of behavior. Some philosophers define the source of ethics to be one's emotions, that is to say an action is ethical if it makes one feel content and good, and bad if it evokes a feeling of disgust and revulsion. Or an action is ethical if it produces joy, and bad if it leads to sadness (this view is espoused by David Hume, Spinoza and Stermack). According to these views, emotions and social habits are the sources for the validity of ethics.

By contrast, some philosophers recognize absolute and universal values which change neither according to external needs and circumstances, nor from society to society, or from era to era. The source of these values is either factual-empiric, intuitive, or metaphysical-religious. This view is based on the thesis that certain values and conduct are universally accepted as ethical or unethical in all societies and in all eras. This view also asserts that relativism is unfounded, unjust and empties ethics of any real content since it changes with differing temporal circumstances and conditions (the main proponent of this view is Immanuel Kant).

Two basic *theories* exist today in the fundamental approach to normative ethics:

The utilitarian (or consequential or teleologic) theory which measures the value of an action by its consequences. An appropriate or good action is one which brings the most beneficial results for the most people. This view in its classic sense opines that the goal of ethics is to bring the most good to the most people so that ethical principles are used as vehicles to attain the highest or ultimate good. Ethics thus has a specific goal and each action is to achieve that goal.

There is obviously great variability in deciding what is the ultimate good towards which attainment one is to strive. Some view a specific individual goal as the ultimate good (=a monistic view, the main proponents of this view are Epicurus, Spinoza and Nietzsche), be it happiness (the main proponents of this view are Aristotle, Socrates and the Greek Stoics, and in modern times Stuart Mill), self-fulfillment (proposed by Hegel and Bradley) or pleasure (=hedonism). Thus, the individual's own opinion is decisive and any action which gives that person benefit is by

definition ethical and good. Others believe that the good should be a general one for society and not just for the individual. Thus, an action is ethical if it brings great pleasure to the largest possible number of people (the main proponents of this view are Hume and Bentham). Some view the attainment of physical pleasure to be the ultimate good whereas others consider mental pleasure and benefit to be the crowning ethical consideration.

By contrast, some philosophers argue that there is no single purpose which is the sole good; rather several goals should be sought (=a pluralistic view, espoused by Mohr). Examples of good goals are love, health, happiness, friendship, and beauty, each one of which is an ultimate good in itself. Therefore, ethical acts need to be assessed on the basis of the greatest progress that they produce towards the conglomerate of these values and not just for pleasure and avoidance of suffering.

A third utilitarian view is that the best goal is to promote individual preferences towards the fulfillment of personal desires and ambitions, that is to say the main goal is the realization of what the individual or the group view as good for them, within specific conditions and time frameworks.

Utilitarianism has been strongly criticized for many reasons:

- It is based on the ability to measure the good consequences and compare between various goods. How can one, however, measure individual ethical 'units' of goods such as pleasure, happiness, love, etc.?
- In many concrete situations, it is very difficult to weigh the expected benefit if varying and conflicting actions are taking place.
- It is impossible to prove with certainty that a single value is the ultimate good for which one should strive. The choice of pleasure as the ultimate good is open to debate just as is the choice of any other simple value.
- Utilitarianism lacks ethical consistency in decision-making because it changes with different expected outcomes.
- It can easily lead to unjust social actions in that actions that benefit the majority of people may create serious harm to the remaining minority.
- In a utilitarian system, who decides what should be the best outcome and how does one decide? The sub-group which views individual preferences as the ultimate good resolves

this question but produces a much more difficult issue in that often other peoples' desires and preferences are ignored. Thus, utilitarianism can undermine the whole ethical foundation of universal applicability.

- The main theoretical objection to utilitarianism is its premise that ethical acts themselves have no intrinsic value because their ethical validity is based on their outcomes or consequences. Thus the goal justifies the means. Hence, some acts can be ethically wrong but are justified because their outcome produces the desired benefit as defined above.

Deontological[10] theories of ethics state that an act is considered ethically proper and good if it fulfills the basic requirements of ethical principles and values of intrinsic validity, without regard to the expected or anticipated consequences. The main proponent of the deontological theory of ethics in its extreme form is Immanuel Kant (1724-1804).[11] According to his theory there exist ethical values that dictate actions categorically without compromise. The source of ethics is logical, universal, and unchanging – irrespective of time or place. The ultimate good is for decisions to be made based on one's intent to act ethically, and not on the result or outcome of that act. Only good intentions are good, without reservation. Kant's thesis is that one must act ethically because of the autonomy of one's will and not because of pressure, inclination or external forces of any kind (=heteronomy). The philosophic basis of this theory of ethics is that the ethical value of an act flows from an obligation, and the latter is the fulfillment of ones autonomous will established by the laws of understanding and wisdom. According to Kant, ethical behavior is required of all people of understanding. It is not learned by experience but is established *a priori* by that understanding. Therefore, ethical law is objective and absolute and nothing can restrict it or attach conditions to it. One of Kant's fundamental rules is the "general formula" whereby a person must always act in a way that everyone else should act similarly.

The deontological theory of ethics has also been strongly criticized:

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10. *Deos* in Greek means obligation.
11. I. Kant: *Groundwork of the Metaphysic Morals* (HJ Paton, Transl.), New York, 1964.

- Pragmatically, it is difficult to determine who decides on absolute values and how they are implemented.
- The extreme view of this theory that completely ignores the goals and consequences of actions, cannot be applied practically, because the absolutism often leads to impossible situations in daily living and may produce great harm.
- The deontological theory provides no mechanism to decide between two or more universal-absolute values when they are in conflict with each other. Situations frequently arise requiring a choice between two "absolute" values. There is no way, in Kant's approach, to apply his general principles to such specific situations.

A number of neo-Kantian theories developed trying to resolve the above difficulties.

Some writers combine deontology with utilitarianism[12] and require one to pay attention to absolute and universal values which every decent human being should follow (= *prima facie* obligation). If, however, they conflict with equal or even stronger ethical imperatives in certain situations, the latter may have to be adopted and the universal values set aside.

Another attempt at resolving the difficulties with the Kantian approach is to emphasize the principles of honesty, equality, and social justice. In this view, ethical principles are those which all people would agree should they be evaluated freely and independently of the actual social situation, were they to examine them from an "original" position.[13] In their view, social justice is the highest ethical value and different characteristics of individual people are ignored.

Because every well-defined ethical theory has its problems, either in relation to its characteristics or in relation to its practical application, some writers speak of relativistic or situational ethics which are determined by the situation, the time, the place, the culture, etc. Thus, according to this approach there are no universal principles applicable at all times, in all places and for all situations. Rather, each situation is decided according to the appropriate culture, time, place, and circumstances. This view can undermine

12. See W.D. Ross: *The Foundations of Ethics*, Oxford, 1939.
13. See J. Rawls: *A Theory of Justice*, Cambridge, 1971.

the basis of ethics and morality and leads to ethical anarchy. It is not helpful in resolving ethical questions in a consistent manner.

In recent years, several fundamental ethical *principles* have been formulated and widely adopted as the basis for ethical discussion in medicine:[14]

Autonomy is defined as a fundamental principle based on the worldview that every person has intrinsic value. One may not restrict nor negate the free wishes of an individual with respect to his own body. One must facilitate any desired action acceptable to a person's own judgement and in accordance with his own choice. The granting of autonomy requires that we recognize and accept the free choice of each person even if that choice seems inappropriate or foolish or even life-endangering.

A precondition for autonomy is complete freedom of the individual from outside control or pressure. Any action that derives from external control which interferes with one's expression of autonomy is termed heteronomy. By definition proper, full autonomy cannot be exercised by the very young, the mentally retarded or the psychotic. Also autonomy is not to be respected if such a choice is likely to harm others.

Many ethicists view autonomy as the most important ethical principle which supercedes all others.[15] In recent years, the tendency is to decide more and more medical ethical and legal dilemmas according to this principle. Other ethicists view autonomy as only one of several important ethical principles.[16] This view is based on the recognition that one should not totally abandon other ethical principles regarding the physician's obligations toward his patients.[17] Some writers even consider it "tyrannical" to view autonomy as the most important value with dominance over all others,[18] and that such a practice might lead to public ethical anarchy.[19] One should also recognize that the Western world's espousal of autonomy is not universally accepted in all societies and

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14. For in depth discussion, see T.L. Beauchamp and J.F. Childress: *Principles of Biomedical Ethics*, 4th edit. 1994; R. Gillon (Edit): *Principles of Health Care Ethics*, 1994.
15. H.T. Engelhardt: *The Foundations of Bioethics*, New York, 1986.
16. E.D. Pellegrino and D.C. Thomas: *For the Patient's Good*, New York, 1988.
17. See. L. Kass, *JAMA* 244:1811, 1980; J. Fletcher: *Situation Ethics: The New Morality*, Philadelphia, 1966; R.C. Sider and C.D. Clements, *Arch Int Med* 145:2169, 1985; P.M. Marzuk, *N Engl J Med* 313:1474, 1985.
18. See S.M. Glick, *N Engl J Med* 336:954, 1997.
19. See A. Steinberg, in R. Gillon (Ed): *Principles of Health Care Ethics*, 1994, pp. 65ff.

cultures, and certainly not in Judaism. Therefore, some writers state that unrestricted autonomy is culturally dependent.[20]

Autonomy is not only the privilege of the patient. It is universally agreed that the physician's autonomy, too, must be respected. A physician may refuse a patient's request for a therapy that has no scientific or rational basis, especially if it may be harmful to the patient. Also, a physician may refuse to implement a patient's decision for a certain treatment if it conflicts with the physician's conscience, for whatever reason. In such situations, the physician has the right not to treat the patient and to transfer such care to another physician. A difficult question relates to very expensive treatment requested by a terminally ill, incurably sick patient which could only minimally extend the patient's life. Some writers justify the physician's autonomy in deciding against the patient's autonomy whereas others consider such action to be unjust.[21]

Non-maleficence (=*primum non nocere*) is defined as the obligation not to harm others and to remove and prevent potential harm.[22] Thus, one must not only prevent intentional harm but must also be appropriately cautious not to cause harm. Health care workers must be properly trained so that they not inflict harm because of lack of knowledge or lack of appropriate skills.

This concept of non-maleficence is applied to the relationship between physician and patient based upon the phrase that "above all do no harm." Some writers state that nowadays non-maleficence should be re-defined to strive not to do harm, by balancing the benefit against the harm of any specific action. However, this ethical principle of not doing harm should not be absolute and cannot be applied fully in all diagnostic and therapeutic interventions.[23] The cause for this change in the definition of non-maleficence relates to the major changes in the practice of medicine today as compared to that practiced in antiquity.

Beneficence is defined as the moral obligation to do good for others, and to help them in an active way. Ethically, it is not enough to avoid doing harm but one must actively do good to others. But,

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20. See S.M. Glick, *loc. cit*.
21. See Hastings Center: *Guidelines on the Termination of Life – Sustaining Treatment and the Care of the Dying,* 1987:8; D.M. Mirvis, *N Engl J Med* 328:1346, 1993.
22. See W.K. Frankena: *Ethics*, 2nd Edit, Englewood Cliffs, 1973.
23. See R. Gillon, *BMJ* 291:130, 1985; T. Brewin, *Lancet* 344:1487, 1994.

obviously there are limits to the requirement that one act to help others at all times. These vary with the degree of need, the ease and ability with which the help can be rendered, and the nature of the relationship between the individual needing help and the one able to provide it.

Justice is the granting and fulfillment of legitimate rights of others, and injustice is their denial. Justice requires the division of rights and assets in an equitable and appropriate manner, but no less so the fair distribution of duties and burdens. In the simplistic sense, justice means equality. However, in daily life, many variables cause unequal division of obligations and rights. Therefore, several ethical theories and techniques have been developed for distributive justice, taking into consideration needs, rights, contributions to society, and other factors.

Different theories of justice place greater priority on different factors: Marxism emphasizes economic needs, while liberalism emphasizes social needs. The differences in views and emphases make it difficult to attain ideal justice, since equality in one aspect may bring inequality in another and, hence, injustice.

Individual rights became a cornerstone in political, legal and social thinking in the nineteenth century. Some believe that people have absolute moral rights unrelated to changing social conditions. These include "natural" universal rights such as the right to life, liberty and privacy. Others believe that rights flow from societal consensus, customs and laws and therefore are relative and may change according to the circumstances.

D. Modern Medical Ethics

Modern medical ethics is based on concepts derived from various disciplines, including the biomedical sciences, the behavioral sciences, philosophy, religion and law. Modern medical ethics is essentially a form of 'applied ethics,' which seeks to clarify ethical questions that characterize the practice of medicine and to justify and weigh the various practical options and considerations. Thus medical ethics is the application of general ethical principles to ethical issues. The application of such an ethic is not specific to medicine but also relates to economy, law, journalism, and their like.

In the past, only a few individuals, mostly physicians, devoted themselves to medical ethics. Beginning in the second half of the

twentieth century, the field underwent explosive expansion and experts from numerous disciplines entered the field.

The rapid advances in medical diagnosis and treatment and the introduction of new technologies have produced numerous new ethical dilemmas,[24] resulting in the maturation of medical ethics as a specialty in its own right. Research institutes of medical ethics have been established. Medical ethics is now part of the curriculum in schools of the health professions at all levels. The medical ethics literature has proliferated, with numerous books and journals devoted entirely to the subject. Nearly all medical periodicals devote considerable space to ethical topics.[25] The general public is also vitally interested in this subject, and public lectures, newspaper articles, legal discussions and legislation on medical ethical issues are numerous.[26]

In the United States, the "medical ethicist" has emerged as a new professional. These individuals generally have specialized in one or more of the fields of philosophy, ethics, law, religion and medicine, and serve as advisors in hospitals to physicians, patients and their families. They attempt to resolve difficult ethical questions posed to them by the medical team or by patients and their families. In one American study, most of the medical staff found ethical consultation and advice to be valuable but only half of patients or families found it to be valuable.[27]

A number of reasons are responsible for the enormous recent interest in medical ethics:

- Significant technological and scientific advances and changes in clinical medicine and research have produced totally new ethical dilemmas and exacerbated old ones.
- The change in philosophy from paternalism to autonomy in the physician-patient relationship has removed from the physician the monopoly on decision-making.
- The involvement of additional caregivers (various medical specialists, a variety of health professionals, students,

24. Concerning the development of modern medical ethics and future trends, see D. Callahan, *N Engl J Med* 302: 1228, 1980; A. Steinberg, *J Assist Reprod Genet* 12:473, 1995.
25. For example, at the end of 1997, Medline had 3400 citations on bioethics. See M. Wadman, *Nature* 389:658, 1997.
26. See A. Steinberg, *loc. cit.*
27. See J.A. McClung *et. al*. *Am J Med* 100:456, 1996. A similar study relating to patients and their families, see R.D. Orr, *et al, Am J Med* 101: 135, 1996.

adminis- trators and investigators), each with their own cultural and social value systems, have increased and sharpened ethical debates and discussions.

- The involvement of society at large (through the mass communication media, courts, legislators) has created the necessity to redefine the societal parameters of the physician-patient and physician-societal relationship.
- Broad social changes throughout the world have damaged the image of the unique nobility of the physician. This change has been enhanced by the commercialization of medical services and the greater sense of consumer criticism. Moreover, in recent years physicians have come to view medicine more in terms of their careers, honor, self-fulfillment and income.[28] There is a call nowadays to return to the historic principles of the medical profession, which differs from most other professions. Medicine should be viewed as service to the sick and the needy, with humility, honesty, empathy, intellectual integrity, and effacement of self-interest.[29]

A number of significant socio-ethical changes have occurred in the portrayal by society of medical practice and the medical profession. In the past, it was thought that all illnesses had a limited number of causes with only minor variations between people. Thus, a holistic view of people was prevalent. The limited armamentarium of diagnostic testing and therapeutic interventions enhanced close communication between the physician and the patient because a detailed history and physical examination were virtually the physician's only diagnostic tools. Scientific knowledge of medicine was limited, and the art of medicine was emphasized. By contrast, modern medicine has traced disease causation to a multitude of processes in individual organs, tissues or even cells. The diagnostic and therapeutic approaches focus primarily on the illness and less so on the patient, changing the physician-patient relationship dramatically. Since most diagnostic tests and many therapeutic interventions are performed in specialized laboratories and

28. This fact became realized in many Western countries in the first half of the twentieth century when physicians strongly opposed any form of socialization of medicine. See M. Romer, *World Health Forum* 3:357, 1982; M. Romer, *Yale J Biol Med* 53:251, 1980.

29. See C.K. Cassel, *Ann Inter Med* 124:604, 1996.

treatment centers, there is far less need for communication and interaction between the patient and the physician. Science and technology are glorified at the expense of humanism, and this is reflected in medical education. A 1984 study reported that only 3% of American medical students had majored in humanistic subjects in their premedical education.[30] Classically, medicine had been identified with the humanities. Nowadays, young physicians choose careers in narrow subspecialty areas with emphasis on clinical or basic research. This approach has led to a reduction of empathy for the sick person and loss of the individual human concern.[31]

This trend began to reverse itself in the 1980's and 1990's. Public pressure and the profound realization of the purposes of medicine and its roles resulted in attempts to balance the technological and scientific advances with the humanistic and ethical approach to medical practice. Medical ethics attempts to help resolve some of these issues.

Economic issues engendered as a result of the high cost of modern medical care have created new dilemmas which require resolution, both on an individual and on a societal level. Economic pressures have added a new dimension to the physician-patient relationship. The physician's responsibility to his patient often conflicts with those to his employer, the insurance company or the government.[32] The physician must skillfully and ethically balance these ethical conflicts.[33]

However, in practice, the influence of medical ethics in the United States on the formation of public policy or even the education of scientists and physicians has not been very great. Some critics regard modern medical ethical discussions as excessively academic and theoretical and insufficiently forceful. Furthermore, governmental, political and economic considerations often influence the appointment and financing of medical ethics task forces or commissions, leading to biased results.[34] If ethics is to have a major impact on society there needs to be greater motivation on the part of society and intensive education towards appropriate ethical conduct and concern for one's fellow human being.

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30. K. Warren, *Ann Inter Med* 101: 697, 1984.
31. See S.M. Glick, *N Engl J Med* 304:1036, 1981.
32. See H.T Engelhardt and M.A. Rie, *N Engl J Med* 319:1086, 1988.
33. See H.G. Welch and E.S. Fisher, *N Engl J Med* 327:1312, 1992.
34. M. Wadman, *Nature* 389:658, 1997.

Medicine is not an exact science. It deals with people and not objects. Therefore, its scientific and humanistic components must be combined. Better and more knowledge *per se* does not necessarily lead to better medical care since the subjective feelings of the patient, which are based on personal, social, cultural, and economic value systems, must also be considered. Therefore, clinical and research medicine need to combine technical knowledge and advances with human feelings, ethics and social justice. Only optimal synthesis of these two elements can educate ideal physicians who can "serve mankind with respect, honor and dignity."[35] Many areas in medicine do not involve pure science but are built on interpersonal relationships, feelings, morality and appropriate psychosocial conditions. If medicine's function was only to cure illness, it would be a pure science without any relationship to morality or justice. However, since medicine's goal is to cure people of their illnesses it has major humanistic and ethical components.

The basic concept of medial ethics is that the physician has a moral (and at times legal) obligation to act for the patient's good, using the most up-to-date information. The question is how to establish that "good," who defines it, and what are the components thereof.

One of the most important areas of discussion in ethics is the doctor-patient relationship which is portrayed in one of several ways:

Paternalism is an approach in which the physician chooses the treatment for the patient because the physician's professional knowledge, experience and objectivity best qualify him to judge the ideal treatment for the patient. This attitude assumes that the physician and the patient have a common interest but that the doctor is better equipped for the necessary decision-making with minimal or no patient involvement.

A number of significant criticisms of paternalism are as follows:

- It impinges on the basic rights of the patient to decide for himself what should be done with his body.
- Many decisions are not purely medical but involve personal and cultural aspects in which the physician has no particular expertise. Such decisions require the patient's input.

35. From the Code of Ethics of the American Medical Association.

- Many diagnostic and therapeutic decisions involve ethics, secular law or Jewish law. For example, the decision as to whether or not to abort a fetus with Down's syndrome is not a medical one, but an ethical, legal and religious one. Similarly, the decision whether or not to attempt to resuscitate a terminally ill patient is an ethical rather than a purely medical one.

Autonomy means that only the patient knows what is best for him and only he has the right to decide. In order to do so he needs to receive from the physician all the appropriate information about his condition to permit him to make an informed decision. The physician's values, and even less his professional knowledge and experience, play no role in the final decision. Traditionally, the physician's role was viewed as giving "orders" to nurses and to patients. In the atmosphere of autonomy, physicians must use a different language such as advise, recommendation, position, etc.

The main criticism of pure autonomy is the relegation of the physician to the role of a technical consultant, with little influence on the patient's decision, which is often based on a lack of full understanding of his condition. Such a decision may cause unnecessary and avoidable harm to the patient.

A compromise or middle position between paternalism and autonomy is one in which the physician provides the patient with the relevant information, the physician and patient discuss the medical and ethical issues and then arrive at a joint decision. This approach preserves the patient's autonomy on the one hand, and the physician's obligation to advise the patient about the best decision, on the other hand. This is considered to be the best system, permitting responsible decisions according to the relevant individual circumstances while preserving the obligations and rights of both patient and physician.[36]

The development of medical ethics in general and the physician-patient relationship in particular can be viewed from three perspectives:

- The Hippocratic view, which is based on a paternalistic physician-patient relationship, and the basic ethical principle to prevent or minimize harm to the patient

36. See J.J. Emanuel and L.L. Emanuel, *JAMA* 267:2221, 1992.

(*primum non nocere*), and on professionalism between physicians;
- The Jewish view, which is based on Jewish ethical principles (see the next article in this book).
- The modern view, which is based primarily on autonomy, the four ethical principles, the multidisciplinary approach, the discussion and resolution of every medical ethical problem, the use of guidelines and the view that medical ethics is a specialty in its own right.

Paternalism has largely given way in favor of autonomy throughout most of the Western world beginning in the 1950's in the United States. There is currently a renewed questioning of whether the pendulum has not swung too far in favor of untrammeled autonomy and individualism. Various suggestions have been put forward to create joint frameworks for the physician and patient while establishing criteria for joint decision making, sharing of responsibilities, mutual respect and mutual trust.[37]

Much of the literature in modern medical ethics has emerged from the English-speaking countries. These views and conclusions do not always reflect the views in other Western countries and even less so Eastern European cultures and Asian and African countries. These differences are to be expected when one considers the socio-cultural differences between the various societies.

Generally, scientific progress in technology and in knowledge precedes discussions and debates about the ethical, religious and legal aspects of that progress. The recent extraordinarily rapid pace of advances in knowledge, science and technology have made it even more difficult for the ethical, legal and religious analysis of these issues to keep pace with the scientific advances. There is a need now to change this approach so that ethical, religious, legal and social implications of innovative scientific and technological measures will be anticipated and acted upon in advance rather than *post factum*.

Modern medical ethics involves a wide range of topics which produce ethical dilemmas in the conduct of physicians, other health professionals, patients, families and society in general.

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37. See E.D. Pellegrino and D.C. Thomasma: *For the Patient's Good*, 1988; J. Balint and W. Shelton, *JAMA* 275:887, 1996.

Medical ethics may be divides into general biomedical ethics which deals with fundamental principles, societal issues and policy determination, and clinical ethics which deals with the application of practical medical ethical principles in the day-to-day care of patients.[38]

The identification and characterization of a medical ethical dilemma is not always obvious. On one general medical ward in a university hospital, while one of every six patients posed an easily identifiable ethical problem many ethical problems were under-identified by the medical staff.[39]

The goals of medical ethics include the analysis of the relative merits of alternative actions in medical ethical dilemmas. Definite and absolute decisions are not always attainable or implementable. Therefore, medical ethics is satisfied with decisions defining the relationship between what is desirable and what is practical or in the choice of the lesser of two evils. Medical ethics is generally pluralistic and multidisciplinary in its approach. Its main function is to identify and characterize the component elements of a given medical situation and to provide an analytic process for assessing and applying the relevant values and principles of ethics. In general, modern medical ethics does not see its function as providing definitive ethical directives in every case. In this respect, ethics differs from law or Jewish halacha. The latter establish specific guidelines, whereas ethics provides pluralistic approaches and clarification and precision of understanding of the ethical aspects of medical questions.

With respect to the relationship between ethics and the law – law by its very nature in contrast to ethics, demands that it be followed precisely. Ethics at times may conflict with the law. Many situations in medicine are not "covered" by the law and their resolution is decided solely on ethical grounds.[40]

The place of legislation in regard to medical ethics is debated. Some writers would like to see major involvement of the law in medical ethical issues and thereby to set ethical norms for society. This view assumes that the legal system is capable of coping with the varied ethical dilemmas created by the rapid advances in medicine. By contrast, others argue that legislators and judges should be

38. See M. Siegler, *Arch Inter Med* 139:914, 1979; B. Lo and A.R. Jonsen, *Ann Inter Med* 92:116, 1980.

39. B. Lo and S.A. Schroeder, *Arch Inter Med* 141:1062, 1981.

40. Concerning the relationship between ethics and law, see E.D. Pellegrino, *Am J Med* 96:289, 1994.

involved minimally only as a last resort in ethical conflicts. The legislative process is by its very nature conservative and slow-moving and therefore ill-suited to deal with the dynamic changes occurring in medicine and the dilemmas thereby engendered.

A common alternative in a pluralistic democratic society is the dealing with medical ethical issues by multidisciplinary ethics committees, which analyze issues and recommend policy or guidelines. There is also considerable utility in the creation of national non-political commissions to study new issues in medical ethics and to recommend policies and procedures and, if necessary, legislation.

E. Teaching Medical Ethics

Because of the need in modern medicine to be knowledgeable in medical ethics and because medical students are exposed to medical ethical issues throughout their medical studies,[41] it has become necessary to teach medical ethics formally in schools of the health professions.

The teaching of medical ethics has advanced greatly in recent years. Nearly every medical and nursing school in the Western world now offers courses of instruction in medical ethics.[42]

Such teaching may take place in both the preclinical and clinical years, during postgraduate training and as part of continuing medical education. There are valid reasons to continue the study of medical ethics throughout the careers of physicians and other health professionals.[43]

The goals of education in medical ethics are:[44]

- To enhance the sensitivities of the student to medical ethical dilemmas.
- To provide the student with the specific knowledge to be able to identify and characterize medical ethical dilemmas.

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41. See D.A. Christakis and C. Feudtner, *Acad Med* 68:249, 1993 and *Hastings Cen Report* 24:6, 1994.
42. In all American medical schools, ethics is taught as part of the curriculum. In Britain, see K. Pond (Ed): *Report of a Working Party on the Teaching of Medical Ethics*, London, Inst Med Ethics, 1987; D.P. Davies et. al. *Arch Dis Child* 74:172, 1996. In Israel, all four medical schools teach medical ethics in one form or another.
43. C.M. Culver et. al. *N Engl J Med* 312:253, 1985.
44. See A. Steinberg, in J.Y. Hattab (Ed): *Ethics and Child Mental Health*, Jerusalem, 1994, pp. 86ff.

- To acquaint the student with terminology, views, values, and relevant basic principles in philosophy, religion, law and sociology.
- To provide the student with the intellectual tools and fundamental thought processes to analyze and resolve ethical problems.
- To present the student with the approaches of philosophy, law, culture and religion in the resolution of medical ethical dilemmas.
- To enhance the student's ability to examine and analyze unresolved ethical issues logically.
- To instill in the student the principles of respect for individuals with different points of view, the empathy and compassion toward patients, and to emphasize the centrality of the patient rather than the illness, and the importance of human values.
- To educate medical specialists and experts in medical ethics.
- There are many obstacles to the teaching of medical ethics. These include the following:
- Pressures of other medical studies and duties and the lack of time for medical ethical instruction.
- Lack of interest in the subject.
- Lack of support from departmental chairmen and medical faculty.
- Logistical problems of adequate numbers and types of trained staff available for medical ethical teaching.[45]

Medical ethics teaching can be implemented in several ways:

- Frontal teaching about ethical principles and issues. Common medical ethical situations may be illustrated and discussed. The material presented should include basic ethical principles, methods for decision making and resolution of medical ethical dilemmas and the application of ethical principles to clinical situations.[46] One approach advocates supplementing teaching of medical ethics by the addition of studies of the humanities.[47] Such an approach

45. See C. Strong *et al., Acad Med* 67:398, 1992.
46. See C.M. Culver *et al*., *N Engl J Med* 312:253, 1985.
47. Sir William Osler (1849-1919) already recommended various humanistic works to medical practitioners. These include the Bible, Shakespeare, Emerson, and their like. See A.R. Moore, *Med J Austral* 2:27, 1975.

could broaden the horizons of the physicians beyond science and technology.[48]

- Theoretical discussions of ethical aspects during seminars of clinical situations. Various teaching aids such as films, videos.[49] and computer programs[50] are widely available.
- Multidisciplinary "ethics rounds" at the patient's bedside with discussion of the ethical issues.[51]

In every kind of teaching, a multi-disciplinary approach is to be preferred.[52] It is essential to integrate the teaching of medical ethics into all facets of medical practice and not confine it to a few theoretical lectures squeezed into the busy schedule of medical students.[53]

48. See S. Jonas, *Lancet* 2:452, 1984; K. Warren, *Ann Inter Med* 101:697, 1984; E.J. Huth, *Ann Inter Med* 101:864, 1984; R.M. Arnold et. al. *Ann Inter Med* 106:313, 1987; R. Charon, *et al*., *Ann Inter Med* 122: 599, 1995; H. Schneiderman and R.M. Schneiderman, *Ann Inter Med* 122:618, 1995.
49. Such as OSCE = objective structured clinical examination. See P.A. Singer, *et al. Acad Med* 71:495, 1996.
50. See M.L. Barclay and T.E. Elkins, *Acad Med* 66:592, 1991.
51. See A. Steinberg, in J.Y. Hattab (ed): *Ethics and Child Mental Health*, Jerusalem, 1994, pp. 86ff.
52. C.M. Culver *et al*., *N Engl J Med* 312:253, 1985.
53. D.P. Davies, *et al*. *Arch Dis Child* 74:172, 1996.

Appendix

1. A variety of books are devoted to medical ethics. These include:*

- Abrams N. & Buckner M.D. (eds): Medical Ethics, Cambridge: MIT Press, 1983
- Beachump T.L. & Walters L. (eds): Contemporary Issues in Bioethics, 2nd ed, Belmont: Wadsworth, 1982
- Beachump T.L. & Childress J.F.: Principles of Biomedical Ethics, 4th ed, New York: Oxford University Press, 1994
- Brody H.: Ethical Decisions in Medicine, 2nd ed, Boston: Little, Brown & Com, 1981
- Campbell A.V.: *Moral Dilemmas in Medicine*, Edinburgh: Churchill Livingstone, 1972
- Culver C.M. & Gert B.: Philosophy in Medicine, New York: Oxford University Press, 1982
- Duncan A.S., et. al. (eds): Dictionary of Medical Ethics, New York: Crossroad, 1981
- Dunstan G.R. & Shineborne E.A. (eds): Doctors' Decisions: Ethical Conflicts *in Medical Practice*, 1989
- Engelhardt H.T.: The Foundations of Bioethics, 1986
- Engelhardt H.T.: Bioethics and Secular Humanism: The Search for a Common Morality, 1991
- Fletcher J.F.: Morals and Medicine, Boston: Beacon Press, 1954
- Gelfand M.: Philosophy and Ethics of Medicine, Edinburgh: Churchill Livingstone, 1968
- Gillon R.: Philosophical Medical Ethics, 1985
- Gillon R. (ed): Principles of Health Care Ethics, Chichester: John Wiley & Sons, 1994
- Gorovitz S.: Doctor's Dilemmas: Moral Conflict and Medical Care, 1982
- Gorovitz S., *et al*. (eds): Moral Problems in Medicine, 2nd ed, Engelwood Cliffs: Prentice-Hall, 1983
- Hering B.: Medical Ethics, Notre Dame:Fides/Claretion, 1973
- Hunt R. & Assas J.: Ethical Issues in Modern Medicine, Mayfield Pub Com, 1977
- Jonsen A.R., *et al.* Clinical Ethics, 3rd ed, New York: McGraw Hill, 1992
- Mappes T.A. & Zembaty J.S.: Biomedical Ethics, 3rd ed, New York: McGraw Hill, 1991

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* The list contains only books devoted to the foundations and principles of basic and general topics in medical ethics. It does not includes books and monographs on specific issues in medical ethics

- Monagle J.F. & Thomasma D.C.: Medical Ethics, Rockville: Aspen Pub, 1988
- Pellegrino E.D. & Thomasma D.C.: A Philosophical Basis of Medical Practice, 1981
- Pellegrino E.D. & Thomasma D.C.: For the Patient's Good, New York: Oxford University Press, 1988
- Ramsey P.: The Patient as a Person, New Haven: Yale University Press, 1970
- Reich W.T. (ed): Encyclopedia of Bioethics, New York: The Free Press, 1978
- Reiser S.J., *et al.* (eds): Ethics in Medicine: Historical Perspec- tives and Contemporary Concerns, Cambridge: MIT Press, 1977
- Shannon T.A. (ed): Bioethics, Ramsey: Paulist Press, 1981
- Sperry W.L.: The Ethical Basis of Medical Practice, 1950
- Spicker S.F. & Engelhardt H.T. (eds): Philosophical and Medical Ethics: Its Nature and Significance, 1977
- Veatch R.M. (ed): *Medical Ethics*, Boston: Jones & Bartlett, 1989
- Walters L. & Kahn T.J. (eds): *Bibliography of Bioethics*, Washington, D.C.: Kennedy Institute of Ethics, Yearly volumes

2. A variety of journals are devoted to medical ethics. These include:

- Bibliography of Bioethics
- Bioethics Literature Review
- Bioethics Quarterly
- Bioethics Research Notes
- Cambridge Quarterly of Healthcare and Ethics
- Ethics in Science and Medicine
- Hastings Center Report
- Humane Medicine
- Journal of Health Politics, Policies and Law
- Journal of Medical Ethics
- Journal of Medicine and Philosophy
- Journal of Religion and Health
- Linacre Quarterly
- Man and Medicine

*Source: Prof. A. Steinberg, The entry "**Ethics, Secular**"*
*from the **Encyclopedia of Jewish Medical Ethics**.*
For further halachic details and references — see Hebrew Edition of the Encyclopedia, Vol. 6, 1998, pp. 646-692 (Schlesinger Institute); English Edition of the Encyclopedia, Vol. II, 2003, pp. 389-404 (Feldheim Publishers)

Source: The Schlesinger Institute for Jewish Medical Ethics