KEY TERMS

Actor  Dilemmas  Justice
Agape  Directive  Morals
Autonomy  Distributive justice  Nonmaleficence
Beneficence  Effect  Pro bono
Bioethics  Ethical relativism  Problems
Categorical imperative  Ethics  Profession
Clinical ethics  Ethikos  Sliding scale
Code of ethics  Ethos  Standards of practice
Comparative justice  Fiduciaries
Conduct  Issues

INTRODUCTION

This course defines and describes morals, ethics, and law; describes the four foundational biomedical ethical principles of beneficence, nonmaleficence, justice, and autonomy; and offers a systems approach to health care professional ethical decision making. The modern “blending” of legal and professional ethical obligations is addressed, under which a substantive violation of law by a health care provider–fiduciary (person in a position of special trust) more often than not also constitutes a violation of professional ethics.
BASES FOR ETHICAL CONDUCT

Morals

Morals refer to beliefs, principles, and values about what is right and what is wrong, which are personal to each and every individual. A person’s moral beliefs are often—but not always—grounded in religion. Morals may also be grounded in secular philosophical theories about right and wrong. One can be a moral person without being a religious person.

Morals, like ethics, are culture-based and culture-driven, as well as time-dependent. Only a few universal (or near-universal) morals exist, including the prohibitions against murder, rape, and incest, and the moral duty to treat others as you would like to be treated.

No one is or should feel compelled to abide by another person’s morality, although individuals are clearly obliged to comply with organized ethical and legal mandates. Morals are exclusively *intrapersonal*. One is acting with moral virtue, or character, when he or she strives to “do the right thing.”

Ethics

Ethics refers to how individuals conduct themselves in their personal and professional endeavors. The word *ethics* derives from the Greek words *ethikos*, which means character, and *ethos*, which means custom. Ethical rules of conduct are firmly grounded in moral theory.

Individuals face problems, issues, and dilemmas with ethical dimensions, which necessitate action (or nonaction) every day. Problems involve questions of conduct, which are relatively straightforward, temporary, and readily resolvable. Issues involve points of debate or controversy with strong sentiments on two (or more) sides, which are normally resolved through compromise by finding a “middle ground.” Dilemmas entail emergent situations wherein decision makers are faced with two (or more) equally favorable or unfavorable alternative options for possible implementation. Examples of problems, issues, and dilemmas include the following:

- Clinical practice problems such as those faced by primary health care providers wrestling with patient services reimbursement policies under managed care
- Issues such as the ethics of elective abortion or whether to withdraw life support and/or nutrition for a patient in a persistent vegetative state
- Dilemmas such as deciding whether to accept or challenge a physician’s invocation of therapeutic privilege (where a physician head of a health care team imposes a gag order disallowing the team to discuss a patient’s diagnosis and/or prognosis with the patient)

Any ethical problem, issue, or dilemma has three fundamental elements. An agent, or *actor*, is faced with a problem, issue, or dilemma. The actor must engage in some sort of *conduct* involving action or nonaction. Further, an *effect*, or consequence, is associated with the actor’s conduct related to the problem, issue, or dilemma.

Ethical theorists have analyzed these fundamental elements of actor, conduct, and effect to develop and refine their classical ethical theories. (A theory involves a set of
assumptions used by theorists to explain or predict phenomena. A theory cannot be proved; it can only be disproved.) Table 2-1 lists and briefly describes the principal classical ethical theories.

**HEALTH CARE PROFESSIONAL, BUSINESS, AND ORGANIZATIONAL ETHICS DEFINED AND DISTINGUISHED**

Every individual comports his or her official conduct with personal or group ethical standards. These standards of conduct may differ greatly, depending on the nature of the person’s occupation, profession, or position.

<table>
<thead>
<tr>
<th>TABLE 2-1</th>
<th>Classical Ethical Theories</th>
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<tbody>
<tr>
<td><strong>Theory</strong></td>
<td><strong>Meaning</strong></td>
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<tr>
<td>Teleological (consequentialism ethics)</td>
<td>The moral quality of conduct is assessed by focusing on its effects or consequences.</td>
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<tr>
<td>From the Greek telos, meaning “end” or “goal”</td>
<td>The tailoring of one's conduct so as to effect the greatest social good with a minimum of adverse consequences is one expression of consequentialism. Whether an actor effects the greatest social utility by carefully obeying established legal and ethical rules of conduct (rule utilitarianism) or by merely conducting himself or herself subjectively in such a way as to effect the greatest good, irrespective of the rules (act utilitarianism), is a matter of opinion.</td>
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<td>Utilitarianism</td>
<td>Deontological (deon ethics)</td>
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<td>From the Greek deon, meaning “duty”</td>
<td>Deonutility ethics</td>
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<td>Virtue ethics</td>
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Business ethics addresses standards of conduct for businesspersons and organizations in general. In sociocapitalist societies such as the United States, Canada, Mexico, Japan, the European community of nations, and others, the coprimary missions of private business organizations are (1) to generate monetary profits and (2) to meet express and implied social responsibilities. Social responsibility includes acts in the public interest, from affirmative action employment practices to civic charity to support for the arts to volunteerism, among a myriad of other activities.²

Health care professional ethical standards differ from general business ethical standards in several ways. A (declining) majority of health care entities are organized as not-for-profit businesses and therefore strive to generate net income (revenue over expenses)³ but not profits, such as those generated in ordinary business ventures. Additionally, health care professionals treat patients who are injured or suffer from disease and are in pain and who therefore are more vulnerable to exploitation than the overwhelming majority of ordinary business clients. Health care professionals are required by law and ethical standards to maintain diagnostic, historical, and treatment-related patient information in strict confidence. Health care professionals treat patients who are injured or suffer from disease and are in pain and who therefore are more vulnerable to exploitation than the overwhelming majority of ordinary business clients. The delivery of health care to patients is often emergent, and the consequences of bad decisions are potentially dire. This is borne out by the findings of the Institute of Medicine, HealthGrades, and the Harvard University–Leape studies involving patient deaths from medical mistakes, introduced in course 201. For all these reasons and more, the legal and ethical standards of conduct for health care professionals are intentionally set high—higher than for most other business pursuits.

Managed care has created a number of ethical dilemmas for health care professionals and organizations that are fiduciaries for their patients, meaning that they are trustees, who must place the interests of their patients above their own. From financial conflicts of interest involving provider variable or incentive pay for limiting patient care costs to “gag clauses,” which inhibit free provider-patient communications, managed care has given rise to a number of significant ethical problems, issues, and dilemmas. These managed care ethical concerns are addressed in different courses throughout this series.

Jennings⁴ described four situations in which a fiduciary-beneficiary relationship may exist. The first involves a classic trust relationship, in which one person gains influence or superiority over another. The second involves one person who is assigned or assumes responsibility for another person. The third involves one person who has a legal duty to act or advise another within a formal relationship. The fourth involves a specific legal duty to be recognized arising out of an interpersonal relationship. The health care professional–patient relationship is unique in that it encompasses all of these bases.

The health care professional–patient fiduciary (trust) relationship is perhaps the most complete and complex of all interpersonal relationships.

What are the attributes of a profession? A profession has the following characteristics⁵,⁶:
• Defined body of accrued knowledge or expertise. The classic [original] professions—law, medicine, and the clergy—were described as having unique domains of knowledge and expertise so that no one else could carry out the professional roles of their members. Modernly, there are many more than three professions.

• **Autonomy**, or self-governance, including the establishment and enforcement of a **code of ethics** and quality standards for the professional product or service (e.g., standards of practice for the health care professions)

• Formal education of its members

• Research activities designed to validate and refine professional practice

• Existence of one or more professional societies or other organizations for the development of the profession and its members

• Recognition of advanced member competency through certification or other processes

**PURPOSES OF PROFESSIONAL CODES OF ETHICS**

Health care professional codes of ethics have four coprimary purposes. First, they are **directive**; that is, they provide guidance for mandatory behavior by members of health care professional disciplines. (Professional ethics codes may also provide nondirective guidance for recommended conduct.) Second, codes must be protective of the rights of patients, clients, and research subjects and their significant others and the public at large. Third, health care professional ethics codes must be specific; that is, they must address areas of ethical problems, issues, and dilemmas particular to the disciplines governed by the various codes. Finally, health care professional ethics codes must be enforceable and enforced.

Codes of ethics may contain two general types of provisions: directive and nondirective. Directive provisions address required conduct. Nondirective provisions are of two types, addressing permissive conduct and recommended conduct. Directive provisions normally contain the words *shall, will, must, required, or responsible* or, in the negative, *may not, shall not, or will not*. Nondirective provisions addressing permissive conduct may contain the words *may or are not prohibited from*. Nondirective provisions addressing recommended conduct typically often contain the words *should or should not*.

A profession, then, has an autonomous body of accrued knowledge; it enforces a code of ethics and offers standards of practice; it provides education for its members and is involved in research activities; it promotes organizations for the development of its members; and it recognizes advanced competency.

**ENFORCEMENT OF ETHICS CODES: DISCIPLINARY PROCESSES**

Health care professional ethical standards are enforced by professional associations, credentialing bodies, and state licensure or regulatory administrative agencies. These ethical provisions are also indirectly enforced by the courts in civil and criminal proceedings in which violations of professional ethics also constitute violations of the law.
Readers are invited to research the ethical jurisdiction and complaint, adjudication, and appeal processes for their respective professions and to compare them with those in place for other disciplines.

**Due Process and Judicial Oversight of Health Care Professional Associations**

In adverse administrative disciplinary actions by state regulatory agencies against health care professionals, the federal constitutional due process clause of the Fourteenth Amendment requires that these governmental agencies afford procedural and substantive due process to respondents. State constitutions, statutes, and case law may afford additional protections to respondents in these public fora.

- Procedural due process means an adequate notice of an adverse action and a reasonable opportunity to be heard. In the case of adverse professional licensure actions, a reasonable opportunity to be heard is synonymous with the right to a hearing.
- Substantive due process means that a disciplinary procedure must be fundamentally fair, especially in light of the fact that a health care professional respondent faces potential loss of a constitutionally recognized property interest in the earned privilege of professional practice.

For disciplinary actions taken by voluntary, private (nongovernmental) professional associations, constitutional due process considerations do not apply. Instead, the internal affairs of voluntary private associations are governed by their own charters and bylaws. The private association analog of the requirement for due process is that private associations must abide by their own rules and procedures when administering discipline.

Courts always have oversight jurisdiction over state administrative agencies and their decisions, as well as over the activities of voluntary, private associations. Courts are reluctant to reverse the decisions of governmental administrative agencies, however, for several reasons. These reasons include deference to the reasonable decisions of administrative entities and considerations of time management. Reasons justifying reversal of administrative decisions include, for public agencies, the denial of due process to a respondent facing the loss of property or liberty interest, such as licensure to practice in a health care profession, and instances in which decisions are characterized as arbitrary, capricious, clearly erroneous, or the result of bias. Reasons for reversal of decisions of voluntary private associations include fraud, malice, bias, prejudicial failure to follow association rules and procedures, and instances in which decisions contravene law or public policy.

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Two other terms related to health care professional ethics warrant definition. **Bioethics** is a term used to define the identification, analysis, and resolution of ethical problems, issues, and dilemmas associated with the biological sciences, especially medicine and health care practice and research. **Clinical ethics** relates specifically to ethical problems, issues, and dilemmas associated with clinical patient care activities.
The Modern Blending of Law and Professional Ethics

Modernly, law and ethics have largely been blended into common standards of professional conduct. Often, professional conduct that constitutes a breach of ethics also constitutes a violation of law, and visa versa. Figure 2-1 illustrates the nature of the modern blending of legal and professional ethical responsibilities.

Part of the rationale for the modern blending of law and health care professional ethics is that society has become highly legalistic in recent times. U.S. citizens and residents claim against and sue one another more than anywhere else in the world. For example, in 2004, there were 16,500,000 new civil lawsuits filed nationwide.10

Another reason for the mixed nature of law and health care professional ethics is the fact that patients and other consumers of health care services and expertise have become more sophisticated in recent times. Patients are more aware of their rights as consumers and are more disposed to assert those rights, including through resort to the legal system.

Legal and Ethical Health Care Four-Quadrant Clinical Practice Grid

The legal and ethical health care four-quadrant clinical practice grid (Figure 2-2) illustrates acceptable and unacceptable health care clinical practice, based on compliance with or violation of legal and ethical practice rules and standards. The same model can also be applied to health care professionals in academia and research settings.

Delineation of clinical practice that clearly meets or violates legal and ethical rules and standards is relatively easy. For example, a clinician such as a certified prosthetist-orthotist who practices in compliance with applicable state and federal laws and the Canons of Ethical Conduct of the American Board for Certification is practicing in a manner that meets legal and ethical requirements. If the same provider is charged with and admits to sexual misconduct with a patient, then he or she has complied with neither legal nor ethical standards. These modes of practice can be labeled +L/+E and −L/−E, respectively.

Professional conduct may be a violation of ethical standards but not a violation of the law, or +L/−E practice. Consider the following example:

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**FIGURE 2-1** | Modern blending of law and professional ethics. *(From Scott RW, Petrosino C: Physical therapy management, St Louis, 2007, Mosby.)*
An employment contract between a physician and a managed care organization contains a provision that prohibits the physician from discussing with patient’s treatment options that are not offered by the managed care organization. (Such a contractual provision is commonly referred to as a “gag clause,” which has largely been eliminated in health care professional employment contracts because of public and press pressure and resultant state and federal regulations.) Even if compliance with the “gag clause” by the physician might be upheld by a court as a legally acceptable course of action, such conduct would still constitute an actionable breach of professional ethics. Under applicable ethical standards governing patient informed consent to treatment, a competent patient must be informed by a physician of all reasonable alternatives to a proposed intervention, irrespective of whether a managed care organization elects to offer them as a matter of its business judgment. The provider in this case might face adverse administrative or American Medical Association professional association action for a breach of professional ethics, in spite of the legality of the contract.

The most difficult mode of clinical practice to describe within the grid involves official conduct by a clinician that meets professional ethics standards but violates legal requirements, the \(-L/E\) mode of practice. Some legal and ethics scholars might argue that a breach of professional ethics also occurs any time a health care professional’s conduct violates the law. However, consider the case of a physical therapist in independent practice who treats an indigent Medicare patient in an outpatient setting. Ignorant of any possible regulatory prohibition against doing so, the physical therapist waives the patient’s Medicare Part B co-payment for 20 percent of the charges but submits a bill to Medicare for its 80 percent contribution to the patient’s bill.

The physical therapist, although perhaps acting ethically in providing \textit{pro bono} services, might be in violation of federal administrative rules promulgated by the
Centers for Medicare and Medicaid Services, which generally prohibit the waiver of Part B Medicare patient co-payments.

Health care professionals should routinely evaluate their professional conduct in light of the four-quadrant grid and strive always to be clearly in compliance with legal and ethical mandates.

Despite the demise of gag clauses incident to managed care, self-imposed communications problems between primary health care providers and patients persist. In a 2003 study, Wynia and colleagues\(^\text{11}\) reported that 31 percent of 720 physicians studied declined to offer or discuss “useful services” to patients because of the physicians’ subjective judgment that the patients’ health insurance would not cover those services. From an ethical standpoint, primary health care professionals must, as fiduciaries, discuss all appropriate services with their patients.

From an ethical standpoint, primary health care professionals must, as fiduciaries, discuss all appropriate services with their patients—whether covered by patients’ health insurance or not.

**“Situational” Ethics**

A foundational ethics question is the question of whether ethical rules and standards of conduct apply all of the time or are flexible enough to be disregarded in special situations. Situational ethics involves selective, elective noncompliance with ethics rules and standards for special circumstances.

Two general circumstances may cause a health care professional to practice situational ethics. First, a health care provider may elect not to comply with an ethical directive out of a sense of caring for a patient, colleague, or some other person. According to Fletcher,\(^\text{12}\) this type of situational ethics occurs because of the health care professional’s agape concern for the welfare of a patient (agape is Greek for love for others). Consider the following hypothetical example:

*O, an occupational therapist employed by ABC Medical Center is treating G, a 53-year-old female patient, who is diagnosed with mild right lower limb hemiplegia incident to a left cerebrovascular accident. G is ambulatory with a standard cane and is involved in group therapy to improve performance of activities of daily living in the kitchen environment. O learned in a rehabilitation team conference that G also is diagnosed with a malignant astrocytoma of the cerebellum. G’s physiatrist, P, imposed a gag order, based on therapeutic privilege, on members of the rehabilitation team—including O—that requires them to refrain from discussing G’s diagnosis or prognosis with her at this time because of P’s judgment that such information would harm G psychologically. During the group therapy session, G finds herself alone with O for a moment and remarks that she sometimes feels dizzy. G asks, “I don’t have a brain tumor or anything like that, do I?” O answers, “Of course not! Don’t worry about such a thing!”*

Has O violated professional ethics rules or standards? Does compliance with the physiatrist’s invocation of therapeutic privilege supercede O’s duty to comply with the Occupational Therapy Code of Ethics? That question must be answered, if it
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arises, by members of the Commission on Standards and Ethics of the American Occupational Therapy Association. Assume for sake of argument that the occupational therapist’s conduct is deemed by the Commission on Standards and Ethics not to be violative of the Occupational Therapy Code of Ethics. Nevertheless, the conduct of the occupational therapist may still violate his or her own personal ethical standards. If, for instance, the occupational therapist believes, like deontologist Immanuel Kant,6 (note 6, p 732) that truthfulness is a universally applicable categorical imperative, then the therapist has acted unethically by lying, even though the lie was occasioned by the physiatrist’s order based on therapeutic privilege.

Situational ethics may also apply when a health care professional breaches professional ethics for reasons other than patient welfare, including out of malice or self-interest. Consider again the previous example (under Legal and Ethical Health Care Four-Quadrant Clinical Practice Grid) involving a physician’s managed care employment gag clause provision, which disallowed the physician from discussing with patients the care options not offered by the patients’ health insurance plans. Compliance with the gag clause—in violation of American Medical Association ethical standards— involves placing the physician’s employment interests above patient welfare and constitutes ethical relativism, or sliding scale ethics.

Is it possible to practice situational ethics and still be an ethical person and professional? That question must be individually answered by each professional. Although every health care professional succumbs to human frailty and breaches professional ethics at some point(s) during his or her career, it may be merely rationalization to create situations under which the breach of professional ethics is routinely acceptable.

BIOMEDICAL ETHICAL PRINCIPLES

Health care professionals are guided by four foundational biomedical ethical principles in caring for patients (or conducting clinical research or educating professional students to care for patients). These four principles are beneficence, nonmaleficence, justice, and autonomy.13

**Beneficence**

Acting out of beneficence for a patient involves official conduct carried out in the patient’s “best interests” by a health care provider. Beneficence is the manifestation of the health care professional’s fiduciary duty owed to his or her patients. The Hippocratic Oath is reflective of the imperative that physicians, nurses, and allied health care professionals are bound to act in patients’ best interests in clinical health care delivery. The oath reads as follows:

> I swear … that I will fulfill according to my ability and judgment this oath and this covenant:

> To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money, to give him a share of mine, and to regard his offspring as equal to my brothers … and to teach them this art—if they desire to learn it—without fee and covenant …
I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick [emphasis added], remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

Medical ethics and health care ethics generally have undergone a tremendous metamorphosis over time from an early deontological focus on strict compliance by physicians with the provisions of law and ethics, like the Hippocratic Oath, to a modern day period of analytical principlism,14 under which health care professionals carefully consider the effects of their professional conduct before acting. This modern attitude is reflected in part in the Patient-Physician Covenant (Box 2-1).

Nonmaleficence

Nonmaleficence means to do no harm. Health care interventions carried out on patients’ behalf, however, may cause them to suffer pain or other injury. The ethical principle of nonmaleficence requires that the health care provider not intentionally and maliciously cause harm or injury to patients under his or her care. Dr. Jack Kevorkian would assert that he did not violate the fundamental biomedical ethical principle of nonmaleficence in assisting his clients to die because his sole purpose in intervening was to alleviate the patients’ suffering.

As with the other foundational biomedical ethical principles, the ethical duty of nonmaleficence applies to omissions (i.e., the failure to act when one should act) and to affirmative acts. For example, the malicious, intentional abandonment of a patient by a treating health care provider constitutes a breach of the duty not to harm the abandoned patient intentionally. An ongoing criminal investigation post–Hurricane Katrina involves a New Orleans area hospital and its staff for possible patient abandonment in the face of power outages, lack of supplies, and looting in the area.15

Another example of a breach of the ethical principle of nonmaleficence involves the situation in which a health care provider engages in sexual relations—nonconsensual or consensual—with a patient under his or her care. A patient may display transference emotions that are romantic toward a health care provider; however, the provider breaches the ethical duties of nonmaleficence and beneficence when he or she allows countertransference emotions to convert the professional relationship into a personal and intimate one.
Box 2-1: Patient-Physician Covenant

Medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient’s best interests. Physicians, therefore, are both intellectually and morally obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times.

Today, this covenant of trust is significantly threatened. From within, there is growing legitimation of the physician’s materialistic self-interest; from without, for-profit forces press the doctor into the role of commercial agent to enhance the profitability of health care organizations. Such distortions of the doctor’s responsibility degrade the doctor/patient relationship which is the central element and structure of clinical care. To capitulate to these alterations of the trust relationship is to significantly alter the doctor’s role as healer, carer, helper and advocate for the sick, and for the health of all.

By its traditions and very nature, medicine is a special kind of human activity—one which cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion and effacement of excessive self-interest. These traits mark doctors as members of a moral community dedicated to something other than its own self-interest.

Our first obligation must be to serve the good of those persons who seek our help and trust us to provide it. Physicians, as physicians, are not and must never be commercial entrepreneurs, gateclosers, or agents of fiscal policy that runs counter to our trust. Any defection from primacy of the patient’s well-being places the patient at risk by treatment which may compromise quality of or access to medical care.

We believe the medical profession must reaffirm the primacy of its obligation to the patient through national, state, and local professional societies, our academic, research and hospital organizations, and especially through personal behavior. As advocates for the promotion of health and support of the sick we are called upon to discuss, defend and promulgate medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed. Thus we honor our covenant of trust with patients.

This covenant was produced by a group of American physicians, including Dr. David Rogers (deceased), who was former dean of medicine at Johns Hopkins University School of Medicine and former president of the Robert Wood Johnson Foundation, and Dr. Christine Cassel, who is now president and chief executive officer of the American Board of Internal Medicine. Dr. Edmund Pellegrino, senior fellow at the Center for Bioethics & Human Dignity, and Dr. George Lundberg, former editor of the Journal of the American Medical Association, also participated in its development. Dr. Roger Bulger, president of the Association of Academic Health Centers, and Dr. Ralph Crashaw, a practicing psychiatrist in Oregon, who has been active locally and nationally in ethical issues that pertain to physicians, were also co-authors. Finally, Dr. Lonnie Bristow, former president of the American Medical Association, and Dr. Jeremiah Barondess, president emeritus of the New York Academy of Medicine, are authors.
Justice

Justice equates to equity, or fair treatment. As it relates to the official conduct of health care professionals, justice involves comporting oneself in a way so as to maximize fairness toward all patients and potential patients requiring intervention by the provider. The concept of justice applies not only to health care professionals as individuals but to specific health care disciplines and organizations and, more broadly, to health care delivery.

Distributive justice is concerned with how equitably health care services are distributed at the macro or societal level. Distributive justice issues include political debate over universal health insurance coverage, Medicare eligibility for patients with end-stage renal disease requiring kidney dialysis, prevention and treatment of patients with acquired immunodeficiency syndrome and other catastrophic diseases, and the rationing of health care interventions near the end of life.

Comparative justice addresses how health care is delivered at the micro or individual level. Comparative justice issues include reimbursement and denial of care issues involving individual patients and the disparate treatment of patients based on age, disability, gender, race and ethnicity, or religion. The Tuskegee Syphilis Study, conducted from 1932 to 1972, is an example of a comparative justice breach of professional ethics. In this study, 400 black men with syphilis were denied lifesaving treatment (i.e., penicillin, after its discovery and release in the 1940s) so that researchers could study the effects of the disease. Publicity about this and other medical research studies led to the publication of the Belmont Report and the promulgation of formal federal (and state and institutional) guidelines concerning the ethical treatment of human research subjects. On May 16, 1997, President Bill Clinton publicly apologized on behalf of the federal government in a White House ceremony to four of eight survivors of this ghoulish experiment.

Consider the following clinical practice dilemma:

D, a nurse practitioner, examines P, a patient who complains of severe abdominal cramping and pain. Fearing a possible bowel obstruction, D requests permission from X, a physician managed care gatekeeper, to admit P for tests. X denies the request, based on a diagnostic algorithm developed and used by the managed care organization to determine whether to admit patients with specified symptoms. D strongly believes that P should be admitted. What should D do?

D has established a professional relationship with P and has the legal and ethical duty to take whatever action is necessary to act in the patient’s best medical interests, including continuing with actions to admit him, irrespective of the reimbursement consequences of the admission. Fulfilling this duty may place D at risk of loss of employment or reinstatement with the managed care organization; however, D’s higher legal and ethical duty is owed to P. To send P home might constitute a breach of professional ethics and intentional abandonment under these circumstances. Neither the law nor standards of professional ethics have changed significantly to accommodate the business of managed care.

Health practitioners are not the only professionals who face economic or other risks for “doing the right thing.” Other professionals also encounter personal risks incident to fulfilling their professional duties. Consider the newspaper reporter who
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is jailed for refusing to violate the ethical duty not to reveal a confidential source to a judge or lawyer in a deposition, or the police, military, or fire professional who makes the ultimate sacrifice of his or her life in the line of duty. During the September 11, 2001, terrorist attack on the World Trade Center in New York City, 343 firemen and 23 policemen gave their lives in the rescue effort.19

A federal law related to the foundational biomedical ethical principle of individual justice is the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), or the federal “antidumping law.” This law was enacted largely in response to broadly publicized instances of indigent patient transfers to charity facilities by for-profit hospitals wishing to avoid a financial loss incident to their care.

EMTALA applies to all hospitals receiving federal funding for patient care. The law mandates that these facilities conduct medical screening examinations on all emergent patients and on all female patients in active labor and to stabilize bona fide emergency patients before transferring them to other (charity) facilities, without regard for the patients’ ability to pay. EMTALA was intended to augment the ethical and common law duties on the part of hospitals to care for indigent emergency patients and patients in active labor and to create a uniform national standard to replace the scant number of inconsistent state laws concerning patient dumping.

**Autonomy**

Autonomy means self-governance. Respect for autonomy is based on respect for individual self-determination. In the health care delivery system, patients and research subjects have the right to control what is done for or to them, respectively. For patients, autonomy rights exist whether or not the patient pays for care. For research subjects, the right of control over the intervention applies irrespective of the existence or amount of compensation.

Health care professionals also exercise autonomy rights. They exercise control over physical facilities, assistants and other support personnel acting under supervision, equipment, and the examination, history taking, evaluative, diagnostic, and intervention processes within their applicable scope of professional practice.

**PATIENT AUTONOMY: THE CONCEPT OF SELF-DETERMINATION**

Patient autonomy rights are prominently reflected in modern-day laws and in the customary practices governing health care delivery. These laws and customs mandate, in part, strong and active patient involvement in interventional decision making. Health care organizations and professionals universally came to recognize in the twentieth century the right of patients with legal and mental capacity (or their surrogate decision makers) to be involved in, and ultimately to control, treatment decision-making processes.

This patient autonomy right of involvement and ultimate control over treatment is reflected in documents found in most or all hospitals describing patient rights and responsibilities incident to care. An excellent example of such a document is the Patients’ Bill of Rights and Responsibilities of the Brooke Army Medical Center.21
A patient’s right of autonomy also includes the right to refuse treatment, after all reasonable options and the consequences of refusal of treatment have been explained to the patient. Is the patient’s right to refuse intervention absolute? No. Courts have ruled on occasion that treatment may be given compulsorily to patients under special circumstances, such as when the life of a third party (e.g., fetus carried by a mother) is at risk if treatment is not provided to the patient. More and more, however, courts are ruling in ways that evince greater respect for patient autonomy, irrespective of the consequences of patient’s decisions to innocent third parties.

Patients’ right to choose their own health care providers is universally recognized. Laws in all states and professional ethics codes recognize this inherent patient right. Managed care and health care reform initiatives have the potential to affect patient and professional autonomy adversely in a number of ways. A draft version of the 1993 federal Clinton health reform initiative would have given regional health alliances broad authority to intervene certification and state licensure restrictions on professional practice in unspecified ways. Managed care contractual networks may create barriers to participation for providers not part of preferred provider networks. Managed care–era restrictions on provider-patient communications—such as employment contract gag clauses or limitations on parameters of practice—also derogate from the professional relationship. These restrictions must continue to be addressed by the health care professional, political, consumer, and other relevant communities.

The four foundational biomedical ethical principles guiding the official conduct of health care professionals are beneficence, nonmaleficence, justice, and autonomy.

THE SYSTEMS APPROACH TO HEALTH CARE PROFESSIONAL ETHICAL DECISION MAKING

Health care ethical decision making, whether in clinical, educational, research, school, home, or other settings, requires careful compliance with professional and, where applicable, institutional ethical standards and with legal mandates. As with legal requirements, ignorance of ethical responsibilities is no excuse for noncompliance.

Many existing frameworks exist for ethical decision making for health care professionals. All ethical decision-making models governing patient care and health client service delivery are based on the foundational biomedical ethical principles of beneficence, nonmaleficence, autonomy, and justice and are reflective of core professional attributes and duties, including accountability, advocacy, altruism, autonomy (patient and professional), compassion, competence, confidentiality, empathy, fidelity, fiduciary status, loyalty, patience, social responsibility, team play, and truthfulness. Conducting oneself in conformity with these principles, attributes, and duties is seemingly more difficult under the current managed care paradigm, which poses...
significant actual and potential conflicts of interest. Most analytical ethical decision-making models have common core elements:

- Identification of a problem, issue, or dilemma having ethical implications
- Identification of relevant facts and unknowns and formulation of reasonable assumptions about the problem, issue, or dilemma
- Delineation and analysis of viable courses of action to resolve the problem, issue, or dilemma
- Selection of an option for implementation based on an appropriate ethics approach and ethical guidelines and in conformity with controlling ethical and legal directives

The systems approach augments this model with a feedback loop. Under the systems approach, a decision maker carefully monitors and obtains feedback on a chosen course of action for appropriateness, efficacy, and effectiveness—on an ongoing basis—and modifies the chosen course of action (or rejects it outright and substitutes another course of action) if, on the basis of negative feedback, it is adjudged not to be optimal.

For more information on general systems theory and thinking, see von Bertalanffy’s *General Systems Theory: Foundations, Development, Application.*

Ignorance of one’s professional ethical responsibilities is no excuse for noncompliance.

Von Bertalanffy developed systems theory in the 1920s. Today, it is widely used in engineering, the natural sciences, and business and management.

Under the systems approach to health care professional ethical decision making, a decision maker must evaluate and reevaluate a myriad of factors relevant to a problem, issue, or dilemma at all steps of the analysis. These factors include the following:

- Sociocultural considerations, such as gender, race and ethnicity, religion, sexual preference, and other factors, as they apply to a problem, issue, or dilemma
- Legal implications associated with a decision
- Ethical imperatives (i.e., Will the decision maker’s conduct conform to a governing professional code of ethics or with the decision maker’s personal morals and ethical standards?)
- Economic impact of a course of action on those persons affected by its implementation
- Political ramifications associated with a course of action, if any

In addition to applying these *S-L-E-E-P* factors, a decision maker should also always apply the principle of symmetry to the resolution of a health care ethical problem, issue, or dilemma within the systems approach to health care professional ethical decision making. The principle of symmetry requires an actor to carry out a multidimensional analysis of a chosen course of action. The principle requires a decision maker to analyze a decision at least by assuming the opposing point of view and analyzing its implementation from that perspective.

Figure 2-3 depicts the circular flow diagram of the systems approach to health care professional ethical decision making. Primary and support health care professionals are urged to consider its implementation in their clinical decision making.
SUMMARY

Health care professionals must comply with their own personal moral beliefs, the civil and criminal laws of the jurisdiction in which they practice, and the professional ethics standards of their professional associations and other entities. Occasionally, these governing directives are in conflict, creating serious dilemmas for health care professionals and patients under their care.

Four foundational biomedical ethical concepts affect health care professional ethics. Beneficence involves acting in a patient’s best interests. Health care professionals are their patients’ fiduciaries (i.e., they stand in a position of special trust and confidence). Nonmaleficence means that health care professionals are bound not intentionally and maliciously to harm patients under their care. Justice involves equitable treatment of all patients. Autonomy evidences respect for patients’ inherent right of self-determination, particularly in controlling treatment decision making. The implementation of these guiding principles has been made more difficult under managed care, in which the interests of providers and third-party payers are often in conflict with patient needs or desires.

Health care professionals must use a systematic approach to health care professional ethical decision making. The systems approach presented in this course shows an easy-to-follow-and-implement decision-making tool. The approach contains the following elements: (1) identification of a problem, issue, or dilemma with ethical implications; (2) identification of relevant facts and unknowns, and formulation of reasonable assumptions; (3) delineation and analysis of viable courses of action; (4) implementation of a course of action; and (5) monitoring and modification (if necessary) of an executed course of action, based on ongoing feedback.

FIGURE 2-3 | The systems approach to health care professional ethical decision. (Adapted from Scott RW: Professional ethics: a guide for rehabilitation professionals, St Louis, 1998, Mosby.)
Promoting Legal and Ethical Awareness

CASES AND QUESTIONS

1. Develop a draft version of a model patient code of ethical conduct, generally applicable to inpatients.

2. Consider the following clinical practice problem:
   A group of orthotists and prosthetists in private practice in a large metropolitan area in the northeastern United States is contemplating the establishment of a pro bono publico (reduced or no fee) service within their practice for indigent patients needing care. Analyze the problem under the systems approach to health care professional ethical decision making.

3. Peruse your professional association code of ethics. Compare and contrast it to at least the codes of ethics of at least two other disciplines. How are the three codes similar? How do they differ? What changes, if any, might you suggest to the ethics or judicial committee of your association regarding the disciplinary code?

SUGGESTED ANSWERS TO CASES AND QUESTIONS

1. A patient code of ethics may contain the following provisions (among possible others):
   **Model Patient Code of Ethics**
   A patient in the inpatient setting is expected to do the following:
   I. Provide accurate and complete information to a primary health care provider relevant to a consultation or treatment.
   II. Listen carefully to information provided by your health care provider; ask relevant questions about recommended interventions; and make a definitive, intelligent, voluntary, and unequivocal decision to accept or decline a recommended intervention. Please share responsibility for your own care.
   III. Respect the rights and dignity of all other persons in the health care setting, and respect the property of others.
   IV. Cooperate with examining, evaluating, and treating health care professionals to the maximum extent feasible, and ask relevant questions throughout the process of care delivery.
   V. Conduct yourself in such a way as to maintain an optimal patient–health care professional relationship with your providers. Insist on the same level of professionalism from everyone in the process.

2. Factors for analysis under the systems approach to health care professional ethical decision making:
   - Problem: A significant number of patients require orthotist’s and prosthetist’s services in the community who present themselves in this clinic for care, lacking the ability to pay for those services.
   - Facts, unknowns, and assumptions: One sample factor is given for each category. Others may also apply:
     - Sociocultural considerations: Indigent patients presenting in this clinic for care are disproportionately working mothers and their children.
     - Legal implications: The assumption is that the state permits indigent patients to sign a waiver of liability for simple negligence incident to no-fee health care.
     - Ethical imperatives: Pro bono publico services are the epitome of ethical behavior and, in many disciplines, an expectation.
Ethical Foundations

- Economic impact: Accepting a fixed small number of pro bono patients for care (e.g., three patients in the practice at any one time) is not expected to affect the profitability of the practice adversely.
- Political ramifications: Establishing a pro bono publico policy and publicizing it will enhance the business goodwill of the practice.
- Courses of action: (1) Do not accept any pro bono patients in the clinic, except as required by law. (2) Accept up to three pro bono patients (based on demonstrated need) in the clinic’s practice mix at any one time.
- Option for implementation: Accept up to three pro bono patients (based on demonstrated need) in the clinic’s practice mix at any one time.
- Feedback: Monitor the option implemented for appropriateness, efficacy, and effectiveness; modify or discontinue as necessary.

SUGGESTED READINGS


REFERENCES

23. Adapted from Moore W Jr: Ethics and values (graduate course), EDA 388V, Austin, spring 1997, University of Texas at Austin. Used with permission.
BROOKE ARMY MEDICAL CENTER

Fort Sam Houston, Texas

We at Brooke Army Medical Center (BAMC) hold the welfare and safety of the patient as our highest priority. The most important person in this medical center is you, our patient. Our goal is to provide you with the best medical care available. Our success will be reflected in your satisfaction with the treatment you receive. We regard your basic human right with great importance. You have the right to freedom of expression, to make your own decisions, and to know that your human rights will be preserved and respected. The following is a list of patient rights and responsibilities.

YOUR RIGHTS AS A PATIENT

You have the right to receive respectful, considerate, and supportive treatment and service.

- We will do our best to provide you with compassionate and respectful care at all times.
- We will do everything possible to provide a safe hospital environment.
- We will be attentive to your specific needs and requests, understanding that they should not interfere with medical care for you or for others.
- We will not discriminate in providing you with care, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, genetic information, sexual orientation, or source of payment.

You have the right to be involved in all aspects of your care.

- We will make sure that you know which physician or care provider is primarily responsible for you care. We will explain the professional status and the role of persons who help in your care.
- We will keep you fully informed about your condition, the results of tests we perform, and the treatment you receive.
• We will clearly explain to you any treatments or procedures that we propose. We will request your written consent for procedures that carry more than minimal risk.
• We will make sure that you are part of the decision-making process in your care. When there are dilemmas or differences over care decisions, we will include you in resolving them.
• We will honor your right to refuse the care that we advise. (In some circumstances, especially for active duty patients, laws and regulations may override this right.)
• We will honor your Advance Directive or Medical Power of Attorney, regarding limits to the care that you wish to receive.

You have the right to receive timely and appropriate assessment and management of your pain.

• We will routinely ask if you are suffering pain. If you are, we will evaluate it further and help you get relief.

You have the right to have your personal needs respected.

• We will respect the confidentiality of your personal information throughout the institution. (For active duty persons, complete confidentiality may not be possible, based on requirements to report some conditions or findings.) We will respect your need for privacy in conversations, examinations, information sharing, and procedures. Also, you may request that a chaperone be present during an examination or procedure.
• We will communicate with you in a language that you understand.
• We will respect your need to feel safe and secure throughout the facility. Hospital employees will be identifiable with badges or nameplates.
• We will take your concerns and complaints seriously and will work hard to resolve them.
• We will respect your need for pastoral care and other spiritual services. Our Chaplain Service is on call at all times. Other spiritual support is welcome, as long as it does not interfere with patient care or hospital function.
• We will respect your need to communicate with others, both family and friends. If it is medically necessary to limit your communications with others, we will tell you and your family why.
• We will use soft fabric restraints, with close and frequent monitoring, if you become so confused that you are in danger of hurting yourself or others. We will untie the restraints as soon as we safely can do so.

You have the right to receive information on how to contact protective services.

• At your request, we will give you information on how you may contact protective services for children, adults, or the elderly. We will do this confidentially.
You have the right to participate in clinical research when it is appropriate.

- Your care provider will discuss this with you when it is appropriate. The Institutional Review Board, a committee that includes people from many parts of this community, monitors all research at BAMC. We will thoroughly explain the proposed research to you and ask your written permission to take part. If you choose not to take part in the research, it will not affect the care that we give you. Participation is completely voluntary.

You have the right to speak to a BAMC Patient Representative regarding any aspect of your care.

- We encourage patients and families to speak directly with ward of clinic personnel if there is a problem. However, if these people cannot solve it, you may contact the Patient Representative at 916-2330 (clinics) or 916-2200 (inpatient tower).

You have the right to expect that this institution will operate according to a code of ethical behavior.

- The Command at BAMC is firmly committed to managing this hospital according to the highest traditions of the military and medical professionalism and ethics. In addition, our Institutional Bioethics Committee meets regularly to review ethical topics, including organizational ethics. This committee is available to you and to our employees if a serious ethical dilemma comes up in either patient care or service.

You have a right to receive a personal copy of these patient rights.

- Copies of these patient rights are available on any ward and in any clinic at BAMC. If you cannot locate a copy for yourself, ask ward or clinic personnel. If you have any questions or comments regarding patient rights, we encourage you to contact a BAMC Patient Representative at 916-2330 or 916-2200.

YOUR RESPONSIBILITIES AS A PATIENT

- You are responsible for maximizing your own healthy behaviors.
- You are responsible for taking an active part in decisions about your health care.
- You are responsible for providing us with accurate and complete information about your health and your condition.
- You are responsible for showing courtesy and respect for other patients, families, hospital staff, and visitors. This includes personal and hospital property.
- You are responsible for keeping your scheduled appointments on time, and for giving us advance notice if you must cancel or reschedule.
• You are responsible for providing us with your current address and means of contact (such as a home phone or cell phone).
• You are responsible for providing us with current information regarding any other health insurance coverage you have.
• You are responsible for keeping yourself informed of the coverage, options, and policies of the TRICARE plan that you subscribe to as a military beneficiary. This information is available in the TRICARE Service Office. (Beneficiary Line: 1-800-406-2832).

Courtesy Brooke Army Medical Center, San Antonio, Texas.