

## Chapter 4

# Benefiting the Patient and Others: The Duty to Do Good and Avoid Harm

### Learning Objectives

1. Differentiate among concepts of benefits and harms to patients.
2. Describe various methods of relating benefits to harms in health care decisions.
3. Explore the tensions between duties to benefit individual patients and obligations to others.

### Other Cases Involving Benefit–Harm Issues

- Case 2-1: Exercise, Diet, or Drugs to Control Cholesterol
- Case 2-2: Treating Breast Cancer: Finding the Value Judgments
- Case 3-3: Providing Less-than-Optimal Services
- Case 5-1: Under the Gun: Staying on Schedule in the HMO
- Case 5-2: Unfunded Dialysis at the Expense of Other Patients
- Case 5-3: Antibiotic for a Child's Otitis Media
- Case 5-5: Dialysis in an End-Stage HIV-Positive Patient:  
Justice, Benefit, and Patient Autonomy
- Case 7-2: Placebos for Addiction Withdrawal
- Case 8-2: I Will Be There for You at the End: A Promise Broken?
- Case 10-1: Abortion for Teratogenic Indications
- Case 11-2: Dwarfism: When Is a Fetus Normal?

- Case 12-1: Guilt over Suicidal Thoughts
- Case 12-2: Obesity: Medical Problem or Lifestyle Choice?
- Case 12-6: Posttraumatic Stress Disorder: Funding Therapy for a Preexisting Condition
- Case 12-8: The Interrogation of Guantanamo Prisoner Mohammed al-Qahtani
- Case 13-2: The Murder of Tatiana Tarasoff: The Therapist's Duty to Warn
- Case 13-3: The Required State Psychiatric Diagnosis Record
- Case 13-4: Reporting the Motorist with Epilepsy
- Case 13-5: Medicine in the Service of the FBI
- Case 15-1: The Sixth Stool Guaic: A Classic Cost-Containment Case
- Case 16-3: Explanation of Risks and the SUPPORT Study

One way to approach medical ethical decision-making is to examine principles that describe general characteristics of actions that tend to make them morally right. In the introduction, the principles of beneficence (doing good), nonmaleficence (avoiding harm), fidelity, respect for autonomy, veracity, avoiding killing, and justice are mentioned. Ethical problems in health care often involve conflicts among these principles. In other cases, the moral problem arises over the interpretation of one of these principles.

The idea that it is ethically right to do good, especially good for the patient, is one of the most obvious in health care ethics. The Hippocratic Oath has the physician pledge to “benefit the patient according to [the physician’s] ability and judgment.”<sup>21</sup> The Declaration of Geneva, the modern rewrite of the Hippocratic Oath by the World Medical Association, limits benefit to “health” but similarly commits to patient benefit, stating that “the health of my patient will be my first consideration.”<sup>22</sup> The other health professions contain similar commitments to patient welfare. The 1994 American Pharmaceutical Association Code of Ethics says that “A pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner.”<sup>23</sup> The American Nurses Association in 2001 adopted a revised version of its Code of Ethics holding that “the nurse’s primary commitment is to the health, well-being, and safety of the patient. . . .”<sup>24</sup> These are all versions of the principle of doing good for the patient. While this seems so obvious as to be platitudinous, in fact, many serious moral problems arise over the interpretation of this principle.

First, even if it is agreed that the benefits and harms that ought to be the focus of the health professional’s concern are the patient’s, there is still considerable room for controversy. The concepts of benefit and harm themselves are controversial. Sometimes these are defined in a way that is purely subjective, in which case a benefit may be whatever the individual finds valuable and a harm whatever he or she finds undesirable. In other views, a benefit or a harm may be thought to be objective so that, for example, we might say that a patient suffers a harm even though the patient does not see it that way. Some conditions may be objectively harmful even though the individual does not perceive the harm. Hypertension could be an

example. The first group of cases provides an opportunity to sort out exactly what it means to benefit the patient and protect the patient from harm.

Equally controversial is the question of whether the health professional should limit his or her concern to benefits and harms that accrue to the patient alone. For example, what if protecting the patient will come at considerable risk of harm to society in general or to specific identifiable people who are not patients? What if the interests of the profession conflict with those of the patient? Or what if doing what is necessary to help the patient conflicts with the interests of the health professional’s family? Is it obvious that the health professional should always place the patient’s interest above those of his or her family? These are the problems of the cases in this chapter.

### Benefiting the Patient

Assume for the time being that it is agreed that an important moral principle is that the health professional should act so as to benefit the patient. Even limiting our concern to this apparently simple principle turns out to raise serious problems of interpretation. For example, many ethical systems take as their goal producing good results for people. The first case in this section forces the health professional to decide what should happen when nonhealth benefits might outweigh the health risks of a medication. Later cases examine the relation between producing good and avoiding harm for the patient and between determining the good produced by various rules rather than the good in individual cases.

### Health in Conflict with Other Goods

Health professionals are normally committed to restoring, maintaining, or improving the health of patients. Health is viewed by virtually everyone as good, as something intrinsically desirable. Yet there are many other goods that rational people desire as well. These include knowledge, aesthetic beauty, and psychological and material well-being. Often, unfortunately, these various goods that people want to pursue compete for scarce resources including time, money, and energy. Deciding what mix of goods is the proper one is a complex and highly individual decision. Normally, however, rational people would not choose to give absolute priority to one of these goods over another. Just as people constantly sacrifice their future material well-being for pleasures of the moment, so they also make some compromise with their health for other goods they consider important. The reasonable goal is not maximum well-being in any one sphere (including health) but maximum well-being across all kinds of possible goods.

This poses a problem for health professionals. They are experts, at most, in the good of health. Normally, they cannot claim to be expert in how to help people in other areas such as their finances, art appreciation, or social well-being. At best, they can advise how to maximize health. Part of the problem is that health professionals will not normally be in a position to advise about what really benefits patients, only, at most, about what serves their health. But rational people would not normally want

to maximize their health; they would want to maximize their overall well-being. Thus, if health professionals are committed first of all to the health and safety of patients, their patients should normally have somewhat broader interests (their total well-being even if it somewhat risks health and safety). On the other hand, if the health professional is committed to the overall well-being or “good” of the patient, he or she is going beyond his or her sphere of expertise. The following case illustrates the problem.

#### Case 4-1

#### Stimulants as Performance Enhancer

Michael Chadwell was a 22-year-old medical student studying for his final exams in the first semester of his first year. He had been struggling all semester to keep up with the amount of reading and studying that was required. He had particular problems with pathophysiology and knew he was “on the bubble.” He needed the best grade he could possibly get on the final to avoid a failing grade.

He simply had to cram for the exam day and night. About a month ago, Michael noticed that one of his classmates, Sheila Tan, always seemed to be alert and full of energy when the other members of their study group were flagging. When he asked how she had so much energy, she told him, “I take those diet pills that you can get over the counter at any drugstore. Sometimes I add phentermine which I can get on the Internet.” He asked her about the possibility of detection of the drugs because the university was a “drug-free” environment and they had agreed to this when entering medical school. Sheila responded, “I was worried about that, but you would have to take a bucket of this stuff to have it show up in your urine.” At the end of their conversation, Sheila had given him some of the phentermine to try. Michael also bought some diet pills at his local pharmacy. He had not used either of them yet, but if there was ever a time he might need help in making it through the week, he reasoned, this was it.

He had never taken either of these drugs, so he was not sure of the effect. He was a little concerned that they might be more potent than Sheila let on because he noticed lately that she had gotten quite thin and haggard looking. She told him, “I am only sleeping about 3 hours a night. I cannot wake up without these pills.” He is not sure how much she is taking, though, and did not plan on taking more than a few pills a day to get him through this week of studying. Without it he felt sure he would not do well on the exam; with the drugs he might do well. He thought he had little to lose and an entire career to gain.

Should he take the pills even though he knows there could be some serious side effects? What if it is discovered that he has broken the “drug-free” policy of the School of Medicine?

#### Questions for Thought and Discussion

- ❑ Refer back to the five-step model for decision-making in Chapter 1. At what point in the case do you sense that there is something wrong?
- ❑ What are important clinical and situational facts in the case?
- ❑ What is the moral relevance of these facts?

#### Commentary

Most cases in this volume involve ethical issues arising in a relationship between a health professional and a patient, but many medical choices are made outside of such relations. People choose whether to follow a regimen of exercise and diet, self-medicate for headache or muscle pain, or call for an appointment with a health professional. All of these are medical choices made daily by laypeople. Some of them can involve important moral dimensions.

Michael Chadwell, the medical student in this case, is facing such a choice. He faces a decision that poses some undeniable medical risk. Although diet pills are available over the counter, they are not without side effects. Phentermine, one of the ingredients in the diet combination known as “fen-phen,” is still available but restricted to prescription use. Nevertheless, it is available on the Internet without any direct contact with a physician. It can cause irritability, nausea, vomiting, and occasionally more serious cardiac problems as well as dependency. The benefits are essentially nonmedical—a possible increased alertness that could produce improvement in performance on a critical medical school exam.

The common wisdom in both the medical professional and lay communities is that Michael’s proposed plan is dangerous. Deciding whether the risks are worth it is a complex issue, however. Michael does not have direct experience with the medication, but he is aware of a classmate who is pleased with its effects. He has heard of her experience, which appears to him to be worth the risks. Assessing risks and benefits of any medical treatment is inherently subjective. Not only does Michael know some things about how the drug might affect him, he is also in a unique position regarding the benefits. He realizes the huge potential benefit—the difference between remaining in medical school and failing. For him, the risks seem worth the relatively large benefits. A physician is in a good position to assess the medical risks of a drug such as phentermine but is not well placed to assess the nonmedical benefit and how that benefit compares with the medical risks.

Some medical ethicists claim that medicine should be used only to pursue medical benefit. They object to any interventions not designed to improve the patient’s health, to cosmetic surgery, abortion and infertility treatment, and drugs for intentional euthanasia, for example. The idea is that there is an “internal morality” in medicine. Its purpose is to promote health, not to strive for general human happiness.

Critics of this “internal morality” thesis reject the idea that medicine can only be used for promoting health. They claim there is no reason why medical science

should not be used for promoting human well-being outside the realm of health. Goals external to medicine are also legitimate.<sup>5</sup> In that case, the choice facing Michael (and already faced by Sheila) becomes a matter of judgment about whether the great potential benefits justify the risks of taking the drug.

In addition to the risk-benefit questions in this case, there are some more subtle questions relating morality to law and social fairness. Sometimes, as in this case, the use of drugs for performance enhancement raises questions of legality. Drugs are bought on the black market rather than conforming to laws requiring that they be legally prescribed by a physician. Others might ask whether using drugs for performance enhancement amounts to cheating. The athlete who clandestinely uses steroids gains a competitive advantage that is reflected directly in having a different winner in a sports contest. Most would see this as raising questions of fairness. Whether Michael's use of these stimulants gives him an unfair competitive advantage over other medical students is a more complicated question. One might argue that he is already at a competitive disadvantage compared with Sheila, who is already using these stimulants. On the other hand, if some students use chemical stimulants, all others will be forced to use them or stand in a relatively disadvantaged place. The problem is similar to sports in which some competitors use chemical performance enhancers. The choices made by Lance Armstrong and his fellow racers come to mind.

Finally, we should consider how Michael's physician should respond if he or she learns of Michael's use of the phentermine without his physician's involvement. We could even consider whether she should cooperate if Michael were to ask her to prescribe the phentermine for his new purpose. Although studying for exams is not a labeled use, it is not illegal for a physician to prescribe a legal drug for "off-label" use. Almost no physician would be willing to cooperate in this case, however. The more difficult question is what the physician should do if he or she discovers that Michael is using phentermine in this way. Surely, she should counsel Michael about the risks. She should realize, however, that her counsel could well be influenced by the fact that she is professionally committed to focus on the medical dimensions of drug use. Since there is essentially no medical benefit and very real medical risks, her counsel is likely to reflect how one-sided the judgment is from a medical perspective. On the other hand, she would have no special expertise in evaluating the educational risks and benefits. She might consider reporting her patient, but it is not clear on what basis she could provide anything more than advice and counsel.

We are left with something of a dilemma for a medical ethic that strives, as the Hippocratic Oath does, to produce benefit for the patient. Not all benefits are health related. Some people may have goals in mind that are not primarily health related. They may be willing to take some risks with their health in order to try for nonmedical benefits. Whether we pursue health-related benefit or total overall well-being will make a big difference. These are issues not only for these stimulants, but also for steroids, growth hormones, and other medications used for performance enhancement.

Usually physicians faced with the tension between medical and nonmedical benefits such as those in Case 4-1 decide that, since total well-being, including nonmedical benefits, is well beyond the physician's expertise, they will limit their attention to the medical sphere. They conclude that at least in the medical realm they can determine what will benefit the patient. They may recognize that it will be up to the patient to determine whether to accept the doctor's recommendation about what is medically beneficial or reject that advice in favor of some nonmedical good. They, in effect, adopt a more modest ambition of focusing on the narrower sphere of medical benefit. Even here, however, controversy can arise. Several kinds of medical benefit can be pursued. In the mid-twentieth century the assumed goal was to preserve life, even preserve life at all costs, but since then other goals have been considered as well, goals such as curing disease, relieving suffering, or preserving health. Thus, even if Michael's physician should decide to focus on Michael's medical interest, it is not clear what his objective should be.

### Relating Benefits and Harms

After the problems of relating health benefits to overall benefits and selecting among various health interests are solved, a second question needs to be addressed if health professionals and patients are to figure out what it means to do what will benefit the patient. Often the intervention that offers the greatest prospect for benefit is also most risky; it offers not only the greatest good but also the greatest risk for harm. How is one to relate the benefits and harms in attempting to determine what will produce the most good?

One possibility is to approach the problem arithmetically. The benefits could be viewed as "pluses" and the harms as "minuses" on a common scale. According to this view, the harms are subtracted from the goods to determine what course will do the most "net" good. This is the position of many utilitarian philosophers. It is sometimes identified with the great nineteenth-century British utilitarian Jeremy Bentham.<sup>6</sup> In carrying out such mental calculations, one has to factor in the probability of each envisioned benefit or harm. Some of these benefits and harms are rather easily quantifiable, such as expected numbers of years of life added with an intervention. Others, such as pain and suffering or the benefit of getting to see a loved one, can, at best, be approximated. Policy analysts have developed sophisticated strategies for estimating such benefits and harms. For example, the quality-adjusted life year (QALY) method is designed to take into account not only number of years of life but also the quality of the years.<sup>7</sup>

It is not obvious morally that it is correct to pursue the course of action that is expected to produce the greatest net good. Many believe there are moral constraints on such actions based on other moral principles, which are to be explored in cases in later chapters. But even for those who limit their ethics to beneficence and nonmaleficence, to doing good and avoiding evil, there are problems.

For example, one might try to maximize the benefit/harm ratio rather than maximize the net goods. This approaches the problem of relating benefits and harms geometrically rather than arithmetically. If one imagines two courses, the second of

which has twice the expected benefit and twice the expected harm, according to the ratios method there is no difference between the two, but according to the method of subtracting harms from benefits, the option with twice the benefits and twice the harms would produce a net gain that is twice as large as the alternative. According to the arithmetic method, one is always obliged to choose the high-gain/high-risk option, while according to the ratios approach the two options would be treated as equally attractive.

Still another way of relating benefits to harms is to give nonmaleficence, the duty to avoid harming, a moral priority over beneficence. According to this view, the duty to not harm is more stringent than the duty to help. One is morally free to try to help only when one is sure that harm will not be done. In contrast to the approaches that calculate net good done or ratios, giving priority to avoiding harm gives a preference to the more cautious course. In fact, if carried to an extreme, it would always lead to doing nothing. In that case, at least one will have avoided harming (even though one would also have missed opportunities to do good and to prevent harm). The following case provides an opportunity to compare different ways of weighing benefits and harms of alternative courses of action.

#### Case 4-2

#### The Benefits and Harms of High-Risk Chemotherapy

Joe Cavanaugh, a 58-year-old professor of economics, was diagnosed with chronic myelogenous leukemia (CML) several months ago. Though this particular type of leukemia is somewhat less responsive to chemotherapy, Dr. Cavanaugh responded well to a course of chemotherapy that he took orally shortly after his diagnosis. Dr. Cavanaugh's last blood count indicated that his white blood count was greatly reduced. During the course of his chemotherapy, Dr. Cavanaugh had become close to Heather Eyberg, Pharm.D., the clinical pharmacist in the cancer treatment center.

After a follow-up visit with the oncologist, Dr. Cavanaugh stopped by Dr. Eyberg's office. Dr. Cavanaugh said, "The doctor has suggested several possibilities regarding my treatment. I trust you, and I would appreciate your opinion on my options. The doctor said that now that I have finished taking the oral chemotherapy, I could start interferon alpha or, if I want to be 'cured,' I should think about a stem cell transplant. The type of leukemia I have can rapidly change from this chronic phase into acute leukemia. If that happens, it is unlikely that anything would help, and I would not have long to live. The doctor wants me to think about a stem cell transplant. He said I could remain in this holding pattern for years, but there is no way of knowing. Or I could have high-dose chemotherapy and stem cell transplant. What do you think?"

Dr. Eyberg respects Dr. Cavanaugh and his capacity to understand the risks and benefits involved in stem cell transplantation. She knows that allogeneic hematopoietic stem cell transplantation (HSCT) is the only therapy proven to cure CML. If Dr. Cavanaugh has a sibling that is a match and has the HSCT within the first year of his diagnosis, he has a better five-year survival rate than those who undergo HSCT after the first year of diagnosis. So time is of the essence. The two options presented to Dr. Cavanaugh are essentially: watch, wait, take the interferon alpha and hope that the disease never progresses or take a chance on HSCT now. The risks of HSCT are substantial. The possibility of infection and other complications is very high. It is not inconceivable that Dr. Cavanaugh could die from the HSCT itself.

Since Dr. Eyberg is part of the cancer treatment team, she is unsure of where her moral commitment should lie. Should she counsel Dr. Cavanaugh to choose the least harmful course of therapy? The conservative route would probably be to watch and wait and take the interferon alpha. Yet, if the disease progresses to acute leukemia, there is little anyone could do to help Dr. Cavanaugh. However, Dr. Cavanaugh could be in the percentage of patients who never progress to this fatal phase of the disease. Even if he eventually did change to the fatal phase, Dr. Cavanaugh might have many good years with his wife and children until then.

Dr. Eyberg could also counsel Dr. Cavanaugh to choose that option that maximizes the benefit for him. It is hard in this situation to determine which course of action will do the most good in the long run. Clearly, HSCT holds greater risk in the short run but offers the potential for a cure of Dr. Cavanaugh's leukemia in the long run.

Finally, Dr. Eyberg is troubled by the memory of another patient with a similar diagnosis who recently chose the option of HSCT and did not survive the procedure. Given all of these considerations, Dr. Eyberg is not sure where to begin.

#### Commentary

The issue in this case is whether there is a *moral* reason to prefer one course or the other. The health professional and the patient can consider the potential benefits and potential harms of the options. They would take into account not only the amount of benefit and harm, but also the probability that they will occur. Sometimes this is hard to do; often one can only estimate quantity and likelihood.

One approach favored by some ethical theories is to give a moral priority to avoiding harm, even to oneself. Sometimes this is expressed with the slogan *primum non nocere*, that is, first do no harm. Many assume this slogan comes from the Hippocratic Oath, but it does not. In fact, it is not found in ancient medical ethical writing that is known to modern scholars. The fact that it is in Latin is a clue that it is not from the Oath, which was written in Greek. Recent scholarship

suggests that it had its origins in the nineteenth century when we were becoming aware that more radical treatments such as bloodletting and mercury were dangerous.<sup>8</sup> Why it is normally rendered in Latin remains a mystery.

If there is a moral duty to give priority to avoiding harm (to the principle of nonmaleficence to use the technical term), then the correct moral advice would be to take the “safer” course and avoid the transplant. No one would then engage in a risky action that could be directly responsible for harming Dr. Cavanaugh, even causing his death. That might, of course, also mean losing a chance at producing great benefit, but those who give priority to not harming are willing to accept that consequence.

This suggests a second approach. Consider the possibility that Dr. Cavanaugh not only estimates the risk of the stem cell therapy to be greater but also estimates the benefit greater in the same proportion. It could be that in comparing benefits and harms, the correct approach is to compare ratios of benefits and harms and choose the course that has the greatest ratio of benefit to harm. If the ratios were the same, then based on ratios one would be morally indifferent between the two choices. It would be a matter of taste.

A third approach is also possible. One could attempt to calculate the *net* benefit from the alternative courses. If Dr. Eyberg or Dr. Cavanaugh feels that the chance of doing harm was greater with the transplant but that the risk of harm was offset by the proportionally greater increase in benefit, then the ratios would be the same, but instead of looking at the ratios, one could calculate the net benefit by subtracting the estimated harms from the estimated benefits. If the ratios were the same but the stem cell transplant posed both greater benefits and greater risk of harm, then the net difference (subtracting the harms from the benefits) would be greater for the stem cell transplant. If one were a Benthamite utilitarian, this would be the favored approach. One would be *morally* obliged to choose the course that would produce more net good, that is, the stem cell transplant.

Dr. Cavanaugh will favor the conservative therapy if he gives priority to not causing harm; he will favor the more experimental stem cell transplant if he looks at the net benefit; and he will be indifferent between the two if he focuses on the ratio of benefit to harm. In order for Dr. Eyberg to know how to advise Dr. Cavanaugh, she needs to know what the correct approach is to relating the benefits and the harms.

### Benefits of Rules and Benefits in Specific Cases

Even if the health professional and patient solve the problem of relating benefits to harms as well as the problem of relating health to nonhealth benefits, there is still another difficulty in figuring out what will benefit the patient. Some people who calculate consequences do so with reference to the specific case considered in isolation. They look only at the effects of alternative actions in the specific case. Others are equally focused on consequences, but they are interested in the consequences of alternative rules. Those people, who were referred to as “rule utilitarians” in the introduction, hold that one should look at the consequences of alternative rules and

choose the rule that produces consequences as good or better than any alternative. Then, once the rule is adopted, morality requires that it be followed without reassessment in specific cases. Only at the stage of adopting rules do consequences count according to this view. Some rule utilitarians oppose case-by-case calculations for pragmatic reasons—because they think there is too much room for error in the heat of a crisis and is too time consuming. Others oppose case-by-case calculations for theoretical reasons—because morality is simply a matter of playing by the rules once they have been adopted. The following case illustrates how these two approaches to calculating consequences affect a physician’s moral choices.

#### Case 4-3

#### Physician Assistance in an ALS Patient’s Suicide

Dr. Jim Witcher was a 57-year-old retired veterinarian who owned a horse farm in Louisiana.<sup>9</sup> He had amyotrophic lateral sclerosis (ALS, sometimes called Lou Gehrig’s disease), which was gradually causing him to lose muscle control. He had been active on his farm and enjoyed caring for his horses but was now wheelchair-bound in a power-assisted chair. He could, with assistance, get out on his farm but was losing the ability to feed himself. He worried about his gradual decline and loss of control. He also worried about the enormous costs that were depleting the resources set aside to support him and his wife during their retirement.

His wife provided around-the-clock care. She resisted suggestions that she place her husband in a nursing home or even hire help for his care. Their children were grown and occupied, raising their own families. Dr. Witcher knew the burdens on his wife were enormous.

Dr. Witcher realized that he would soon lose all ability to consume food and medicine unaided and anticipated the day when he would not be able to hold his grandchild or even breathe on his own. He knew what he did when one of the horses under his care developed incurable disability. One day during a routine visit with his internist, he raised the question of why humans could not get similar assistance to quickly end their misery when their suffering and disability became unbearable.

His physician told Dr. Witcher what he already knew. Physician assistance in suicide was illegal and violated the traditional norms of the physician’s medical ethics. His physician pointed out that highly skilled and compassionate hospice care was available that would make his inevitable deterioration as comfortable as possible but that he could not legally or ethically assist by prescribing or administering a lethal drug.

Dr. Witcher acknowledged that what he desired was illegal but asked why the law could not be changed.

## Commentary

This case involves the ethics of physician-assisted suicide. A complete analysis must carefully differentiate it from the ethics of suicide that does not involve a physician's assistance as well as from physician euthanasia, what could be called "homicide on request." This moral and linguistic analysis will occur in detail in the cases of Chapter 9, which examines the ethics of medical killing. Here our focus is on how the assessment of benefits and harms should be handled in such cases.

Dr. Witcher is of the opinion that the burdens he and his family will suffer under any legal strategy for his terminal care will exceed the benefits. He believes that an active, intentional termination of his life at a point before the burdens become unbearable and the family resources are depleted will be, on balance, better than any alternative including compassionate hospice care. With ALS he is completely lucid mentally and has had many months to contemplate his alternatives. He has a stable, ongoing relationship with a personal physician. He would like for that physician to be able to actively assist in ending his life at the proper moment either by prescribing medication and instructing Dr. Witcher on how to use it (physician-assisted suicide) or actually administering a lethal injection (intentional mercy killing).

Many controversies could take place over whether Dr. Witcher has calculated the consequences properly. For discussion purposes, let us give him the benefit of any doubt and assume he has calculated correctly what will produce the best possible consequences for him and his family. It is possible that, even if he has correctly determined that assisted suicide is better for him than any alternative, it is still morally the wrong course.

One possibility that will be discussed in Chapter 9 is that intentional killing of a human, even for mercy, is simply a violation of some moral norm that prohibits such behavior—some principle of avoiding killing or the sacredness of life. Another possibility is that we cannot decide morality directly by analyzing the consequences on a case-by-case basis.

The real issue needing attention at this time is whether it is morally acceptable for Dr. Witcher and his physician to consider the benefits and harms of this specific act in isolation. If Dr. Witcher concludes that physician-assisted suicide would be morally right in this case, he seems to be claiming that whatever will produce the best consequences in an individual case determines what is moral. Judging the ethics of a decision by calculating the consequences of the individual action is what is sometimes called "act-utilitarianism."

Others, even some who believe ethics should be based on consequences, might conclude that, on balance, even though in this case it would be better for Dr. Witcher to have access to physician assistance in ending his life, the practice of permitting physicians to provide such assistance whenever they thought the consequences justified it would have such a bad result that it is better to affirm the rule, "physicians should never intentionally kill their patients even if they believe the consequences would be better than any alternative course. . . ." If he took that position, he would be a rule-utilitarian.

Some support rule-utilitarianism on the practical grounds that the consequences of rigidly following some rules may be better in the long run than permitting individuals to decide on a case-by-case basis. Humans are fallible; they may miscalculate. Particularly for irreversible decisions of such momentous importance as terminating human life, it may be better to follow a simple rule prohibiting intentional killing. Others may defend rule-utilitarianism on more theoretical grounds. It may simply be a matter that morality requires playing the "game" of life by a set of rules, moral rules in this case. Either way, those who are rule-utilitarian will choose the rule or set of rules that will produce the best consequences in the long run rather than applying calculations of benefit and harm to make decisions directly in the individual case.

While this might sound legalistic, it need not be viewed as a totally exceptionless position. A rule-utilitarian may tolerate exceptions in extreme cases. One might even build exception clauses into the rules. An exception clause might require that the consequences of violating the rule be overwhelming in order to justify making an exception.

The problem facing Dr. Witcher and his physician is one of deciding whether they will calculate the consequences looking only at the specific case or whether they will calculate consequences of alternative rules and choose the rule that has the best consequences.

## Benefiting Society and Individuals Who Are Not Patients

The focus of benefit in the cases thus far in this chapter has been the patient. Occasionally benefits to others have emerged in the cases, but it was usually in a very marginal way. In other situations, the health professional appears caught between doing what will benefit the patient and doing something else that will have much greater benefit on other parties.

According to the classical Hippocratic ethic, the health professional was, in such cases, to choose to benefit the patient. The modern paraphrase of the Oath, The Declaration of Geneva, is not quite as unilaterally focused on the patient, but it has the physician pledge that "the health of my patient will be my first consideration."

As early as the nineteenth century, the writers of the professional codes began to realize that sometimes the moral obligation of the health professional extended beyond the individual patient. The emergence of public health in the nineteenth century made code writers realize that sometimes the health professional had to consider the welfare of the population as a whole. More recently, health professionals have recognized ethical tensions created by their obligation to others such as the family of patients, the profession as a whole, or to their own families. These cases raise this conflict between benefits to the patient and to others.

## Benefits to Society

During the past century, health professionals have gradually reached the conclusion that they bear responsibilities not only to individual patients but also to the community. In fact, focus on community interest became sufficiently prominent that, in

the most recent revision of the American Medical Association code of ethics in 2001, the association saw fit to reemphasize the primacy of the duty to the patient. The new eighth principle states, "A physician shall, while caring for a patient, regard responsibility to the patient as paramount."<sup>10</sup> Thus the pattern is one of organized American medicine struggling with the tension between a duty to benefit the individual patient, which is recognized as paramount, at least when dealing with the patient, and a duty to the broader society that persists in a secondary position. Many other codes of the health professions have incorporated similar notions of the health professional's duty to the community in addition to the individual patient.

The ethically difficult issue is what should happen when the health professional's opportunity to serve the public comes at the expense of the individual patient. They are variously asked to participate in medical research for the purpose of creating generalizable knowledge, in public health campaigns, and in cost-containment efforts. None of these is ethically possible on strictly Hippocratic (individual patient welfare) grounds. The next case forces a physician to choose between serving a community of patients and an individual patient.

#### Case 4-4

#### **Blocking Transplant for an HMO Patient with Liver Cancer: Serving the Patient and Serving the Community**

Rafael Villanueva was a 38-year-old venture capitalist with a serious liver problem. He had been diagnosed with a primary tumor of the liver at the health maintenance organization (HMO) where he was a member. Mr. Villanueva had been asymptomatic during the early stages of the tumor's development. When he was diagnosed the tumor had grown to 5 cm in diameter, which meant it had developed to the point that it was beginning to pose a serious risk of metastasis or, in other words, spreading throughout his body. He was informed by his HMO hepatologist, Dr. Edwards, that the only possible therapy was a liver transplant, but given the size of the tumor it was not medically appropriate.

Dr. Edwards had researched the options. He discovered that the liver transplant center with which the HMO had a contract would not accept patients once the tumor size had reached 5 cm. They reasoned that the chances of metastatic disease were sufficiently great that the transplant was unlikely to succeed. On that basis, Dr. Edwards had told his patient that the transplant was not medically indicated.

Mr. Villanueva gradually realized that this was a death sentence. The liver cancer would continue to develop until it took his life. He began researching the treatment options. He had amassed a sizable estate and traveled internationally reviewing start-up enterprises in which he could invest. He discovered that there was general agreement in the transplant

world that liver grafts should not be attempted once the tumor had reached this size but that two centers in the United States and one in Sweden were performing transplants on an experimental basis.

On the basis of this discovery Mr. Villanueva returned to his HMO and asked if he could once again be considered, given the fact that death was the certain alternative. He expressed concern that his wife and small child would be left without a father and income provider, should he die. When Dr. Edwards again refused to recommend him for transplant, Mr. Villanueva discovered that he could appeal his clinician's decision.

The case was appealed to the medical director, the final HMO authority in such cases. The medical director, Dr. Florence Cunningham, received Mr. Villanueva's appeal. After a week to investigate the facts, she again denied his request, citing both the clinical judgment that the transplant was not medically appropriate and the fact that one-year cancer-free survival following transplant in the programs doing experimental grafts for primary liver tumors was only 5–15 percent. If the tumor has not metastasized, the transplant will remove the cancer, but in most cases cancer cells will already have migrated beyond the liver. She also noted that livers for transplant were very scarce, life-saving resources and should not be used for patients who have such a small chance of successful transplant.

#### **Commentary**

Two physicians at the HMO are involved in deciding that Mr. Villanueva should not be listed for a liver transplant. Their moral roles need to be analyzed separately. Dr. Edwards, the internist, would traditionally have been seen as having a Hippocratic duty to do what he thinks will benefit the patient. That may be what Dr. Edwards did in this case. He advised his patient that the transplant was not "medically indicated."

Part of the problem in this case is that the term "medically indicated" is vague and sometimes misleading. Sometimes it is used to mean that the treatment will produce an effect. Saying a treatment is not medically indicated can therefore mean it will not be effective for the patient's condition. When physicians say that antibiotics are not medically indicated for a viral infection, they mean the antibiotic will not have an effect on the virus. If the liver transplant would have no effect on Mr. Villanueva's cancer, the term could be used in this way. However, the transplant does have a chance of being effective; it has a 5–15 percent chance of producing a 1-year cancer-free survival. Nevertheless, that means an 85–95 percent chance that the transplant will not overcome the cancer. Moreover, transplant combined with immunosuppression therapy produces serious, burdensome side effects. Dr. Edwards could mean when he says that the transplant is not "indicated" that, even though the transplant has a small chance of working, he believes that the burdensome side effects outweigh



any chance of benefit. The original Hippocratic Oath holds that benefit to the patient is to be determined by the physician's "ability and judgment." If Dr. Edwards believes that the burdens outweigh the benefits, this could be what he means by saying the transplant is not indicated.

Of course, Mr. Villanueva may have a different evaluation of the risks and benefits of the transplant. He may believe the 5–15 percent chance of success make the burdens worth it. If benefits and burdens are inevitably subjective, some would hold that it is the patient's judgment that should count.

There is another possible explanation of Dr. Edwards's claim that the transplant is not indicated. The internist never mentions that livers for transplant are a scarce, life-saving resource and that listing Mr. Villanueva for transplant could lead to using up a liver that otherwise could be used for another patient who would have a much better chance of a successful graft. Although clinicians are traditionally committed to focus exclusively on the welfare of their patients, they are increasingly pressured to consider the interests of other patients. Some interpretations of professional ethics summarize the clinician's duty as servicing the interest of "patients" rather than the single, isolated patient with whom the clinician is presently interacting. If the patient population as a whole is the proper target of clinician concern, then refraining from listing Mr. Villanueva in order to save the organ for some other needy patient would be more defensible. If that is Dr. Edwards's reasoning, he needs to face the question of what he conveys to Mr. Villanueva. He could plausibly be obligated to tell him that he bases his recommendation on his judgment about the interests of other patients as well as Mr. Villanueva.

The case also involves a second physician, the medical director, Dr. Florence Cunningham. It was to her that Mr. Villanueva appealed when he was denied a transplant listing. Dr. Cunningham is in a different position than that of the primary physician, Dr. Edwards. As medical director, she has responsibility for the joint welfare of all her patients, not just the one who is making an appeal. She may also be thought of as having responsibility to the HMO management and board of directors. Hence, she needs to take into account the welfare of all patients and maybe the economic interests of the HMO as well.

She never mentions the economic interest of the HMO in denying Mr. Villanueva's appeal. The cost of the transplant would have been about \$200,000. Since the transplant has only about a 10 percent chance of success, she could have reasoned that it would cost \$2,000,000 for one life saved. While medical people do not like to think in dollar terms, that is a very large amount to spend to save one life. Most insurers who understand medical economics would not be willing to spend that amount to save a life. Looked at from the point of view of the subscribers to the HMO, if they expected such expenditures, their premiums would be unacceptably high. Spending the same money on other life-saving interventions such as health maintenance programs would be a much wiser investment.

Given these facts, all health insurers, including HMOs, have to set some implied limit on what they would be willing to pay for a chance at saving a life. Unless subscribers were willing to pay extremely large premiums, they should

expect some decision-maker within the insuring organization to cap the long-shot, expensive efforts at saving life. Had Dr. Cunningham overtly said she was blocking the transplant because it would cost too much given the probability of saving a life, would she have been justified?

In fact, she did not appeal to this cost. She appealed to the fact that livers were scarce and that other lives could be saved if Mr. Villanueva were not listed. That raises the question of whether the medical director (or any gatekeeper within a health insurance system or HMO) has any moral responsibility to sacrifice patients' interest for the benefit of the society, in this case, the group of liver transplant candidates who would stand to benefit from having Mr. Villanueva excluded from the list. The lawyers who eventually represented Mr. Villanueva's wife after he died from a lack of a transplant argued that the medical director would be within her rights to claim that the economic interests of subscribers would justify not listing the patient, but that a medical director has no responsibility to sacrifice her patients for the good of others on the transplant waiting list. In fact, the United Network for Organ Sharing, the national body responsible for organ allocation, has policies that control who should be listed and who should be excluded. The attorneys claimed that it would be their responsibility to decide whether Mr. Villanueva should be listed. In fact, he would have qualified for listing and, given his urgent medical situation, would have been given high priority for a transplant at any center willing to perform it.

#### Benefits to Specific Nonpatients

A variant on the problem in the previous case arises when the health professional can promote the interests of those other than the patient and those others are specific, identifiable nonpatients. For example, the other person might be a member of the patient's family. Others in the family could have their psychological or economic interests jeopardized by offering an expensive experimental procedure to a patient when that procedure is very unlikely to work. A parent, in fact, may prefer that his or her own interests be subordinated to those of other family members. In other cases, the patient's interest may directly conflict with the interest of someone who is not a patient of the health professional. The patient may, as in the following case, threaten violence or an exposure to AIDS.

#### Case 4-5

#### Intentional Exposure of Unknowing Sexual Partners to HIV

In 1997 Nushawn J. Williams was 20 years old.<sup>11</sup> He was publicly identified by name as a drug dealer who in upstate New York and New York City had intentionally had unprotected sexual relations with as many as three hundred women and adolescent girls, one as young as thirteen years of age. At least thirteen of them had since been found infected with human

immunodeficiency virus (HIV). Mr. Williams had learned of his HIV status the previous September while in Chautauqua County jail on a charge of stealing a car. He continued to be sexually active after being told by a public health nurse of his HIV status.

Mr. Williams kept a list of his sexual partners. Thus, it would be possible to identify them, contact them, and offer testing. In the case of pregnancies, treatment could be provided, lowering the probability that the newborns would acquire the infection. Mr. Williams, who claimed he suffered from schizophrenia, had many contacts with health professionals while in jail after being prosecuted by Chautauqua County District Attorney James Subjack. Although it has never been made public whether the diagnosis of schizophrenia has been confirmed, his claim provides a reason why his contacts with health professionals were so extensive.

Traditionally, health professionals owe a strict duty of confidentiality to their patients or clients. The World Medical Association's Declaration of Geneva states bluntly, "I will respect the secrets that are confided in me." It also states that "the health of my patient will be my first consideration."<sup>12</sup>

Other traditional codes require that the health professional remain dedicated to the welfare of the patient. In this case, however, the health professional who learns of Mr. Williams's aggressive and dangerous behavior would be aware that his sexual partners are at serious risk from his activity. Moreover, should they become pregnant, their children could receive life-saving benefit if the women are informed, diagnosed, and treated. Their future sexual partners also have a direct interest in learning of their situation. It is plausible that Mr. Williams has a legal, financial, and psychological interest in not letting this information be passed to the women he has exposed. If a health professional becomes aware of Mr. Williams's behavior and knows he has a list of the women he has exposed, is that professional's duty exclusively to serve the patient's interest, or must he or she in determining the moral duty also take into account the interests of the women and those associated with them?

### Commentary

The underlying substantive moral issue in this case is the ethics of confidentiality. That topic will be addressed in detail in Chapter 13. In that chapter we will see that there are two moral arguments that could lead a health professional to consider breaching confidentiality: to serve the welfare of the patient and to protect others from the patient. Some patients may be engaging in behavior that is dangerous to themselves, which could plausibly be stopped only if confidentiality were broken. In other cases, the patient's interest will be served by maintaining confidentiality, but others could be helped dramatically if they were warned or treated.

We will examine these issues in the forthcoming chapter. Here we confront the more general underlying issue: Is the health professional's duty to the patient and the patient exclusively, or do other parties have a claim on the health professional's attention? Here a nurse and perhaps others could have had an opportunity to intervene; by learning the identity of the sexual partners, they could be warned, tested, and treated. In turn, their further sexual partners and offspring could be protected. If, however, the first, primary, or sole duty of a clinical professional is to serve the patient's interests, then these other parties are off the agenda. Unless it could be argued successfully that it is in Mr. Williams's interest to have the sexual partners warned, the physician or nurse should keep quiet even if she learns of the partners' identity.

The question is whether the professional's duty is solely to the patient as the Hippocratic tradition suggests or, alternatively, whether physicians and other health professionals also have to take into account the interests of others.

In Case 4-4, we faced a similar problem, but there the potential beneficiaries if the physician cast a gaze beyond the patient was some unidentified person—the one who would gain an organ that would otherwise go to the patient with liver cancer and the ones who would pay smaller premiums if the money were saved that could be spent on the transplant. In the present case, a group of specific women and children are the potential beneficiaries. Sometimes, in public health, the nurse or physician will claim that these identifiable people are really patients even though they are not interacting directly with the public health officer. The issue is whether the fact that they are identifiable individuals who are or could be some health professional's patients makes a moral difference.

This problem is sometimes referred to as the "statistical" lives problem. If a public health officer knows that statistically a hundred people will benefit from a public health campaign but has no idea who these beneficiaries are, is that morally different from the case of the public health officer who learns the specific identity of Mr. Williams's victims? If the clinical health professional's duty is to serve the patient, does the identifying of the patient—by name, age, and gender—change the nature of the moral relationship?

### Benefit to the Profession

One of the possible groups other than patients that could command the attention of the health professionals is their professional group. Professionals often perceive that they have an obligation to the professional group, which commands loyalty that requires certain sacrifices on the part of the individual. This is sometimes thought to include an obligation to conform to the moral standards of the profession, a problem addressed in the cases of the previous chapter. It also is sometimes believed to include a duty to promote the good of the profession. Since physicians and other health professionals are traditionally thought to have a duty to promote the good of the patient, this raises an interesting problem when the good of the profession conflicts with the good of the patient. The following case poses the problem dramatically.

**For the Welfare of the Profession: Should Nurses Strike?**

The nurses at University Hospital were showing all the signs of professional burnout—irritability, fatigue, and impatience. Owing to the worst nursing shortage in history, increasingly ill and fragile patients, and the “aging” of the nursing staff as a whole resulting in a number of retirements, the nurses who were left at the bedside were stretched beyond their limits. A large number of the hospital’s 220 nurses met to discuss their dilemma.

One of the nurses, Anne Roberts, R.N., stated, “We are at the point where our exhaustion is going to affect patient welfare. Additionally, I don’t think any of us can continue to take this much stress. I think we have to take a stand, demand a salary increase commensurate with the work we are being asked to do, and ask for an increase in full time positions on the busiest units. We are just not able to meet our professional obligations to our patients under these conditions.”

Another nurse added, “If we have to, I think we should go on strike.” After considerable discussion, the majority of the nurses concurred. Ms. Roberts was not as certain about the strike as were her colleagues.

The union presented their demands to the hospital administration. The hospital administration was quite concerned about the nurses’ threat to strike if their demands were not met. Although the nurses were required by law to give the hospital ten days notice to prepare for a strike, that was not a lot of time to transfer the hospital’s sickest patients. Ms. Roberts watched with growing concern as it appeared a strike was imminent. She thought a strike might or might not be effective in changing the administration’s mind. In other states where nurses had “walked out,” the hospitals had merely used agencies who advertised online to cover staffing during labor disputes. She had heard that these replacement nurses sometimes made upwards of \$5,000 per week. She knew of one strike that lasted more than a month. One thing was certain: the strike had the potential of exposing a substantial number of patients to inconvenience and perhaps even considerable risk. However, things could not continue the way they had been going. Ms. Roberts was not certain what she would do—stay or strike.

**Questions for Thought and Discussion**

- Use one of the methods of relating harms and benefits described in this chapter to determine whether the nurses should go on strike. In other words, what are the harms and benefits, to whom, and what values should take priority in deciding whether to strike or not?

**Commentary**

This case raises the question of whether the consequences should be used to evaluate a rule or should be applied directly to the individual case, an issue raised earlier in this chapter. The case is presented here, however, to examine what appears to be a conflict between the welfare of patients and the interests of the profession. The conflict Anne Roberts faces has the appearance of a conflict between the interests of patients in getting proper care and the interests of her professional colleagues in having tolerable working conditions and meeting professional obligations. In fact she will have to do considerable work to sort out whose interests are in conflict here. The most obvious patient welfare issue is the interest of the patients who may need to be moved to other facilities during the strike. Other patient interests are at stake as well, however.

We might also ask if there are ways in which patients’ interests would be served by the strike. In the longer run, the nurses could argue that they are really pursuing patients’ interests by striking. After all, if the acuity of patients and short staffing increases, it is the patients who could be injured. Hence, in some ways this is a case of pitting one group of patients against another.

From another perspective, however, it might be that the interests of the profession and its members are in conflict with those of patients. On the one hand, the profession has traditionally claimed that its first interest was the well-being of patients. If that is so, then striking might be simultaneously a professional obligation and in the interest of those patients who will eventually benefit from the strike. On the other hand, the strike can be seen as serving the interests of the nurses, whose working conditions would eventually be made better (at the expense of those patients whose care will at a minimum be disrupted during the strike). It appears that the interests of the employees, then, conflict with the interests of at least some patients.

This raises the question of whether “the interests of the profession” can be taken to equal the sum of the personal interests of the members of the profession. Is it possible that there is something called a professional interest beyond this interest of individual nurses? For instance, if nurses were objecting to a hospital’s staffing policy that risked the quality of the nursing care in order to save money, would that count as a true “professional” interest that differs from the self-interest of nurses? If so, would that be legitimately on the nurse’s agenda if this professional interest conflicted with those of the patient?

**Benefit to the Health Professional and the Health Professional’s Family**

There is one final group of interests that could conflict with those of the patient: those of the health professional and his or her family. In the traditional Hippocratic health professional ethic, the only welfare that counted was that of the patient. There was never a formal recognition that the interests of the health professional could ever legitimately compete with those of the patient. Of course, health professionals have always recognized some limits to serving the patient. The following case explores those limits.

### A Physician Choosing between His Patient and His Own Family

William Peters, a general surgeon in a small practice that included three general surgeons, two obstetricians, and two general practitioners, was on call on a weekend. His daughter, Suzy, was a high school senior who was scheduled to sing a solo in a major musical production that Saturday afternoon. Dr. Peters, perhaps unduly optimistic that he would not be called, failed to change the schedule with one of the other surgeons. Unfortunately, he got a call from the emergency room just before Suzy was to make her debut. The patient was a 7-year-old boy whom Dr. Peters saw a year earlier for appendicitis. The boy had sustained a full thickness laceration of the face, obviously requiring repair.

Dr. Peters immediately realized his dilemma: if he went to the hospital, he would miss being present for his daughter's long-practiced performance. He considered one of the other general surgeons in the practice but that seemed unfair to the colleague and would mean the boy would see a stranger rather than someone he would remember from their previous contact.

He guiltily stayed for her introduction and heard a few notes, then left the auditorium. As he drove to the hospital, his frustration grew. On arrival, the nursing staff had done the basic preparation; he briefly re-introduced himself and gave minimal information to the parents and to the child. As he repaired the injury, he couldn't help but share his disappointment of missing his daughter's performance. Instructions were given for care of the wound and follow-up for office removal of the sutures. The father of the child later called Dr. Peters's office to notify the doctor that the child would not be brought back to him for further care.

#### Commentary

Dr. Peters is challenged to find out whether he literally believes that the physician always works for the well-being of the patient. It is hard to see what else he could do but miss his daughter's singing debut if his only concern is his patient's welfare. Presumably, if that were his only concern, he would keep responding to emergency calls day and night until he became so stressed from ignoring his family that his patients' interests were jeopardized. Yet no health professional really would do this.

Dr. Peters also lives other roles in life. He is husband, father, neighbor, and citizen. He has made commitments in these other roles to work for the welfare of others in his life. He is also a person in his own right and has an interest in his own welfare. A utilitarian would resolve such conflicts by asking which course would do the most good taking into account the effects of all parties—his patient,

his children, and everyone else including himself. Is this the way all people should decide whenever he is on call on a weekend?

Suppose that Dr. Peters realizes that there are occasions on which he could do more good overall if he simply ignored his patients and did something good for a stranger. According to utilitarian reasoning, he should abandon his patient in such cases. What is the difference between Dr. Peters's duty to his children, his patient, his colleagues, and strangers?

Dr. Peters faces an interesting set of choices. He could completely ignore his daughter and his interest in hearing her sing. He could completely ignore his patient and stay for her entire concert. He could also make some compromise. One would be to call a colleague. This would provide competent care for the boy even if it was not psychologically ideal since the boy would see a stranger rather than a surgeon who was an acquaintance. This would also be an inconvenience to the colleague and would test Dr. Peters's relation with him. The most interesting option is the one Dr. Peters chose—a compromise in which he attends some of his daughter's performance and yet provides adequate, if not ideal, attention to his patient. Dr. Peters could mentally calculate the benefits and harms of each of these options, but they do not all seem to have the same moral weight. For example, the inconvenience to his surgical colleague might not have the same claim as the interests of the patient. If he did not already have an existing relation with the patient, disrupting the colleague's weekend would be an option to consider.

One possibility is that these conflicts cannot be resolved ethically solely by looking at which course will do the most good. Perhaps one has to take into account other moral obligations grounded in principles other than beneficence and nonmaleficence, principles calling for distributing goods justly, respecting autonomy, telling the truth, keeping commitments, and avoiding taking human life as well as the amount of good that is done. Dr. Peters has special commitments to both his patients and his family. The problem in this case is that those special commitments conflict. The resolution may require abandoning the traditional maxim that health professionals owe to their patients a literal commitment to doing what is best for them. An intriguing feature of this case is that Dr. Peters can choose to balance the commitments to his patient and his daughter by picking the proportion of the performance he will see (and thereby determining how much time he will devote to his patient). In the next five chapters we shall examine how these moral principles other than beneficence and nonmaleficence are factored into moral decisions confronting health professionals.

#### Notes

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- 4 American Nurses Association. *Code of Ethics for Nurses with Interpretive Statements*. Washington, DC: American Nurses Association, 2001, p. 14. [http://www.ana.org/ethics/code/protected\\_nwcoe303.htm](http://www.ana.org/ethics/code/protected_nwcoe303.htm), accessed September 8, 2006.
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- 8 Smith, Cedric M. "Origin and Uses of *Primum Non Nocere*—Above All, Do No Harm!" *Journal of Clinical Pharmacology* 45 (2005): 371–377.
- 9 This case is based on the PBS documentary, *On Our Own Terms: Moyers on Dying*, which first aired September 10–13, 2000. More information and a study guide are available at <http://www.pbs.org/wnet/onourown/terms/about/index.html> (accessed September 19, 2007).
- 10 American Medical Association, Council on Ethical and Judicial Affairs. *Code of Medical Ethics: Current Opinions with Annotations, 2002–2003 Edition*. Chicago, IL: American Medical Association, 2002.
- 11 <http://query.nytimes.com/gst/fullpage.html?res=9B06E1DC173AF93AA15752C0A96E958260&sec=health&pagewanted=print>, accessed September 15, 2006.
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## Chapter 5

# Justice: The Allocation of Health Resources

### Learning Objectives

1. Define distributive justice.
2. Distinguish among principles of justice such as need or prognosis.
3. Identify conflicts between the principle of justice and other ethical principles.

### Other Cases Involving Justice and Resource Allocation

- Case 4-4: Blocking Transplant for an HMO Patient with Liver Cancer: Serving the Patient and Serving the Community
- Case 4-5: Intentional Exposure of Unknowing Sexual Partners to HIV
- Case 4-6: For the Welfare of the Profession: Should Nurses Strike?
- Case 4-7: A Physician Choosing between His Patient and His Own Family
- Case 12-6: Posttraumatic Stress Disorder: Funding Therapy for a Preexisting Condition
- Case 14-5: Whites Only: The KKK and Socially Directed Donation
- Case 14-6: Is an Organ Swap Unfair?
- Case 14-9: Patients with Alcohol Dependency and Their Rights to Livers for Transplant