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Ethical Resources for the Clinician: Principles, Values and Other Theories

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1. Introduction

Medical students heading out on to the wards can encounter a bewildering array of ethically problematic scenarios. A recent study (Donaldson et al., 2010) looking at how medical students define and discuss moral problems, identified a large number of issues as the source of these moral problems. These included situations involving decision making at the end of life, the termination of pregnancy, pre-natal testing, reproductive technologies, child protection issues, substance misuse, and interpersonal conflict. Many of these issues are focussed in or even unique to a medical setting, with little or no precedence or guidance available from life outside medicine. These were the issues that students raised, and they sought further ethical resourcing to guide them through these tricky situations.

Only a small percentage of the medical students had discussed their dilemma within an ethical framework, which may suggest a lack of knowledge of ethical theories to resource their thinking. However, some of the students used the Four Principles of medical ethics (Beauchamp and Childress, 2009) to analyse their cases, whilst others highlighted that conflict occurred as a result of a divergence in values. There were also students who discussed their cases in ways that suggested parallels with Kantian, Utilitarian and Virtue Ethics. These are all important ethical theories which form the basis of the resources available to clinicians facing such ethical dilemmas.

Ethics is the branch of philosophy striving to describe and discuss how to lead a good life and medical ethics is the application of ethics to the professional life of the clinician. This chapter will look in more detail at the key resources available from moral philosophy to the clinician faced with a medical ethical dilemma. Whilst full philosophical analysis of different theories is beyond the scope of this chapter, discussion of the strengths and weaknesses of the different resources from moral philosophy, when applied to a clinical setting, will allow suggestions to be made about how they can be useful to the clinician. The resources that will be covered are Principalism, Values Theory, Deontology, Teleology and Virtue Ethics.

2. The four principles (Beauchamp and Childress, 2009)

The Four Principles Approach to biomedical ethics (Principalism) put forward by Beauchamp and Childress is a tool for analysing ethical dilemmas using the principles of Beneficence, Non-Maleficence, Autonomy and Justice. These principles represent various traditions in ethical thinking and highlight different obligations and ideals. The weighing

and balancing of these principles is suggested as a way to find a solution to ethical dilemmas. However, there is not clear guidance about how a clinician should weigh and balance the principles, and this is a limitation to the use of the Four Principles in a clinical setting.

2.1 Beneficence

The Principle of Beneficence refers to the moral imperative to act in such a way as to do good and benefit others. Beneficence arises from a number of traditions including Judeo-Christian ethics, the Hippocratic Oath as well as Utilitarianism, with its slogan "the greatest happiness for the greatest number," and the striving for good outcomes that is characteristic of Teleological Ethical Theories. The term Beneficence suggests acts of love, mercy, kindness and charity and this principle exhorts clinicians to act in a patient's best interests.

Beauchamp and Childress discuss to what extent Beneficence can be considered a moral obligation against which clinicians can be judged, rather than a moral ideal for clinicians to aspire towards. They conclude that there are some situations where Beneficence is obligatory, such as to family and those in close relationships, or scenarios where a significant good can be achieved, such as the rescue of a person in danger when there is no-one else closer and there is no significant danger to oneself. This obligation can extend to doctor-patient relationships.

The ideal of Beneficence, rather than Beneficence as an obligation, should be a powerful motivating factor for all clinicians. Every medical intervention offered to a patient should be done because of a belief that it will benefit the patient and out of a desire to do the patient good. Many clinicians have chosen this career out of a desire to use their professional life to do good for patients. Beneficence can thus be considered as the appropriate starting point with which to begin any analysis of a dilemma in medical ethics using the Four Principles, as the desire to do good for patients should be the motivation driving clinicians to seek the best resolution of the problem.

The other three principles of Non-Maleficence, Autonomy and Justice can be seen as principles that balance the beneficent desire of clinicians to do good for patients, in order to ensure that unrestrained and ill-considered good intentions do not lead to un-intended and potentially disastrous ethical outcomes.

2.2 Non-maleficence

The Principle of Non-Maleficence refers to the moral obligation not to inflict harm on others. This principle need not be limited to the prohibition of active harm but also implies an obligation not to expose patients to an increased risk of harm through negligence (whether intentional or not), departure from professional standards or a failure of a clinician's duty of care. Non-Maleficence is often ascribed to the Hippocratic tradition, although the often misquoted slogan "first do no harm" is not actually found in the Hippocratic Oath. However, Non-Maleficence is also an important feature of Deontological and Judeo-Christian ethical traditions.

Non-Maleficence acts as an important balance to the principle of Beneficence because no medical intervention is without risks or side effects, and all medical decision making involves a balancing of benefits and risks. The practice of medicine must not be overwhelmed by the

desire to do good at any cost and the unchecked consideration of extra-ordinary or heroic treatments for patients could expose them to significant harms and risks for little potential benefit. For example, the balancing between Beneficence and Non-Maleficence is often important in decisions regarding managing patients at the end of life.

In such discussions the distinction between an act and an omission is an important one. The principle of Non-Maleficence implies a prohibition to clinicians acting in such a way as to harm patients, for example by administering potassium chloride to a patient with a terminal illness, even if the patient has requested this to end their suffering. However, the withholding or withdrawing of treatment by the clinician can be ethically viewed as an omission rather than an act, for example, the withdrawal of active treatment and the starting of palliative management for a patient with a terminal condition. The principle of Non-Maleficence should not be seen to prohibit such decisions. Instead the analysis of such a situation should be started with the principle of Beneficence, tempered and balanced by the principle of Non-Maleficence. A clinician should only provide a medical intervention if it is likely to benefit the patient, and so when it will no longer provide that benefit, such as to a patient with a terminal condition, then according to the principle of beneficence it can and should be withdrawn. Non-maleficence actually supports such a decision since the risks or side effects associated with any medical intervention could be harmful to a patient with a terminal condition and so should be avoided, especially if there is to be no benefit.

The principle of Non-Maleficence is not absolute and 'the Doctrine of Double Effect' is an example of a rationale for accepting that there are situations where a clinician can act in such a way which may result in harm to the patient, as long as the harm is not intended, but only foreseen. The main situation where 'the Doctrine of Double Effect' has been used is in the administration of analgesia in terminally ill patients with significant pain. In order to adequately control such pain it can be necessary to administer large doses of opiates, which risk the hastening of a patient's death. However, since this harm is not the intended consequence of the action, the intention is to control the pain, it is argued that this is ethically justifiable. Whilst 'the Doctrine of Double Effect' has proved a successful argument in the legal setting, it faces a number of philosophical challenges that are difficult to resolve. In particular it is difficult to provide a coherent and consistent account of what makes an outcome foreseen but not intended and yet another outcome foreseen and intended.

In complex situations arising from having two or more patients involved, the principle of Non-Maleficence can be difficult to apply. Kidney donors who undergo significant risks for no personal benefit are such an example. Non-Maleficence as an absolute principle would seem to prohibit such an intervention which can result in such a good outcome for another patient with renal failure. A pregnant woman who would die without a life saving treatment that would result in the death of her foetus demonstrates further difficulties, and the necessity of involving other principles, including those of Autonomy and Justice.

2.3 Respect for autonomy

Just as the principle of Non-Maleficence reminds the clinician not to intentionally harm a patient in their beneficent drive to do good, so the principle of Respect for Autonomy also balances Beneficence by posing the question: who decides what is good for the patient? Medicine has traditionally had a paternalistic ethos, with the expert clinician deciding for a

patient what is best for them. Respect for Autonomy, however, is the principle that acknowledges the right of a patient to hold their own views and to make choices and take actions based on their particular views and beliefs. Autonomy has a strong base in Deontological ethics, Rights Theory and many Utilitarians also emphasise its importance. It is also the foundational principle in Values Based Medicine (which will be discussed later in the chapter).

Respect for Autonomy involves an obligation on the clinician not to control or constrain patients, and the importance of autonomous self-determination and bodily integrity necessitates that patient consent must be gained by a clinician proposing a medical intervention. This consent can be explicit consent (written or verbal) or implied/implicit consent. However in order to be valid, consent must be voluntary and informed. Therefore, respect for autonomy also imposes a positive obligation on the clinician to foster autonomous decision making, disclosing information and even striving to help patient's overcome unhealthy dependence on doctors. Respect for Autonomy involves both a respectful attitude towards patients as free individuals with their own legitimate values and beliefs, as well as respectful actions in providing information and facilitating decision-making to allow informed consent.

For Beauchamp and Childress, respect for Autonomy is a fundamental obligation for the clinician, rather than an ethical ideal to be strived for. However, the philosophical ideal of Autonomy in its purest sense of freedom from any form of influence is something that few (if any) patients are able to achieve. Nevertheless most patients can and do want to decide for themselves on the basis of their own beliefs and values (even if they are unable to express these values or they are not well thought out). There needs to be an excellent reason for overriding a patient's autonomous decision, and so the clinician's desire to do good for a patient should not override their autonomous refusal of their intervention. This has led to the concept of the "Autonomy trump card" or the "triumph of Autonomy", which demonstrate the power of the principle of Respect for Autonomy over other principles, especially in situations involving patients who are able to decide for themselves. Most of the time what the patient decides is what should happen.

There are, however, exceptions to the "Autonomy trump card", where concerns for Beneficence, Non-Maleficence and Justice can and do override patient autonomy. These tend to occur when a patient's decisions affect others, and the "greater good" must be considered. Such a situation is the notification of sexual partners of HIV affected patients, who could potentially be harmed by the patient's choice not to tell them this information. Another example is when public health is endangered, such as when an epileptic patient wants to choose to continue driving and the doctor may have a duty to prevent them doing so, for the greater good and to prevent harm to others. Also in situations where resources are scarce, a patient's choice may not actually be available to them, and considerations of Justice override Autonomy.

Not all patients are able to make autonomous decisions. Children, those suffering from acute attacks of certain mental illnesses, patients under the influence of strong drugs or otherwise incapacitated or unconscious are all often unable to make autonomous decisions. In treating such patients the concept of acting in their best interest (in line with the principle of Beneficence) becomes of vital importance. In order for a patient to be judged unable to make an autonomous decision their capacity (or competence) must be assessed. In order to

demonstrate capacity to consent to treatment a patient must be able to understand the information needed to give informed consent, be able to retain it, be able to weigh and judge the information in light of their beliefs and values and be able to communicate their decision. Capacity is always specific to particular decisions or tasks, so whilst there may be certain decisions that a patient is not competent to make there may well be others things that they can decide for themselves. In addition, capacity may vary or be intermittent. Respect for Autonomy exhorts the clinician to strive to maximise a patient's capacity, by creating the best environment, optimising treatment and giving information in such a way as to allow patients to make decisions based on their own beliefs and values wherever possible.

Not all patients want to make autonomous decisions, and would rather ask their doctor to make a decision for them. Even though patients have the right to make decisions for themselves, this does not imply a duty upon them to do so. A patient's choice to delegate responsibility for a decision to their doctor is still an autonomous act.

2.4 Justice

The clinician who out of Beneficence would do good for his patient must weigh this good against the principle of Non-Maleficence and the principle of Respect for Autonomy. The final principle against which Beneficence must be weighed is that of Justice, which raises the issue of to whom the clinician should be doing good. This is vital to remember because a clinician and their patient, even in the privacy of a consultation room, are not alone in the world. Medicine is practiced in a world of great need and limited resources and it is important that the clinician should remember that, as well as the patient he is seeing today, there are many other potential patients who also have potential demands on medical resources. Why should the clinician treat one patient and not the other?

Theories of Justice arise from many ethical theories, and these describe Justice in very different ways. In Utilitarianism (which will be discussed later in the chapter) Justice is the same as utility, and as long as a situation has the best possible outcome it is deemed just, no matter what potential inequalities exist. Libertarian Theories see justice as fair process, so that a situation can be just even if outcomes are uneven, as long as individuals have had equal opportunity and so been subject to a just process. Justice in Egalitarian theories demands that persons should receive equal distribution of goods such as healthcare. However, it is also argued that not everyone should receive the same when the needs of different individuals vary. As Aristotle is quoted to have said, "equals should be treated equally, and unequals unequally".

The principle of Justice involves the allocation of resources, and different criteria have been proposed to guide this distribution. These include equal share, effort, contribution, merit, free market exchange and need. Beauchamp and Childress advocate distribution according to need. They also propose a fair opportunity rule, with distribution weighted to mitigate the negative effects of life's social and biological lotteries.

Beauchamp and Childress divide decisions of Justice into various categories. The first category of decisions are about how to allocate resources, such as political decisions of how much to allocate to a healthcare budget or how to allocate within health and healthcare budgets, all they way down to decisions regarding the allocation of scarce treatments to individual patients. The need for rationing creates another set of decisions of Justice. And

finally the setting of priorities in healthcare also involves decisions of Justice. One of the key tools for this is cost-effectiveness analysis, which seeks to allow allocation of resources, rationing and setting of priorities in the most cost-effective way. One of the most important examples of such cost-effectiveness analysis are QALYs (quality adjusted life years). QALYs provide a measure of benefit weighted for quality of life and are an example of utilitarian calculus when applied to the question of Justice. QALYs will be discussed further later in the chapter.

The principle of Justice broadens the ethical responsibility of the clinician from the patient he is seeing and engages him in a world of medical need and limited resources. Peter Singer's Utilitarianism (Singer 1979) proposes a global perspective that every human has a right to a decent minimum of healthcare. Such an ethical demand can seem overwhelming and any individual clinician should obviously not feel responsible for providing complete global Justice. However, it is important for individual clinicians to remember that they are part of a healthcare response to a need that is global but whose resources are limited. The principle of Justice reminds the clinician that the good they intend to do for a patient must never be done out side of this wider context.

2.5 Strengths and weaknesses of the four principles

Principalism has been widely adopted in medical ethical thinking and education and there are many good reasons for this. The Four Principles are simple and easy to remember and yet provide a clinician with tools for ethical reasoning that arise from careful analysis, distillation and amalgamation of many theories and traditions of moral philosophy. The Four Principles are at their most useful to the clinician as concepts which allow the analysis of a decision or scenario from a number of different ethical perspectives. The perspectives of Beneficence, Non-Maleficence, Autonomy and Justice can provide insights into confusing situations and allow the reasons for this conflict to be clarified, as well as allowing reasoning and argument from different perspectives to be thoroughly examined.

The weakness of Principalism comes when the ethical analysis of a scenario is finished and a decision must be reached. Beauchamp and Childress suggest that the principles should be weighed against each other, but have been unable to offer a coherent account of how this should be done (De Grazia, 2003). There is no clear indication of when one principle should be deemed to be more important than another, and the most common default position is that Autonomy is given pre-eminence, though this is done without clear justification.

Donaldson et al's study of the cases brought by medical students for discussion in medical ethics seminars highlights this problem with Principalism. A number of the students used the Four Principles to analyse their case, but none of them had reached a conclusion through this process on what course of action should be taken. The hypothesis proposed as a result of the findings of this study suggested that the use of the Four Principles in medical ethics can lead medical students to see medical ethics as a discipline for analysing ethically problematic scenarios, without needing to reach a decision on the right course of action, and perhaps even leading to the belief that there is no right or wrong course of action (only legal or illegal ones).

A helpful method of weighing these principles against each other is to use Beneficence (the desire to do good) as the motivating drive for a clinician when faced with an ethical decision. This must then be weighed against Non-Maleficence, Autonomy and Justice

(Gillon 1985). If the ethical motivation to do good is not quenched or overridden by the perspectives of the other principles then this provides the clinician with an ethical justification for the intervention they propose. This method is by no means complete and does not answer the problem of specifying at what point one principle overrides another, and so the clinician may need to look to other ethical resources for guidance when faced with making an ethical decision and weighing between the principles.

As mentioned earlier, Teleological and Deontological ethics are both branches of moral philosophy that are important foundations for Principalism. Later in the chapter these philosophies will be discussed in more detail. Whilst it is beyond the scope of this chapter to give a full philosophical analysis of each theory, there will be discussion of each theory to unearth resources and insights that can be of use to the clinician who is balancing and weighing principles against each other. The chapter will also discuss virtue ethics, which has enjoyed a recent resurgence in moral philosophy, and offers a different perspective to resource the clinician. However, next for discussion is Values-Based Medicine.

3. Values-based medicine (Fulford, 2004)

Conflict was a recurring theme raised by medical students in cases brought for discussion in the study by Donaldson et al. It was hypothesised that the high frequency with which conflict was raised by medical students was because conflict is a good indicator that divergence of values has occurred. Values-Based Medicine is an approach to decision making in healthcare which emphasises the importance of acknowledging and exploring differences in values as part of the decision making process.

Values-Based Medicine is proposed as a counterpart to Evidence-Based Medicine. The progress of science has led not just to a growing complexity of facts (to which Evidence-Based Medicine is a response), but also to an increasing level of choice in the practice of medicine. Increasing choices, as well as an increasing diversity in society, contribute to an increasing complexity of values in the practice of medicine. The response proposed to this complexity by Bill Fulford is Values-Based Medicine and he outlines his theory in the 10 principles of Values-Based Medicine.

3.1 The 10 principles of values-based medicine

1. The "two feet" principle – The "two feet" on which all decisions stand are facts and values.
2. The "squeaky wheel" principle – Values, though present all the time, are most noticeable when different values conflict in decision making.
3. The "science-driven" principle – Scientific progress, far from making facts superior to values in decision making, increase the importance and diversity of values by creating a wider array of choices.
4. The "patient-perspective" principle – The perspective of the patient/patient group is of first importance in decision making
5. The "multiperspective" principle – Values-Based Medicine seeks to resolve conflicts of values through a process of balancing legitimately different perspectives, rather than by reference to a rule or "right outcome".
6. The "values-blindness" principle – Raising awareness of values is crucial to the practise of Values-Based Medicine, and careful attention to language is crucial to this.

7. The "values-myopia" principle – Values-Based Medicine encourages the clinician to improve their knowledge of values that may be held by other people, and that empirical and philosophical methods can be important resources for this.
8. The "space of values" principle – Values-Based Medicine uses ethical reasoning not to determine what is "right", but to explore differences in values as a resource to clinical decision making.
9. The "how it's done" principle – Communication and listening skills are central to Values-Based Medicine, both in establishing different values perspectives (especially the patient's perspective) and in resolving conflicting values to decide upon a practical course of action.
10. The "who-decides" principle – The importance of exploring and seeking to resolve differences in values makes decision making the job of clinicians and patients, rather than ethicists and lawyers.

3.2 Strengths and weaknesses of values-based medicine

Bill Fulford's assessment of the increasing complexity of both facts and values in medical practise, and his facts + values model of healthcare decision making are both hugely helpful insights. Values-Based Medicine also gives a very necessary challenge to clinicians to be aware of the potential for "value-blindness" and to seek to overcome or avoid this by making use of empirical and philosophical resources, as well as by focussing on the patient's perspective, the patient's narrative and the language that they use. In doing this, Values-Based Medicine adds to Bauchamp and Childress' principle of Autonomy, grounding what can otherwise be an abstract principle into clinical practice as well as equipping the clinician to negotiate their way through the complexities of clinical decision making whilst truly seeking to respect a patient's autonomy as they explore their values.

The focus on the skills, especially communication skills, required in healthcare decision making is also a valuable perspective that Value-Based Medicine brings to Medical Ethics. Reasoning and logic skills may suffice for the ethicist in an ivory tower, but will never be enough for a clinician making healthcare decisions in partnership with patients. Furthermore, that healthcare decision making should rightly happen in the clinical setting is another valuable insight of Values-Based Medicine. Values-Based Medicine also emphasises the importance of "right process" in healthcare decision making, rather than "right outcome". Whilst the importance of "right process" is often overlooked in medical ethics, right outcome cannot be neglected either. Both right process and right outcome are vital in healthcare decision making.

This leads into the main weakness of Values-Based Medicine, namely the inability to determine for a clinician what is right, even when they are fully aware and engaged with a patient's values. Values-Based Medicine is an analytical and descriptive tool that seeks to increase awareness and understanding of different values, rather than offering a resource to guide clinicians towards an understanding of the right decision, or even the right value. Values-Based Medicine also suffers from a similar criticism as Principalism, namely that of being useful in the analysis of ethical dilemmas or situations, but offering no definite guide to the right decision. However, whilst Principalism acknowledges the need to discover the right decision, Fulford's account of Values-Based Medicine criticises what he describes as the "quasi-legal model" of ethics which seeks for a "right" outcome and claims instead that

different values should be seen as equal. Values-Based Medicine encourages clinicians not to judge or weigh values against each other, but rather it seeks to exhort the clinician to use communication skills to create a space in which values can co-exist. However, when directly opposing values are brought into conflict, the use of communication skills by the clinician to create such a space could seem to be little short of deception.

Even Fulford, in his account of the ten principles of Values-Based Medicine, acknowledges that not all values are equal, and only "legitimate values" (values legitimised by rules and regulation dictated by consensus of the community involved) should be included in healthcare decision making. In doing this, Fulford limits the scope of Values-Based Practice to a narrow range of decisions within tightly defined guidelines, and so seriously limits its usefulness to Medical Ethics. Values-Based Medicine cannot offer any explanation (beyond a mention of consensus, with no idea of how this could or should be reached) of the basis of these guidelines upon which it depends. Since the formation of such guidelines also falls into the remit of medical ethics, this is another aspect of the ethical endeavour for which Values-Based Medicine provides little or no resourcing. The usefulness of Values-Based Medicine is also limited by its inability to add anything to situations in medical ethics where a patient's values are not accessible to the clinician, such as in the treatment of either the child, the demented, the delirious, the intoxicated or the unconscious patient. Since these situations can be some of the most ethically difficult for the clinician, Values-Based Medicine cannot on its own provide a sufficient ethical resource. Values-Based Medicine is, therefore, best seen as a practical outworking of the principle of Autonomy. It can give clinicians skills and resources to understand a patient's perspective, but has little power to guide the clinician towards the right decision.

4. Teleological ethical theories

The term Teleological Ethics describes a group of theories that are focussed on the outcomes or consequences of actions, and so this group of theories are also described as Consequentialist Ethics. The word Teleology derives from the Greek word *telos*, meaning end or goal, and so Teleological Ethics regard an action as right or wrong according to the balance of good or bad consequences that it has. Therefore, the right act is the act with the best foreseeable overall result. According to Teleological Theories the only features of an act that are morally relevant are its foreseeable outcomes. The motivation for an action is, therefore, seen as irrelevant, as is the fact that an act may 'break the rules'.

In order for Teleological Ethics to be discussed as a complete moral theory it must give a valid account of what aspects of the consequences of actions are morally important. One answer to this suggestion comes from the most important of the Teleological Theories, Utilitarianism.

4.1 Utilitarianism (Bentham, 1789 and Mill 1861)

Whilst the ideas underlying Utilitarianism may stretch back as far as Epicurus, the fathers of Utilitarianism are Bentham and Mill, whose writings gave birth to the theory of Utilitarianism during the Enlightenment. They suggested that morality was not about faithfulness to a code or inflexible rules. Rather Utilitarianism is a monist theory, with one foundational principle against which the consequences of actions are to be judged. This

principle is that of Utility – the "greatest happiness" principle, often captured in the slogan, "the greatest happiness for the greatest number". In Utilitarianism the overriding focus is the amount of happiness or unhappiness produced by an action.

Bentham argued that it is self evident that suffering is bad and happiness is good, and he saw suffering and happiness (described in terms of simple pleasure) as opposite poles of a continuum. From these intuitions he derived his hedonistic version of Utilitarianism, arguing that actions should be decided upon by determination of the net effects of potential alternative actions in terms of producing happiness or reducing suffering. The action that produces the most happiness, or the least suffering, is the right action. This is Bentham's hedonic calculus, which he proposed as a consistent and reliable procedure for making decisions. For Bentham, therefore, morality is the attempt to bring about as much net pleasure (pleasure minus suffering) as possible into the world.

Mill, however, gives an account of Utility that is not purely hedonistic, because his view of happiness is not based on simple pleasure. He argued that not all pleasures are comparable, and saw happiness in terms of eudaimonia (human flourishing, a concept that is important in virtue ethics and will be discussed later in greater detail). His famous quote, "better to be a human being dissatisfied than a pig satisfied", highlights this point. However, to Mill pleasure and pain are still fundamental to his understanding of happiness and his conception of Utility is still the balance of pleasure over pain.

Utilitarianism has been further developed by numerous philosophers. Modern liberal democracies have given rise to new concepts of Utility that emphasise the importance of maximising individuals' autonomous choices and preferences. This is seen as the best way of maximising happiness when people from diverse communities vary in their perceptions of happiness and flourishing. This approach also gives weight to the importance of Autonomy and the powerful desire for self determination that is a foundational principle of liberal democracies.

A further development of Utilitarianism is to move the place of Utilitarian calculus away from decisions about individual actions and use it instead in the formulation of rules, the following of which will maximise happiness and minimise suffering. This rule based application of utility to maximise welfare is described as Rule-Utilitarianism, to distinguish it from the Act-Utilitarianism of Bentham and Mill. Rule-Utilitarians will, therefore, argue that the rules should be obeyed even in situations where doing so may produce a negative outcome that will reduce the Utility. Their justification for this is the fact that the overall outcome of the rule still produces a net increase in Utility, even if it produces reduction in Utility in certain cases. However, it is possible to argue that this development of the Theory of Utilitarianism displays a lack of consistency from the original concept of Utility. Rule-Utilitarianism is also subject to the criticisms that face other rule based theories, such as that the rules may conflict (these will be discussed in more detail in the deontological ethics section). Attempts to provide a multi-level Utilitarianism with rule-Utility combined with a remainder rule allowing act-Utility to override rule-Utility in certain situations are too flexible and as such become little more than justification for intuitions.

4.2 Advantages and disadvantages of utilitarianism

Utilitarianism, as a monist theory with a single foundational principle, has the potential to provide the clinician with a simple and clear system with which to approach ethical

dilemmas. This would allow the clinician to avoid the confusion of conflicting principles (in pluralistic theories such as Principalism). The Principle of Utility offers, in theory, to provide a reliable decision making procedure allowing the clinician to choose the correct course of action in every situation. Also Utility does not rely on a clinician's moral intuitions to identify or balance moral principles, which can sometime produce varying and unreliable outcomes. Utilitarianism is regarded as a very democratic system as each person's happiness has the same value; a King is not more valuable than a beggar. Utilitarianism shares, along with all Teleological Ethics, the valuable insight that the outcomes of our actions are important and should be taken into account in the ethical process.

As well as these considerable strengths, the greatest advantage of Utilitarianism is that it captures the heart of what ethics is for, being a system aiming to make people happy and alleviating suffering. These aims are in line with clinician's moral motivation to do good for patients and sum up for clinicians the purpose of medical ethics. Despite Teleological Ethic's rejection of the moral significance of motivation, Utilitarianism describes the strong desire to make people happy and reduce suffering that should be the starting point for a clinician's moral motivation.

Utilitarianism does, however, have a number of significant disadvantages and problems associated with it. The struggle to provide a coherent account of what is meant by happiness is an ongoing problem. It is by no means clear that happiness is the only good. Other goods, for example friendship or art, can be seen as goods in themselves, independent of the happiness they may or may not provide. In fact, it can be argued that it may be appropriate to suffer for such goods as friendship or art. There is also the issue of justification in Utilitarianism. For even if a satisfactory account of happiness as the good were provided, it would not necessarily follow that maximising happiness should be the overriding principle and so be considered morally obligatory.

However, a far greater problem for the clinician is that there is no way to measure happiness. There is no such thing as a Utility Calculator, and so with no units with which to measure happiness, so hedonistic calculus becomes meaningless in the clinical setting. Clinicians will also have the humility to realise that even the wisest person cannot know all the possible outcomes that will occur from an action. Evidence Based Medicine and Randomised Controlled Trials provide information with regards to the probabilities of a good clinical outcome from a medical intervention. However, applying such information to a patient cannot provide surety of happiness, as health is not the only good and the wider implications and long term outcomes often remain unknown. This is a problem with all Teleological Ethics. The future is essentially uncertain and so if all that matters about actions is their future consequences then morality is reduced to guesswork.

There are also significant problems with how happiness is distributed according to Utilitarian Calculus. Instead of "the greatest good for the greatest number", many situations arise in clinical practice in which the greatest good and the greatest number are in conflict. It is not clear whether total happiness or average happiness is the best and fairest outcome to strive for. According to simple hedonistic calculus the right action could often involve oppression of a minority for the benefit of a majority. According to Utilitarianism, Justice must be reduced to Utility, so violating the moral feelings of most clinicians and patients that equality and fairness are of great importance.

The principle of Utility followed through in clinical scenarios to its logical conclusions leads to a number of results that many clinicians find morally counter-intuitive. If consequences are all that matter, then for the sake of the best outcome many of the principles that govern human relationships, such as Justice or Rights, can be abandoned. In Utilitarianism, as in all Teleological Ethics, the ends always justify the means. This could lead to a clinician following hedonistic calculus to commit acts such as murder in the name of Utility, for example to provide organs to 5 other individuals. This would result in a loss of integrity that would be unacceptable to clinicians and to patients, the majority of whom would agree that this act is blatantly wrong.

Utilitarianism also has no mechanism for taking into account past actions in present decision making, as it is entirely focussed on future outcomes. This makes keeping a promise (such as maintaining the confidence of a patient), acting in gratitude or punishment difficult concepts to take account of in Utilitarianism, as they have no weight in hedonistic calculus. It is also possible that two acts that clinicians would consider opposite, for example attempting or not attempting Cardio-Pulmonary Resuscitation, can be given the same moral value according to hedonistic calculus, if their outcomes are the same (e.g. if the patient dies). Whilst Utilitarian's would argue that clinicians must let Utility challenge their common sense, if Utilitarianism demands such a complete rejection of the moral intuition of most clinicians and patients it loses any descriptive power to provide an account of moral feelings and intuitions.

Because Utilitarianism sees the happiness of all people as equal, there is no place in Utilitarianism for obligations arising from special relationships, e.g. to family, or to a patient. As well as this neglecting the doctor-patient relationship, it also creates a further problem that is compounded by the fact that in Utilitarianism there is no distinction between duty and supererogatory actions. This is the problem that Utilitarianism is too demanding, with too wide a scope, leaving clinicians morally responsible for all good outcomes that they were unable to achieve and for all negative outcomes that they failed to prevent. The scope of the demands of Utility cover anything that can suffer, so not just all people, but all animals create a demand to have their happiness maximised and their suffering relieved. Taken to its logical extremes the demands of Utility give no leave to a clinician to rest and no time for personal projects or the cultivation of special relationships (e.g. family and friends). Such a demand is not possible for a human to meet. However, it would be wrong to reject an ethical theory simply because it is not possible to measure up to its demands. Whilst in humility clinicians must remain aware of their finite resources and limitations, it is still beneficial to feel the demand of a Utilitarian Ethic that is both challenging and inspiring. An example of such a Utilitarian Ethic is Peter Singer's imperative for action to reduce third world poverty (Singer 1979).

4.3 Utilitarianism and QALYs

One of the areas in which Utilitarianism is considered the most useful is that of public policy and the distribution of resources. This is because it is a beneficence based theory, and when the goal is to produce as much good as possible with limited resources, Utilitarianism is by definition the best tool to use. Also in the sphere of public policy, where moral decisions are made abstracted from particular individuals and situations, many of the principles that govern human relationships, against which Utilitarianism seems to clash, are less apparent. However, Justice is key in such discussions and Utilitarian concepts of justice must continue to be weighed against other conceptions of justice.

QALYs (Quality Adjusted Life Years, as discussed earlier) are a cost-effectiveness analysis tool used in resource allocation and public policy decision making. QALYs are the best tool available to Utilitarianism to provide some measurement for Utilitarian Calculus. QALYs cannot be used in a strictly hedonistic Utilitarian Calculus, as they are not measures of pleasure. However, as a measure of years of life gained, weighted by the quality of the life gained, they are a powerful means of measuring and so weighing different consequences and as such provide a powerful tool to teleological ethics.

5. Deontological ethics

Deontological Ethics describes a group of ethical theories that judge actions as right or wrong on the basis of rules and duties. The word Deontology is derived from the Greek word *deon*, meaning duty. This means that, according to Deontology, it is not the outcomes of an action, but rather something intrinsic to the action itself, that makes it right or wrong. The intrinsic nature of the action is judged against a rule or set of rules, regardless of the outcome of that action. In order to act rightly, a moral agent must do their duty in accordance with the rules. The language of duty is used in some of the professional codes of conduct that govern clinicians' professional practice, for example in the UK the General Medical Council's "Duties of a Doctor." We will discuss deontological systems, starting with the most important, that of Immanuel Kant.

5.1 Kantian ethics (Kant 1785)

Kant argued that we can never know the full consequences of our actions and so, because we cannot know if our actions will have good or bad outcomes, we should perform actions that we know to be intrinsically good and avoid actions that we know to be intrinsically evil, and let the consequences unfold as they will. He argued that we know whether actions are good or bad from reason and not from their consequences. In fact, Kant based his ethical system entirely on reason. For Kant, reason was what defined a moral being and so he argued that reason underpinned the entire ethical endeavour and was sufficient for establishing moral law. He sought to use reason to work out a consistent, non-overridable set of moral rules that would be universal and binding to all rational creatures – a Supreme Moral Law. Kant argued that rational agents intrinsically possess absolute moral value and should recognise this in themselves and other rational agents. He argued then that the Supreme Moral Law should be obeyed out of duty alone, duty for duty's sake. For Kant it was not possible to be truly moral if acting out of self interest, or for any other motivation other than duty, even if the action is the same. The good will acts for the sake of the supreme moral law alone. Kant's Ethic can be described as "act as you wish, providing that your action conforms to the requirement of the Supreme moral law as represented by the categorical imperative" (Gillon 1985).

Kant's Ethical Theory is, therefore, an absolutist theory. Reason dictates the Supreme Moral Law, and this must be obeyed absolutely, out of duty alone. Kant's Theory is also a Monist Theory, a theory with only one principle. That principle is Kant's Categorical Imperative. Kant compares hypothetical imperatives, which indicate what ought to be done if a certain outcome is desired (if you want A, do B), with the categorical imperative, which is a simple binding command (do A) with no qualification. For Kant, hypothetical imperatives arise

because we have desires for certain outcomes, but the categorical imperative arises from reason and as such is unqualified to demonstrate the weight of moral obligation. Kant, therefore, argued that this categorical imperative is absolute and immediate and all rational agents should understand it because of their rationality.

Kant has three formulations of his categorical imperative, which he saw as three ways of saying the same thing. The first of his formulations communicates the principle of universibility and is as follows, "act only according to the maxim by which you can at the same time will that it become a universal law". A maxim is a rule governing an individual's action and so a law is a maxim that passes the test of universibility. By this first formulation of the Categorical Imperative Kant argues that if rules are to have any validity and be considered as part of the Supreme Moral Law then they must be binding to all people at all times.

The second formulation of the Categorical Imperative expresses the value and dignity that Kant argued was intrinsic to rational agents. It is as follows, "So act as to treat humanity, whether in your own person or in that of any other, in every case as an end and never merely as a means". According to Kant human beings as rational agents embody the supreme moral law and have intrinsic moral worth, and so are the end that gives value to everything else, as means to the end of humanity. Humans, therefore, have unconditional worth, which is not derived from anybody or anything else's valuation of them.

The third formulation of the Categorical Imperative expresses Kant's Principle of Autonomy, "Every rational being is able to regard oneself as a maker of universal law". Kant's conception of autonomy is not simply the same as self-determination as discussed earlier in the section on Principalism. Rather he views only actions of moral self determination that are in line with reason as truly autonomous actions, expressing humanity's freedom as rational agents to act in accordance with duty to the Supreme Moral Law. Therefore, according to Kant, actions taken from passion, ambition or self interest all inhibit autonomous action. Kant sees the rational agent much like a King seeking to make laws for a Kingdom full of other rational agents.

When these three formulations of the Categorical Imperative are taken together Kant's rational agent must act like a King making rules to govern a Kingdom full of other rational agents, who will themselves be making rules in the same way. However, on the basis of the first formulation of universibility, Kant is confident that all the rules created by rational agents will not conflict, but rather be in harmony because all are derived from reason, which underpins the entire moral endeavour. This basis of reason for ethics means that Kant has no need for external authority for his ethics, such as the state, culture or God. God does, however, have a place in the Kantian system, even if He is not required as the basis of ethics. Kant requires God to bring justice by distribution of happiness to rational agents in accordance with their fulfilment of duty to the moral law (which doesn't happen in this life, but rather in the next).

5.2 Advantages and disadvantages of Kantian ethics

Kant's ethical theory provides an insight to clinicians that rules are important in ethics. Rules provide an excellent description of the expectations that most patients have of their doctors, e.g. don't break confidentiality, be honest. Reason provides Kant with a justification for many such moral rules, which in practice govern most human relationships, including

the doctor-patient relationship. However, the greatest insights that Kantian ethics has to offer the clinician are demonstrated in the formulations of the categorical imperative. The first is that in order for an action to be judged right there must be good reason underlying it and this should be universible, so that a rule can be made that in a similar situation other people should act in the same way. This principle does not only apply when working within a Kantian System, and patients expect consistency from doctors dealing with similar cases. When such cases are compared doctors shave to be prepared to defend their decisions and the Bolam test defines the legal test that a reasonable body of other medical professionals would have acted in the same way. The second valuable insight of Kantian Ethics is Kant's Valuation of Humans as rational agents with absolute moral value. The insight of the second formulation of the categorical imperative, that people should never be treated merely as a means but rather as an end in themselves, has been a foundational principle in medical ethics and is in accord with the general feeling of clinicians with regards to the value of persons.

Kant's Ethical System can, however, be criticized for a number of reasons. That the Kantian system is far from clear limits its application to clinical practice. For example, the three formulations of the Categorical Imperative do not seem truly equivalent, as Kant argues and so the second and third formulations could be better thought of as supplementary principles that add content to Kant's morality. However the use of Kant's principles in this way brings in the problem of conflict between rules to the clinician. There are many clinical scenarios where obligation to one law derived from the categorical imperative, conflicts with an obligation to another law which is also derived from the categorical imperative, for example do not lie and do not break confidence. Kant's system provides no answer for this dilemma.

The first formalisation of the categorical imperative also seems to be too wide and too unqualified a principle upon which to develop of a moral law that could be applicable to clinical practice (Pojman 2006). It can be used to justify trivialities, even contradicting trivialities. Despite Kant's argument that consistency requires rules with no exceptions, there is nothing in the Categorical Imperative to prevent exceptions being added into maxims which still meet the requirements of Universalisation. However, this process is time consuming and impractical and of little benefit to the clinician facing an ethical dilemma.

As such Kant's system of derivation of rules from the categorical imperative is excessively formalistic, and thus lacks the implications on action necessary for appropriate application to the clinical setting. Kant's use of reason alone over-emphasises law and underemphasises relationships, as well as being unable to give an account of the moral importance of motivation. Most clinicians would regard a right action arising from sympathy, empathy and a desire to help their patient as more valuable that similar actions arising simply out of a sense of duty. Kant's focus on duty creates a version of morality that has been described as "austere and arid" (Gillon 1985), with no central place for beneficence or a desire to promote happiness or to love. This is perhaps the greatest criticism of Kant's ethical system for the clinician, namely that it seems to have missed the heart of moral motivation.

5.3 Some examples of other deontological systems

In contrast to Kant's Monist and Absolutist Theory, it is possible to create pluralist (with more than one rule) and objectivist (acknowledging that conflict between rules will occur) deontological theories. An example of such a theory is that of WD Ross. He distinguished between Prima Facie (at face value) and actual duties (Ross 1930). Prima Facie duties were

derived from a number of rules/principles that it was the job of ethical discourse to elucidate. These duties were to be balanced against each other in specific situations to determine the actual/absolute duty in any given situation. The moral obligations listed by Ross include fidelity, beneficence, non-maleficence, justice (distribution of happiness in accord with merits/deserts), reparation, gratitude and self-improvement. Ross argued that these principles incorporate and reflect basic moral intuitions, but he denied that there is any overarching principle underlying them. He gave no account of how conflicts between principle are to be resolved except by citing the use of intuition, and he did not rank his principles in order of importance. The importance of Ross' Ethical System as an influence on the development of Principalism, demonstrates that Non-Absolutist Pluralist Deontological systems provide a useful platform for bridging with Utilitarianism and allowing the exploration of compatibility between these ethical systems in a clinical setting. Such exploration seems a promising avenue of inquiry for a clinician seeking for ethical resources when facing an ethical dilemma.

5.4 Rights theory

Rights Theory describes a set of claims that individuals (or groups) can make on other individuals (or groups). These claims are called rights. Rights Theory, often associated with the work of John Locke (Locke 1960) and his claims to life, liberty and estate, often seems to go hand in hand with liberal democracies and theories of liberal individualism. In such systems society's role is to provide space for individuals to pursue personal goods and projects. This space for the individual is protected by their rights.

There are different forms of rights. Legal rights can be enforced by law, but are created and abolished by the very parliaments, committees and dictators that write and enforce that law. Examples of legal rights are those enshrined in the Human Rights Act. Moral Rights (or natural rights) are rights that, it is argued, are possessed by everyone and cannot be taken away, even if they are ignored or trampled by governments or dictators.

Some Moral Rights are described as universal, meaning that they are attributable to all humans. An example of this is the right to autonomy (self-determination). However, there are also specific rights that are possessed by some and not others on the basis of special social relationships (e.g. the right of a child to be looked after by its parents/guardian or the doctor-patient relationship) or promises. The recipient of a promise has a right to claim what was promised, and legal promises (contracts) create legal rights which are enforceable by law. These specific rights are potentially universal, in the sense that anyone who receives such a promise or has such a special relationship will receive the same rights.

Some rights impose obligations on others to do something specific. These are called positive rights and they entitle the holder of such a right to receive a good or service from another. The other person is obliged to give the good or service demanded by the right. The specific rights based on a promise or a special relationship (e.g. the doctor-patient relationship) can be positive rights, but other rights which are claimed as universal, e.g. the right to healthcare or to education, also imply an obligation on someone else to provide this. However, it is not always clear who the other is that is obliged to provide the goods/services based on such universal positive rights.

Other rights require people not to do a certain thing. These are called Negative rights and they entitle the holder to be free from some action that others could potentially undertake.

The other person/people are obliged not to act in such a way. Examples of such rights are the right not to be killed or the right not to be tortured. Negative rights are in practice easier to enforce than positive rights. It is not always clear, however, whether rights are or should be positive or negative rights. For example, does John Locke's "life, liberty and estate" require other people not to kill, imprison or steal (negative rights) or does it require them to heal, liberate and provide (positive rights)?

Rights imply duties. Positive rights imply a duty on others to provide a good or service, and negative rights create a duty on other not to act in a certain way. Rights theory has been included in the section on deontological ethics for this reason. It is not clear whether rights could provide the basis for the rules which underpin deontological theories, or whether rights arise from such rules. However, clinicians need to be aware that a relationship between rights and duties does exist, because when a patient claims a right to healthcare, the duty will fall to the clinician to provide.

Often rights are claimed as absolutes and so any action against rights is seen as a direct violation of the right itself. This allows rights to be used as a trump card against society, protecting the individual. However, this creates problems for the clinician because in many clinical situations the rights of one individual impinge on the rights of another, just as in deontological theories rules can often conflict with each other. An example of this could be the right of a patient diagnosed with an STI to confidentiality and the right of their partner to know of the risk to their health. Rights may be seen by the clinician, however, as valuable but not absolute principles, which often have to be weighed against each other, much in the same way as Ross' Prima Facie Duties. So certain rights may on occasion need to be impinged, especially when they conflict, but this must always be justified and rights remain as a constant reminder to the clinician of the dignity and equality due to all individuals.

5.5 Advantages and disadvantages of rights theory

The great strength of right's theory is the protection for individuals that it provides, especially in the light of the great abuses that have been done to individuals throughout history in the name of the "greater good", by society or even by the medical profession (e.g. in Nazi Germany). Rights represent the promise from the majority to the minority, from the powerful to the weak, that their dignity and equality will be respected. Since doctors are often in positions of significant power over patients, the rights of the patient are an important reminder of the duty and respect due to the patient that the doctor's power implies. Rights have often encouraged the oppressed and maltreated to stand up and protest, which serves and important and beneficial role in a society, although this can be uncomfortable for the powerful members of that society.

However, Rights Theory cannot provide clinicians with a complete ethical theory in itself. It provides no account of the role of emotion, supererogatory action or virtue, instead providing only minimally enforceable rules. In its protection of the individual it excludes and ignores group interests and communal values. By focussing on what an individual is owed, it changed the focus of morality from one of duty, responsibility and a desire to do good, into an egotistical focus on what can be demanded. Rights could, therefore, be one factor underlying an increasingly consumer based culture driving healthcare in the developed world. Whilst protecting the value of patients , Right Theory cannot account for or exhort clinicians to the beneficent drive to strive of the best for their patients, which is the heart of moral motivation.

In this way right's theory can be best seen by the clinician as an outworking of one of the great insights of deontological ethics, that of human value. Right's Theory puts flesh on the bones of how this principle is worked out in human society, where valuable humans live side by side. Rights theory dictates the boundaries of protection for individuals from others, limiting what can be done to them in the name of a "greater good", and negative rights are a valuable tool in this. Positive rights, however, especially when taken out of the sphere of specific rights into universal rights, have difficulty identifying who has the duty to fulfil the right. In a resource limited world many of the universal positive rights that are claimed are often seen as aspirational rather than realistic. Therefore, a universal positive right implies a duty (perhaps on all) to try to provide the good demanded, but because of the scale and practical impossibilities, of for example providing healthcare to all, does not create a duty on clinicians to actually provide all people with the services required. Rights can provide a coherent imperative to the clinician against doing wrong to a patient, but often fail to provide a coherent imperative to exhort good to be done to that patient.

5.6 How the clinician could use utilitarianism and deontological ethics

Whilst Utilitarianism and Deontological Ethics seem so divergent as to be almost opposites, they both highlight different insights of Ethical Theory which are of great importance to the clinician in medical ethics. Utilitarianism, with its emphasis on the importance of outcomes and its focus on maximising happiness and relieving suffering, expresses the heart of moral motivation and embodies much of the beneficent drive that motivates clinicians to seek the best outcomes for their patients. Utilitarianism also has special use in the particular area of the development of public policy and resource allocation.

Deontological Ethics, in particular Kantian Ethics, claims that ethical decisions should be justifiable by reason and, therefore, be universal. Deontology gives expression to many of the rules that in practice govern human relationships and describe well the expectations of patients and clinicians of the doctor-patient relationship. The most importance insight of deontology is the value of humans. From this can be derived the importance of non-maleficence, respect for autonomy and justice. In this way Deontological Ethics act as a check on the beneficent drive and moral motivation to do good, in terms of creating happiness and relieving suffering, that arises from Utilitarianism, preventing it from reaching counterintuitive conclusions or disregarding the value of human beings. Utilitarianism describes the starting moral motivation of the clinician, but deontological ethics ensures that this is worked out in the right way. This can perhaps be expressed by adapting Gillon's Summary of the Kantian Ethic "Act as you wish providing that your action conforms to the requirements of the moral law" to include a Utilitarian motivation. This could be expressed as "A clinician should act to maximise happiness and relieve suffering providing that such action conforms to the requirements of the value of humanity of the patient, in terms of duties to the principles of Non-Maleficence, respect for Autonomy and Justice".

This is similar to the earlier proposal that, in Principalism, Beneficence forms the starting point and motivation in an ethical dilemma but must be weighed against the other principles of Non-Maleficence, Autonomy and Justice in order to ensure that the ethical weight of these perspectives is not overlooked. Whilst not providing a defining solution to dilemmas in medical ethics, and seemingly leaving the clinician weighing between principles as does Principalism, discussing and seeking to balance Utilitarianism and

Deontology provides additional depth to the clinician's understanding of the Four Principles. Seeing Beneficence in terms of maximising happiness and relieving suffering and seeing Non-Maleficence, Autonomy and Justice in terms of valuing humanity allows the clinician to have a better understanding of what the Four Principles are for and so when choosing one principle over another may be appropriate. In some situations the imperative to maximise happiness and relieve suffering will be so powerful that it should not be tempered, but in other situations overriding Non-Maleficence or respect for Autonomy would devalue the humanity of a patient in an unacceptable manner.

This still, however, leaves clinicians weighing between principles. In order to provide further resources to such a clinician a change in perspective is necessary. Such a change in perspective is provided by Virtue Ethics.

6. Virtue ethics

Virtue Ethics is a description of a way of thinking ethically that, rather than focussing on the rules or outcomes relating to specific actions, focuses on character and motivation. Actions are judged in the light of character, meaning that the right action in a situation is defined as the action that, in that situation, a virtuous person would take. A virtuous person is described according to the Virtues (good character traits or moral habits, for example kindness, generosity, courage, justice, prudence, etc), and it is from these virtues that Virtue Ethics takes its name.

According to Virtue Ethics it is not just important to do the right thing, but to have the right disposition, motivation and emotions to be a good person who does the right thing. This makes Virtue Ethics well suited to both Public and Private Life, bridging the gap between the two and demanding integrity in both. Virtues such as justice and beneficence define the virtuous person's public life, whilst the virtues of love and care direct their private lives. Virtue Ethics is an ethics of aspiration, not an ethic of duty. In order to become a virtuous person it is necessary to discover a proper moral example and imitate that. Becoming a virtuous person involves an apprentice-like training in virtue. Imitating the right model results in a virtuous person, who has trained to spontaneously do good.

Virtue Ethics was brought to prominence in modern ethics by Elizabeth Anscombe and Alasdair MacIntyre. They argued that since the enlightenment moral philosophy had become unable to provide a meaningful moral imperative, and that a return to virtue ethics was the only possible way forward (MacIntyre 2011). Virtue Ethics, as an inspiring ethical theory that took ethics away from legal context and embraced both the importance of spirituality as well as the value of community, was therefore, proposed as an alternative to the flawed deontic (action based) systems.

The modern resurgence of Virtue Ethics, relies on theories of Virtue Ethics that date back to Ancient Greece. Both Plato and Aristotle discussed the virtues, but it is Aristotle who is considered the father of Virtue Ethics.

6.1 Aristotelian ethics (Aristotle 1998)

The concept of a *telos* (goal or end) underpins all of Aristotle's ethics. The *telos* in Aristotle's ethics is different, however, from the use that is made of the word telos in teleological ethics, where *telos* describe the focus on the goals or outcome of actions. The *telos* for Aristotle

describes the goal towards which all of humanity is moving. It is this goal that gives the meaning and purpose to humans that is necessary to provide the ethical imperative to be a virtuous person. The *telos* towards which Aristotle describes all humanity moving, he calls *Eudaimonia*. *Eudaimonia* means literally having a good angel, but describes a state of human flourishing, happiness, well-being and blessedness – the good life. For Aristotle, therefore, humanity has an essence or a function, to pursue *eudaimonia*, the good life. This human flourishing is a much richer concept than the simple happiness described by Utilitarianism. It describes health, wealth, social well-being and growth in virtue. Aristotle's conception of human flourishing, however, is coloured by his context of life in an Athenian City State and can seem egotistical in focus. It is possible, however, for the concept of human flourishing to be developed beyond this and for the virtuous person to be governed by a *telos* that desires and seeks flourishing in all of these ways not just for the self, but for others around, and for all of humanity.

For Aristotle, in order to lead a human life well, and so to pursue *eudaimonia*, the virtues are necessary. He describes the good of man (humanity) as "the activity of the soul in conformity with virtue". Aristotle defines the virtues as a trait of character manifested in habitual action, that it is good for a person to have. These virtues are the qualities needed for successful human living, and Aristotle describes the virtues as the good mean between two negative vices, represented by deficiency and excess. For example, courage is the mean between cowardice and foolhardiness. Other virtues that Aristotle describes include generosity, honesty, self control and loyalty to friends or family. Friendship is of great importance to Aristotle, and he argues that no-one would choose to live without friends, even if he had all other goods.

Aristotle acknowledges that we do not have direct control over our emotions, and are susceptible to temptation with dispositions that cannot be simply turned on or off. However, he argues that we do have indirect control over our emotions, and it is possible to take steps to develop the right dispositions and attitudes, as well as correcting wrong ones. This can be a long and difficult process that Aristotle describes by the metaphor of a garden. The emotions are plants that grow of their own accord. They will grow wild if left alone, but the virtuous person is the gardener who works to guide and control the plants, cutting some back and encouraging others to grow more. Such an account of emotion and its role in the ethical life is missing in deontic systems and is a powerful description of the importance and role of emotion in ethical development. A further ethical imperative is discovered by Virtue Ethics here. We must not simply do the good, nor is being good sufficient, we must learn to love the good.

Aristotle grounds his concept of the quest for the good life and growth in the virtues in real life. The virtuous person, whilst always focussed on the *telos* of human flourishing, is constantly engaged in real life situations and circumstances. *Phronesis* (practical wisdom) is how Aristotle describes the virtuous person's ability to respond realistically to specific circumstances, whilst remaining directed and guided by the *telos* of human flourishing. *Phronesis* allows the virtuous person to find the right means with which to accomplish the right ends, as demanded by the virtues (Kaldijan 2010).

6.2 Advantages and disadvantages of virtue ethics

As discussed earlier, Virtue Ethics has the great advantage for the clinician of providing an account of the importance of moral motivation to the ethical life. It values friendship, love,

respect and mutual regard in relationships and values action taken for those reasons, rather than just from a sense of duty. Virtue Ethics also points to the importance of moral saints and heroes as inspiring examples for clinicians to imitate. One such moral example for clinicians is set by the life of Albert Schweitzer, who as a doctor, philosopher and theologian spent many years in Africa working to help the impoverished there. His life not only provides an informative example of a virtuous person, but one that inspires clinicians to imitate it. In doing this, Virtue Ethics creates an emphasis on the importance of moral development that is missing in deontic ethics.

Virtue Ethics also provides the clinician with a different perspective by addressing some of the weaknesses of deontic ethics, including broadening the scope of ethics from a now defunct "legal" context borrowed from theology, over-emphasising autonomy and neglecting communal goods (as described above). Virtue Ethics also provides a good account of and potential solution to the tension in many deontic systems between partiality and impartiality. Utilitarianism in particular has no place for special relationships such as the doctor-patient relationship, or special duties arising from such a relationship. This seems to miss something important about the importance of the doctor-patient relationship, and Virtue Ethics can both fill in the gap and explain the tension. Different virtues can be used to both emphasise the importance of impartiality (such as beneficence and justice), whilst others demonstrate the importance of partiality (including love and friendship). The virtuous clinician will exhibit all these virtues and by *phronesis* work out when it is right to be impartial (for example in public policy making) and when it is right to fulfil duties based on special relationships (for example in the doctor-patient relationship).

Criticisms of Virtue Ethics are that it cannot give a complete account of the ethical life for a clinician. In particular it cannot provide a complete account of the importance of doing the right thing and the place of rules in ethical decision making. The focus of Virtue Ethics is away from the moment of decision about whether a particular action is right or wrong. Thus turning to Virtue Ethics for guidance in that moment can often yield little guidance to the clinician. The answer to "do what a virtuous person would do", can be of very little help, when it is unclear what a virtuous person would do, or when two virtuous clinician differ in opinion about what should be done.

Virtue Ethics also contains a number of different virtues. Whilst this adds richness and explanatory power to describe a number of tensions within human experience, relationships and the ethical life, it can also creates uncertainty about what to do when virtues clash. This is a similar problem to that faced by pluralist deontological theories and right's theories, as a weighing between the claims of different virtues is required in order to decide the right course of action, and no clear account of how this is to be done is given. Aristotle's concept of *phronesis* foresees this problem and provides a concept with which the clinician can be equipped when facing dilemmas between virtues in specific circumstances. The concept of *phronesis* is not, however, fleshed out to the degree whereby it could provide a clear process for such decision making. Rather it is more of an acknowledgement that a virtuous clinician, when seeking the *telos* of human flourishing and exhibiting the virtues, should be trusted to face and overcome such dilemmas.

6.3 How the clinician could use virtue ethics to complement deontic ethics

In order to overcome the apparent incompleteness of a solitary account of either deontic or Virtue Ethics, attempts have been made to combine the two. Differing weight can be given

to either deontic or virtue ethics in such a combination, and this gives rise to theories with different emphases. Correspondence Theories describe a combination of virtue and deontic ethics where deontic, in particular deontological emphasis on rules or principles, is given precedence over Virtue Ethics. The virtues, therefore, are seen as habits of obedience to certain principles or rules, and as such the virtues are derived from those rules or principles. Virtues have a motivational role, which could otherwise be lacking in a purely deontological theory, as they inspire people to obey the rules. Possessing the virtues makes a person more likely to obey the rules and in doing so the virtues have value in Correspondence Theories.

Complementary or Pluralistic Ethical Theories describe theories in which the virtues have an equal role alongside rules or principles, as necessary in order to live the good life. The virtues are not simply derivative or instrumental, but describe duties to be certain kinds of people that are equally as important as duties to behave in certain kinds of ways. Such a Complementary Theory could place the virtues alongside the principles arising in a pluralist non-absolutist deontological theory, giving rise to the prima facie duties that must be weighed in order to determine the actual/absolute duty in any given situation. As such Virtue Ethics can perhaps best be seen as part of an overall theory of ethics rather than a complete theory in itself. Virtue Theory, therefore, would find its place in ethical theory alongside an adequate conception of right action arising from Deontic Ethics.

Just as Utilitarianism can be seen to provide the clinician with an explanation of the ethical drive to do good, and Deontological Ethics provides guidance in how that good is to be worked out in light of the value of persons, justice, and the importance of universibility in ethical decisions, Virtue Ethics also provides important additional resources to the clinician. The development of character and growth in the virtues by imitation of a virtuous role model describes very well the apprentice-like way that much of clinical practice is learned by junior and student clinicians. Aristotle's description of the good life as the pursuit of excellence in accordance with the virtues, describes well the twin needs of clinical trainees to develop both in clinical skill as well as in character and moral habit. By introducing this perspective into the framework already provided by Utilitarian and Deontological Ethics, Virtue Ethics broadens the clinician's view of the role and importance of ethics. The relevance of ethics is no longer limited to problematic situations, but should also govern the entire life of the clinician, encouraging development of character and moral habit to allow a clinician to become a virtuous clinician. Virtue Ethics provides the motivation, inspiration and an account of the role of emotions that are all necessary for such character development.

Virtue Ethics adds something of greater importance to Utilitarianism and Deontological ethics. Virtue Ethics adds the perspective of a *telos*, a goal or purpose, for humanity, that of human flourishing. This *telos* is a guide in ethical decision making and by *phronesis* the virtuous person engages with the realities of the situation they are faced with, while still striving to act to bring about human flourishing. This provides a model for clinicians when faced with ethical dilemmas and the balancing of different principles. A decision should be made, guided by the *telos* of human flourishing, using practical reasoning (*phronesis*) which is a learned ability that clinicians develop. This model emphasises the importance of character development and growth in virtue and moral habits and these produce not only the development of *phronesis*, but also transform clinicians into virtuous people, who are the ones who should be trusted to make such ethical decisions. As clinicians we should strive to make ethical decisions, guided by the *telos* of human flourishing. We should make our aim

to make ethical decisions that help our patients to flourish in health, happiness and also in moral development. It is as we do this that we will also flourish into virtuous clinicians.

7. Conclusion

This chapter has discussed a number of ethical resources that are available to clinicians. These resources have relevance to all clinicians from students encountering some of the medical ethics dilemmas for the first time to experienced clinicians striving for the good of their patients. Each theory has its own merits, but also its own limitations, and no theory alone is able to provide all the answers necessary when striving for the good in clinical practice. However, in trying to hold some of the theories together a clinician can gain from the cumulative strength of a number of theories, and so find a balanced perspective, free from the weaknesses of individual theories.

This chapter discussed the Four Principles: Beneficence, Non-maleficence, Justice and Autonomy , which provide a useful analytical tool in ethical dilemmas. These principles are useful to the clinician in that they draw from a number of ethical theories. However, they leave the clinician with a dilemma in how the principles are to be balanced when they come into conflict. This problem arises from Ross' system of Prima Facie duties, on which Principalism is heavily dependent. The chapter also discussed Values-Based Medicine which is a useful outworking of what the Principle of Autonomy looks like in clinical practice and patient interactions.

Utilitarianism was also explored, with its fundamental principle of utility, seeking to maximise happiness and relieve suffering. This principle captures the heart of moral motivation in the desire to act ethically. The outworkings of this principle of utility, when given free reign in ethical thinking, may lead to many counterintuitive results, and this is why comparison and combination with Deontological Ethics adds balance to Utilitarianism. Kant's Deontological system, in particular, provides important insights into the value of persons, the importance of justice, and the need for ethical decisions to pass the test of universibility. Rights Theory is important as a further outworking of this insight into the value of humans, and seeks to prevent abuse of the individual for the "greater good" of society. Using these insights as principles in a non-absolute, pluralist deontological system (such as that described by Ross) allows them to balance and temper the clinicians desire to do good (as encapsulated by utilitarianism). This creates a system that is not dissimilar to the Four Principles of Beauchamp and Childress balanced by Gillon's method, using Beneficence/Utility as the driving motivation of the clinician, tempered by Non-Maleficence, Justice and Autonomy (which arise from deontological ethics).

Virtue Ethics opens up a different perspective in ethical discussion to cover not just the process of making an ethical decision, but also to cover character development and growth in virtue through the whole life of the clinician. In doing so, Virtue Ethics points clinicians not just to the virtues as abstract principles, but also as displayed in the lives of virtuous senior clinicians from whom the virtues can be learnt by imitation as apprentices. The examples of moral saints and heroes are part of the inspiration and motivation that virtue ethics adds to the potentially negative and uninspiring discussion of the action-based deontological and utilitarian systems. Virtue Ethics also provides a model with which to approach ethical dilemmas that arise from situations where principles conflict and must be weighed against each other. The virtuous clinician must use their practical wisdom

(*phronesis*) to assess the realities of the situation in the light of the goal or essence (*telos*) of humanity, which is human flourishing. Virtue Ethics places trust in the virtuous clinician, who has worked hard to develop these virtues and to grow in the practical wisdom necessary to decide how to maximise human flourishing and in particular the flourishing of their patients.

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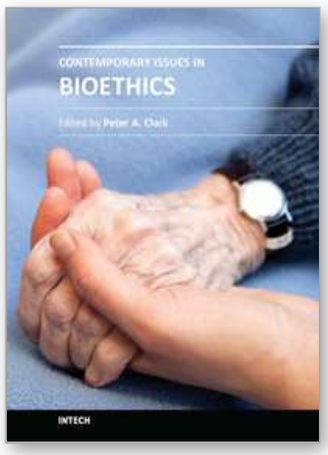

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The main strength of this book is the international exchange of ideas that will not only highlight many of these crucial bioethical issues but will strengthen the discipline of bioethics both nationally and globally. A critical exchange of ideas allows everyone to learn and benefit from the insights gained through others experiences. Analyzing and understanding real medical-ethical issues and cases and how they are resolved is the basis of education in bioethics for those who will have to make these decisions in the future. The more we examine, analyze, and debate these bioethical issues and cases, the more knowledge will be gained and hopefully, we will all gain more practical wisdom.

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