Philosophical Medical Ethics

Beneficence: doing good for others

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Among the more pious remarks to be heard in discussion of medical ethics is, "The patient's interests always come first." It takes only a few moments of reflection to see that this is certainly not true in practice and undesirable as a moral imperative. There are many competing interests in a person's life, including his own and those of his loved ones, the interests of those to whom he has special obligations, and the interests of his community. In the context of such conflict of interest it is, generally at any rate, unthinking absolutism to state that any one person's or group's interests always come first. Indeed, the extent to which beneficence or doing good for others is morally obligatory is vigorously debated by moral theorists¹ (see bibliography), and some even argue that there is no such moral obligation, though they usually hasten to add that beneficence is undoubtedly a virtue and morally commendable.²

Whatever the case in general ethics, it is undoubtedly true that members of the medical profession undertake to place the interests of their patients before their own in many circumstances. This undertaking differentiates them from, for instance, merchants, who, while they may also on occasion put their clients' interests first, will do so (qua merchants) only to further their own longer term interests—for example, when it is good for business to put themselves out for their clients. Although an element of such self interest undoubtedly exists in the practice of medicine and although the grandiose claim that interests of patients always come first is false as a description and undesirable as a prescription, the medical profession none the less conceives itself, and is conceived by society, as having a duty of beneficence to the sick in general and to its patients in particular. One does not hear the Tannoy ringing out during a ball with the request, "Would any architect present please report to the manager's office"; and if one did no architect there would feel the slightest moral obligation to respond.

The source of this additional moral obligation of beneficence taken on by doctors is presumably a certain feeling of benevolence, good will, or sympathy towards the sick. No doubt there are some who go into medicine only for the money, power, and prestige, and perhaps these factors are part of the motivation for most, but there cannot be many who do not at least start off their medical careers with a large measure of sympathy for people afflicted by illness and a desire to commit their working lives to helping them. If, however, such benevolence is to result in real beneficence—that is, doing good rather than, for instance, merely feeling good, do-gooding, meddling, or even behaving unjustly—various constraints apply.

Constraints to beneficence

Three important constraints are: (1) The need to respect the autonomy of those whom one intends to help, especially to find out what it is they want in the way of help (the duty of beneficence needs to be tempered by the duty of respect for autonomy). (2) The need to ensure that the help one renders is not bought at too high a price (the duty of beneficence needs to be tempered by the duty of non-maleficence). (3) The need to consider the wants, needs, and rights of others (the duty of beneficence must be tempered by the duty of justice).

THE DUTY OF RESPECT FOR AUTONOMY

In previous articles on autonomy and medical paternalism I have argued that in general autonomy, when it exists, ought to be respected in so far as such respect is compatible with respect for the autonomy of others. In a subsequent article I shall consider circumstances in which the presumption of beneficence supersedes the presumption of respect for autonomy. In most cases, however, of a doctor's dealings with patients (or clients—they are not always patients) not only is there an independent moral presumption that he must respect their autonomy but, even if he is interested only in doing them good, he must generally respect their autonomy in order to do so.

If one wants to do good for a patient or client one generally needs to find out what he or she actually wants one to do. Often this does not need much inquiry; a person who has broken his arm wants it set and the pain relieved. Doctors, however, are often too ready to assume that they can tell what the patient wants, or even what is best for the patient, without asking. In even the simplest of interactions patients in similar circumstances want different things from their doctors. One patient with a sore throat wants antibiotics, another wants a pain killer, a third wants information about what it is, whether it is likely to go to his chest, whether deterioration can be prevented, and if so how, and a fourth wants a sick note for his employer but refuses treatment, preferring to let nature take its course. The doctor who "knows" what the patient wants without asking him is quite likely to get it wrong.

Sometimes it is true that patients' wants and needs may be in conflict. The patient who wants antibiotics for his sore throat may be wanting something that will not benefit him—for example, if he or she has a viral infection, as is commonly the case. Conversely, he may want not to have what will benefit him (as when a patient with a persistent, confirmed pathogenic streptococcal infection refuses penicillin—"I can't abide antibiotics"—and risks heart and kidney damage). In each case the duty of beneficence requires at least discovery of what the patient does want and an explanation of why a different course of action would probably (for almost all such assessments are probabilistic) benefit him more. Such respect, even if an independent priority to respect for autonomy is rejected, is required by beneficence simply because the patient is more likely to do what the doctor considers to be medically optimal if the doctor

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explains why the patient's own preference is less likely to be beneficial. Conversely, the doctor is more likely to make a truly beneficial proposal if he knows and takes into account the patient's own preferences.

The doctor is not obliged by the (*prima facie*) duty of beneficence always to do what the patient after such discussion wants. Self respect for one's own moral autonomy is properly part of the moral assessment, and there are some actions that one may properly refuse to take because they go against one's own moral principles: one may believe, whether or not the person concerned agrees, that they would be too harmful; one may wish to respect the law or one's professional code of ethics; or one may consider them unjust even if they will benefit the patient. Prescription of an expensive drug preferred by the patient when there is good reason to believe that a cheaper one is likely to be just as effective is, at least when others are paying, ultimately unjust for it places unnecessary and therefore excessive burdens on those others (taxpayers, contributors to insurance schemes, or charitable benefactors). Similarly, the provision of as much time for discussion as the patient (and doctor) may like may be unjust in depriving other patients of adequate time in their turn. None of that, however, negates the *prima facie* requirement of the obligation of beneficence to find out what the patient wants and to try to meet those requirements.

THE DUTY TO DO NO HARM

A second moral obligation that must necessarily temper the duty of beneficence is the duty to do no harm (the duty of non-maleficence). It is obviously not beneficial overall to do something that in itself is beneficial if one wreaks havoc in the process, a danger to which modern doctors are particularly susceptible. Various medical obligations stem from the need to weigh the expected bad effects of any proposed intervention against the intended beneficial effects. The most obvious is the need to be good at one's job, and thus an effective medical education with continuous postgraduate updating can be seen to be a direct requirement of the principles of beneficence and non-maleficence.³ Similarly, the content of that medical education needs constant scrutiny in the light of these principles. Audit⁴ and clinical trials, not just for longevity but also for quality of life (including patients' own perceptions),^{5,6} are obvious corollaries; it is essential properly to assess the types, amounts, and probabilities of benefit and harm that result or would result from one's clinical decisions.⁷

Respect for the patient's autonomy is needed once again, here as a component of non-maleficence, for people's conception of what they would find harmful is, like their conception of what they would find beneficial, intensely personal.⁸ For example, one person will choose laryngectomy and a 60% three year survival rate for vocal cord cancer, whereas another will prefer radiation to spare his voice at the cost of a three year survival rate of only 30-40%.⁹

Another correlate of beneficence tempered by non-maleficence is effective, sympathetic, and adequate communication, for obviously in such delicate matters poor communication skills are likely to harm patients.^{10,11} Incidentally, the ordinary, old fashioned medical virtues of friendliness, warmth, concern, and politeness (including good time keeping) remain obvious requirements of the principle of beneficence. It should hardly be worth stating except that my impression is that these seem to be decreasingly valued, especially in the public sector of British medical care. Can it be that a guaranteed income decreases concern within the profession for these beneficent attributes?

THE DUTY OF JUSTICE

Finally, beneficence must be tempered by justice. It seems clear and virtually beyond dispute that if all the available medical resources were used to provide care for only a favoured section of the sick population (say, the rich or members of a particular political party or race or just those whom the doctors fancied) no matter how beneficent and non-maleficent that care was, no matter how excellent, it would be unjustly, because unfairly, provided.

When medical resources are scarce (the inevitable case) some form of just distribution of those resources must be achieved. Such justice entails not only some form of fairness, of which more anon, but also efficiency in their provision. Here the growing business of cost benefit analysis and its variants is increasingly urged on the profession as a vital aspect of medical ethics.¹²⁻¹⁶

In this context doctors face a major dilemma. They may insist on raising their professional obligation to help their patients above the requirement of justice, arguing that it is not their business to share out inadequate resources but rather to do their best for the patients under their care^{17,18} and to make as clear as possible the appalling results to other patients and potential patients of having inadequate resources. This position accords well with the circumscribed beneficence of the Hippocratic oath, which concentrates a doctor's moral obligation on "the benefit of my patients." Such doctors may see their position as similar to that of a barrister who does his utmost for his client and assumes that the other side will be equally partisan and that justice will result from such an adversarial system of advocacy. It is a reasonable approach provided that doctors accept the corollary that someone else (equivalent to the judge and jury) will decide, after listening to all their special pleading, on how the scarce medical resources are to be distributed most justly.

Alternatively, doctors may accept as part of their moral purpose not just the health of "my patients" but the health of all sick people, including future sick people (if medical research is to be justified) or, more broadly still (if preventive medicine is to be encompassed¹⁹), the health of all potentially sick people as part of their moral purpose. If they do so they clearly commit themselves and medical ethics to require justice in the distribution of medical resources: justice not only for their patients, not only for their country's patients, but for all the world's sick, present and future (and even perhaps the world's potentially sick).

Such a commitment if taken seriously would have quite staggeringly radical results in terms of taking away medical care from the well provided and redistributing it to the medically destitute. No wonder that we doctors have preferred to stick with the Hippocratic objective of concern for our patients. On the other hand, no wonder also that those concerned with fairness for all have sought—and continue to seek—to reduce medical control over the distribution of medical resources. It is a dilemma that the profession has on the whole evaded. If, however, we do not resolve it ourselves it is likely to be resolved for us.

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