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MORALITY AND ETHICS

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The word morality comes from the Latin word 'moralitas', which means 'proper behaviour'. The usual meaning of morality is in its prescriptive sense, i.e. a universal code of value judgements of what is right or wrong that is accepted by rational people (for example, murder is immoral).

Confusingly, morality is sometimes equated to ethics. More correctly, ethics is a study of morality in a particular domain, i.e. ethics is the way of examining morality. Ethics can generally be said to be normative (it answers the question 'what action should be accepted as moral and why?'), or non-normative ethics.

Non-normative ethics usually refers to descriptive ethics. This is the way in which a historian might determine how different were the morals expressed in Singapore 100 years ago as compared to today; or the way in which an anthropologist might try to determine what were the morals in an ancient civilisation. Non-normative ethics also sometimes refers to meta-ethics, which is an analysis of the concepts and thoughts and language of ethics.

The problem with non-normative ethics is that it is essentially a descriptive analysis of morality. It is not really useful in trying to help make judgments that will guide our actions. This is where normative ethics comes in. Basically, normative ethics tries to formulate and defend a system or morality that will help us to decide whether a particular action we take is right or wrong. Normative ethics can then be applied to examine moral problems in different situations – this is called applied normative ethics. Normative ethics can be applied to certain professions, for example what should a journalist, lawyer or doctor do (or not do) in certain situations. Broadly speaking, biomedical ethics refers to the application of ethics to formulate and defend a system of morals in the biological sciences and healthcare, and often more specifically in medicine.

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MORAL DILEMMA AND REASONING

When we are caught in making a decision over matters or morality, (for example, should I encourage a dying patient with end-stage renal failure to buy a kidney from a healthy individual who is starving and has consented to donate a kidney), most of us would desire a resolution to this issue at hand. We try to reason why we should act in one particular way. This is called moral reasoning.

Moral reasoning is the way in which we decide what choice to make. Strictly speaking, moral reasoning is the way in which we decide to make a choice in a moral dilemma.

A moral dilemma can refer to a situation in which we know that there is a good reason that action A is right, but also believe that there is good reason that action A is wrong. For example, the right of self autonomy might be considered a good reason that abortion is right, but the principle of the sanctity of life is a good reason that abortion is wrong, if we believe that life begins at conception. A moral dilemma can also arise when we are in a situation where we believe we should perform action A, but at the same time, we also believe that we should not condone action A. For example, an obstetrician might think that she should perform an abortion on a pregnant 13-year-old rape victim, but at the same time think that she should not because that is killing a human being. A moral dilemma can also arise when we have to choose to perform an action which may benefit person A, but which might cause harm to person A, and also could cause greater harm in general. For example, if person A tells a psychiatrist that he has violent thoughts against person B, should the psychiatrist tell person B or the police, thereby breaking patient confidentiality, and risk treatment failure in person A? If a psychiatrist must tell, what happens if patients with violent thoughts then refuse to see psychiatrists, leading to an increase in the number of assaults from untreated patients? And what happens if this leads to an erosion of the trust between doctors and patients? These are real questions that were debated in the case of Tarasoff v Regents of the University of California, California Supreme Court, 1976.

Moral dilemmas should be distinguished from hard choices. Sometimes, there may be conflict between choosing something that is moral and something that is 'non-moral' (neither right nor wrong) or in one's self interest. For example, should I give my $50 to help a starving homeless person (it is neither right nor wrong to give), or should I save it for a rainy day because I have just been retrenched (it is neither right or wrong to save)? This is a hard choice, but it is not a moral dilemma.

MORAL VERSUS NON-MORAL

What makes a particular principle, problem or judgement moral or non-moral? What is a moral judgement, as opposed to a judgement which is religious, political, legal, or etiquette? This is a very difficult question to answer, and one where meta-ethics may more rightly try to answer.

As a general guide, it has been said that there are three main criteria acting together that form a moral principle.

1. **Supremacy.** This means that the principle over-rides other interests like self-interest, politics, and religious affiliation.
2. **Universality.** This means that the principle applies to similar people in relevant and similar situations, because what is right for one person should be right for another similar person in a similar situation. Universality does not mean that the principle must apply to everyone throughout history, irrespective of the current moral standards in a particular society.
3. **Welfare.** This means that the principle must have some value in safeguarding and promoting the welfare of oneself and others.

The key word is 'acting together'. These criteria by themselves do not indicate a moral principle. To illustrate, take for example alcoholism in a group of similar alcoholics. To this group of persons who are in similar situation, the need and pleasure of alcohol ingestion is the supreme principle that over-rides all other principles. It is universal to all alcoholics. But does it promote the welfare of oneself and family and others?

MORAL JUSTIFICATION

Generally, most people go through life making moral judgements about what action they do is right without any difficulty. This is because we learn values and virtues like truth and honesty from our parents, in school, and from the rules imposed on by society. But when we are faced with a moral dilemma and we make a choice, we implicitly try to defend our actions to ourselves (or explicitly to others), by some rule or principle that will guide our action. These rules and principles are called action guides. For example, should we tell a demented and depressed patient who has asked what's wrong with him that he has terminal cancer, and when the patient's relatives have specifically forbidden you from telling? This is a moral dilemma. If we choose to tell the patient, then our justification might be that doctors must tell because it says so in a code of conduct, or it might be that we believe that in the principle of a patient's right to know, or it might be that we believe that it is wrong to lie. These rules and principles and beliefs are our action guides. Another doctor might choose not to tell at that point in time when the patient is depressed, believing in the principle of the patient's best interest. Another doctor might choose not to tell because of a non-moral reason – self interest (i.e. "I don't want to get sued").

But how do we decide which action guide is correct? We can do so by falling back on guidelines, public policy, the law, some formal code (a code of conduct) or by an analysis of the moral problem in that situation (the last being normative ethics, and also called moral theory or ethical theory). To complicate matters, how we act is intertwined with our belief systems for example, our scientific,

religious, or political beliefs. We may believe that life begins at conception – but is that a scientific or a religious belief? A further complication is that a fact which may be relevant to us in believing something may not be adequate reason for us to act. Thus we may believe that scientifically, tobacco smoking has absolutely no benefit to health – but is that an adequate reason to ban smoking completely, or to raze all tobacco farms? Or if we believe that killing is wrong, is that adequate reason to deny a 13-year-old rape victim an abortion?

NON-MORAL ACTION GUIDES
One way in which we can justify our actions is by acting in accordance to the law. For, example, there are laws which govern how we do biomedical research. The problem with the law is that it tends to deal with very broad or very specific situations, and thus makes it useless as an action guide in many situations. A statute may tell us that it is wrong to lie in a court of law, but it does not tell us that it is wrong to lie to our patient in certain situations. A statute also does not tell us why it is wrong to lie to our patient. A big problem with the law is that just because the law says that action A is legally right, it does not follow that action A is morally right. And neither is an action that might be considered morally acceptable (for example, the right to die) mean that the law will allow it.

Another way is to fall back on guidelines. But guidelines generally tackle very specific issues, and mostly offer no help when one has to make moral judgement. The same can be said of public policy. Public policy generally refers to a set of prescriptive guidelines directed at a particular issue that has been accepted by a public body and then which becomes enforceable. In fact, the very codified nature of guidelines and policy make it an oxymoron to talk about abstract ethical ideas dictating guidelines and policy.

Another way in which we can justify our actions is by acting according to a code of conduct. These codes have generally evolved through time based on

philosophical thinking, on what a body of people or what society deems to be right. A code can be a general one that applies to everyone – for example, you must not kill. A code could also be one that governs a particular group of people – as in a professional code of conduct.

A profession is generally a cluster of occupational roles, valued by society, performed by people earning a living from that role in a full-time job, and where there is some control of entry by a formal certification that a person has the necessary knowledge and skills to perform that role. Professions typically

enforce responsibilities and obligations to ensure that their members are competent, morally upright and trustworthy – through a code of conduct. A particular professional code is usually justifiable and defensible based on some principle. However, what is one to do when one part of the code conflicts with another? For example, to do good, one might have to do some harm (beneficence versus non-maleficence). To complicate matters, codes are increasingly focusing on the rights of the person dealing with the professional (the patient), as opposed to the obligations of the professional (the doctor).

So, what we have to fall back on is ethics (ethical theory), or more specifically, normative ethical theory – the study of moral dilemmas in different situations to defend the principles and rules which form our action guides.

ETHICAL THEORY
The basis of an ethical theory provides the framework in which we can

determine whether our actions are morally appropriate.

Broadly speaking, there are two kinds of ethical theory: consequentialism and deontologism.

Consequentialism refers to the philosophy that actions are either right or wrong based on their consequence (the outcome).

The main form of consequentialism is utilitarianism (altruism is another form). In utilitarianism, the rightness of an action is determined by the maximisation of the value or good produced by the action. This means that what we do is guided

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either by trying to produce the greatest amount of value, or the least amount of dis-value. Thus, if we have a different number of equally efficacious treatments (same benefit) for the same patient, then we should choose the treatment which has the least risk and cost.

In its purest form, the actions, by themselves, are intrinsically devoid of being either right or wrong (act utilitarianism). Therefore, if we lie to a patient but subsequently maximise the benefit to the patient's overall well-being and 'act utilitarian', we might say that the act of lying was right because it led to a good outcome. Sometimes, utilitarianism does work within a broad moral framework (rule utilitarianism), but even then, it can be problematic. If we allow seriously-ill patients with poor prognosis to die (but not actively kill them because the rule is that killing is wrong), so that more resources can be spent on less seriously-ill patients with better prognosis, the action of allowing patients

to die that might be considered (by a rule utilitarian) as a right action because the outcome (on balance) has a higher value. In rule utilitarianism, a rule (for example, patients can be allowed to die) can be chosen because it has a desirable outcome on balance.

There are other difficult problems with utilitarianism. How do we define which value is good to be achieved, and in what context? When two patients with kidney failure have access to one dialysis machine, should we give the patients with more social responsibility (say a minister compared to a beggar) access to the dialysis machine because keeping the minister alive would bring greater benefit to society? How do we measure a person's worth, happiness (or pleasure, or health) and compare it with another, and then decide which one has a higher value? How do we compare the value of action A to an individual, as compared to the value of action B to a group of people? Because of these problems, utilitarianism is sometimes often rejected as the basis of medical ethics.

In contrast, deontologism holds that an action can be inherently right or wrong for reasons other than its consequence. Thus, actions can have other features (besides its consequence, as in utilitarianism) which make it either right or wrong. The features might include motives like beneficence, non-maleficence, justice, promise-keeping, gratitude, and reparation. For these reasons, many people find deontologism as a more preferable basis for medical ethics. There are two main problems with deontologism. One is that that there are no defined universal features of what is right and wrong. Second is that some rules may be considered so binding (i.e. we have a duty to follow the rule no matter what) that we have to follow them even if utility is not maximised.

What then should be the basis of medical ethics? The fact is that no theory can justify actions or resolve moral dilemmas to the point of completeness. We may have to eventually decide on

a common ground – that we have to maximise benefit and minimise negative outcomes (consequentialism), that actions do have features which are inherently right and wrong (deontologism), but that we may have to trade off some values for the sake of other values to maximise benefit and minimise harm.

But how do we know that we are applying an ethical theory correctly or appropriately? Several general tests of ethical theory can be used. Even so, it has to be said that no ethical theory can possibly adequately satisfy these tests, but that is probably the best tool we have. These tests try to ensure that there are consistent solutions to dilemmas (although we live in an imperfect world and we know this is not universally true, but we try).

So what are these tests?
1. The theory must be as clear as possible in whole and in part.
2. The parts of the theory must be mutually supportive and coherent.
3. The theory must be as sufficiently comprehensive as possible.
4. The theory must be as simple as possible.
5. The theory must be able to cover a wide range of moral experience. (This test is the most difficult one, because one can say that this test is circular. We formulate a theory to describe our experience, and then we use our experience to test our theory. However, the strength of this test is that we build up our judgement as we gain experience.)

BINDING RULES
Some people might consider that rules and principles might be considered as absolute, for example, killing or lying is absolutely wrong. But we know that even these absolute rules may permit exceptions. Thus, it might be justified to kill someone if that is the only way you can defend yourself and your family. If a father did not want to donate his organ to his child with end-stage renal failure and asked the doctor to tell his wife that he was not

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histo-compatible (when he was) to prevent wrecking the family, a doctor might not tell the whole truth to the wife and child.

Therefore, the model of absoluteness is not a feasible model for medical ethical theory. It might be better to say that there are rules and principles which we would accept as binding at face value (prima facie binding), but which may over-ride other rules and principles depending on the context. These rules and principles have weight, but we do not assign rank until we know what the circumstance is – that is, they are situational.

These rules and principles impose duties on doctors, i.e. they impose obligations. In the same vein, these obligations are prima facie and are situational.

RIGHTS
But obligations are insufficient. Many controversies and dilemmas involve debates about rights – for example, the rights to die, to life, to autonomy, and to health care. Rights have a legitimate role in ethical theory, but to what extent? Are rights absolute? Not really. We have a right to life for example, but it would be difficult to argue that sometimes a life might be taken if there is sufficient justification. Thus, rights, like rule and principles, are prima facie and are situational. Thus, one needs to differentiate violation from infringement of rights. If I take an unjustified action against your right, then I am violating

your right. However, if I were to take a justified action that over-rides your right based on a competing right, then I infringe your right, but I have not violated it.

A right is a claim that we can justifiably make against others in society. This means that when one claims a right, it creates an obligation on others in society. Rights can be positive (requiring a positive action from someone, for example, the right to health care requires that the government provide adequate health care), or negative (requiring that a person does not do something, for example, the right to autonomy requires that I do not give you a blood transfusion for your religious reason).

If having a right requires that a person has an obligation to do something for you, then if there is an obligation, it follows that a right should be involved. Thus if a doctor accepts person A as a patient, the doctor has an obligation to care, and the patient has a right to expect a certain standard of care.

For obligations and rights to make sense, it is important that they are enforceable. This enforcement can be through some form of legal punishment, or social disapproval (showing contempt, blaming, shaming).

However, not all obligations are related to right. For example, I may feel that I have an obligation to donate to charity to return to society, or I may have an obligation to love my spouse, but no one can claim my charity or my love as a matter of right. Strictly, these obligations are duties which are self-imposed or imposed by society, rather than obligations (duties that are required by morality).

A BASIS OF MEDICAL ETHICS

For most doctors, the practical guide to how we reason and make a choice in medical moral dilemmas is probably the use of conscience, which is a vague way to describe an equally vague concept of moral intuition. Our intuition may change with each patient

encounter. The vagueness of conscience and intuition makes it very difficult to articulate and defend.

Medical practice is circumscribed by outside forces, like public attitude and the law. The law does not hesitate to impose morality where necessary (for example in organ transplantation). The law has also imposed standards of care on doctors (for example, the Bolam test). Also, by relying on the law, the doctor's self-interest might over-ride, subconsciously or otherwise, the best of interest of the patient. This can be seen in defensive medical practice.

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However, the extent to which the law scrutinises medical practice is quite limited. Doctors are also regulated on how they practice by self-regulation (for example, through the Singapore Medical Council, which imposes a code of conduct. These codes of conduct did not appear out of thin air. They were formulated as medical practice became more organised.) These rules can help us in our conduct with patients, but they do not take into account that each doctor-patient encounter is unique.

These unique encounters and the need to balance good value to the individual and society often lead moral dilemmas that our intuition, the law and codes cannot help us with. Medical

ethics is an attempt to go behind these shibboleths. Medical ethics includes all these rules, but also includes higher principles, like beneficence, non-maleficence, autonomy and justice. How did these principles become stated? Again, these principles became formulated with the organisation of medical practice. For example, very early medical practice was based on supernatural intervention and power. There was no culpability in failure. Later, the code of Hammurabi (about 2000 BC) cited penalties for negligent failure. Later codes of principles like the Hippocratic Oath further influenced philosophical medicine. More modern codes of principles like the Declaration of Geneva and the International Code of Medical Ethics followed. We must also not forget that religion greatly influenced medical ethics.

The principles of the organisation of medical ethics have become distilled into what we know them to be today – non-maleficence, beneficence, justice, autonomy (and also dignity and honesty). These classical principles do not tell us how to handle day-to-day encounters, but they help us to resolve conflicts or dilemmas. How we justify the actions and decisions that we make or which principle over-rides another can be said to be based on ethical theory (often the common ground of utilitarianism and deontologism). These principles and ethical theory do not provide a complete normative medical ethical theory, but it does seem to be sufficient for medical practice.

I will discuss the classical principles of medical ethics in greater detail in another article. ◼ⓢⓜⓐ

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