UNIT II

ETHICS AND THE HEALTH CARE PROFESSIONS

Ethical dilemmas in the field of health care involve some of the most troubling and dramatic incidents of professional life. The task of applied ethics is to provide a reasoned and justifiable response to the question, "What is the right thing to do (in a particular situation)?" Health care professionals have to make literally life-and-death decisions, and often they must decide quickly, without the luxury of time for reflection. In order to develop a moral consciousness to guide their choices, they need a firm grounding in ethical principles, combined with an understanding of the nature of justifications. The material in this unit—together with Unit I—is aimed at providing the necessary groundwork.

Many problem areas in health care ethics are not new: abortion and euthanasia are examples. However, recent advances in medical technology have added new dimensions to old questions and fostered a sense of urgency in attempts to resolve them. In the case of euthanasia, for instance, techniques have been developed to prolong biological functioning in persons who are irretrievably comatose and in neonates with severe defects. Individuals who previously would have died can now be sustained at some level, sometimes for years. The question arises whether an organism with no more than artificially maintained respiration and heartbeat is truly alive. Is it right to prolong such a life? The line between life and death, once easily recognized, has become agonizingly difficult to locate.

Shifts in social patterns and attitudes also affect issues in health care ethics. For example, the changing status of women in American society has had an impact on views concerning the morality of abortion. As women gain greater independence and rights of self-determination, more importance has been placed on the right of an individual woman to choose whether or not to bear a child. Changes in women's career patterns have increased the demand for family planning, with abortion as the last-resort means to terminate unwanted pregnancies.

While some problems are long-standing ones, others have come to light as a direct result of technological innovation. Reproductive techniques like *in vitro* fertilization and long-term preservation of sperm and ova by freezing raise ethical questions that are unprecedented. Still another source of problems is the changed setting of contemporary health care. The one-on-one relation of physician and patient has given way to a complex pattern of institutional care. The diversity of professionals in the institutional setting makes it harder to fix responsibility and aggravates problems of communication and authority.

The first chapter of this unit focuses on the relations between patients and professionals. Separate sections are devoted to the issues of Paternalism, Confidentiality, Informed Consent, and Truth Telling. The underlying theme of the chapter is the nature of communication and authority in the professional–patient relationship. Traditional medical practice is grounded in paternalism and places strong emphasis on professional authority. Dissatisfaction with the traditional approach has led to greater awareness of patients' rights to know the truth and to make their own choices.

The values of autonomy and self-determination play an important role in issues of reproductive health, the subject of Chapter 6. The problem areas examined are Abortion, Selective Abortion, Genetic Screening, and Reproductive Technologies. Conflicts exist between those who support women's right to make personal reproductive choices and those who believe that fertilized ova have a right to live. New techniques for examining a fetus *in utero* raise questions about reproductive responsibility. What kind of genetic screening is appropriate? How should test results affect abortion decisions? Advanced reproductive technologies prompt questions about the morality of their use and the responsibility for resulting offspring.

In Chapter 7 we move from the "right to life" to the "right to die." These sections deal with Euthanasia and Treatment of Defective Neonates. How far does the autonomy of individuals extend in making decisions about the end of life? Do health care providers have a duty to prolong life at all costs? Where infants are concerned, who should make the decision to continue or refrain from treatment? Questions arise, as they do in the area of abortion, about the quality and value of an individual life.

Issues of autonomy, paternalism, informed consent, and proxy consent surface again in Chapter 8, concerning Treatment of Mental Illness and Rights of the Mentally Retarded. To what extent is interference with the freedom of mentally handicapped or disturbed persons justifed? Should such persons be institutionalized or subjected to medical intervention (such as lobotomy or sterilization) without their consent? Who should make decisions on their behalf? Is the concept of mental illness a myth, as some theorists argue?

Chapter 9, the final chapter in the unit, is devoted primarily to issues in the broader context of social policy concerning health care. The sections deal with The Concept of Health, Macroallocation Decisions, and Microallocation Decisions. The basic concepts of health and disease require study and clarification, because defining health has important implications for the allocation of health care funds and services. Ideas about social justice also affect allocation decisions, both at the policy level and in individual cases. How much of the nation's budget should be spent for health care? When lifesaving treatments are scarce, which candidates should receive them? In this chapter, as in the preceding ones, we attempt to show how ethical theory applies to specific problems. Using the principles of basic theory makes it possible to frame a coherent moral response to questions that otherwise might seem irresolvable.

It is important to remember that the article that follows each section should *not* be seen as the right answer to a problem. Rather, each is an example of *one* way of reasoning out the problem and justifying a decision. Other arguments and approaches can be found in the suggested reading list at the end of each section.

5. PROFESSIONAL–PATIENT RELATIONS

1. PATERNALISM

Many problems in biomedical ethics revolve around issues of professional–patient relations. Which moral rules ought to govern the conduct of health care professionals toward patients, and what rights should an individual retain upon assuming the role of a patient? The traditional paternalistic approach in medicine assumes that the professional always knows what is best for the patient. The issue of paternalism is involved in questions of confidentiality, informed consent, and truth telling, and each of these concepts is considered in a separate section.

We place a high value upon autonomy and the right of individuals to self-determination. However, patients seek out the knowledge and special skills of physicians, technicians, nurses, and the like and voluntarily surrender some of their autonomy to these experts. They place a great deal of power in the hands of physicians in particular, whose opinions and decisions generally take precedence over those of other health care professionals.

The dependency of the patient upon a physician carries a considerable weight of responsibility, and this responsibility is reflected in medical codes of ethics dating back as far as the Hippocratic Oath, which is believed to have been written in the late fourth century, B.C. Traditional medical ethics stresses the obligation of physicians to help patients and not to harm them. The tradition overlooks or places little emphasis on the right of patients to self-determination, however. Physicians are enjoined from exploiting the vulnerability of patients in a relationship of unequal power. The problems of dependency and unequal power are also factors in assessing the obligations of corporations to employees and consumers and of attorneys to clients. **[See Business, Chapter 10, Section 1; Chapter 11, Section 1; Criminal Justice, Chapter 16, Section 2.]** Patients are willing to accept the powerful influence of physicians because of a trust in the latter's adherence to the principles of *beneficence* and *nonmaleficence* (summed up in the command, "Do good and do no harm").

In recent years people have begun to question the paternalism implicit in the dependency of patients upon physicians. It is argued that physicians ought to be viewed like consultants whose advice may be freely accepted or rejected. As medical knowledge and technology grow increasingly complex, the argument appears impractical. How can a layperson be expected to understand and make reasonable judgments about the desirability or efficacy of different courses of available treatment? Nevertheless, a belief exists that patients ought to retain a greater measure of self-determination in their relationships with health care professionals.

Respect for a patient's right to autonomy at times conflicts with the physician's professional or personal judgment regarding treatment. Physicians are tempted, because of their special knowledge, to disregard or give insufficient weight to patients' opinions. On occasion, a patient's power of judgment is (or may appear to be) weakened by a condition of injury or illness. In such situations, who ought to make proxy decisions on the patient's behalf: the physician, family members, the courts, or another party?

The patient and physician may simply disagree about what constitutes or will promote the patient's well-being. Under what circumstances are physicians morally justified in interfering with patient autonomy? Consequentialists justify paternalism by arguing that highly trained professionals can make better decisions regarding health care than laypersons. According to this view, the medical benefits resulting from expert decision making outweigh the utility of respecting a patient's right to choose. By contrast, a deontological approach assigns greater value to the respect due to individuals. In this approach, paternalism is justified only in special situations, such as when a patient's ability to decide is temporarily impaired and limited paternalistic intervention can restore the person to an autonomous state.

In the following selection Dan W. Brock argues for the use of a contract model to delineate the nurse–patient relationship. Applying the model, Brock asserts, clarifies the duties and obligations of the nurse toward the patient and demonstrates the limitations of professional authority. Paternalism is most often discussed in the context of the physician–patient relationship. Brock's analysis is particularly useful as a critique of paternalism in health care since nurses typically exercise less authority over patients than do physicians. The author's decision to employ what might be viewed as sexist language (using only female pronouns to refer to nurses and male pronouns to refer to physicians) is explained in a footnote.

DAN W. BROCK

The Nurse–Patient Relationship

There are at least two sorts of moral considerations relevant to a full understanding of the moral relationship between the nurse and patient. First, those general moral considerations, rights and duties, that the nurse and patient would have simply as individuals and apart from their roles as nurse or patient—e.g., on most any moral theory it is prima facie wrong to kill or seriously injure another human being, and this holds for persons generally, not merely for nurses and patients. Second, there are moral considerations which arise only out of the particular relationship that exists between a nurse and her[1] patient, just as there are in other relationships such as parent and child, public official and citizen, and so forth. A complete account of the nurse's moral situation must include both sorts of considerations, and would be far too complex and lengthy to attempt here: I shall emphasize considerations of the second sort, and even then my discussion will not be at all comprehensive. On virtually any account of the nurse–patient relationship, the nurse owes at least some care to her patient and the patient has a right to expect that care; this is not,

---

This paper originally appeared in a longer version as "The Nurse–Patient Relation: Some Rights and Duties," in *Nursing: Images and Ideals*, ed. Stuart F. Spicker and Sally Gadow (New York: Springer Publishing Co., 1980). © 1980 by Stuart F. Spicker. Reprinted by permission.

however, an obligation the nurse has to just anyone, but only to her patients, nor a right a person has towards just anyone, or even towards any nurse, but rather only towards his nurse. How then does each get into a relationship at all, how does he become *her* patient, and she become *his* nurse? If we pose the question in this way, I think it is clear that the common alternative accounts of the nurse–patient relationship are not all plausibly construed as even possible answers to this question, and that more generally, they address two different questions—some speak to the origin of the relationship, how it comes about, while others speak to the nature or content of the relationship. I think we gain a clearer understanding of the relationship if we separate these two issues, because the account of the origin of the relationship will affect in turn the account of its content. Consider six of the more common accounts of the relationship, of the role of the nurse vis-à-vis the patient:[2]

1. The nurse as parent surrogate.
2. The nurse as physician surrogate.
3. The nurse as healer.
4. The nurse as patient advocate or protector.
5. The nurse as health educator.
6. The nurse as contracted clinician.

I do not want to deny that nurses do not at times, and at times justifiably, fill each of the first five of these roles, though none of them are unique to her. And at least most of these first five roles refer to professional duties a nurse assumes in entering the profession of nursing. But how is it a nurse has any duty to perform in any of these roles towards a particular person (patient), and how is it that a person (patient) has any right to expect a particular nurse to perform in these roles toward him? Only the last model, the nurse as contracted clinician can explain that—we must be able to make reference to a contract, or better an agreement, between the two to explain this. This point may be obscured somewhat by the fact that what a nurse would do for a patient in any of the first five roles can be generally assumed to be beneficial for the patient, or at least intended to be beneficial. If it is for the patient's good, why must he agree before she is permitted to act? But just imagine someone coming up to you on the street and giving you an injection, even one intended to be, and in fact, beneficial to you. A natural response would be, "You have no right to do that," and underlying that response would likely be some belief that each person has a moral right to determine what is done to his body, however difficult it may be to determine the precise nature, scope, and strength of that right. Or, imagine a strange woman in a white uniform coming up to you and lecturing you about the health hazards of your smoking or failing to exercise. Well-intentioned though it might be, a natural response again might be, "What business is it of yours, what right do you have to lecture me about my health habits?" Again, the point would be that it is a person's right to act even in ways detrimental to his health if he chooses to do so and bears the consequences of doing so, a particular right usually derived from some more general and basic right to privacy, liberty, or self-determination (autonomy). Yet both these actions are, of course, of the sort frequently performed by nurses toward their patients. Likewise, any duties of a nurse to provide care to a particular person cannot come simply from duties she assumes from her role as a nurse, nor can any right of a particular patient to care from a specific nurse.

If we think of the nurse–patient relationship as arising from a contract or agreement between the nurse and her patient, then these otherwise problematic rights and duties become readily explicable. The patient contracts to have specified care provided by the nurse, in return for payment by the patient, and the patient in so doing grants permission for the nurse to perform actions (give him injections, perform tests, etc.) that she would otherwise have no right or duty to do. In agreeing to perform these duties, the nurse incurs an obligation to the patient to do so, as well as a right to be paid for doing so.

A natural objection to such an account is that it seems to rest on a fiction, since in the great majority of cases nurses and patients never in fact make any such agreement; rather, the patient finds himself in a physician's office, or in a hospital, where the nurse as a matter of course performs certain tasks, while the nurse if she makes any such agreements at all, makes them with the physician or hospital that employs her. This reflects the fact that the provision of health care is considerably more complex and institutionalized than any simple nurse–patient account would suggest, but it does not, in my view, show the contract or agreement model to be mistaken. The patient makes his agreement generally with the physician or the hospital's representative, and that agreement is to have a complex of services performed by a variety of health care professionals. The nurse is indirectly a party to this agreement, and can become committed by it, by having contracted or agreed with the employing physician or hospital to perform a particular role, carrying out its attendant duties, in the health care context.

[illegible]

A related objection to this account is that at both these intervening agreement points, it is still the case that the contract or agreement often, if not generally, never takes places, certainly not where what is to be done is spelled out in any detail, and so the account still rests on a fiction. But these agreements can and do have implicit terms, terms which can be just as binding on the parties as if they had been explicitly spelled out. These implicit terms are to be found in the generally known and accepted understanding of the nature of such health care relationships, and in the warranted social expectations the parties to them have concerning who will do what in such relationships. The content of such expectations will in large part derive from the nature of the training of various health care professionals, the professional codes and legal requirements governing their conduct, as well as more general public understandings of their roles.

Why insist on a contract or agreement model of the nurse–patient relationship that requires appeal to agreements between intervening parties, as well as to implicit terms that are generally not spelled out? The reason is that such an account makes clearer than does any other alternative the fundamental point that the right to determine what is done to and for the patient, and to control, within broad limits, the course of the patient's treatment and care, originates and generally remains with the patient. One important reason for insisting on this is that it is insufficiently appreciated and respected by health care professionals. Many health care professionals believe that if what they are doing is in the best interests of the patient, that is sufficient justification for doing it. That, however, is in my view a mistake of primary importance, because it does not take adequate account of the patient's right to control the course of his treatment.

An important part of at least one common understanding of the physician–patient relationship, and in turn of the patient–other-health-care-professional (including, but not limited to, the nurse) relationship, is that the health care professional will, with limited exceptions (e.g., public health problems arising from highly contagious diseases), act so as maximally to promote the interests of his or her patient. Treatment recommendations and decisions are to be made solely according to how they affect the interests of the patient, and ought not be influenced by the interests or convenience of others.[3] The confidence that the health professional will act in this way is especially important because of the extreme vulnerability and apprehension the ill patient often feels, the patient's incapacity to provide for himself the care he needs, and the patient's often very limited capacity to evaluate for himself whether a proposed course of treatment and care is in fact the best course for him. This focus on the patient's interests to the exclusion of others, however, is different from and should not be confused with, the physician or nurse being justified in acting in whatever manner they reasonably believe to be in the patient's best interest.

The right of the physician or nurse to act in the patient's interest is *created and limited by* the permission or consent (from the patient–nurse/physician agreement) the patient has given. To take two extremes, a patient might say to his physician or nurse, "I want you to do whatever you think best, and don't bother me with the details," or he might insist that he be fully informed about all factors and alternatives concerning his treatment and that he retain the right to reject any aspect of that treatment at any stage along the way. In my view, should the patient desire, either of these arrangements can be justifiable, as well, of course, as many modified versions of them. This has the important implication that the various expectations referred to above concerning what the health professional will do, which generally give content to the nurse–patient relationship, only partially determine that relationship, and it is subject to modification determined principally by what the patient desires of the relationship, and how he in turn constructs it. This is the other difficulty, besides their failure to explain how the relationship comes into being between particular persons, of the five alternatives mentioned above to the contract or agreement model of the nurse–patient relation. One cannot speak generally about the extent to which the nurse ought to act or has a duty to act, for example, as health educator or parent surrogate, because it ought to be the patient's right to determine in large part the extent to which the nurse is to take those roles with him. What the patient wants will often only become clear in the course of treatment, but to put the point in obligation language, the nurse's obligation is in large part to accommodate herself to the patient's desires in these matters.

I have been considering the case of patients who satisfy conditions of competence, that is persons who possess the cognitive and other capacities necessary to being able to form purposes and make plans, to weigh alternative courses of action according to how they fulfill those purposes and plans, and to act on the basis of this deliberative process; such persons are able to form and act on a conception of their own good.[4] Some of the more difficult moral problems in health care generally arise in cases where these conditions of competence are not satisfied, e.g., with infants and young children, with cases of extreme senility, and with some forms of mental illness.[5] However, I think we must first understand the nurse–patient relation in the case of the competent patient, before determining how that relationship may have to be modified when the patient is not competent. It may, then, be useful to consider what the contract or agreement model of the nurse–patient relation, with its emphasis on the patient's rights, might imply for some typical moral problems the nurse encounters with the competent patient. Common to many such problems insofar as they involve only the nurse and her patient is a conflict between what the patient wants and believes is best for him, and what the nurse believes is either in his best interests, in the interests of all persons affected, or morally acceptable. Consider the following cases:

Case 1. Patient A has requested of the nurse that she inform him fully of the nature of his condition and of the course of treatment prescribed for it. However, the treatment called for, and which the nurse believes will be most effective in his case, is such that given her knowledge of the patient, she believes that fully informing the patient will reduce his ability and willingness to cooperate in the treatment and so will significantly reduce the likely effectiveness of the treatment. What should she tell him?

Case 2. Patient B instructs his nurse that if his condition deteriorates beyond a specified point, he considers life no longer worth living and wishes all further treatment withdrawn. The nurse believes that life still has value even in such a deteriorated state, that it would be wrong for the patient to deliberately bring about his own death in this way, and in turn wrong for her to aid him in doing so. Should she follow his instructions?

Case 3. Patient C, after being fully informed of principal alternative treatments for his condition, has insisted on a course of treatment that the nurse has good reason to believe is effective in a substantially smaller proportion of cases than an alternative treatment procedure would be. She considers the additional risk in the rejected treatment, which seems to have affected the patient's choice, completely insignificant. Should she insist on the more effective treatment, for example, even by surreptitiously substituting it, if she is able to do so?

Each of these cases lacks sufficient detail to allow a full discussion of it, and in particular, each artificially ignores the presence and role of other health care practitioners, most notably the physician, who is generally prominent if not paramount in such decision making. But the cases are instructive even in this oversimplified form. Case 3 is perhaps the least difficult. It would be permissible for any interested party, and a duty of the nurse following from her roles as health educator and healer, to discuss the treatment decision with her patient, and to attempt to convince him that he has made a serious mistake in his choice of treatments. But just as the patient should be free to refuse any treatment for his condition if he is competent and so decides, he is likewise entitled to select and have the treatment that the nurse (or physician, for that matter) would not choose if it were her choice; the point simply is that it is not her choice. She has no moral (or professional) right to insist on a treatment the patient does not want, even if it is clearly the "best" treatment, and it would be still more seriously wrong to surreptitiously and deceptively substitute the treatment she prefers.

Case 2 can be somewhat more difficult because it may at least involve action in conflict with the nurse's moral views rather than a conflict over what course of action is, all things considered, medically advisable, as in Case 3. Case 2, of course, raises the controversial issue of euthanasia and the so-called right to die. This is a complex question that I have considered elsewhere, and here I only want to note that Case 2 involves only fully voluntary euthanasia, generally accepted to be the least morally controversial form of euthanasia.[6] I shall suppose here, as I think is the case, that a patient's right to control his treatment, and to refuse treatment he does not want, includes the right to order withdrawal of treatment even when that will have the known and intended consequence of terminating his life. If we interpret the nurse's view that life under the circumstances in question would still be worth living as merely her own view about what she would do in similar circumstances, then her view is relevant only to what she would do if she were the patient and nothing more; it entails nothing about what should be done here where it is another's life and his attitude to it that is in question. She would not waive her right not to be killed in these circumstances, but the patient would and does, and it is his life and so his right that is in question. I would suggest as well that a mere difference over what it is best to do in the circumstances (apart from moral considerations) does not justify the nurse's refusal to honor the patient's expressed wishes. However, her difference with the patient may be a moral one; in particular she may hold as a basic moral principle that she has an inviolable moral duty not deliberately to kill an innocent human being. In that case, to assist in the withdrawal of treatment in order to bring about the patient's death will be on her moral view to commit a serious wrong, to participate in a serious evil. The nurse's professional obligations to provide care should not, in my view, be understood to require her to do such, just as she should not be required to assist in abortions if she holds fetuses to be protected by a duty not deliberately to take innocent human life. While there should be no requirement in general for her to participate in medical procedures that violate important moral principles that she holds, that of course in no way implies that another nurse who does not hold such duty-based views about killing should not assist in the withdrawal of treatment. (Of course, if she holds killing to be wrong because it violates a person's right not to be killed, then she will correctly reason that the patient in Case 2 has waived that right, and so no conflict between her moral views and what the patient wants will arise.)[7]

Finally, consider Case 1. The "Patient's Bill of Rights" proposed by the American Hospital

Association specifically allows that "when it is not medically advisable to give . . . information to the patient" concerning his diagnosis, treatment, and prognosis, such information need only "be made available to an appropriate person in his behalf" but need not be given to the patient himself. This would seem clearly to permit the nurse to withhold the information from the patient in Case 1. However, I believe the Patient's Bill of Rights is mistaken on this point. This is a particular instance of a general over-emphasis on and consequent over-enlargement of the area in which health professionals should be permitted to act towards patients on the basis of their own judgment of the "medical advisability" of their action toward the patient. It is perhaps natural that health professionals, trained to provide medical care for patients, and who undertake professional responsibilities to do so, should consider medical advisability a sufficient condition generally for acting contrary to a patient's wishes, and here for withholding relevant information from the patient. But once again, so long as we are dealing with patients who satisfy minimal conditions of competence to make decisions about their treatment, then unless the patient has explicitly granted the nurse the right to withhold information he seeks when she considers it medically advisable to do so, medical advisability is not sufficient justification for doing so. Our moral right to control what is done to our body, and our right in turn not to be denied relevant available information for decisions about the exercise of that right, does not end at the point where others decide, even with good reason, that it is medically advisable for us not to be free to exercise that right. In general, one element of the moral respect owed competent adults is to respect, in the sense of honor, their right to make decisions of this sort even when their doing so may not be deemed medically advisable by others, and even when those others are health professionals generally in a better position to make an informed decision. When other health professionals are in a better position to make an informed decision, a patient may have good reason to transfer his rights to decide to them, or to allow himself to be strongly influenced by what they think best, but he is not required to do so, and so they have no such rights to decide for him what is in his best interests when he has not done so.

I want to emphasize that on my view moral rights generally, and in particular the rights of the patient relevant in the three cases above, are not absolute in the sense that they are never justifiably overriden by competing moral considerations. But such justifiable overriding requires a special justification, and that human welfare generally, or the welfare of the person whose right is at issue, will be better promoted by violation of the right is *not* such a special justification.[8] Thus, rights need not be absolute in order to have an important place in moral reasoning. And it is not necessary that a nurse never be justified, for example, in withholding information from a patient for the patient's right to control his treatment to limit importantly when she may do so. Cases involving young children and non-competent adults are important instances where specifically paternalistic interference with a person's exercise of their rights can be justified.

Perhaps the point of emphasizing the contract or agreement between the patient and the health care professional is now a bit clearer. That contract model emphasizes the basis for and way in which the right to control the directions one's care will take ought to rest with the patient. It is not, of course, that the nurse is mistaken in taking her role to be a healer, or health educator, for these are important professional services she performs, but rather that her performance in these roles ought to be significantly constrained and circumscribed by the rights of her patients to control what is done to their bodies.

I should like to end by noting that focusing on the nurse–patient relationship, as I have done here, has the effect of ignoring at least one extremely important aspect of most nurses' overall moral situation. Specifically, most nurses now work in hierarchic, institutional settings in which they are in the employ of others—hospitals, physicians, etc. Many of the most important moral uncertainties and conflicts nurses experience concerning their rights, duties, and responsibilities derive from their role in this hierarchical structure, and from questions about their consequent authority to decide and act in particular matters. The patient has a place in such issues, but the issues do not arise when only the nurse and patient are considered. To fill in the picture would require consideration of what might be called the nurse-physician/hospital relation, but that is a complex matter that cannot be pursued here.

Notes

1. I have chosen throughout this paper to use feminine pronouns to refer to nurses and masculine pronouns to refer to physicians, rather than to adopt gender-neutral pronouns. Since something on the order of 96% of nurses are women, while the great majority of physicians are men, gender-neutral usage in this context seems to mask a significant social reality and problem. My pronoun usage acknowledges the gender distribution among nurses and physicians, while in no way endorsing it.

2. I have drawn these from the very helpful paper by Sally Gadow, "Humanistic Issues at the Interface of Nursing and the Community," in *Nursing: Images and Ideals,* eds. S. Gadow and S. Spicker (New York, 1980).

3. Such a view, with specific reference to the dying patient, is advocated in, among other places, Leon Kass, "Death as an Event: A Commentary on Robert Morrison," *Science* 173 (August 20, 1971), 698–702. To what extent this account of the physician–patient relationship is defensible, or is in fact adhered to in practice by physicians, is problematic.

4. Plans of life, and their relation to a conception of one's good, are discussed in John Rawls, *A Theory of Justice* (Cambridge, 1971), ch. 7, and Charles Fried, *An Anatomy of Values* (Cambridge, 1970).

5. For philosophical accounts of the principles of paternalism relevant to treatment of the incompetent see, for example, Gerald Dworkin, "Paternalism" in *Morality and the Law,* ed. R. Wasserstrom (Belmont, Calif., 1971) and John Hodson, "The Principle of Paternalism," *American Philosophical Quarterly* 14 (1977), 61–69. I have discussed paternalism with specific reference to the mentally ill in, "Involuntary Civil Commitment: The Moral Issues," in *Mental Illness: Law and Public Policy,* eds. Baruch Brody and H. Tristram Engelhardt, Jr. (Dordrecht, Holland, 1978).

6. I have discussed some implications of a rights-based view for euthanasia in my "Moral Rights and Permissible Killing," in *Ethical Issues Relating to Life and Death,* ed. John Ladd (New York, 1979). See also the paper by Michael Tooley, "The Termination of Life: Some Moral Isuses," in the same volume.

7. On the general distinction between duty-based and rights-based moral views, see Ronald Dworkin, *Taking Rights Seriously,* ch. 6, (Cambridge, 1977).

8. For an attempt to specify the limits of such special justifications, see R. Dworkin, *op. cit.,* ch. 7.

Suggested Further Reading

Buchanan, Allen, "Medical Paternalism," *Philosophy and Public Affairs,* 7, no. 4 (Summer 1978), 370–90.

Gadow, Sally, "Existential Advocacy: Philosophical Foundation of Nursing," in *Nursing: Images and Ideals,* ed. Stuart F. Spicker and Sally Gadow. New York: Springer Publishing Co., 1980, pp. 79–101.

Gert, Bernard, and Charles M. Culver, "The Justification of Paternalism," *Ethics,* 89, no 2 (January 1979), 199.

Smith, Sheri, "Three Models of the Nurse–Patient Relationship," in *Nursing: Images and Ideals,* ed. Stuart F. Spicker and Sally Gadow. New York: Springer Publishing Co., 1980, pp. 176–88.

Veatch, Robert M., "Models for Ethical Medicine in a Revolutionary Age," *Hastings Center Report,* 2, no. 3 (June 1972), 5–7.

Zembaty, Jane S., "A Limited Defense of Paternalism," *Proceedings of the 13th Conference on Value Inquiry: The Life Sciences and Human Values,* State University of New York College at Geneseo, pp. 145–58.

2. CONFIDENTIALITY

The rule of confidentiality in professional–patient relations has been affirmed in a wide variety of ethical codes for physicians, nurses, and other health care professionals; these include the Hippocratic Oath, the A.M.A. Code, and the World Medical Association International Code of Medical Ethics (see Appendix for examples). The principle of confidentiality is recognized by laws which exempt physicians and psychotherapists from giving testimony about patients and which provide sanctions against practitioners who divulge patient information given them in confidence.

Confidentiality is important in the practice of medicine in part because of its practical function. Physicians require private and possibly intimate information about patients in order to make correct diagnoses and prescribe proper treatment. It is argued that unless patients feel confident that such information will not be revealed to others, they are unlikely to entrust it to physicians. The professional obligation for attorneys to preserve client confidentiality is based upon a similar argument. **[See Criminal Justice, Chapter 16, Section 2.]** Additionally, a patient's trust in the practitioner is believed to play a part in successful treatment. Emphasis on the practical benefits of confidentiality reflects a consequentialist approach.

From a deontological standpoint, preserving patient confidentiality and privacy is one expression of the broader respect physicians owe to patients as autonomous individuals. The principle of confidentiality is related to the right of privacy. Privacy—personal control over information about oneself—is an important element of individual autonomy.

Ethical dilemmas arise when a health care professional is forced to choose between a duty to respect a patient's confidentiality and a conflicting obligation to other persons or institutions within the society. In some cases a breach of trust is thought necessary in the patient's best interest (a paternalistic approach), as with a patient who threatens suicide. Breaching confidentiality, it is argued, permits eventual resumption of autonomy by a person whose competence is temporarily compromised. On other occasions, the physician may be legally obligated to violate confidentiality, as in the duty to report gunshot wounds, suspected child abuse, and certain communicable diseases.

The dilemmas posed by conflicting loyalties are acute in the area of psychiatric medicine. Suppose a patient reveals a strong feeling of anger or actually threatens other persons or their property. Does a therapist have an obligation to warn law enforcement officials or the intended victim of possible harm? Such questions are more urgent in view of the special importance of trust in the psychotherapeutic relationship. In the following article, William J. Curran discusses a widely publicized case in which the California Supreme Court ruled that a group of psychotherapists were negligent in their duty to warn a woman whose life had been threatened by a patient, despite the fact that they *had* notified security personnel about the threats. Curran raises questions regarding the obligations of physicians in situations of conflicting loyalties.

WILLIAM J. CURRAN

Confidentiality and the Prediction of Dangerousness in Psychiatry: The Tarasoff Case

The California Supreme Court continues to make financial awards to patients in suits against physicians with seemingly little regard for the effect of these awards and decisions upon the practice of medicine and the availability of insurance to cover this largesse of the judiciary, and without regard for the social consequences of this "money-for-everything" attitude.

The particular case, *Tarasoff vs. Regents of the University of California,*[1] has already become infamous among mental health programs in California and among college and university student medical programs all over the country as it has taken its course through the various levels of trial and appeals courts in the Golden State.

The facts of the situation are undisputed. A student at the University of California's Berkeley campus was in psychotherapy with the student health service on an outpatient basis. He told his therapist, a psychologist, that he wanted to kill an unmarried girl who lived in Berkeley but who was then on a summer trip to Brazil. The psychologist, with the concurrence of another therapist and the assistant director of the Department of Psychiatry, reported the matter orally to the campus police and on their suggestion sent them a letter requesting detention of the student and his commitment for observation to a mental hospital. The campus police picked up the student for questioning but "satisfied" that he was "rational," released him on his "promise to stay away" from Miss Tarasoff. The police reported back to the director of psychiatry, Dr. Powelson. Dr. Powelson asked for the return of the psychologist's letter to the police and directed that all copies of the letter be destroyed. Nothing more was done at the health service about the matter. Two months later, shortly after Miss Tarasoff's return, the student went to her home and killed her.

The parents of Miss Tarasoff brought suit for damages against the University and against the therapists and the campus police, as employees of the University and individually. In suing Dr. Powelson, the plaintiffs sought not only general money damages for negligence in failure to warn the girl and her parents and to confine the student, but exemplary or punitive damages (which could be assessed in huge amounts as multiples of the general damages or in any amount at the determination of the jury) for malicious and oppressive abandonment of a dangerous patient.

The Superior Court dismissed all these grounds for legal action against the defendants. The Supreme Court, in a four-to-two decision, reversed the decision and found that on these facts a cause of action was stated for general damages against all the therapists involved in the case and the assistant director and the director of psychiatry and against the University as their employer for breach of the duty to warn Miss Tarasoff. The Court dismissed the claim for exemplary damages against the therapists. It also dismissed the action against the police as protected from a suit by a statutory immunity, as well as the suit against the therapists for failure to confine the student under a commitment order, again because of a statutory immunity. The Court implied that without the immunity, both these actions might have been meritorious.

It seems to me that most physicians would throw up their hands in dismay over this result

---

Reprinted with permission from *The New England Journal of Medicine*, 293 (August 7, 1975), 285–86.

and the massive contradictions in the assessment of who was and who was not legally responsible for this death. If I were to describe in detail the reasoning of the court, the confusion of the medical mind would be compounded a thousand times.

The Court asserted that the *Principles of Medical Ethics of the American Medical Association*, Section 9, did not bar breaching the confidentiality of this patient "in order to protect the welfare of this individual [the patient] or the community." From this premise the Court jumped wholeheartedly to a positive duty to warn Miss Tarasoff. This is not what the *Principles* said. The traditional code of medical ethics allows a physician in his sound discretion to breach the confidentiality, but does not require it. It is almost impossible to draft an ethical principle to force a duty on physicians to breach confidences. Must they always warn of death threats, but have discretion on less dangerous threats? Must they warn if the patient is psychotic, but not if he is less disturbed? Does this case mean that every time a patient makes a threat against an unnamed person, the therapist must take steps to find out who it is and warn him (of anything at all, from vague threats to murder) or suffer money damages in the thousands or tens of thousands if the threat, or an aspect of the threat, is carried out?

This case was greatly confused by the array of immunities from suits created under California law. It can be strongly argued that the thrust of these immunity statutes regarding the duty to warn should also have been applied to the therapists, since the statutes were intended to encourage police and mental health personnel to release patients and not confine them on the basis of unreliable diagnoses of dangerousness. In the past it was thought that too many mental patients were confined for years and years because of their threats to other people, rarely carried out, and because of the conservatism of mental health personnel in exercising any doubt about dangerousness in favor of confinement as the safest way to prevent harm to third parties.

It seems clear that the therapists here thought that they had done all they could to protect their patient and the community by reporting the case to the police. They had exercised their discretion to warn the community and to breach the confidence of the patient, for his own sake, and that of the unknown girl. They could hardly warn her, since she was not even in the country at the time. Also, the threat to Miss Tarasoff might actually have been vaguely directed. The student could well have turned his anger and violence toward another person or toward himself. The only basic recourse was to recommend temporary observational commitment. The practice was to make this to the campus police. It was the police who acted, and they decided to release the student with a warning and a promise to stay away from the girl. How many thousands of such warnings—and releases—do police departments make every year? How many people then proceed to kill? The immunity statute was established to encourage release in these circumstances. But the statutory armor had a hole in it. The director of psychiatry was found by the Court to have a "duty" to warn the girl, irrespective of the police action. The Court utilized some precedents, none clearly applicable to this case, to justify its decision. It seems, however, that the real rationale was the aggravated nature of the case—a killing—in which the family was left without someone else to sue. The therapists, particularly Dr. Powelson, could have warned the girl if they had wanted to go against the police action and if they had thought the specific threat to Miss Tarasoff so serious as to warrant that action. The Court did not apply any test to ascertain the custom of psychiatrists and mental health programs actually in such situations. The Court declared the duty as a matter of law, regardless of the accepted practices of the profession. As in the *Helling* decision[2] discussed in an earlier column,[3] the Court made the physician a guarantor against harm to this party, here not even a patient, on the basis of its own concept of monetary justice.

Notes

1. 529 P. 2d 553
2. Helling vs. Carey and Laughlin, 519 P. 2d 981.
3. Curran W. J. Glaucoma and streptococcal pharyngitis: diagnostic practices and malpractice liability. N Engl J Med 291:508–509, 1974.

Suggested Further Reading

Abrams, Natalie, et al., "The Urban Emergency Department: The Issue of Professional Responsibility," *Annals of Emergency Medicine*, 11, no. 2 (February 1982), 86–90.

Gaylin, Willard, "What's an FBI Poster Doing in a Nice Journal Like That?" *The Hastings Center Report*, 2 (April 1972), 1–3.

Siegler, Mark, "Confidentiality in Medicine—A Decrepit Concept," *The New England Journal of Medicine*, 307 (1982), 1518–21.

Walters, LeRoy, "The Principles of Medical Confidentiality," *Contemporary Issues in Bioethics*, ed. Tom L. Beauchamp and LeRoy Walters. Encino, Calif.: Dickenson Publishing Co., Inc., 1978, pp. 170–73.

DECISION SCENARIO 1

Confidentiality

As a young boy, Thomas was perceived by his father, a former all-conference football player, as oversensitive and effeminate. The father repeatedly tried to direct Thomas's interests toward athletics and outdoor activities. During adolescence, the conflict was transformed into Thomas's silent rebelliousness. In high school Thomas was placed on academic probation although he was regarded as an intelligent student.

Thomas's father placed him in an all-boys' prep school in the area. After a year, his grades improved. When his father arranged to transfer him back to public school, Thomas went into a deep depression. He told his parents of his homosexual activities.

He was given tranquilizers and treated for gonorrhea. His blood test for AIDS was negative.

Thomas took a job for a large corporation which did defense contract work. Although he received security clearance, his homosexual tendencies were noted on his record.

When he was thirty, he met Tanya, fell in love, and prepared to marry. Tanya went to her family physician for the blood test required by the state. In their conversation, it came out that Thomas was her fiancé. The doctor realized that it was the same person he had several years before treated for venereal disease. He said nothing.

The marriage lasted little more than a year. Thomas told Tanya of his homoerotic preference. He also told her about the physician whom they had in common. Tanya felt betrayed and confused. She required psychiatric support for many months after the separation. She felt deep hostility toward the doctor whom, to her mind, ought to have spared her the trauma of a bad marriage.

Questions

1. Did the physician's obligation to keep confidentiality override his duty to inform Tanya of the facts of the matter?
2. Was the physician too literal in his understanding of confidentiality? Was there another way for him to deal with the two persons under his care?
3. Is keeping silent about information the way to tell the truth in this case?
4. What if Thomas's test for AIDS had come back positive? How would the case be different?

3. INFORMED CONSENT

The notion of informed consent is grounded in the principle of autonomy and the right of self-determination. Individuals have a right to control what is done to their bodies. They must freely agree to medical intervention and must be given sufficient information upon which to base their judgment. Some theorists argue that informed consent is an ethical concern in other professions such as advertising **[See Business, Chapter 11, Section 1]** and engineering **[See Business, Chapter 13, Section 1]**.

The moral and legal requirement of informed consent seems at first glance to be fairly straightforward. In application, however, it proves troublesome. At least three questions need to be considered in deciding whether the requirement is met. First, how much information must be supplied in order for a patient to make a competent decision? Some physicians insist that offering patients too much complex medical data serves to confuse and frighten them. The paternalistic attitude leads to the assumption that no layperson fully understands all the information relevant to his or her treatment and that obtaining informed consent is a meaningless formality. Others argue that the fact that medical procedures and theories are complicated and unfamiliar (and frequently couched in difficult, technical language) imposes a special obligation on physicians to find a way to explain the information so that patients understand it.

The second question is whether the patient is competent to make rational decisions regarding treatment. Certain persons, such as young children, the severely mentally retarded, and those with psychiatric disturbances, lack such competence. Even otherwise rational adults are at times less-than-competent decision makers. For example, a person suffering extreme pain or fear or having an illness that causes confusion or disorientation might not be fully competent to give consent.

A third question involves the voluntary nature of consent. Pressures exist within the hospital setting as well as in other institutions that may compromise the voluntary character of patient consent. The authority of medical personnel, particularly physicians, can be intimidating, and patients may feel obliged to be "good" and accept the judgment of these powerful figures. In such situations, is the patient's consent truly voluntary?

Informed consent is problematic in the area of medical research and experimentation. The literature about informed consent centers on the context of experimentation. Ethical codes and guidelines exist to identify the conditions under which human experimentation is permissible. One of the foremost among these is the "Nuremburg Code," written after World War II in response to the barbarous experiments conducted by German doctors on concentration camp inmates. The first and longest provision of the Nuremburg Code deals in great detail with the importance of informed consent. The use of prisoners as research subjects is strongly criticized on the basis that such persons are subject to duress and coercion and can never consent freely.

In the following article Franz J. Ingelfinger, editor of the *New England Journal of Medicine,* discusses the problem of informed consent in medical research. Ingelfinger holds that some coercion exists in almost all transactions between researchers and potential subjects. The objections raised by the author are also applicable to physician–patient relations.

FRANZ J. INGELFINGER

Informed (but Uneducated) Consent

The trouble with informed consent is that it is not educated consent. Let us assume that the experimental subject, whether a patient, a volunteer, or otherwise enlisted, is exposed to a completely honest array of factual detail. He is told of the medical uncertainty that exists and that must be resolved by research endeavors, of the time and discomfort involved, and of the tiny percentage risk of some serious consequences of the test procedure. He is also reassured of his rights and given a formal, quasilegal statement to read. No exculpatory language is used. With his written signature, the subject then caps the transaction, and whether he sees himself as a heroic martyr for the sake of mankind, or as a reluctant guinea pig dragooned for the benefit of science, or whether, perhaps, he is merely bewildered, he obviously has given his "informed consent." Because established routines have been scrupulously observed; the doctor, the lawyer, and the ethicist are content.

But the chances are remote that the subject really understands what he has consented to—in the sense that the responsible medical investigator understands the goals, nature, and hazards of his study. How can the layman comprehend the importance of his perhaps not receiving, as determined by the luck of the draw, the highly touted new treatment that his roommate will get? How can he appreciate the sensation of living for days with a multi-lumen intestinal tube passing through his mouth and pharynx? How can he interpret the information that an intravascular catheter and radiopaque dye injection have an 0.01 per cent probability of leading to a dangerous thrombosis or cardiac arrhythmia? It is moreover quite unlikely that any patient-subject can see himself accurately within the broad context of the situation, to weigh the inconveniences and hazards that he will have to undergo against the improvements that the research project may bring to the management of his disease in general and to his own case in particular. The difficulty that the public has in understanding information that is both medical and stressful is exemplified by [a] report [in the *New England Journal of Medicine*, August 31, 1972, page 433]—only half the families given genetic counseling grasped its impact.

Nor can the information given to the experimental subject be in any sense totally complete. It would be impractical and probably unethical for the investigator to present the nearly endless list of all possible contingencies; in fact, he may not himself be aware of every untoward thing that might happen. Extensive detail, moreover, usually enhances the subject's confusion. Epstein and Lasagna showed that comprehension of medical information given to untutored subjects is inversely correlated with the elaborateness of the material presented.[1] The inconsiderate investigator, indeed, conceivably could exploit his authority and knowledge and extract "informed consent" by overwhelming the candidate-subject with information.

Ideally, the subject should give his consent freely, under no duress whatsoever. The facts are that some element of coercion is instrumental in any investigator–subject transaction. Volunteers for experiments will usually be influenced by hopes of obtaining better grades, earlier parole, more substantial egos, or just mundane cash. These pressures, however, are but fractional shadows of those enclosing the patient-subject. Incapacitated and hospitalized because of illness, frightened by strange and impersonal routines, and fearful for his health and perhaps life, he is far from

---

Reprinted with permission from *The New England Journal of Medicine*, 287, no. 9 (August 31, 1972), 465–66.

exercising a free power of choice when the person to whom he anchors all his hopes asks, "Say, you wouldn't mind, would you, if you joined some of the other patients on this floor and helped us to carry out some very important research we are doing?" When "informed consent" is obtained, it is not the student, the destitute bum, or the prisoner to whom, by virtue of his condition, the thumb screws of coercion are most relentlessly applied; it is the most used and useful of all experimental subjects, the patient with disease.

When a man or woman agrees to act as an experimental subject, therefore, his or her consent is marked by neither adequate understanding nor total freedom of choice. The conditions of the agreement are a far cry from those visualized as ideal. Jonas would have the subject identify with the investigative endeavor so that he and the researcher would be seeking a common cause: "Ultimately, the appeal for volunteers should seek . . . free and generous endorsement, the appropriation of the research purpose into the person's [i.e., the subject's] own scheme of ends."[2] For Ramsey, "informed consent" should represent a "covenantal bond between consenting man and consenting man [that] makes them . . . joint adventurers in medical care and progress."[3] Clearly, to achieve motivations and attitudes of this lofty type, an educated and understanding, rather than merely informed, consent is necessary.

Although it is unlikely that the goals of Jonas and of Ramsey will ever be achieved, and that human research subjects will spontaneously volunteer rather than be "conscripted,"[3] efforts to promote educated consent are in order. In view of the current emphasis on involving "the community" in such activities as regional planning, operation of clinics, and assignment of priorities, the general public and its political leaders are showing an increased awareness and understanding of medical affairs. But the orientation of this public interest in medicine is chiefly socioeconomic. Little has been done to give the public a basic understanding of medical research and its requirements not only for the people's money but also for their participation. The public, to be sure, is being subjected to a bombardment of sensation-mongering news stories and books that feature "breakthroughs," or that reveal real or alleged exploitations—horror stories of Nazi-type experimentation on abused human minds and bodies. Muckraking is essential to expose malpractices, but unless accompanied by efforts to promote a broader appreciation of medical research and its methods, it merely compounds the difficulties for both the investigator and the subject when "informed consent" is solicited.

The procedure currently approved in the United States for enlisting human experimental subjects has one great virtue: patient-subjects are put on notice that their management is in part at least an experiment. The deceptions of the past are no longer tolerated. Beyond this accomplishment, however, the process of obtaining "informed consent," with all its regulations and conditions, is no more than elaborate ritual, a device that, when the subject is uneducated and uncomprehending, confers no more than the semblance of propriety on human experimentation. The subject's only real protection, the public as well as the medical profession must recognize, depends on the conscience and compassion of the investigator and his peers.

References

1. Epstein, L. C., Lasagna, L.: "Obtaining informed consent: form or substance." *Arch Intern Med* 123:682–688, 1969.

2. Jonas, H.: "Philosophical reflections on experimenting with human subjects." *Daedalus* 98:219–247, Spring, 1969.

3. Ramsey, P.: "The ethics of a cottage industry in an age of community and research medicine." *N Engl J Med* 284:700–706, 1971.

Suggested Further Reading

Alfidi, Ralph J., "Informed Consent: A Study of Patient Reactions," *Journal of the American*