Medical ethics is a branch of medicine that focuses on the ethical ramifications of patient care, ensuring that treatment is in the patient's best interest. Most healthcare providers have medical ethics boards that review patient care directives.

Medical ethics is that branch of applied ethics that is concerned with the ethical problems of healthcare professionals and healthcare systems. It is a subset of bioethics, and can itself be further divided in medical ethics (narrowly defined), nursing ethics, public health ethics, research ethics, management ethics, etc.

There are extensive overlaps between the field of medical ethics and cognate fields such as the ethics of genetics (genethics), the ethics of new technologies, and professional ethics in general.

History

The history of medical ethics can be traced to two sources. The first of these is the professional ethics of the medical profession, its internal rules of conduct. The second is general moral philosophy and theology. Although there has been mutual influence between these two lines of thought and practice throughout history, strong interaction between moral theory and medical ethics is a relatively recent phenomenon.

Within medical historiography some have tried to trace an unbroken line of rules or principles of conduct from the Hippocratic Oath (see Box 6.1) attributed to the Greek physician Hippocrates (c. 460–370 BC) to current rules of conduct, often in order to be able to claim that medicine stands in an unbroken Hippocratic tradition and should follow the principles in the oath (e.g. its prohibition against prescribing abortifacients). Some even seem to think that all doctors still swear the Oath. But both claims are fallacious. Only a minority of modern doctors swear the Hippocratic Oath, and even within Western medicine there have been long periods in which the Oath played no role in setting the standards for medical conduct.

Box 6.1 The Hippocratic Oath

I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership

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with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art – if they desire to learn it – without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

From Ludwig Edelstein, The Hippocratic Oath: Text, Translation, and Interpretation, Baltimore, Md.: Johns Hopkins Press, 1943

The history of modern medical ethics is usually traced back to the publication by the British physician Thomas Percival in 1803 of a book entitled Medical Ethics (to what extent this is a result of academic linguistic Anglo-centrism is a matter for debate), but it is probably more accurate to say that the current form of medical ethics debates had their beginning in the 1960s and early 1970s (for views on the history from the two sides of the Atlantic, see Campbell 2000, Jonsen 1998). At that time, general social developments made it legitimate to criticize the medical profession for its paternalism and argue for a greater role for patients in decision-making, and the development of new medical technologies created new moral problems such as “Who should have access to kidney dialysis if not all can get it? And who should decide this?” and “What should we do in a situation where respirators can keep people in a coma alive indefinitely?”

In the 1960s and 1970s two partly overlapping conservative streams were evident in medical ethics, one religious and one based on a secular skepticism toward medical technology and the “medico-industrial complex,” but these have become less and less prominent over time in academic medical ethics. Today liberal arguments are much more prevalent, especially in North America and Northern Europe. The liberal arguments often draw on elements from American pragmatism, classical political liberalism and modern preference consequentialism.

Specific Features of Medical Ethics

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Medical ethics differs from other branches of applied ethics in some respects. A number of ethical frameworks have been developed that try to mediate between abstract ethical theory and healthcare practice by providing a simple and structured method for analyzing and evaluating moral issues. The most prominent of these frameworks is the four-principles approach developed by Tom Beauchamp and James Childress (Beauchamp and Childress 2001). According to Beauchamp and Childress, four principles are central to medical ethics:

- Respect for autonomy
- Non-maleficence
- Beneficence
- Justice

These principles are mid-level in the sense that they are at a level between ethical theory and concrete moral decisions. They are both justified from above – any plausible ethical theory will support some version of each of the four principles – and from below – critical reflection on our day-to-day decision-making will show that it adheres to these principles. Although there is disagreement at the level of ethical theory, and at the level of unreflective day-to-day decision-making, these four mid-level principles can therefore form a relatively stable ground for resolving ethical conflict. When healthcare professionals encounter a moral problem they should therefore identify all the relevant actors, analyze how the problem engages each of the four principles and reach a decision based on balancing the four principles against each other in the concrete situation.

Many papers on ethical issues in general medical journals use this or other similar approaches rather uncritically and will therefore often seem very simplistic to someone with a background in moral philosophy.

Critics of the four-principles approach and other similar approaches have pointed out that the claimed agreement on the four principles is not an agreement on their content or substance, but only an agreement at the level of labels (Holm 1995). We can all agree that we should do good – the principle of Beneficence – but we do not agree on what this actually entails. Another common criticism is that the procedure for balancing the four principles against each other is vague and will not lead to determinate results.

Another specific feature of modern medical ethics is that it has developed in an intensive interplay with regulatory efforts, first in the area of research ethics and more recently in the areas of human (assisted) reproduction and end-of-life decisionmaking. This has meant that many quasi-legal concepts and modes of argumentation have entered medical ethics, especially in US medical ethics because of the practical importance of US Supreme Court decisions in these fields (the right to abortion in the US, for instance, comes from a Supreme Court decision not from legislation passed by Congress). Concepts like “privacy,” “freedom of speech” and “separation of church and state” have thus been pressed into service in ethical arguments, instead of concepts that are more basic to ethical theory and political philosophy like “liberty” or “liberalism.”

**Recent Developments**

In recent years many have argued that medical ethics has been too preoccupied with the ethical issues actualized by modern technologies, and with the ethical problems that are common in affluent...
healthcare systems. There has therefore been a call to globalize medical ethics and focus more on issues of justice, power and exploitation relevant to the developing world.

The emerging debate on these issues has shown that there is an underlying individualism in the most prominent approaches to medical ethics that makes it difficult to engage with more systemic issues. Many medical ethicists agree that the distribution of resources in the world is grossly unjust and inequitable, and that this should be rectified, but still defend the right of those who have resources (the rich) to engage in exchanges with those who lack them (the poor) where the resource disparities are used by the rich to extract much better bargaining outcomes for themselves than they could have extracted under conditions of justice.

Another recent development is the formal international codification of medical ethics, often under the label of bioethics. The Council of Europe agreed on the “Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine” in 1997, and the General Assembly of UNESCO adopted the “Universal Declaration on Bioethics and Human Rights” in 2005. The development of these formal documents is seen by some as part of a widening split between official and academic medical ethics.

References and Further Reading


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