An ethics refresher for doctors in moral distress: theory and practice

This article describes a gap between ethics-in-practice and ethics-in-theory; clinicians are often better at knowing what to do than articulating why to do it. This gap can go unnoticed until moments of moral distress. To reduce this gap, this article presents the four principles approach to medical ethics as a helpful framework when implemented carefully.

Ethics is both invisible and inevitable

As we contemplate the jobs list and the on-call rota, it can seem like there is neither time nor place for ethics. However, the title 'Dr' carries with it a heritage steeped in ethical concern. Western medicine, rooted in the Hippocratic tradition, has historically existed as a public moral good 'for the benefit of the sick' (U.S. National Library of Medicine, 2012). With developments in science and the advent of evidence-based medicine, what is of benefit to a patient is increasingly premeditated by way of guidelines and protocols. However, the question of what is of 'benefit' to a patient can only be addressed by clinical evidence (the author would assert) insofar as that evidence is connected to ethical concern.

For example, consider Mrs Apple and Mrs Orange (*Case study 1*). For both women, medications could be prescribed to prevent further myocardial infarctions. For both women, such secondary prevention may be clinically effective at reducing cardiovascular risk. However, measures to reduce cardiovascular risk do not necessarily benefit Mrs Orange; she only benefits insofar as treatment accords with the ethical concern to keep her comfortable. Only with respect to Mrs Apple, is secondary prevention considered of benefit to her.

Such an ethical judgment is arguably a defining feature of doctoring:

> **'The culmination in a right and good healing action is what constitutes medicine qua medicine' (Pellegrino and Thomasma, 1981).**

In time and place metrics, ethics is nowhere to be seen; nevertheless, it remains a central thread in the tapestry of medical practice.

Ethics is both practical and theoretical

Where scholarly ethicists may fail to practise what they themselves preach, clinicians may fail to preach what they themselves practise. Clinicians are perhaps better at knowing what should be done than justifying why it should be done; formulating a management plan can be done without stopping to articulate the ethical principles involved. To do so may feel like a shift from intuitive to analytical thinking, a slow cognitive step clinicians can do without (Hughes and Nimmo, 2017). As a result, there remains a gap between the fluency of our ethics-in-practice and the fluency of our ethics-in-theory.

This gap between practice and theory may ordinarily persist unacknowledged. However, there are moments in clinical practice when it rises to the fore. When a situation strikes a clinician as frustrating, upsetting or hurtful, these emotions can be indicators that circumstances are not how they ought to be. This 'ought' may be an ethical ought, and is increasingly described as 'moral distress'. Moral distress was first articulated within nursing by Andrew Jameton (1984), and refers to the experience of clinicians who 'cannot carry out what they believe to be ethically appropriate actions because of various constraints' (Allen et al, 2013). In such moments, the ethical 'thread' in the medical tapestry is seen most clearly, and the gap between ethics-in-practice and ethics-in-theory felt most exquisitely.

It could be countered that the experience of moral distress is not eradicated by mere theorising. In emotionally difficult situations, moral principles often antagonise one another, pulling the clinician in opposite directions; moral theory evidently does not

CASE STUDY 1: APPLES AND ORANGES

Mrs Apple is a 72-year-old woman who was recently admitted to hospital with chest pain and was diagnosed with non-ST-segment elevation myocardial infarction. She has never had any cardiovascular problems before. She is keen to go home today, as she feels much better. The ward sister asks you to see Mrs Apple first 'as she's for home today'. As you read through the notes, you notice that there have been no changes to Mrs Apple's regular medication. You raise the topic of secondary prevention with her and she is very willing to 'take anything that will stop this happening again'. You are surprised that this was not addressed in yesterday's ward round but pleased that you managed to tie up loose ends before her discharge.

On the same ward round, you review another 72-year-old woman, Mrs Orange. She is a frail, cachectic woman who has known end-stage heart failure, previous myocardial infarctions and multiple comorbidities. She is drowsy and becomes distressed taking tablets. Yesterday's consultant documented that Mrs Orange is extremely unlikely to recover from her acute deterioration and suggests a discussion with next-of-kin about end-of-life care. You speak with Mrs Orange's son, her next-of-kin, who understands the severity of her illness and requests that she be kept comfortable and transferred to a hospice. You describe the care of the dying pathway, including your intention to 'stop any unnecessary medications', with which he is in agreement.

As you cross off medications from her list, you notice that many of the medications you stop for Mrs Orange were the very ones you started for Mrs Apple.

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circumvent moral conflict. However, the usefulness of ethics-in-theory is not by way of resolution but of navigation. Moral principles do not by themselves provide a solution for distressing situations, but they do provide a language with which to express concerns. They furnish the clinician with the resources to express his/her moral distress in terms of nuanced principles, so that the cause of his/her unease may come to light. They do not weaken the difficulty by going round it; they strengthen the clinician going through it.

If the gap between our ethics-in-practice and our ethics-in-theory could be narrowed, the clinician may be helped during times of moral distress. This article will now consider whether an ethical framework can be usefully applied in a morally distressing clinical scenario.

Ethics is both painful and helpful

Consider the emergency presentation of Mr Klein (*Case study 2*). If Mr Klein leaves without further medical attention, it will evidently be upsetting for his wife and family. Yet, were he compelled to have treatment, it would be upsetting for Mr Klein himself. There is thus a sense of unease associated with either course of action. Clinicians may intend to persuade him to accept medical care but may be limited in their ability to do so, leading the clinician to experience moral distress in his/her decision making.

Faced with this scenario, the author proposes that increased ethical literacy would assist the doctor's clinical decision, discussion and distress. Being able to articulate the ethical principles at stake in a dilemma may help the clinician to justify the decided course of action. Familiarity with an ethical framework may help the clinician structure discussions with the patient and family, and document a medicolegally robust entry in the notes. Ethical terminology may help the clinician more precisely understand the cause of his/her unease in a given situation.

Hence there is a need to narrow the gap between ethics-in-practice and ethics-in-theory. This article now considers one of the most influential approaches to medical ethics (Holm, 1995), and whether it addresses this need.

The four principles approach is a practical framework

The four principles of beneficence (doing good), non-maleficence (avoiding harm), justice, and respect for autonomy were established by Tom Beauchamp and James Childress (2013) in their landmark work, *Principles of Biomedical Ethics*, the first edition of which was published in 1979. In the words of one of principlism's key proponents, Raanan Gillon (2015), the four principles 'provide a universalisable though prima facie set of moral commitments which all doctors can accept, a basic moral language and a basic moral analytic framework'. While allegedly avoiding the twin dangers of moral relativism (there are no absolutes… absolutely) and moral imperialism (there are absolutes… my ones), Gillon (2003) proposes the analogy that the principles are the four nucleotides of our 'moral DNA, — capable… of explaining and justifying all the substantive and universalisable moral norms of health care ethics and I suspect of ethics generally!' How might the four principles approach assist clinicians in *Case study 2*?

To allow Mr Klein to go home without further attention is consistent with the principle of 'respect for autonomy'. He has expressed his wishes clearly. This principle emphasizes the duty of a doctor to respect the values of the person who is the patient. However, the other three principles may pull in the other direction.

Were Mr Klein to go home, the neurological deficit could become irreversible, rendering him unable to work or sustain a satisfactory quality of life. Can the doctor in good faith claim that allowing discharge has done no harm? Thus the principle of non-maleficence is arguably contravened by permitting Mr Klein to go home.

The principle of beneficence, bedfellow of non-maleficence, describes a duty of the doctor to actively do good. If allowing discharge is likely to result in harm, perhaps the responsible clinician then has a duty to admit the patient for livelihood-saving, if not life-saving, treatment.

Finally, the principle of justice broadens the horizon of consideration beyond the potential tunnel vision of individualism. What are the knock-on effects for others, if Mr Klein were allowed home without further medical attention? As his wife has expressed with tear-filled eyes, there is possible devastation in store for Mr Klein's family as a whole. In terms of distributive justice, allowing discharge may result in significant expense for the taxpayer, who is likely to foot the bill for the long-term health and social care of a disabled Mr Klein, diverting resources away from other patients.

With relatively little abstraction to philosophical questions, the four principles approach has provided a framework for the ethical deliberation of this case. This quickly makes it possible to articulate the ethical principles at stake which serve to elucidate our intuitive discomfort.

The four principles approach is a problematic framework

It must be conceded here that the four principles approach does not resolve moral distress; the principles are in conflict with one another and each principle is open to interpretation.

For example, there is ambiguity in how respect for autonomy is to be understood. Given the distress of the situation, perhaps

CASE STUDY 2: MR AND MRS KLEIN

Mr Klein is a 40-year-old man who is usually fit and well. He is brought into the accident and emergency department by ambulance with symptoms and signs of a total anterior circulation stroke. There is a clear time of onset 45 minutes ago and, as you prepare to insert a cannula and explain the routine of computed tomography scan and possible thrombolysis, he gestures to stop you. Mr Klein asserts that he has no intention of staying for a scan or permitting cannulation. You endeavour to explain the risk of severe, chronic disability if his condition goes untreated, and the potential benefits of timely intervention. Despite your efforts, he requests that he be transported home, remarking 'I get what you're saying. It's nothing against you. I just hate hospitals and I don't want to be here'. There is no evident lack of capacity.

As you step outside the curtain, Mr Klein's wife and 6-year-old daughter approach you, appearing tearful and anxious. His wife said: 'Please, doctor, I know he's said he doesn't want it, but he's got to have it. We're frightened he's gonna be disabled all because he doesn't like hospitals. He's the one with the income; I can't work. We can't look after him like this. He's gonna ruin our family life all because he's too stubborn to have treatment. Will you make him have it, please doctor?'

the reliability of Mr Klein's expressed wishes is compromised. His expressed wishes may be at odds with what his wishes would be if he were in a more ordinary state of mind. To respect Mr Klein's extraordinary-circumstance autonomy may be to disrespect his ordinary-circumstance autonomy. Furthermore, it is not self-evident that Mr Klein is the only agent whose autonomy ought to be respected; to respect his autonomy is arguably to disrespect his wife's autonomy.

Similarly, non-maleficence cuts both ways. Perhaps it urges the doctor to allow discharge because the recommended treatment, especially if administered under duress, has associated risks. Furthermore, allowing discharge is not an example of doing harm because it is not, strictly speaking, doing anything; it is an act of omission, not commission; passive, not active. Beauchamp and Childress (2013), however, consider this a vague and confusing distinction.

Beneficence, arguably, is in the eye of the beholder. In Mr Klein's eyes, going home is good for him. In the eyes of Mrs Klein, receiving early investigation and treatment is good for him. The imperative 'do good' does not clarify what 'good' means in this situation. Offering good care is not simply a principle problem, it is a perspective problem; how you see it depends on who's looking.

Finally, the principle of justice also suffers from ambiguity. Why should the decision to decline treatment be monopolised by one person, Mr Klein, when multiple persons bear its consequences? What is the 'whole' that holistic medicine seeks to restore, the individual or the family unit? Perhaps it is a community or society? Such questions reveal the influence of the 'big picture' on the 'little picture'; our meta-narrative frames our medical narrative.

Additional shortcomings of the four principles approach have been proposed in bioethics literature. Virtue ethicist Alastair Campbell (2003) summarizes three main 'vices' of the four principles: 'neglect of emotional and personal factors, oversimplification of the issues, and excessive claims to universality'. John Harris (2003), while conceding that the four principles method 'constitutes a useful "checklist" approach to bioethics for those new to the field', complains that implementing it can lead to 'sterility and uniformity… of a quite mind bogglingly boring kind'. Furthermore, for all the painstaking research into 'common morality' by Gillon, there remains an argumentum ad populum; just because it is popular does not make it right! As oncologist and theological ethicist James Rusthoven (2014) points out, even a commonly accepted set of moral principles may lack a 'firm and reliable authoritative grounding'.

The four principles approach is a preliminary framework

In cautious defence of the four principles approach, these shortcomings are not so much addressing the four principles approach per se as its simplistic and careless implementation. It is not intended to provide a general theory. Rather, it provides 'only a framework of norms with which we can start' (Beauchamp and Childress, 2013). The four principles approach is not so much a recipe as a set of initial ingredients, which is intended to become action-guiding through a deliberative process which includes specification and balancing.

The four principles approach is not a solution to difficult situations. It does not close the gap between the real world and the ideal world; it narrows the gap between ethics-in-practice and ethics-in-theory. The four principles approach is described as preliminary because by itself it does not complete nor ensure ethical deliberation; it is preparatory. The approach is a starting framework by means of which the clinician can begin the careful work of interpreting ethical principles and weighing up their relative importance in light of the clinical context.

Conclusions

The four principles approach provides a preliminary framework to assist clinicians' ethical deliberation. It provides a means of conceptualisation for the clinician in a conflict (decision), a means of communication for the clinician in a rush (discussion), and a means of self-diagnosis for the clinician in perplexity (distress). Through its careful implementation, the gap between ethics-in-practice and ethics-in-theory can be narrowed and clinicians can be helped through times of moral distress. **BJHM**

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KEY POINTS

- Although not easily measured, ethics is an essential, ubiquitous element in medical decision making.
- The gap between ethics-in-practice and ethics-in-theory is felt most exquisitely during times of moral distress.
- Ethical theory, such as the four principles approach of Beauchamp and Childress, does not eliminate moral conflict but can help the clinician through times of distress.
- The four principles can be summarized as beneficence, non-maleficence, justice, and respect for autonomy.
- If the four principles approach is implemented simplistically or carelessly, it may prove problematic and unhelpful.
- By reducing the gap between ethics-in-practice and ethics-in-theory, the four principles approach can help a hospital doctor's decision, discussion and distress.

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