OVERSEAS ARTICLE

The Application of Bioethical Principles to Resolve Conflicts in Values

George R. Beauchamp MD

INTRODUCTION

Each clinical encounter between a patient and physician has multiple levels of perception and reality. That is to say, each of us comes to such encounters with certain "baggage", consisting of preconceived notions about the context and meaning of what is occurring, how it should be managed and what the outcomes should be. Philosophically, the practice of medicine is a relationship-one between a person who is in real or potential need (a patient) and another with the capacities and willingness to care and/or cure (a physician). Thus, the values and perspectives of both physicians and patients must be resolved to effect results that meet the expectations of both. The preponderance of responsibility to assure such resolutions of values, context and meaning, and their integration to the scientific and medical aspects of care rest with the physician. Accordingly, the physician needs to be armed with sensitivity and openness to the ethical dimensions of every clinical encounter, possess capacities to constructively resolve differences in values and be sufficiently perceptive to discern when such conflicts in values have been resolved.

BIOETHICAL PRINCIPLES

There are four (some believe five) principles to be understood and used in the process of resolution of conflicts in values. Between and among these principles, as we shall explore together, there can be conflicts; and these circumstances test the moral resolving capacities of physicians, patients and society alike.

Autonomy

The concept of autonomy speaks to the positive obligation physicians bear to enhance the personal autonomy, or personal power of patients. This is achieved in part by increasing the patient's independence through enhanced health as well as decision-making capacity; that is, by educating the patient so that he/she will make wise choices and avoid poor ones. Herein, the role of physician as teacher is prime.

Beneficence

This principle carries the positive obligation of a physician to do good things on behalf of his or her patients. This traditional value of medicine has a darker side in a modern world of consumer enlightenment and activism, i.e., that such actions may be taken as overly paternalistic and therefore manipulative. Please note therefore that beneficence may be in conflict with autonomy. A core moral capacity for physicians includes the ability to discern when one or the other of these two

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principles should be dominant; and generally the patient is the ultimate source (explicitly or implicitly) of this clarity.

Non-maleficence

Physicians here assume the (again positive) obligation to avoid doing a bad thing. Traditional medical practitioners are deeply imbued with the admonition, *primum no nocere*, latin for "first do no harm". Non-maleficence is the bioethical principle in the moral realm to complement "do no harm" in the technical realm of medical practice. It is not difficult to imagine that this principle can come in conflict with beneficence; for example, if physicians do nothing to avoid doing harm, good things with acceptable risks may be omitted.

Justice

Justice has two components that may be frequently in conflict with one another. *Individual justice* speaks to the right or just thing to do for individual patients, with the implicit assumption that the greater good will be served by these collected individual just acts. *Distributive justice*, on the other hand, speaks to the obligations of physicians to seek out a greater good for a population (or group), with the implicit assumption that more individuals will prosper (in the sense of good health) if the general well being of the community is served. The potential for conflicts, particularly as one approaches the interests of individual patients, is obvious. Indeed, entire professional disciplines are organized around such distinctions, such as independent practitioners serving individual patients as distinct from public health or epidemiologic specialists. The issues of justice are intensely focused when real resource availability and allocation are considered.

Life

Some regard life and its preservation as a fundamental principle. By implication, life should be preserved and enhanced at virtually all costs.

SOURCES OF ILLUMINATION

Where does one seek the wisdom in order to apply such illumination to the challenges of clinical practice? The traditional sources are three:

- Philosophy, e.g., in traditional Western culture (recognizing there are other, perhaps more worthy philosophies to apply)
  - Aristotle, the ethics of virtue
  - Immanuel Kant, the ethics of acts
  - John Stuart Mill, the ethics of consequences (sometimes called a utilitarian approach, where the ends justify the means);
- Religion, a traditional and dominant source of determination of right and wrong
  - Beware of the notion of completeness, sometimes either assumed or demanded by the strict adherence to a particular faith and its practice. Sometimes beliefs may inhibit one's ability to accept a differing world-view and thereby limit constructive and useful options in patient care.
  - From a process point of view, beliefs will likely limit the discourse between doctor and patient, and therefore may fail to evoke autonomy enhancing and beneficent acts. Please understand that this is very difficult work; nonetheless, it can be personally and professionally expanding;

of this make the practice of medicine too complex to manage idiosyncratically. If the practice of medicine is to make sense, principles must take precedence over power. This is difficult, yet much more rewarding.

ABOUT THE AUTHOR

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Education :

- A. B., University of California, Berkeley, 1965
- M. D., Northwestern University Medical School, 1968
- Internship, Walter Reed Army Medical Center, 1968-1969
- Residency, Walter Reed Army Medical Center, 1970-1973
- Fellowship training in corneal transplantation and pediatric ophthalmology, Washington D. C., 1975-1976
- Physicians in Management, Courses I and II, Cleveland Clinic Foundation, 1985-1986
- Institute for the Humanities in Medicine, Hiram College, Ohio, 1989-1990

Contribution to Literature :

- 44 Articles
- 7 Chapters
- 2 Instructional Videotapes
- 7 Abstracts

Current Principal Interests and Activities (April 1998–present)

- Physicians' values, culture and practice issues
- Medical information technology, clinical computing, workflow integration and value appraisal
- Medical practice—Pediatric ophthalmology and strabismus

Healthcare Values Alliance, Inc. (HVA) :

Position : President

Healthcare Values Foundation (HVF)

Position : President

Integrated Medical Systems, Inc. (IMS), New Kinetra, LLC (April 1991 - March 1998).

- Physician Services Consultant (Sep 1997 - March 1998).
- Senior Vice President Physician Affairs (1996 - August 1997)
- Senior Vice President for Strategic Marketing (1995)
- Senior Vice President for Strategic Development (1994)
- President IMS Medacom Texas (1992-1993)
- Vice President, Medical Affairs (1991-1993)

Cleveland Clinic Foundation (1983-1990)

Positions :

- Medical Director, Office of Regional Health Affairs (1987-1990)
- Chairman :
  Fund Development Committee.
  Advisory Committee.
  Centre for Children & Youth.
  Task Force on Public Education.
  Computer Task Force.
  Division of Surgery.
  Marketing Strategy Task Force.
  Committe to implement a consumer health informaltion network.
  CompreCare Committee on Utlilization Review & Quality Assurance.

Medical Practice & Related Activities : (1976-83)

Director of Residency Programme and Chairman Department of Ophthalmology, Doctor's Hospital 1976-1979
Owner/Manager of an HMO, for Vision Services (1977-1983).
Private Medical practice, Washington, D.C (1976-1983).

U. S. Army Medical Corps (1968-1975)

Chief Ophthalmology Service, William Beaumont A.M.C., El Paso, Texas (1973-1974)
Assistant Chief, Ophthalmology Service, Walter Reed A.M.C., Washington D. C. (1974-1975)

Additional Professional Activities :

American Academy of Ophthalmology

Chairman, Ethics Committee (1988-1992)
Member & Vice Chairman (1980-1983).
Member Quality of Care Committee. Chairman, Pediatric Ophthalmology panel. Primary Author of Preferred Practice Patterns.

National Children's Eye Care Foundation :

President (1987–present)

American Board of Ophthalmology :

Director (Two terms, 1991, 1998)

American Ophthalmological Society :

Member.

University of Texas, Southwestern Medical Center, Dallas (USA)

Professor of Clinical Opthalmology, teaching clinical pediatric ophthalmology and ethics.

Selected : The Best Doctors in America ®: Central Region 1996-1997 and the Best Doctors in America ® 4th ed. Woodward and White 1998.