Fostering Medical Students' Commitment to Beneficence in Ethics Education

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ABSTRACT

When physicians use their clinical knowledge and skills to advance the well-being of their patients, there may be apparent conflict between patient autonomy and physician beneficence. We are skeptical that today's medical ethics education adequately fosters future physicians' commitment to beneficence, which is both rationally defensible and fundamentally consistent with patient autonomy. We use an ethical dilemma that was presented to a group of third-year medical students to examine how ethics education might be causing them to give undue deference to autonomy, thereby undermining their commitment to beneficence.

Keywords: Beneficence, Autonomy, Education, Principlism, Clinical Ethics, Medical Students

INTRODUCTION

The right of patients to choose which treatments they prefer is rooted in today's social mores and taught as a principle of medical ethics as respect for autonomy. Yet, when physicians use their clinical knowledge and skills to advance the well-being of their patients, there may be a conflict between patient autonomy and physician beneficence. We are skeptical that today's medical ethics education adequately fosters a commitment to beneficence, which is both rationally defensible and fundamentally consistent with patient autonomy.

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I. An Ethical Dilemma

The impetus for this paper arose when students who were completing their third clinical year discussed a real-life ethical dilemma. A middle-aged man developed a pulmonary hemorrhage while on blood thinners for a recently placed coronary stent. The bleeding was felt to be reversible, but the patient needed immediate intubation or he would die. The cardiologist was told that the patient previously expressed to other physicians that he never wanted to be intubated. However, the cardiologist made the decision to intubate the patient anyway, and the patient eventually recovered.[1]

Students were asked if they believed that the cardiologist had acted ethically. Their overwhelming response was, "No, the patient should have been allowed to die." We looked into how students applied ethical reasoning to conclude that this outcome was ethically preferred. To explore how the third-year clinical experience might have formed the students' judgment, we presented the same case to students who were just beginning their third year. Their responses were essentially uniform in recommending intubation.

While there is likely more than one reasonable view in this case, we agree with the physician and the younger medical students that intubation was the ethically appropriate decision and will present an argument for it. But first, we explain the reasoning behind the more advanced medical students' decision to choose patient autonomy at the expense of beneficence.

II. Medical Ethics Education and the Priority of Autonomy

Beauchamp and Childress's *Principles of Biomedical Ethics,* first published in 1979 and now in its 8th edition, is a significant part of the formal ethics education in medical school.[2] Students learn an ethical decision-making approach based on respect for four ethical principles: autonomy, beneficence, nonmaleficence, and justice. While Beauchamp and Childress officially afford no *prima facie* superiority to any principle, the importance of respect for patient autonomy has increased through the editions of their book. For example, early editions of their book opposed the legalization of physician-assisted death compared to recent editions that defended it.[3] As another example, Beauchamp and Childress make paternalism harder to justify by adding an autonomy-protecting condition to the list of conditions for acceptable paternalism.[4] Authority, they contend, need not conflict with autonomy—provided the authority is autonomously chosen.[5] "The main requirement," they write, "is to respect a particular patient's or subject's autonomous choices, whatever they may be.[6] In the principlism of Beauchamp and Childress, autonomy now seems to have a kind of default priority.[7] However, the bioethics discourse has strong counternarratives, noting some movement to elevate the role of beneficence and to respect the input of stakeholders, including the family and the healthcare team.

Ethics education achieves particular relevance in the third clinical year when students become embedded in the care of patients and learn from what has been called the informal curriculum. They observe how attending physicians approach day-to-day ethical problems at the patient's bedside. In this context, students observe the importance of informed consent for serious treatments or invasive procedures, a practice that highlights the principle of patient autonomy.

In both the formal and informal curriculum, medical students observe how, in the words of Paul Wolpe, "patient autonomy has become the central and most powerful principle in ethical decision-making in American medicine."[8] In short, students appear to learn a deference for patient autonomy. This curricular shift in favor of autonomy coincides with legal developments that protect patients' rights and decision-

making with respect to their healthcare choices. The priority of autonomy in medicine benefits patients by reflecting their choices and, in some cases, their fundamental liberty.

III. The Practice of Medicine and the Commitment to Beneficence

There are many critiques of the dominant place that autonomy has in biomedical ethics,[9] especially considering that autonomy seems to be biased toward individualistic, Western, and somewhat American culture-driven values.[10] In addition, many bioethical dilemmas are cast as a conflict between autonomy and beneficence. Our point is that medical students bring to their study of medicine a commitment to beneficence that seems to be suppressed by practical ethics education. We think this commitment is rationally defensible and should be nurtured.

It is striking that young medical students have a pre-reflective commitment to beneficence at all. For, as we mentioned, it is not just medicine but Western culture generally that prioritizes autonomy in settling ethical dilemmas. In wanting to act for the good of others (rather than simply agreeing to what others want), physicians are already swimming somewhat against the cultural tide.[11] However, doing so makes sense, given the nature of medicine and the profession of healing. When prospective medical students are asked why they wish to become physicians, the usual answer is some variation on caring for the sick and preventing disease. It is unlikely that a reason to become a physician is to respect a patient's autonomy.

It would be easy to dismiss medical students' commitment to beneficence as a mere intuition and contrary to a more reasoned and deliberative approach. Beauchamp and Childress seem to minimize the value of physician intuition, stating that justifications for certain procedures are "…supported by good reasons. They need not rest merely in intuition or feeling."[12] Henry Richardson writes that "situational or perceptive intuition…leaves the reasons for decision unarticulated."[13] We think this is a crude and rather thin way of understanding intuition. Some bioethicists have defended intuition as essential to the practice of medicine and not something opposed to reason.[14]

In the case we describe, we believe the ethical justifications s for the patient's intubation are fundamentally sound: the patient did not have a "do not intubate" order written in the chart, the emergency intubation had not been foreseen, so the patient did not have the opportunity to consent to or reject intubation; the patient had consented to the treatment for his cardiac disease so his consent for intubation could have been assumed;[15] and the consequences of respecting his autonomy did not justify allowing him to die.[16] While it is possible to have more than one reasonable view on this case, we think the case for beneficence is strong and certainly should not be dismissed out of hand.

We do not deny that if a patient makes a clearly documented, well-informed decision to forgo intubation that this decision ought to be respected by the physician (even if the physician disagrees with the patient's decision). But, in this situation, as in many others in the practice of medicine, the patient's real wishes and preferences are not well-articulated in advance. There are many cases where a physician acts based on what she believes the patient, or the surrogate, would want, sometimes in situations that do not allow much time for reflection. An example might be resuscitation of a newborn at the borderline of viability. In their ethics education, beneficence would mean acting first to save a life. If the patient or surrogate makes an informed decision to the contrary, a beneficent physician respects that autonomous decision.

In the case presented, the patient expressed gratitude to the cardiologist when extubated. But what if he had expressed anger at the physician for violating his autonomy? There are those who could argue that not only was intubation ethically wrong but that the cardiologist put himself in legal jeopardy by his actions

(especially if there had been a written refusal applicable to the specific situation). In the example we use, we point out that the cardiologist may not have escaped a lawsuit if the patient had died without intubation. His family, when hearing the circumstances, may have sued for failure to act and dereliction of the cardiologist's duty to save him. Beyond a potential legal challenge for either action or inaction, there is an overriding ethical question the cardiologist had to address: what course would be most satisfying to his conscience? Would he rather allow a patient to die for fear of recrimination, or act to save his life, regardless of the personal consequences? In the absence of real knowledge about the patient's considered wishes, it is most reasonable to err on the side of promoting patient well-being.

A physician's commitment to beneficence is not necessarily a way of undermining a patient's autonomy. In acting for the patient's good, physicians are also acting on what it is reasonable to believe a patient (or most patients, perhaps) would want, which is obviously connected to what a patient *does* want. Pellegrino and Thomasma argue that beneficence includes respect for a patient's autonomy since "the best interests of the patient are intimately linked with their preferences."[17] Instead of conceptualizing ethical dilemmas in medicine as conflicts between autonomy and beneficence, it is possible that medical schools could teach students that truly practicing beneficence is a way of valuing patient autonomy, especially when the patient's wishes are not specific to the situation and are not clearly expressed.

CONCLUSION

It is important for students and practicing physicians to understand the principle of respect for patient autonomy in a pluralistic society that demands personal self-determination. However, the role of the physician as a beneficent healer should not be diminished by this respect for autonomy. Respecting a patient's autonomy is grounded in and manifested by physician beneficence.[18] That is, seeking what is good for the patient can only be good if it respects their personhood and dignity.

We propose that a commitment to beneficence, incipient in young medical students, should be developed over time with their other clinical reasoning skills. Such a commitment need not be sacrificed on the altar of patient autonomy. Beneficence needs greater relative moral weight with students as they proceed in their ethics education.

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[1] S. Jauhar, "When Doctors Need to Lie," *New York Times*, February 22, 2014, https://www.nytimes.com/2014/02/23/opinion/sunday/when-doctors-need-to-lie.html.

[2] T. L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 8th ed. (New York, NY:

Oxford University Press, 2019).

[3] Louise A. Mitchell, "Major Changes in Principles of Biomedical Ethics," *The National Catholic Bioethics Quarterly* 14, no. 3 (2014): 459–75, https://doi.org/10.5840/ncbq20141438.

[4] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 8th ed. (New York, NY: Oxford University Press, 2019), 238.

[5] Beauchamp and Childress, 103.

[6] Beauchamp and Childress, p. 108.

[7] For other accounts that prioritize autonomy, see e.g. Allen E. Buchanan and Dan W. Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (Cambridge University Press, 1989), 38–39; R Gillon, "Ethics Needs Principles—Four Can Encompass

the Rest—and Respect for Autonomy Should Be 'First among Equals,'" *Journal of Medical Ethics* 29, no. 5 (October 2003): 307–12, https://doi.org/10.1136/jme.29.5.307. For examples of critiques of these accounts, see footnote 9.

[8] P. R. Wolpe, "The Triumph of Autonomy in American Bioethics: A Sociological View," in *Bioethics and Society: Constructing the Ethical Enterprise*, p. 43.

[9] V. A. Entwistle et al., "Supporting Patient Autonomy: The Importance of Clinician-Patient Relationships," *Journal of General Internal Medicine* 25, no. 7 (July 2010): 741–45; C. Foster, *Choosing Life, Choosing Death: The Tyranny of Autonomy in Medical Ethics and Law*, 1st ed. (Oxford ; Hart Publishing, 2009); O. O'Neill, *Autonomy and Trust in Bioethics*, The Gifford Lectures, University of Edinburgh 2001 (Cambridge, UK: Cambridge University Press, 2002).

[10] P. Marshall and B. Koenig, "Accounting for Culture in a Globalized Bioethics," *The Journal of Law, Medicine & Ethics: A Journal of the American Society of Law, Medicine & Ethics* 32, no. 2 (2004): 252–66; R. Fan, "Self-Determination vs. Family-Determination: Two Incommensurable Principles of Autonomy," *Bioethics* 11, no. 3–4 (1997): 309–22.

[11] Arguments stressing the importance of beneficence, as ours does here, certainly approach paternalistic arguments. We set aside the complex issue of paternalism for purposes of this paper and simply note that the principle of beneficence as such does not say anything specifically about acting against the patient's will. In the case study that focuses this paper, we do not believe the patient's will or wishes were clearly indicated.

[12] Beauchamp and Childress, *Principles of Biomedical Ethics*, p. 20, see note 2 above.

[13] H. S. Richardson, "Specifying, Balancing, and Interpreting Bioethical Principles," *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 25, no. 3 (January 1, 2000): 285–307, p. 287.

[14] H. D. Braude, *Intuition in Medicine a Philosophical Defense of Clinical Reasoning* (Chicago ; University of Chicago Press, 2012).

[15] R. Kukla, "Conscientious Autonomy: Displacing Decisions in Health Care," *The Hastings Center Report* 35, no. 2 (2005): 34–44.

[16] M. Schermer, *The Different Faces of Autonomy: Patient Autonomy in Ethical Theory and Hospital Practice*, vol. 13, Library of Ethics and Applied Philosophy (Dordrecht: Springer Netherlands, 2002).

[17] E. D. Pellegrino and D. C. Thomasma, *For the Patient's Good - the Restoration of Beneficence in Health Care* (New York, NY: Oxford University Press, 1988), p. 29.

[18] Pellegrino and Thomasma, *For the Patient's Good*.