

# Medical ethics: four principles, two decisions, two roles and no reasons

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## ABSTRACT

The 'four principle' view of medical ethics has a strong international pedigree. Despite wide acceptance, there is controversy about the meaning and use of the principles in clinical practice as a checklist for moral behaviour. Recent attempts by medical regulatory authorities to use the four principles to judge medical practitioner behaviour have not met with success in clarifying how these principles can be incorporated into a legal framework. This may reflect the philosophical debate about the relationship between law and morals. In this paper, legal decisions from two cases in which general practitioners have been charged with professional shortcomings are discussed. Difficulties with the application of the four principles (autonomy, beneficence, nonmaleficence and justice) to judge medical practitioner behaviour are highlighted. The four principles are relevant to medical practitioner behaviour, but if applied as justifications for disciplinary decisions without explanation, perverse results may ensue. Solutions are suggested to minimise ambiguities in the application of the four principles: adjudicators should acknowledge the difference between professional and common morality and the statutory requirement to give decisions with reasons.

## Introduction

Ethically acceptable conduct by New Zealand health care practitioners is determined by statute in the Health Practitioners Competence Assurance Act (HPCAA) 2003 Section 118(i). For medical practitioners the HPCAA authorises the Medical Council to set the "standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession".

The NZ Medical Council (NZMC) endorses the four ethical or moral principles which are also the moral mantra of medical practice emerging from the UK and USA.

Standard treatises on medical ethics cite four moral principles: autonomy, beneficence, nonmaleficence, and justice. Autonomy recognises the rights of patients to make decisions for themselves. Beneficence requires a doctor to achieve the best possible outcome for an individual patient, while recognising resource constraints. Nonmaleficence implies a duty to do no harm. (This principle involves consideration of risks versus benefits from particular procedures.) Justice incorporates notions of equity and of the fair distribution of resources.<sup>1</sup>

The Health (formerly Medical) Practitioners Disciplinary Tribunal is established under the HPCAA to investigate and, if necessary, discipline a health practitioner. The grounds for discipline include "malpractice or negligence" or bringing "discredit to the profession". The Statute does not include reference to any moral codes, but it is not uncommon for judges to consider moral criteria before coming to a decision. The relationship between moral principles and law is the subject of debate among legal philosophers. Consistent with the dominant legal positivist view, here it will be assumed that there is no necessary connection between law and morals and "...it is in no sense a necessary truth that laws reproduce or satisfy certain demands of morality, though in fact they have often done so."<sup>2</sup> The separation of law and morals is a consistent theme and is supported by courts in New Zealand and Australia.<sup>3,4</sup> One instance of the incorporation of morals into law occurred with the changes to the Crimes Act 1961 with the 2007 Section 59(2) amendment making it illegal to use parental force for purposes of "correction" or punishment. A moral principle of nonmaleficence towards children became law and now does not require consideration of the moral force behind the principle.

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The **ETHICS** column explores issues around practising ethically in primary health care and aims to encourage thoughtfulness about ethical dilemmas that we may face.

**THIS ISSUE:** Dr John Kennelly addresses the difficulty of applying the four moral principles (autonomy, beneficence, nonmaleficence, justice) in the legal context of two cases of general practitioners charged with professional misconduct.

The following two cases will demonstrate that the use of moral principles to regulate medical practitioner conduct is not simple. A tribunal wishing to refer to moral principles should give reasoned decisions and be prepared that their findings about moral behaviour do not survive a legal decision.

## Two cases

The two cases concern two general practitioners (GPs): one (Dr S) who failed to complete an Accident Compensation Corporation (ACC) form for a patient with a suspected work-related disease and the other (Dr G), who was charged with having a sexual relationship with a former patient.

### Dr S

Dr S, a GP with an interest in occupational medicine and employed by a freezing works, was consulted by Mr A, a freezing worker who was suffering from symptoms suggestive of Leptospirosis. Dr S chose to delay the completion of an ACC claim for a work-related disease, but eventually the laboratory tests confirmed the presence of Leptospirosis. Eventually, in Dr S's opinion, Mr A recovered and he was sent back to work despite his protestations that he was not well. Mr A's own GP diagnosed Chronic Fatigue Syndrome (CFS) which Dr S believed was not caused by Leptospirosis and hence not an ACC claim. Mr A complained and this was referred to the Medical Practitioners Disciplinary Tribunal (MPDT). The MPDT decided that the issue was not about Dr S's clinical skills but his skills in relation to "communication, and ethical issues surrounding conflicting interests..."<sup>5</sup> The MPDT also charged Dr S with breaching the four principles, "relating to nonmaleficence, beneficence and justice". Counsel for the disciplinary body submitted that the allegations relating to the ethical

guidelines were self-explanatory and "non-maleficence by failing to accept the hospital diagnosis" and "principle of justice by failing to accept the hospital diagnosis" and not providing "ACC certification during this period resulting in major stress and financial hardship for Mr A".<sup>6</sup>

Dr S appealed the decision to the District Court and charges that Dr S breached the fundamental principles of nonmaleficence, beneficence and justice, were dismissed.<sup>7</sup> The Court did uphold the charge that Dr S "did not accept that the patient's chronic malaise and fatigue were due to the after effects of Leptospirosis and therefore did not provide ACC certification during this period resulting in major stress and financial hardship for the patient." In agreeing with this decision the District Court may have been influenced by the Tribunal's findings that Dr S's "primary focus was on protecting his [Dr S] employer and that he was clearly not focusing on Mr A's needs". The Court decision was not reported so the reasoning of the Court is not available.

There are three unanswered questions about certification, financial hardship and the blurring of professional roles:

#### 1. Was Dr S acting illegally to refuse to complete the ACC certificate and insist that Mr A returned to work?

A medical advisor to the Medical Council stated—reflecting the Council's guidelines and commenting on a case where a doctor refused to claim ACC funding for a patient—that the doctor "acted entirely correctly (though bravely): the diagnosis is a professional judgment for the doctor, and he would have been wrong to sign a document he believed to be false and misleading."<sup>8</sup> Dr S believed what he was doing was correct and had expert evidence to support that view.

#### 2. Should Dr S be responsible for "major stress and financial hardship for the patient"?

It is unlikely that a court would consider that Mr A would have suffered 'harm' from having to receive social welfare assistance compared with ACC payments, despite the monetary difference. In a 2008 High Court decision, the benefits of ACC versus non-ACC compensation were considered and the Court stated that it was "illogical to claim that the Ministry of Health has failed [the patient] by not giving her the benefits that another government agency would, if her circumstances were different".<sup>9</sup>

If it was decided that Mr A did suffer economic loss, then there are strong legal arguments against Dr S having to bear economic responsibility for the advice he gave Mr A or ACC, whether or not that advice was negligent.<sup>10</sup>

#### 3. Did Dr S blur his roles and favour his employer over the patient when considering his actions during his treatment of Mr A?

The Tribunal was of the view that Dr S's "primary focus was on protecting his employer and that he was clearly not focusing on Mr A's needs" and that Dr S "was blurring his various roles and did not appear to be addressing his mind to which role he was undertaking and for whom at any given time".

The MPDT had previously recognised the importance of legal obligations to insurance companies when it recognised the obligation arising out of a contract between the patient and the insurance company and the "trust between insurance companies and members of the medical profession".<sup>11</sup>

In the case of Dr S, the Tribunal preferred the expert evidence from Dr Walls that Dr S had a primary responsibility to Mr A at the expense

of his responsibility to ACC. “Dr Walls took issue with Professor Gorman’s opinion that with regard to matters of certification Dr S was operating as a commissioned agent of a third party and that this therefore altered in some way Dr S’s responsibilities to Mr A.” Dr S had two roles, the role of the treating physician and the role to a third party, the insurer (ACC). Those roles need not be conflicting and Professor Gorman was correct, the obligations to the third party did alter Dr S’s obligations but did not eliminate them, they were no longer just to the patient. It would appear that Dr S fulfilled his obligations in those two roles: he followed his belief that CFS in this case was not caused by Leptospirosis and Mr A’s chances of rehabilitation were improved by his being back at work. The latter is a strongly evidence-based medical recommendation and officially endorsed in the UK, Australia and New Zealand.<sup>12</sup>

It is possible that Dr S did not fulfil the roles of treating doctor and occupational advisor to a high standard, and he also felt that he could have improved the way he dealt with Mr A. Dr S was charged because of his poor communication and a conflict of interest, but that is a different scenario to Dr S making a professional decision not to sign an ACC certificate and the remote possibility that this decision contributed to Mr A’s financial hardship. The Tribunal decided after considering the four principles that the allegations they made based on those principles were “self-explanatory”. With a finding of a serious charge such as professional misconduct against Dr S, a reasoned decision should be considered obligatory.

### Dr G

Dr G met Mrs B at an immigration medical examination and at a later date performed a cervical smear and urine test. He also later employed her as a

practice nurse. Mrs B maintained that she had a sexual relationship with Dr G while there was a doctor/patient relationship, but Dr G denied that this ever took place. The Health and Disability Commissioner (HDC)<sup>13</sup> and the HPDT preferred Mrs B’s recollection of events.<sup>14</sup> The HDC duly charged Dr G with breaching Right 2 (freedom from sexual exploitation) and Right 4(2) (services provided that complied with professional and ethical standards).

Dr G chose to defend the charges in the High Court against the HPDT who contended that Dr G’s “conduct amounts to both misconduct and to the bringing of discredit to the medical profession”.<sup>12</sup> It was alleged that Dr G had initially entered into an employer/employee relationship and then developed a sexual relationship that lasted three years. Dur-

not given...” and a similar failing was identified from the minority decision: “Like the majority, the minority did not express the standards and objectives he applied to arrive at his view. This makes it hard to assess the minority’s view.”<sup>15</sup> Furthermore, the “majority’s failure to express a proper basis for its finding on the duration of the doctor/patient relationship is an error that makes their decision on this issue unreliable and wrong.”<sup>15</sup> The Judge then gave both parties time to make further submissions that “should deal with whether or not Dr G’s conduct...constitutes professional misconduct...”<sup>15</sup>

At a later hearing, after further submissions, the Director of Public Prosecutions (DPP) “set out broad principles underlying the practice of medicine that can be used to undertake an ethical

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ing that time Dr G had given medical treatment including a cervical smear and requested a midstream urine. The HPDT concluded that there was a doctor/patient relationship during the time Dr G was having a sexual relationship. One HPDT member disagreed with these findings thus raising the possibility of another view.

The High Court preliminary decision was strongly worded that “...the majority has identified the evidence it relied on to find the doctor/patient relationship... but the rationale for that reliance is

analysis of a problem in medicine...”<sup>16</sup> and listed the four principles of autonomy, nonmaleficence, beneficence and justice. The DPP stated that these were “the underlying fundamental principles which...should be the basis from which Dr G’s actions are considered.”<sup>16</sup> In relation to the four principles the DPP asked the questions: “which situations are possibly harmful to patients, at what point in the situation is the patient’s status as a person with the power to decide and act in his or her own best interests threatened?” but was silent on questions related to justice and beneficence.<sup>16</sup>

The DPP submitted that there was “potential for harm” when Dr G performed a cervical smear and urine analysis on Mrs B because “there was still a role for Dr G in respect of subsequent treatment” and a “potential for impaired judgment regarding diagnosis or treatment due to a lack of independence and objectivity remained”.<sup>16</sup> The Judge disagreed with the DPP’s conclusions “regarding the broad principles underlying the practice of medicine”. He did “not consider that there has been any maleficence...because I do not see how what has occurred can be said to have been harmful to Mrs B. Nothing that happened has interfered with her autonomy. Nor has there been any interference with justice or professional integrity”.<sup>16</sup>

The Judge seemed sympathetic to counsel for Dr G who was “critical of the prosecution not producing evidence from a medical ethicist or some similarly qualified expert on appropriate professional conduct. Apart from the guidelines from the Medical Council on doctors not entering into sexual relationships with their patients, there was no evidence before the Tribunal” because “it means that there is little to use as a measure against Dr G’s conduct”.<sup>16</sup>

In the absence of any professional guidance, the Judge measured Dr G’s behaviour against common morality: “Whilst there are those in the community who would consider a married man engaging in sexual relations with a married woman who was not his wife was shabby, if not immoral conduct, it is clear to me that the professional standards and ethical standards to be applied do not go so far as to regard extra marital affairs per se by doctors as amounting to professional misconduct.”<sup>16</sup>

Both the DPP and the Judge were silent on how the four principles might be applied in a legal setting. However, the

Judge correctly identified that immoral conduct (measured by common morality) is different to the morality demanded by a professional role. It is surprising that the Tribunal missed this point. They appear clumsy in their handling of the four principles in a legal setting. If they had done as Section 103(1) of the HPCAA demanded, that “an order of the Tribunal must (b) contain a statement of the reasons for the order” then unnecessary litigation would have been avoided. The Judge challenged the Tribunal to provide reasons for the application of the four principles and recognised the importance of the moral demands of professional roles.

In both cases (Dr S and Dr G) the four principles did not provide the legally enforceable path to judge professional behaviour. The Tribunal failed to make the transition from a moral wish-list to producing principles that the Courts could use so as to judge practitioner behaviour and incorporate the principles into law. They failed to do so because they did not undertake the intellectual exercise of providing reasons for their decision and because they failed to recognise the importance of role morality. The Tribunal also showed naivety in their handling of the meaning of the four principles which were glossed over summarily. For example, justice is a complex topic and if it is to be applied with any meaning, deserves some discussion. Justice is concerned with distribution of health care resources, not whether or not a patient should have one type of certification compared with another. If the Tribunal persists in using the four principles, some reference to standard texts for guidance on the application of the principles is recommended.

### Objections to the four principles

The four principles in medical ethics compete with other approaches to

moral theory, such as virtue ethics as one example, but the principles were never intended to exclude other moral discourse and are complementary to other approaches.<sup>17,18</sup> As a checklist for a student or ‘newbie’, the principles may ensure that all relevant moral considerations have been covered, although the teaching of the four principles in medical schools has been accused of being “pointless and at worst dangerous”.<sup>19</sup>

The two cases discussed give credence to Harris’s concern that: “The principles allow massive scope in interpretation and are, frankly, not wonderful as a means of detecting errors and inconsistencies in argument.” And that: “The four principles impose a sort of straitjacket on thinking about ethical issues and encourage a one-dimensional approach and the belief that this approach is all that ethical thinking requires.”<sup>20</sup> Harris’s concerns are reflected in the Tribunal decision. If all that is required to be said is that this action is prohibited because it is maleficent or unjust then the argument risks being fatuous. Simple answers about maleficence or harm may mask other deeper questions about degree of harm, harm to individual or others, pre-existing conditions causing harm or a calculation of risk of harm versus benefit. Considerations need also to be run in tandem, discussing justice, beneficence and autonomy. Consideration of one or two principles before pronouncing that the behaviour is bad, harmful for the patient, not good for the patient, or does not respect their autonomy, may justify a disciplinary action but it does not deliver an explanation and risks an easy guilty verdict without consideration of opposing moral views.

### Discussion

One judgement from the Courts (regarding Dr G) was available for analysis and demonstrated the heavy reliance of the HPDT on the four principles in mount-

ing a case against Dr G's behaviour. The Judge expressed frustration with the lack of reasoning for the Tribunal's decision against Dr G. The second case also relied upon the four principles and the majority of the Tribunal's decision was overruled in the District Court. In both cases it was decided by the Tribunal that the doctors had caused harm to the patient. It is not questioned that from the patient's perspective they were harmed in some way and that this could justify the decision that the doctor's behaviour is maleficent. One Judge suggested that the behaviour may be "shabby if not immoral conduct" but that is not enough to impose disciplinary proceedings against a doctor. Had the Tribunal in both cases given reasoned decisions with explanations as to why they were imposing moral standards rather than purely just-

tifying the imposition of a disciplinary measure, their conclusions might have been safer. The moral behaviour of the doctors in these two cases emphasises the often difficult consideration of role-related obligations, e.g. to the patient versus third party or employer/employee. When two professional roles are operating, it is important to give clear reasons in the argument that imposes disciplinary action. The four principles may have a place in disciplinary procedures but no reasons are good for no-one.

#### References

1. Medical Council of New Zealand. Coles Medical Practice in New Zealand. 10th ed. [cited 2011 March 10]. Available from: [http://www.mcnz.org.nz/portals/0/publications/coles/coles\\_medical\\_2011%20-%20george.pdf](http://www.mcnz.org.nz/portals/0/publications/coles/coles_medical_2011%20-%20george.pdf).
2. Hart HLA. The concept of law. Oxford: Oxford University Press;1997.
3. Lowns v Woods [1996] Aust Torts Reports 81-376.
4. Brownie Wills v Shrimpton [1998] 2 NZLR 320.
5. Dr S v MPDT 309/03/115C.
6. CAC v Dr S 306/03/115C.
7. Doctor T v CAC DC Wellington CIV-2005-085-355, 6 October 2008.
8. St George IM. Issues with medical certificates. NZ Fam Physician. 2004;31(3):184.
9. Tevethick v The Ministry of Health HC Wellington CIV-2007-485-2449, 1 April 2008.
10. Coote B. Assumption of responsibility and pure economic loss in New Zealand. NZ Law Review; 2005;1.
11. MPDT v Dr Singh 50/98/28C.
12. RACP, Australasian Faculty of Occupational and Environmental Medicine. Realising the Health Benefits of Work. Position Statement: Sydney; April 2010.
13. Case 07HDC11761.
14. DP v Dr N HPDT 202/Med08/100D.
15. Dr G v DP Auckland CIV-2009-404-000951, 13 October 2009.
16. Dr G v DP Auckland CIV-2009-404-000951, 5 March 2010.
17. Beauchamp T. Kennedy Institute Ethics J. 1995;5(3):181-198.
18. Campbell AV. The virtues (and vices) of the four principles. J Med Ethics. 2003;29:292-296.
19. Cowley C. The dangers of medical ethics. J Med Ethics. 2005;31:739-742.
20. Harris J. In praise of unprincipled ethics. J Med Ethics. 2003;29:303-306.

## LETTERS TO THE EDITOR

### The frail elderly and their bitter pills

I read with interest in your December issue the *Back to Back* on treating the elderly with statins. In the same journal I was also stimulated by Bruce Arroll's book review of *A Bitter Pill: How the Medical System is Failing the Elderly* by John Sloan and have purchased a copy. Bruce says this should be compulsory reading for all GPs and I can only agree. Dr Sloan is a Canadian family physician who specialises in care of the frail elderly and his observations resonate with all of us who see in our daily practice the dangers, risks and futility of much preventive treatment in this group. The book points out that there is NO scientific basis for the vast majority of prevention that is advocated for the frail elderly, and gives a persuasive and logical argument for offering withdrawal of much of it.

Can I suggest that Bruce shares this book with his colleagues who seem so eager to recommend yet more medications for the elderly. Although Sue Wells's advice on prevention seems reasonable in theory, the net effect is often frail elderly patients on 20-30 medications, sometimes losing weight because after taking their pills there is literally no room in their stomach for food! The standard fare for frail elderly unlucky enough to be hospitalised for any reason is to leave on two to three osteoporosis medications, statins, oral hypoglycaemics, aspirin, several antihypertensives and of course omeprazole. I am sure a good case can be made for each of these drugs in a younger person—the cumulative result in the elderly is usually a disaster.

Paul Corwin

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