Doctor Does Not Know Best: Why in the New Century Physicians Must Stop Trying to Benefit Patients

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ABSTRACT

While twentieth-century medical ethics has focused on the duty of physicians to benefit their patients, the next century will see that duty challenged in three ways. First, we will increasingly recognize that it is unrealistic to expect physicians to be able to determine what will benefit their patients. Either they limit their attention to medical well-being when total well-being is the proper end of the patient or they strive for total well-being, which takes them beyond their expertise. Even within the medical sphere, they have no basis for choosing among the proper medical goals for medicine. Also, there are many plausible strategies for relating predicted benefits to harms, and physicians cannot be expert in picking among these strategies.

Second, increasingly plausible ethical systems recognize that in some cases, patient benefit must be sacrificed to protect patient rights including the right to the truth, to have promises kept, to have autonomy respected, and to not be killed.

Third, ethics of the next century will increasingly recognize that some patient benefits must be sacrificed to fulfill duties to others – either the duty to serve the interests of others or other duties such as keeping promises, telling the truth, and, particularly, promoting justice.

Physicians in the twenty-first century will be seen as having a new, more limited duty to assist the patient in pursuing the patient’s understanding of the patient’s interest within the constraints of deontological ethical principles and externally imposed duties to promote justice. The result will be a duty to be loyal to the consumer of health care with the recognition that often this will mean that the physician is not permitted to pursue the physician’s understanding of the patient’s well-being.

Key words: benefits and harms, deontological ethics, Hippocratic ethics, justice, medical well-being, societal interests, total well-being

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I. INTRODUCTION

The essence of traditional medical ethics can be summed up with the slogan, “The physician should always do what is best for the patient” or, put in the vernacular, “Doctor knows best.” That is the core of the Hippocratic Oath in which the physician pledges to work “for the benefit the sick according to my ability and judgment” (Edelstein, 1967, p. 6). It was reflected in the AMA’s Principles at the beginning of the twentieth century in the injunction that “Physicians should not only be ever ready to obey the calls of the sick and the injured, but should be mindful of the high character of their mission and of the responsibilities they must incur in the discharge of momentous duties” (AMA, 1903, p. 241).

Medical ethics entered the twentieth century with this patient-benefiting focus pretty much intact. It enters the next with the Hippocratic slogan in shambles. By the end of the next century, I expect the Hippocratic ethic will be relegated to the ash heap of history – a benevolently paternalistic morality that may have worked for a culture in which patients were patient – when they were (as the word patient implies) passive, long-suffering, ignorant, and believed to be incapable of making choices.

In spite of the uniformity of commitment to this platitude, it is becoming increasingly clear that no one really believes literally that the physician should always act so as to do everything that will benefit his or her patient. Or at least no one would believe this if they really understood the implications. (For example, quite a number of patients would have their interests served best if their personal physician stayed with them in their homes twenty-four hours a day, yet no one ever advocates that they do so.) No one who understands all that would be necessary to know what is best for a patient – knowledge of the patient’s beliefs, values, preferences, cultural commitments, and idiosyncratic inclinations – believes that the physician can even know what is best for the patient. The time has come to debunk the platitude, slaughter the slogan. That debunking I expect to be the story of medical ethics over the next century. There are three ways in which I expect the Hippocratic ethic to be challenged in the next century’s medical ethics. (1) We will learn that physicians cannot be expected to know what will benefit their patients; (2) we will learn that there are moral situations in which, even if the physician knows what will benefit, he or she will be constrained from benefitting in order to fulfill some fundamental moral duties; and (3) there will be times when benefitting the patient so jeopardizes the interests or the rights of third parties that the physician will be morally (and legally) constrained from providing the benefit. After examining each of these three ways that physicians
will be forced to abandon their traditional Hippocratic commitment to benefit patients, I shall suggest a limited, more realistic way in which physicians in the next century will be able to continue their commitment to patient well-being by serving as their advocates or assistants in the medical realm.

II. PHYSICIANS CANNOT BE EXPECTED TO KNOW WHAT WILL BENEFIT A PATIENT

The first problem that we discovered with the Hippocratic patient-benefitting ethic in the twentieth century is that it is very hard – indeed usually impossible – for physicians to know what actions on their part will truly benefit their patients. We began the century (and many people have ended it) still believing that “doctor knows best,” that is, that somehow a physician could be expected – at least in the ideal case – to be able to know what actions would be beneficial to patients. In the old Hippocratic cult, knowledge was considered esoteric, potent, and dangerous in the hands of the uninitiated. Moreover, given that it was a homogeneous culture, there was little disagreement about what would count as a beneficial outcome. All that was needed was for the all-knowing initiate into Hippocratic wisdom to decide what would be beneficial based on his judgment (we were dealing exclusively with male practitioners) and then prescribe. In the last third of the twentieth century, however, that view has collapsed. We now know that even in the ideal case physicians generally have no basis for knowing what would benefit their patients. Even if they can accurately diagnose disease and prognosticate its future course under various treatment options, they still cannot be expected to have any basis for knowing that one outcome is better than another for the patient who presents the medical problem to them. There are at least three problems:

A. Why Physicians Cannot Know Patients’ Best Interests: Total Well-Being Vs. Medical Well-Being

The first is that during this period we gained a much greater insight into the complex relation between medical goods and other goods legitimately on a patient’s agenda. In contrast with early Hippocratic or early Judeo-Christian times, we now have a considerable division of labor in the area of the good. In early times, there were no sharp differentiations between the medical sphere and other goods such as the psychological, the economic, the spiritual, the aesthetic, the legal, the familial, or the social. The same all-purpose wise man might appropriately give advice in any of these
areas. Disease was seen as punishment from God for wrongful behavior. Medical matters were integrated with the other spheres.

By the end of the twentieth century we still have not completely sorted out these relationships. For example, there remains considerable confusion over the links between the organic and the psychological. We still do not know whether schizophrenia is dependent on some genetic, organic cause or on psychological and familial interactions. Undoubtedly, both play some role. We still do not know whether alcoholism is caused by some neuro-genetic factor or by weakness of the will. Undoubtedly, both. Likewise, we have only partially differentiated the spiritual from the psychological, the aesthetic from the moral, or the familial from the legal.

It is increasingly clear, however, that there is a huge difference between being medically well-off and being well-off considering all spheres in life. If the physician’s task is to focus on maximizing the patient’s medical well-being, he or she must realize that rational patients usually do not want their medical well-being literally maximized (at least if that comes at the price of sacrificing goods in other spheres of life). We constantly trade off goods in one sphere for another. We attend art shows rather than exercise class, eat steak rather than granola – at least on occasion. If the physician’s task is to focus on maximizing the medical well-being of the patient, then wise patients will recognize that they want merely very good health, not maximum medical well-being.

This poses an enormous problem for the medical professional role. On the one hand, if the physician is to strive to maximize patient medical well-being, that will not be the same as maximizing patient total well-being. There is absolutely no reason to assume that the physician is skilled in making the value trade-offs between the medical and other spheres. In fact, we can predict that physicians (like experts in any other sub-sphere of well-being) will be biased in their recommendations. Just as lawyers want us to be unrealistically cautious in protecting our legal well-being, accountants want us to keep unrealistically good financial records, dentists want us to brush unrealistically often, and priests want us to attend religious services at unrealistic rates, so we can expect that physicians will want us to expend more of our limited resources of time, energy, and money on the medical sphere than makes sense when one takes into account the impacts on other spheres of life (and, therefore, on total well-being). They will not be able, other than accidentally, to figure out what is truly beneficial if they concentrate exclusively on the medical.

On the other hand, if they shift to a World Health Organization view of treating health as total well-being, then physicians become imperialistic. They take responsibility for all of life, carrying them well beyond their
expertise. They really are not equipped to promote our spiritual, legal, aesthetic, financial, or mental well-being. Either way – whether they view their responsibility as limited to the narrowly medical or expand their sphere to total well-being – they can be expected to fail at guessing what the proper mix between the medical and other spheres ought to be for a particular patient. In the next century this division of labor among the spheres of the good will become more important and also more complex. As expertise in various areas becomes more complex, experts will become more specialized and their knowledge of the other spheres will be correspondingly less. Moreover, as cultures get more and more pluralistic, we can expect people to support widely varying trade-offs among the different spheres of the good and individual physicians to be less likely to understand the value mix of any one of their patients. There is no reason why physicians should to be able to know how to balance the medical and the other spheres.

B. Why Physicians Cannot Be Expected to Know What Is Medically Beneficial

Even with the medical sphere the problem will be more acute in the next century. By the mid-twentieth century, the typical physician had a rather simplistic view about the nature of the medical good for his (or occasionally her) patients. The medical good was increasingly equated with preserving life. We had discovered antibiotics, we were aggressively pursuing polio, and we were still focused on acute illness that threatened life. The goal was to preserve life as long as possible. With the invention of the respirator soon after the middle of the century, physicians naturally were inclined to use it to preserve life whenever they could. Patients, however, had a much more complex view about the medical good (as did physicians of earlier centuries). They sometimes were committed to preserving life, but also desired cure of disease, relief of suffering, and, increasingly, promotion of continued good health.

Once the univocal goal of preserving life was challenged in cases such as that of Karen Quinlan, lay people realized that even within the medical sphere, there were many disparate goals that one could choose to pursue. Moreover, there was often conflict among them and there was no definitive method for balancing among these competing claims when they came into conflict. Relief of suffering might come at the expense of preserving life; preserving health might come at the expense of increasing risks for certain pain and suffering.

Once again, however, we discovered that there was no reason to assume that one’s physician had a special expertise in balancing among these
competing claims – even within the medical sphere. Being an expert in medicine does not imply one is an expert in the way the patient should trade off one medical good against another. In fact, as we have seen before, there may be reasons to fear that physicians tend to make these medical value trade-offs atypically. Since physicians were at one point uniquely committed to preserving life and there is evidence both that many people went into medicine to fight death (Feifel, 1960) and that physicians were further socialized into the death-fighting perspective once they were in the profession, physicians, when thinking about how to balance competing medical benefits for their patients, can predictably be seen as making the trade-off in ways that patients would not choose. Physicians cannot be expected to be able to know how to balance the competing goods even within the medical sphere.

C. Why Physicians Cannot Be Expected to Know How to Balance Benefits and Harms

The problems for physicians who strive, according to their ability and judgment, to do what will benefit the patient and protect the patient from harm are becoming even greater. Assuming for purposes of discussion that the physician could determine what action among plausible courses would maximize the medical benefit for the patient, by the end of the twentieth century enormous theoretical problems would remain. Even before we ask whether it would be moral or legal to provide this benefit for the patient, we need to understand that the physician faces a serious problem in reconciling the Hippocratic mandate to benefit the patient with the equally Hippocratic mandate to protect the patient from harm.

Many analysts have, until now, overlooked the fact that almost any medical procedure will involve a mixture of potential benefits and potential harms. Almost any procedure or therapeutic agent has potential side effects. Even determining that an effect is a “side” effect rather than a “benefit” involves value judgments that are complex. Prevention of pregnancy by the use of estrogen/progesterone combinations may be a tragic side effect for the Catholic woman who needs these drugs to regulate her menstrual cycle, but a cherished benefit for the woman who is trying to contracept. Preserving life with penicillin is wonderful for someone who wants to live but a tragic consequence for someone with advanced metastatic cancer who wants desperately to die.

Even bracketing the obvious fact that physicians have no expertise at determining whether an effect is a benefit or a harm (much less how much of a benefit or a harm it is), physicians face the even more complex task of having to reconcile the benefits and the harms expected from each poten-
tial treatment course. There are many theories about how to integrate expectations of benefit and expectations of harm into a single decision. Classical Benthamite utilitarians would attempt to quantify the benefits and quantify the harms and then subtract the latter from the former to arrive at an estimate of net good. This, however, is not the only approach or even necessarily the most plausible.

Other utilitarians would examine the ratio of benefits to harms and opt for maximizing the size of the resulting number. This geometric combining can, on occasion, be very different from combining the two arithmetically. Different physicians might be inclined toward one or the other approach, yet neither is obviously correct. The physician who takes on the task of deciding what will serve the best interest of the patient must consider himself or herself authoritative in deciding which method of comparing benefits and harms is appropriate.

The options are even more complex. Historically, some physicians entered the twentieth century with a corrupt variation on the Hippocratic slogan. They converted “benefit and protect the patient from harm” to “primum non nocere” or “first of all, do no harm.” Although many physicians assume this traces back to Hippocrates, it is nothing Hippocrates ever said. (That it is in Latin rather than Greek is a warning signal.) Several of us have tried to trace this slogan’s origin (Sandulescu, 1965; Jonsen, 1977; Veatch, 1981, p. 161). None of us can trace it back to either Greek or Latin medicine. I think it dates from the mid-nineteenth century when physicians were particularly worried about the great harm that their colleagues had caused by the use of blood letting, mercury, and other toxic treatments.

One interpretation is that doing no harm should come first in the sense that the physician should make sure he or she will do no harm before moving on to strive to do good for the patient. This, of course, if taken literally would have terribly conservative implications. The best way to conform would be to never do anything at all for patients. One would thereby never harm the patient (although obviously great opportunities to do good would be lost).

For our purposes we need to recognize that some philosophers (Ross, 1930) as well as some physicians have given the duty to avoid harming (nonmaleficence) precedence over the duty to benefit (beneficence). This might come as a kind of special consideration given to nonmaleficence, such as giving it double or triple weight when comparing harms and benefits or might even come as an absolutely priority over beneficence – although this latter view is terribly implausible. The point is that a physician trying to follow the Hippocratic mandate has to know how to compare
benefits and harms and there is no obvious way to proceed. Even if the physician can figure out how to relate medical benefits to overall benefits and can figure out how to relate various medical benefits to each other, there is still no reason to expect he or she will be able to know how to compare benefits and harms. The physician can not be expected to be able to figure out correctly how to benefit the patient and protect the patient from harm. Medical ethics of the twenty-first century will have to acknowledge that this is a task beyond the ability of even the wisest, most dedicated physician. Perhaps we will opt for the pluralistic view that equates the good with preference theory or desire fulfilment theory of the good (Parfit, 1984, pp. 493-94). In that case it is hard to see why the physician’s preferences or desires rather than the patient’s should prevail. Or, more plausibly, we may accept some version of an “objective list” theory of the good (Parfit, 1984, p. 499). This view holds that there are some objective goods independent of preferences or desires. Even if there are objective goods and bads, however, there is absolutely no reason to believe that individual physicians have the skill for knowing what those are. There is, in fact, not even any reason for believing that the consensus of physicians would be accurate in predicting what would be best for a particular patient (Veatch, 1991). The conclusion is inescapable. Physicians can not be expected to be able to predict what will benefit patients and protect them from harm. At best they can guess. They cannot be expected to guess correctly beyond what any ordinary citizen could do who has knowledge of the medical facts, but lacks expertise in the nonmedical facts as well as expertise in knowing the nonmedical values, the proper mix of medical values, and the proper way to compare benefits and harms. The only way physicians in the future will be able to approximate knowledge of what serves their patients’ interests is to ask them. It is not that patients will always be correct in their assessment of what is in their interests. But, if they are educated with the assistance of physicians and others, and gradually become comfortable telling physicians what their interests are, eventually the patients themselves are likely to be the most reliable source physicians have of knowing their patients’ interests.

III. SACRIFICING PATIENT BENEFIT TO PROTECT PATIENT RIGHTS

The insurmountable problem that physicians have in predicting what will benefit their patients is only the first challenge to the Hippocratic ethic that will cause it to be abandoned during the next century. There are two
other problems that are even more serious. The next we should consider is
the problem of deciding whether a physician who somehow knows what
will maximize benefit to his or her patient should be permitted – legally or
ethically – to pursue that benefit. Beginning about 1970 we have seen that
there are many interesting cases in which we conclude that physicians
should refrain from benefitting their patients even if they correctly guess
at what would be beneficial.

In terms of ethical theory, the Hippocratic patient-benefitting theory
is consequentialistic. It strives to produce benefits (and avoid harms). Yet
the history of medical ethics of the past thirty years has been the
history of the reintegration of nonconsequentialist ethical perspectives
into medical ethics. Although the Hippocratic ethic has always been con-
sequentialistic, many other general ethical theories have treated certain
right-making characteristics of actions other than consequences to be mor-
ally relevant.

For example, virtually all religious traditions accept nonconsequential-
ist dimensions in their ethics. Talmudic ethics is based on certain religious
laws, including medical prohibitions related to autopsy and prolongation
of life, that are not directly based on good consequences (Rosner and
Bleich, 1979). Likewise, while Catholic natural law theory incorporates
beliefs about the telos or natural ends of human beings, it is not narrowly
consequentialistic (Ashley and O'Rourke, 1989). Protestant ethics is usu-
ally grounded in a contract or covenant theory appealing to fidelity to
promises rather than mere consequences (May, 1975). Eastern religious
traditions also incorporate nonconsequentialistic elements such as prohi-
bitions on killing (of nonhuman animals as well as humans) and injunc-
tions to truthfulness.

Also, all fashionable secular ethical systems of the twentieth century go
beyond benefits and harms to individual patients. Classical utilitarianism
requires consideration of consequences to third parties and most other
ethics incorporate notions of rights and duties not based on consequences
at all. Kantian ethics, for example, is deontological, i.e., based on duty, not
consequences. Liberal political philosophy produces an ethics of rights
that acknowledges certain duties to request autonomy and promote justice.
Marxism and libertarianism both abandon traditional consequentialist ap-
proaches, as does feminist ethics. The one common feature is that no
plausible ethical system limits the morally right to consequences to a
single party such as a patient. Most incorporate notions of rights and/or
duties that make the ethic decidedly nonconsequentialist. The result is that
these ethics, whatever their differences, can all agree that the Hippocratic
commitment to benefits and harms to the patient is indefensible. After
looking at certain deontological limits to benefitting patients, in the next section, I look at appeals to social consequences as well as social obligations.

A. The Duty to Tell the Truth
Imagine a patient seeing a physician for a diagnosis of a mysterious disease, which the clinician has found to be cancer. For many millennia of paternalistic medicine, the moral wisdom of the professional Hippocratic physician ethics commanded the physician to assess whether disclosure would benefit or hurt the patient. If the disclosure were helpful, the patient was to be told, but if it were deemed hurtful, it was the clinician’s benevolent duty to withhold – to use euphemisms, jargon, or just plain lie. In such circumstances, the consequence-driven ethic of Hippocratism instructs the physician to beneficence – to use his or her judgment to protect the patient from the bad news, even though it may mean that the patient cannot plan for his own future, consent to medical treatment, or live his remaining life according to an autonomously chosen life plan. The 1903 version of the AMA Principles of Medical Ethics was fully committed to this approach even at the price of serious breaches of confidentiality. That code says:

Ordinarily, the physician should not be forward to make gloomy prognostications, but should not fail, on proper occasions, to give timely notice of dangerous manifestations to the friends of the patient; even to the patient, if absolutely necessary. This notice, however, is at times so peculiarly alarming when given by the physician, that its deliverance may often be preferably assigned to another person of good judgment (AMA, 1903, p. 242).

The 1903 text goes on to entreat that the “solemn duty is to avoid all utterances and actions having a tendency to discourage and depress the patient” (AMA, 1903, p. 243). The guiding Hippocratic notion was what the law called “therapeutic privilege,” the doctrine that a physician had the privilege (indeed the duty) of avoiding disclosure when telling the truth would discourage or depress the patient, actually even if this were only the “tendency.”

By 1980 the AMA had confronted the Kantian imperative regarding truthfulness. The latitudinarian tolerance of dishonesty was replaced in the 1980 code rewrite with a provision requiring that the physician, without qualification, “deal honestly with patients and colleagues” (American Medical Association, 1998, p. xiv). Nevertheless, that the complete conversion of the AMA to this policy of honesty is a twenty-first century
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project is revealed by the AMA’s Council on Ethical and Judicial Affairs when it puts its own paternalistic spin on this exceptionless pledge of honesty. It retreats on this commitment by saying in a 1981 interpretation that disclosure need not be made when:

risk-disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated (AMA, 1998, p. 135).

That exception, of course, is a direct contradiction of the obvious deontological commitment of the AMA’s principles themselves as well as the moral legal requirements of duty-based systems or systems grounded in the rights of patients that are independent of consequences. Clearly, the implications of this deontological commitment remain to be addressed in the next century.

We now realize that, in such cases, it is not so obvious that physicians should try to benefit the patient and protect the patient from harm. Some would say that the truthful disclosure should be told because we now know that physicians are not very good at figuring out when a diagnosis will hurt a patient and when it will help. But more fundamentally, many believe with Immanuel Kant that it is not right to lie just because one has a benevolent motive (Kant, 1797). They believe the patient has the right to the diagnosis, to form a realistic basis for consenting to future treatment and to plan one’s future life.

One of the great contributions to ethics in the twentieth century is a book by the British philosopher, W. D. Ross (1930), entitled The Right and the Good. Its thesis is that there is a crucial difference between behaviors that produce good consequences and those that are morally right. Many people hold there are certain behaviors that are simply morally right or wrong. They are right or wrong not because of their consequences, but because of their inherent characteristics. There is a formal structure to human conduct that can tend to make actions right or wrong regardless of the outcome or the mental and physical consequences for the patient. One of the characteristics of actions that some people believe makes them wrong regardless of the consequences is that they contain intentional misinformation. This, of course, does not imply that all dishonest communication is always morally wrong on balance, but it does mean that some behaviors may be immoral even if, hypothetically, they would produce good consequences.

B. The Duty to Keep Promises

1. Confidentiality. A similar claim can be made in the area of confidentiality. Imagine a physician who comes to believe that the best way he can
help his patient is to disclose confidential information. This is not entirely theoretical. One of the most important cases in the history of medical ethics cases involved a physician who believed that he could benefit his sixteen-year-old patient by disclosing to her parents that she was using birth control pills (“General Medical Council,” 1971). He defended his disclosure by citing the Hippocratic Oath, the British Medical Association Code of Ethics, and the Principles of the AMA, all of which conveyed that it was appropriate to break confidentiality when it was believed to benefit the patient. As a result of that case, medical ethics changed, recognizing that it may still be wrong to break confidence even if it will benefit the patient to do so.

2. Promise-Keeping. Similarly, many believe that there is a moral duty to keep other promises besides the promise of confidentiality – regardless of the consequences. For example, when a physician promises to stand with a patient during a critical medical crisis, then, even if the physician comes to believe that he could do more good – perhaps even more good for the patient – if he transferred responsibility to another care giver, the physician might be obligated to stand by the patient. Of course, if the patient consents to the changing or abandoning of the promise, the physician is released, but, barring such factors, the mere fact that one could do more good for the patient by breaking a promise does not automatically exonerate the one who breaks the promise. Once again, there are times when it is morally wrong to do what will benefit the patient.

C. The Duty to Respect Autonomy
Even in cases in which there are no violations of perceived moral duties, some patients may decline certain benefits that have been offered them. Consider a terminally ill cancer patient who is told that a long and expensive course of chemotherapy has a modest chance of benefit. This treatment would involve considerable burdens on family members. Some people may conclude that it is indeed in their interests to receive the therapy, but nevertheless they do not choose to accept the offer because it conflicts with the interests of certain other family members (by consuming resources or imposing care-giving burdens). If a patient decides to reject a proposed benefit in order to advance the interests of loved ones, it is not at all obvious that the oncologist should benefit this patient. Treating in the face of a refusal of treatment is not only a violation of patient autonomy; it is also a violation of the reasonable ethic of permitting people to make self-sacrifice in order to express their loyalty to the familial community of which they are members.
Respect for persons’ autonomy is perhaps the most well-rehearsed discussion of the way in which late-twentieth century medical ethics departs from the earlier paternalistic Hippocratism. We have become accustomed to permitting people to make foolish choices that conflict with their own interests as well as the interests of others. Yet what has just been said is premised on the assumption that the patient and physician correctly understand what is really in the patient’s interest. First, we found that many people believe that patients should not be benefited when doing so will violate some basic moral duties. Second, many people find it reasonable that a patient may waive actions in his or her interest in order to benefit loved ones. But what of cases in which the patient, perhaps through confusion or error, chooses to decline a beneficial treatment for other reasons beyond these? Many who defend patient autonomy to refuse consent to treatment do so because they believe that the patient may know his own interests better than the physician. We have seen in the first portion of this paper how hard it is for the physician to claim that he or she knows the patient’s interests better than the patient does.

But that is not always the case. There surely are situations in which the physician really does know best. If those situations, no matter how rare, can be identified, then the ethic of doing what is best for the patient would not only permit, but actually require that the physician act on his or her judgment. Even in these cases, however, many believe that the patient has the right to act autonomously to refuse the offer of treatment. If that is true, it would be morally wrong for the physician to benefit the patient in these cases. The duty to respect autonomy has its real bite when there is good reason to believe that the patient really can be helped by violating his or her autonomy. Those committed to autonomy including anyone standing in the tradition of liberal political philosophy will insist that the physician has a duty not to benefit the patient in these cases.

**D. The Duty to Avoid Killing**

The most dramatic example of a case in which many believe that one should not automatically do what will benefit the patient is the current controversy over the active killing of patients for mercy and physician-assisted suicide. Here is a puzzle: if the Hippocratic Oath requires the physician to act so as to benefit the patient, why should the physician not act to put a patient out of her misery if there is no other way to relieve severe, intractable suffering?

One interpretation of Hippocratic ethics is that patient-benefit ethics does indeed lead to the conclusion that in these cases, the duty of the physician is to relieve the suffering by killing or helping the patient kill
herself (Kevorkian, 1991; Quill, 1993). Others follow another provision in the Oath that prohibits physician participation in active killing even if it would produce a net improvement in the patient’s well-being. It is very widely held that there is simply something wrong with intentional killing of humans. Catholics, Jews, Hindus, Buddhists, and Muslims, as well as the mainstream of secular liberal political philosophy, have traditionally believed that active mercy killing is morally wrong, regardless of the possibility of good consequences.

Once again, as with the duties related to veracity, fidelity to promises, and respect for autonomy, many ethical theories simply hold that there is something morally wrong about killing a human being (at least an innocent human being) even if the person killed is better off than had the killing not taken place and even if the individual explicitly and repeatedly asks to be killed. These are four examples of situations in which many believe it would be wrong for a physician to do what would benefit the patient even if the physician could successfully identify what would benefit the patient – a task we have argued physicians are not in a position to complete in most cases. Thus the second reason why physicians of the twenty-first century must stop trying to benefit patients is that virtually every moral system that is at all plausible incorporates some standards whereby it would be considered unethical to act so as to benefit the patient.

IV. SACRIFICING PATIENT BENEFIT TO PROTECT SOCIETAL INTERESTS AND FULFILL DUTIES TO OTHERS

This brings us to the third and final reason why physicians in the twenty-first century will have to develop an ethic that recognizes that they must stop trying to benefit patients. Almost every plausible ethical system other than the Hippocratic acknowledges that there exist legitimate societal interests that impinge on the patient-physician relationship or that the physician has certain duties to others that may take precedence over his or her duty to benefit the patient.

A. Sacrificing Patient Benefit to Serve the Interests of Others in Society

We have already seen that classical social utilitarianism is based on the moral principle that that action (or system of actions) is morally correct that produces as much or more net good consequences as any other possible one taking into account the interests of all parties potentially affected. If the deontological ethics of respect for autonomy was the challenge to
Hippocratic ethics of the late twentieth century, then the social ethics requiring consideration of the interests and/or rights of other parties will surely be the challenge of the twenty-first century. We are moving into a period when virtually everyone who is thoughtful will eventually recognize that an ethic that permitted each physician to do whatever would serve the best interest of his or her patient (even taking into account the condition that autonomy and other rights be respected) would be a grossly irresponsible ethic. It would not only permit, but would require lying, cheating, and stealing from the health insurance system in order to serve the patient. It would require that physicians use scarce medical resources for the benefit of their own patients even if the benefit to them was infinitesimally small and the cost to others was tremendous. The Hippocratic ethic, taken literally, would require the physician to do whatever he or she could to bring any possible benefit to the patient, no matter how small the benefit.

The Hippocratic ethic is an utterly individualistic ethic. It is as if there were only one patient in the world and one physician, and the physician’s task was to maximize the interests of the patient. But in the real world, there are other patients. There are also nonpatients who have interests, some of which may be legitimate. The final challenge to the medical ethics of the twenty-first century is to develop a social ethic for medicine that ameliorates the hyper-individualism of the Hippocratic tradition without sacrificing the individual patient capriciously to the vicissitudes of social utility.

B. Fulfilling Duties to Others

Working out that responsible social ethic for medicine will be one of the great projects of the new century. It cannot possibly be resolved here. Nevertheless, I think we already have a hint of how that resolution will occur.

We note that at the level of individual ethics we overcame the consequentialism of the Hippocratic tradition by appealing to certain duties or rights that provided limited justifications for abandoning patient benefit. I suggest that the same strategy will lead to the resolution of the conflict between the interests of the individual and the interests of society. We may find that the conflict is resolved by recognizing that certain claims of others in society against the rights and interests of the individual patients are legitimate while others are not. I suggest that the legitimating feature will be found in other ethical principles not grounded in consequence maximizing, principles such as promise keeping, honesty, and, most importantly, justice.
1. Duties of Promise Keeping. Promise keeping is suggested first because the structure of the moral analysis is relatively simple although it is unlikely to occur often in practice. The idea is quite simply that if a physician realizes that he has a duty to benefit her patient that conflicts with the interests of a third party, one justifying reason for abandoning the patient is that a legitimate promise has been made to some third party to behave in a contrary manner. (A legitimate promise is one, for these purposes, that both the patient and the physician have been a party to.) Consider, for example, if a patient is in a relation with a physician in which both parties agree that it is in the interests of the patient to get a kidney transplant. Now let us suppose that this physician comes to know that a cadaver kidney is likely to become available that would benefit this patient. The physician may also know that he could plant the idea in the minds of the family of the person who is the potential source of the kidney that they could donate the kidney directly to the physician for him to use for his needy patient, thereby by-passing the standard organ allocation system. Such directed donations are legal. Planting this idea would certainly be required if the physician’s only duty were to serve his own patient’s interests. (Assume for purposes of discussion that this physician has presently only one needy patient for whom this organ would be appropriate.)

If this physician and patient have both agreed to be part of the national organ procurement and allocation system and have promised to play by the national allocation rules, then the promise (of which both physician and patient were parties) can potentially supercede any duty of the physician to serve his patient’s interest, thereby legitimating the sacrificing of his patient to the standard national allocation protocol. The physician is subordinating his patient to the social system, but not merely because it maximizes social utility. Rather, it is because the deontological principle of fidelity to promises requires that he do so.

2. Duties of Honesty. Second, consider the classic cases of gaming the insurance system in order to benefit the patient (Novack, *et al.*, 1989; Morreim, 1991). Suppose that a physician realizes that her patient needs a medical procedure which she cannot afford and that the insurance company will not cover if it is described honestly, but would cover if a deceptive, equivocal diagnosis were given. (For example, the insurer might not cover a routine pap smear for a nervous, cancer-phobic 45-year-old, but would cover it if the physician describes it as a test to “rule out cancer.”) It seems it is in the patient’s interest for the physician to be deceptive, but contrary to the interests of the insurance company and the other subscribers for her to do so. The Hippocratic ethic would appear to require lying or deceiving
here, but the physician might decide it is morally appropriate to refrain from deceiving without adopting a purely social utilitarian ethic, merely by acknowledging the moral principle of veracity—that it is morally required that she act truthfully. In this case, as in the transplant example, the physician may decide to sacrifice her patient and promote the social interest without adopting social utility as the basis. Fidelity to promises and veracity open the door to very limited patient sacrifice without opening the flood-gates of social utilitarianism.

3. Duties of Justice. By far the most important way of moving in the direction of a social ethic that will sometimes permit the physician to sacrifice the patient at the margin and lead to serving societal interests without adopting the principle of social utility is to incorporate a principle of justice into one’s medical ethic. A principle of justice would provide a non-consequence-maximizing way of considering some social claims while ruling out others.

Justice is a principle that recognizes the legitimacy of certain patterns of distribution of good other than those that will maximize the net good in aggregate. Depending on the type of pattern one supports, it could lead to distribution based on (as Aristotle puts it) noble birth, free birth, or excellence (Aristotle, 1962, p. 119). In the twentieth century the dominant basis for a non-consequence-maximizing distribution is need. According to this egalitarian notion of justice, distributions are morally just insofar as they arrange resources on the basis of how poorly off people are or on what actions are necessary to make people more equal (Veatch, 1991b).

This suggests a basis upon which future medical ethicists might develop a limited strategy for sacrificing individual patients at the margin. The patient might be seen as having no entitlement to a scarce medical resource when there are others with greater need who also have a need for that resource. Of course, a full theory of health care justice would be exceedingly complex. I have advocated allocating certain high-tech, experimental, life-prolonging technologies on this basis, but a more complete theory must be left to the ethicists of the new century to create. The point is that if it is obvious that the hyper-individualistic Hippocratic ethic is to be replaced with a more social ethic that requires certain compromises with patient interest, then some basis for limiting that social ethic will be needed. I suggest that the key is in limiting the sacrifice of the patient to those cases in which some other non-consequence-maximizing ethical principle provides a justification – whether that principle be fidelity to promises, veracity, or justice. An alternative – which I consider, but reject – would be to balance these non-consequentialist principles against consid-
erations of utility (or use some other method of judging among conflicting appeals). That is the method suggested by W.D. Ross (1930) as well as many contemporary medical ethicists (Beauchamp and Childress, 1994; Brody, 1988), but I find that this approach poses serious risks to well-established rights and leads to conclusions that are contrary to considered moral judgments.

V. THE NEW, LIMITED TWENTY-FIRST-CENTURY ROLE FOR PHYSICIANS AS PATIENT ASSISTANTS

The implications of this three-pronged analysis for why physicians must stop trying to benefit their patients are complex. It would mean, first, that physicians are going to have to realize that, if they want to know their patients’ interests with any reliability, they will have to ask them. It would mean, second, that even once the patient’s interests are known, physicians will have to recognize that there are good moral reasons why, in some cases, they have a moral duty not to pursue the patient’s interests. They may be required by the moral principles of fidelity to promises, autonomy, veracity, and avoidance of killing to back off and intentionally refrain from doing what is not only believed by them to be in the patient’s interest, but actually is in his or her interest. Finally, it will mean that, even when all of the deontological duties are fulfilled, there may be limited times when the physician is obliged to refrain from serving the patient’s interests by duties oriented to others in society. In order to avoid this becoming a repressive, anti-liberal subordination of the patient to the society, it will be better if only certain societal claims are considered legitimate – claims grounded in deontological duties such as promise-keeping, veracity, and justice.

Nevertheless, it may turn out to be a mistake to instruct physicians to abandon their patients and those patients’ interests whenever some other person or people have stronger claims of justice to resources. It is deeply troublesome to contemplate a patient-physician relation in which the physician takes down the Hippocratic Oath and replaces it with a sign saying, “Warning all ye who enter here. I have been asked by society to abandon you at the margin and serve society as its cost-containment agent.” There may be something left of the sacredness of the patient-physician relation that requires continued loyalty of the primary clinician to the patient even in the face of legitimate societal claims of justice for the resources to be used elsewhere.

Here is an alternative that I think may emerge in the next century: physicians could be given a limited exemption from the societal obliga-
tions to promote justice in the allocation of resources. They would be charged with the duty of loyalty to their patients while in the patient-physician relation. They would, thus, pledge to work always for the benefit of the patient within three constraints. The first constraint would be the knowledge that the only way they can reliably know the patient’s interest is to ask the patient. Thus they would not follow the Hippocratic dictum to work for the patient’s interest according to the physician’s “ability and judgment” but rather according to the patient’s ability and judgment.

The second constraint would be that of the deontological principles. They would sometimes be permitted to refrain from serving the patient’s interests in order to avoid breaking promises (including promises of confidentiality), telling lies (including lies about diagnosis and prognosis), violating respect for patient autonomy, or killing (even killing the patient at the patient’s own request).

The third constraint will be the most difficult to articulate. I suggest that the clinician should promise to the patient that he or she will always remain loyal to the patient in informing the patient about treatment options and providing those options chosen by the patient subject to certain limits to prevent the physician from having to violate unjustly his or her own conscience and subject to limits imposed from the health care system in the name of the just claims of others who are in greater need.

Hence, the physician can say to the 45-year-old patient whose interests will be served by the Pap smear, “I promise to advise you about all your options (including the test that is not covered by your insurance policy) and do everything in my power to follow the course you choose. I cannot, however, lie for you to get the test covered. Moreover, even though I will fight for you to get the test at the insurer’s expense, it may be that the insurer has morally just reasons for setting limits that I can do nothing about. I will remain loyal to you as your agent and assistant in procuring what you believe are your medical interests, but, in the end, I may lose.”

This would be a radically different role for the physician than that of one that saw the physician trading off the interests of the patient against those of society (whether the basis of society’s claim is utility or justice). It would mean that the decisions about the just claims of society against the patient’s well-being are adjudicated not by the physician, but by others—presumably a democratic process in which the patient participates. The physician would be totally exempt from any obligation to suggest limits on the patient’s well-being, even at the margin. Instead, the physician would always (within the constraints of the difficulties of determining patient interest and the deontological obligations discussed above)
pursue the patient’s interests, but know that he or she is working in a just
system in which often, at the margin, he or she will lose to other claims
that are more just.

One thing is clear: medical ethics in the next century will be radically
different from the outmoded, anachronistic, paternalistic, individualistic
ethic attributed to Hippocrates. It will acknowledge that physicians nor-

mally cannot be expected to figure out on their own what will benefit their
patients and that often they should not try to provide such benefits even if
they can figure them out. While many people, especially theorists in med-

ical ethics, increasingly have a vague understanding of this insight, almost
no one yet realizes that it means that literally every decision a physician
makes, the pattern of every practice, will have to be altered radically. It
will mean that in every patient/physician encounter it will no longer make
sense for physicians to prescribe, certify “medical necessity,” or even
recommend any treatment, let alone give “orders” or claim they know
what is best for the patient. I see that radical change on the horizon for the
new century.

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