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The Application of the Criteria of the Just War Theories in the Resolution of Medical-Ethical Dilemmas at the Bedside

by

Ms. Anne B. Baker

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In an age of technology gone awry there is a desperate need for moral, philosophical, and ethical reasoning to play "catch-up" in the arena of practical application. This was a problem in 1945 at the dawn of the Nuclear Age and is a problem now in the early childhood years of the medical technological age.

Here, we propose to address the need for a means to make basic ethical decisions as a part of routine medical care. Applied ethics seeks not only to answer the question "what is the just¹ thing to do?" It also directs its effort toward making choices in actual cases. We will introduce a process for decision-making which provides the tools for the practitioner and the patient to use veryday, in every circumstance. The process has to be able to stand the tests of universibilizability, that is it must be useful in all areas of medicine and generalizability, that is it must be applicable to all like situations by all people in the same way. Which ever method of ethical reasoning is used, for instance in an emergency room in Boston must also be usable in a neonatal ward in Houston. The usefulness of the method of ethical reasoning must work regardless of the people, places, or circumstances involved.

In the United States the method must also find acceptance in a pluralistic society. It must be open to all philosophical and religious calculation. We can not impose a singular view on people who would find it repugnant or morally reprehensible. At the same time we must provide a framework in which we ask, "What is the just thing to do?" "The moral challenge of pluralism is the search for a consensus broad enough to provide moral coherence, but narrow enough to protect religious liberty."² There should be no forseen exclusion of people from

any religious or ethnic group in the application of this method of ethical reasoning. For instance, the pacifists of politics would be consistent with the Christian Scientists of medicine.

The purpose of this article is to introduce a formulaic process, framework, algorithm if you will, for making ethical decisions in actual medical cases. The formula has a 1500 year tradition. It has demonstrated a comprehensive inclusion of the ethical considerations presented by the dilemmas at hand. It has also been adaptable enough to stand the tests of time and place. Evidence for the proclivity for comprehensive, adaptable tools for decision-making and subsequent action in medical practice, can be seen in the widespread use of the Glasgow Coma Score in head injury, the Apgar Score for the immediate evaluation of newborns, the ABCs of the basic rescue, and the American Heart Association's algorithms for advanced cardiac life support, to name a few. These allow health care providers to be on common ground with common standards in the field, clinic, or hospital whether they are in Boston or Los Angeles.

At this time, there appears to be no standardization of ethical reasoning routinely used in medicine. Many decisions are made using the processes physicians learned during internships and residencies. In spite of their good intentions, these were not taught by people who were trained primarily in philosophy or ethics. There is an increasing need for a straightforward method for bioethical decision-making. This requires no graphs, no charts, no conversion equations. In a phrase, we need "adaptable simplicity." Terribly complex solutions can't be applied in urgent situations.

One of the pitfalls of the non-standardized method of good intention, is the problem of making medical judgments based on moral sentiment and not on a fixed formulaic process of comprehensive questioning, such as we present here. "As ethicists, we must, in turn, give the highest priority to careful reconsideration of the limits and functions of various modes of moral discourse in different contexts, lest we be left to the capricious whim or definition of 'right' as the will of the strongest."³

In this article we will demonstrate the use of the criteria of the just-war theories, primarily as defined by James Childress.⁴ In his work, Childress bases the historical granting of permission to take up arms, on the conflict between the *prima facie* duty⁵ to do no harm, and the duties to restore peace and to protect the innocent which override it.⁶

It cannot be stressed too often or too strongly that the criteria must be used as a group. Not to consider them as a unit would be tantamount to starting an I.V. and not connecting anything to it, or taking an X-ray without using film, or performing surgery and not closing the incision. There are many things in medicine which must be done completely. This is one of them!

It may at first seem incongruous to even consider the use of the criteria of the just-war theories to make treatment or care decisions in medicine. However, a close look at the development and purpose of these criteria will provide a plausible connection to modern medicine.

In modern medicine we start with the *prima facie* duty to do no harm. As we move from that duty as an idea to the duty as a bedside practice, we equip

ourselves with the stuff of modern medicine. Our modalities of treatment include: testing, such as "lab work" and imaging; treatment with drugs, therapies and surgical intervention; nursing care with human and technical monitoring; and the advanced technologies of modernity: dialysis, artificial ventilation, anesthesia, and feeding tubes, among others.

As we glance through this familiar list we see two things. First, as in war, they all do harm. Harm in the form of pain, restriction, invasion and exposure. We need to remember this. To stick people with needles to obtain blood samples or or to administer therapy hurts! To take an X-ray is to expose the patient to potentially deadly radiation. To make a proper diagnosis or to monitor patients, we frequently obtain information that people would prefer no one know about them, and yet we invade privacy.

Secondly, in both war and medicine we must seek an exemption to our duty to do no harm. For deciding if we can be granted an exemption to the *prima facie* duty to do no harm the criteria of the just-war theories are very helpful. The use of these criteria do not necessarily lead to just one conclusion for a specific treatment plan. Think for a moment of the good people found on both sides of the Gulf War debate or the invasion of Bosnia debate. For this reason, the agent or agents seeking an exemption from doing no harm must strive to develop as virtuous agent in order to reach the most satisfactory decisions possible.

When the Hippocratic Oath was penned it could not have been imagined that serious debate about over-treating would arise and continue for decades. In the United States today health care providers constantly face the task of making decisions about what constitutes the ethical treatment of people entrusted to their care. Never before in medical history have so many been so confused by a myriad of choices set before them by the creators of medical technology.

Every day, every minute, choices for drug therapy alone represent thousands of hours of decision-making effort. As the complexity of patients' medical problems rise, the options for technological interventions rise exponentially. Considering the ethics of the means we use for care, no longer is the simple question of yesterday, i.e. ordinary v. extraordinary means, entirely adequate to resolve bioethical dilemmas. We now must ask: "Which of the extraordinary choices set before me, as a health care provider, should I or may I offer as treatment to the patient at hand?" The questions posed by old means of treatment are complicated by questions of autonomy, cost, futility, experimental treatments and the rapid introduction of new technologies.

The Childress model of the just-war theories uses eight criteria. They are: legitimate authority, just cause, reasonable hope for success, just intention, due proportion, just means, declaration, and last resort.⁷ Arthur Dyck considers these criteria to demonstrate ethical decision-making in the decision to perform an appendectomy. The purpose of, or cause for, the surgery is to prevent the death of the patient. The intention is the well-being of the patient. The operation must be performed on the one who has appendicitis, accurately diagnosed as such. The risk of death from untreated appendicitis is very high. The risk from surgery is small; the chance of success is very high. There is no alternative treatment, given the condition of the appendix of the patient and given existing knowledge.

Informed written consent is obtained within a hospital setting. The operation is performed by a credentialed doctor, experienced as a surgeon, or supervised by one who is.⁸

In this article we will formalize and expand the process. We will set forth an algorithm of eight criteria. All eight criteria must be considered to make the formulaic process viable. In our opinion, all the areas of concern in bioethical decision-making are given consideration. This process differs from other ways to make ethical decisions because it is comprehensive, rather than focusing on just one criterion such as: the benefit/burden proportion, rules, consequences, emotional sentiment or utility as the only consideration.

We recognize that no idea is complete when first thought. We wish to solicit comments and constructive criticism from our colleagues in both medicine and ethics. This will surely lead to improvements not only in the use of this method but, more importantly, it will benefit the patient to whom we dedicate our lives of service and care. Finally, it is our hope that this method of reasoning will be one of the methods used as we move ethical theory into ethical practice.

Now we will discuss the criteria. We will present the historical context first and then demonstrate the appropriate application in bioethics. Finally we will present an actual case in which this formulaic process was used.

Legitimate Authority

Who decides?

The purpose of this first criterion is to identify what party or parties are primarily responsible for making the decision to move forward. It is this party who is "primarily responsible for judging whether the other criteria are met."⁹ Determining right or legitimate authority in civil or political matters, varies with the type of government in power. In general a government which can: maintain order within its state and protect its borders is a legitimate government. In a democracy a very important addition is that the consent of the governed is necessary to legitimate government action and power because "the citizen is ruler as well as subject."¹⁰ In the United States the duly elected Congress represents the will of the people to work in conjunction with the President in the decision to take up arms and go to war.

The legitimate authority not only decides whether or not to intervene but also how to have the combatants conduct themselves during war. During the conflict the individual has a moral right (although not a legal right) not to participate in activities he or she finds morally unjust.¹¹

The legitimate authority in medicine is analogous to the model of the legitimate authority in government. The physician and the patient constitute the legitimate authority in medicine as the duly elected officials and the electorate constitute the legitimate in politics. There are few exceptions to the rule of the patient as autonomous in medicine.¹² Physicians are vested with legitimate authority for a number of reasons. They have been educated in credentialed schools of medicine; had supervised medical experience; received licensure from their government; practice in credentialed facilities; have been accredited and credentialed, in their area of expertise, by various professional medical boards;

and assent to the ancient, sacred physician/patient covenant. Some physicians have been burdened by the full weight of decision-making for some of their patients. Although the physician is the leader of the health care team and has considerable authority for making the diagnosis and for developing the treatment plan, the patient must also take part in the decision-making process. The patient's ability to make an informed decision about which therapeutic course to freely elect to follow, depends greatly on the skill of the physician and the health care team to present accurate diagnoses and treatment options.

Since the dilemma of the case of Karen Ann Quinlan¹³ the government has become increasingly involved in the issue of legitimate authority in medical decision-making. Rare is the week during which there is no report in the secular press of bioethical decision-making reaching the courts. Interestingly, in 1957 Pius XII stated "The rights and duties of the doctor are correlative to those of the patient. The doctor, in fact, has no separate or independent right where the patient is concerned. In general he (sic) can take action only if the patient explicitly or implicitly, directly or indirectly, gives him (sic) permission."¹⁴ However, because the legitimate authority of the physician is correlative to that of the patient, the authority of the physician is strictly bound to his or her own conscience. As a result, if the physician finds the health care wishes or plans of the patient to be medically and/or morally untenable or outside the scope of his or her expertise or the expertise of the facility, the physician may find it necessary to transfer the patient to another service and/or facility. Concomitantly, the patient has this same right.

With the enactment of the Health Care Proxy Law in 1990, the weight of decision-making responsibility has expanded from the patient, when able to speak competently, to the inclusion of proxy declarations of the patient's wishes when incompetence is established.¹⁵ Several legal cases in Massachusetts have been precedent-setting in the area of patient autonomy. Their implications for legitimate authority are useful to remember. The adult patient (and emancipated minor) has the right to refuse medical intervention¹⁶ if he or she is competent, which is presumed¹⁷ unless proven otherwise and it is considered assault¹⁸ to treat him or her without proper informed consent. This is based on the right to privacy against interference with bodily integrity.¹⁹ Exercise of legitimate authority and its expressed need for not only a credentialed and competent care provider, but also for informed consent, is not necessarily an easy task.

The patient in medicine, as the congress and the people in politics, have the obligation to actively engage in the process of informed consent in the face of intervention. It is the duty of the credentialed and experienced physician to make an accurate diagnosis, develop a reasonable care plan and to find the language which will be adequate to allow the patient to make a reasonable decision about care. Informed consent does not necessarily happen all at once. It should start during routine care when the caregiver and the patient engage in conversation about the patient's goals and values for living. The patient cannot be left to his or her own devices in highly stressed situations to sort out dilemmas. Autonomy does not leave the patient in a vacuum.²⁰

Once the legitimate authority criterion is met it will be an ongoing factor in

the decision-making process. It may even occur that the patient and the practitioner need to separate because of irreconcilable differences in the care plan.

Just Cause

For what reason do we seek to intervene? Is it just?

In the political arena we may seek an exemption to the *prima facie* duty to do no harm and to take up arms "if a serious and weighty reason exists"²¹ to do so. There are classic reasons. First, to protect the innocent from unjust attack by using the least amount of force necessary to stop the aggressor. Second, to restore rights wrongfully denied. Finally, to re-establish just order.²²

Just cause for medical intervention can follow the same thinking as that in war. Understanding it is important for several reasons. In the model for care in Western medicine the Hippocratic Oath states, "I will follow that system of regime which, according to my ability and judgments, I consider for the benefit of my patient." Secondly, the first tenet of medicine *Primum non nocere* (first do no harm) alerts us to the need to examine, the reason(s) for which we seek to intervene in the life of another. We need a just reason. Also, competing with claims of good health and well-being, a disruptive interference with bodily integrity must be serious and weighty.

Based on this assumption, we must examine what constitutes a just cause for doing harm to a patient. Let us remember at this point that unintentional harm is, in fact, being done when we: stick people with needles to obtain samples for examination or to administer therapy. Harm is being done when we expose people to radiation for diagnostic or therapeutic reasons. Harm is being done when we save lives with cardiopulmonary resuscitation, surgery and give medications, among other things.

We must remember that the weight of the claim of the patient to be treated and cared for needs to be considered in the light of the cause for intervention. Therefore we must refrain from intervening unless we can satisfy the claim that we seek to help the patient to live in such a way that his or her values and integrity are protected. To do this it is reasonable to defend the patient against their own body parts which threaten life and well-being through unjust aggression of agents such as pathogens; failed organs; pain too terrible to bear; injury or mental anguish. Further, we can recover something wrongfully taken, such as the patient's good health. We can eliminate evil, as in removing a tumor, to prevent future or further damage to the patient. These are just causes for inflicting the least amount of unintentional harm in the form of medical treatment in the care of another person.

In this criterion we are asking only if there is just cause to harm people, even slightly, in our effort to help them maintain well-being or restore good health. We ask, what is the reason to intervene for this patient, at this time, under these circumstances? Is it just?

Probability For Success

What will be the predictable outcome? Is it reasonable to assume that we will achieve a just peace if we take up arms? This criterion is based on the reasonable (not absolute) hope for achieving peace through the taking up of arms in war. It is derived from the prohibition against suicide.²³ We also need to be aware of the deleterious effects of war on the spirit of the people and the possibility of having a military success at the cost of a national disaster.²⁴ The American Bishops are succinct about the purpose of this criterion "to prevent irrational resort to force or hopeless resistance when the outcome will clearly be disproportionate or futile."²⁵ Here is the clear point at which we apply this criterion to the practice of medicine.

Reasonable hope for success is established through the just cause and the right intention, using just means and being based on the telos of the patient and reasonable medical standards. In light of this, there are four questions to consider as we proceed. First, can we/must we use every available technology, on every patient, without consideration of the possibility of the end point of this treatment to be futile?²⁶

Second, is there a likelihood that the patient will be returned to a reasonable state of well-being? Third, what are the qualities of life that the patient is enjoying before the intervention? Are they what the *patient* finds to be acceptable? Finally, how does the patient define success?

As far as the use of technology is concerned, we are on the horns of a dilemma. However, defining our purpose in the just cause criterion, will help determine which, if any, technology we will consider using. A problem arises from the public demand for a cure for everything. We see it in the demand for the use and misuse of technology on the one hand and the fear people have of being enslaved to technology on the other. There is great need for extensive public discourse on the meaning of success vis a vis global medical outcomes.

One of our most visible dilemmas in the use of the success criterion is the Do Not Resuscitate Order (DNR). Looking at the rationale for the DNR is helpful in making determinations for other interventions. Resuscitation should not be initiated if there is no demonstrated benefit to the patient; if there will be a poor quality of life after resuscitation, in the patient's opinion (for instance it would leave the patient permanently unconscious and he or she finds that unacceptable); there is a poor quality of life, in the patient's opinion, before the attempted resuscitation, (for instance if the patient is in end-stage organ failure or cancer).²⁷

Although the DNR is written by the physician, it prescinds from the legitimate authority discussed above. The order signifies that the patient has refused a procedure.²⁸ Of course in the case of real uncertainty, good medicine errs on the side of life. If it is found that a patient has been resuscitated who did not want to be, treatment can be withdrawn with the same legal, ethical and moral certainty as it can be forgone.

Consider here that futility is dependent on the intended end of our treatment and on the telos of the patient. For these reasons futility is sometimes an illusive

notion. We need to discuss the futility of care with patients as part of an evolutionary care plan. A good clinical description of futile care is that it will fail in clinical terms or that it will work but won't postpone death for even a few minutes.²⁹

Success, futility and qualities of life are all considered first in light of the patient's most deeply held proclivities and inhibitions. As we stated earlier, the rights of the physician and the health care team are correlative to those of the patient. The inclinations of the health care providers, family and community should be considered in decision making along with those of the patient and the physician. However the physician, as the team leader and medical expert and the patient, as a moral agent are the most important decision makers.

Just Intention

What do I reasonably hope to achieve by this intervention? Why am I doing this? Is it in keeping with good medical practice and the telos of the patient? Do I seek first to do no harm?

Just intention is to achieve the just cause or goal by using just means. The just cause in war is peace. Childress considers the just intention of both the decision to take up arms and of the conduct of those who justly bear arms. The just intention of and in war focuses on the just cause of peace as the object, end or telos of war.³⁰ It is in the consideration of just intention that we examine the motive for our actions. If we seek good health and life as a particular, precious member of a sacred group, must we or can we sometimes do some harm to achieve an equal or greater good? The right intention also means "avoiding unnecessarily destructive acts or imposing unreasonable conditions" during the course of war.³¹

Our intent in medicine is first to do no harm and second to restore the patient to the best health and well-being that he or she can reasonably expect. This includes helping the patient to live as fully as possible in community. Our intention can not stand alone in the process of moral evaluation. Right intention, just means, and due proportion are inextricably linked in the ethic we are describing. What we say we intend must be verifiable by the means we use and by the proportion of foreseeable harm done to the good achieved. It is very difficult to ascertain the interiority of the intent of others and sometimes even ourselves. Nevertheless, the outcome of the action is verifiable and must be considered and accounted for in order for right or just intention to be met. Therefore we ask: "Do the means I have chosen verify the intent I have stated for this choice of treatment?"

Problems can arise when we are routinely confronted with ways to help patients that are harmful in some measure. They may be painful, costly, inconvenient or burdensome for the patient. We need to take care not to employ means that are unnecessarily destructive or impose unreasonable demands on the patient in his or her opinion. Frequently, the principal of double effect has been employed in the consideration of the intent of medical intervention.³²

Due Proportion

What is the balance between the true, overall harm done and the good reasonably hoped for? Is the anticipated good equal to or greater than the expected harm?

When taking up arms, due proportion is considered in the granting of an exception to the *prima facie* duty to do no harm. Balancing the good and evil effects in war is uncertain because the total infliction of harm must be considered and this is of course very difficult.³³ In war the cost of lives of troops and noncombatants, from all causes as well as the financial drain and destruction of resources needs to be accounted for and balanced before intervening. The probable good is balanced with the foreseeable harm in both the political and medical application of this criterion.

Again, we consider the need to inflict some harm with sharp objects, medications, and invasion of privacy, among others. In considering proportion we can not be frozen in inaction, rather we assess the benefit/burden ratio. An example of the need to consider benefit/burden ratios can readily be seen in therapy requiring punctures. Have we escalated a therapy's burden with multiple sticks when an indwelling catheter might be placed early in the intervention?

One is not required to use extraordinary means to save one's life. These means have been referred to as disproportionate means in recent years. The benefit/burden ratio is considered first from the patient's perspective. The questions explored are: is the intervention too painful, too costly, too inconvenient or too great a burden in light of the expected outcome? The physician has two responsibilities here. First to advocate for the patient and second to consider the true, overall cost of this intervention. We ask, "Is this treatment the right fit for this patient, at this time"?

"There is no such thing as free care. Somebody always ends up paying for it."³⁴ This is a reminder of the financial cost of treatment which, more and more is considered in the proportionality of benefit to burden. We are frequently challenged by the allocation of scarce resources. In this area the balance is between the needs of this patient as a member of the community as a whole. However, the allocation of scarce resources can not be confused with rationing or intentional shorting of medical goods and services to the significant detriment of the patients.

What is the true, overall cost of our intervention? Will we do more harm than good when we intervene in a particular way?

Just Means

Is the intervention which I propose, going to give each his or her due? The act can be either an act or omission.³⁵ Is the act or omission a good or indifferent act? Not to act is, of course, active medical intervention.

To grant an exception to the duty not to harm, the means used in the conduct of war is considered. This includes not only a limit to the kinds of weapons used but also places limits on the conduct of the combatants in conflict. That is, noncombatants must be protected and no more force than is necessary to stop

unjust aggression and restore a just peace may be employed. Further, just means requires good faith, respect for the humanity of the enemy, and an immediate object not to kill.³⁶ The conduct of war today is especially important because of the overwhelming devastating potential of the weapons available to some nations.

We can not go beyond the immediate goal of obtaining a just peace by using means with the intent merely to destroy. Just as obliteration bombing was condemned³⁷ because the means employed, the intentional slaughter of the innocent, was unjust and out of proportion to the intent: to demoralize the spirit of a nation, so too, must we examine the use of modern technology, such as nuclear weapons and the purpose of their use in war.

When we examine the means we must be sure that they involve good or indifferent acts or methods and that the intent which must also be good can verify the means which we use. In medicine we focus on the intent to restore good health and well-being while minimizing the harm done. Therefore, interventions must not create a new victim. That means, that 1) one intervenes on the basis of a legitimate, diagnosed need and 2) the patient makes an informed voluntary decision. These points are critical and parallel "never deliberately targeting a noncombatant", i.e. never targeting an "innocent" or unarmed person.

There is no requirement to use every means available especially if they represent too great a burden to the patient. We often ask, "Just because we can do it, must we do it?" The answer is, no. We need to know if the intervention fits the need of this patient in these circumstances. Proportionality is considered under its own criterion, in order to determine if the means are in proportion to the good they can do.

We must first seek to do no harm. This includes the overtreatment as well as the undertreatment of our patients. Will the means we propose help this patient to realize his or her telos?³⁸ In a practical sense, we need to have the patient consider what values and meaning they find in life. If life to one patient is primarily physiological and metabolic, the just means considered would differ from those means considered by one who places emphasis on life lived in community. We will listen to the patient who is telling us, as well as possible, what means will be appropriate. This formulaic process will accommodate a wide variety of predilections on the part of the physician and the patient.

In medicine we ask the following questions. Is the means good in itself? Is it too painful, costly, inconvenient or unlikely to succeed? Does it create an innocent victim of either the caregiver or the patient? Does the means fit the medical need to maximize the patient's health and well-being? Finally, and very importantly, does the means used verify the stated, just intention of the intervention?

Declaration

Have we discussed and made public our intention to intervene?

This is the final stage before intervention. It is the responsibility of the parties seeking an exemption to the duty to do no harm to explain themselves.³⁹ There are limits as well as requirements to this criterion. The truthful declaration of war must be stated while the details of the battle plan remain secret. In a democracy,

the declaration allows the governed to consent or to refuse to go to war. It allows for public discourse and for retreat to less violent means.

The same prescription for disclosure and confidentiality hold true in medicine. The patient must supply informed consent. The importance for the criterion in medicine is that it allows for moral disclosure among the health care team, the patient, the family, and the community. Further, it allows for retreat to less drastic means or the foregoing of extraordinary means. Several things are considered at this time: informed consent, the right to privacy, public disclosure, and professional consultation.

Informed consent has been discussed under legitimate authority. It overlaps here because it is in this criterion that the patient, having been reasonably well informed, either consents to the care plan or chooses a less drastic course of action. Informed consent is necessary because the patient, as a moral agent, must understand the benefit/burden ratio of the proposed care plan before consenting to the risks and anticipated harm to be inflicted.

It is the duty of the one seeking to intervene, that is the health care provider, generally the physician, to explain and justify the care plan, and the patient to accept it. This is analogous to the responsibility described in political intervention. The health care provider is responsible to find the language which the patient can understand and which is not overly prejudicial in nature. Disclosure of sufficient information is necessary to allow the patient to reach a reasonable decision.⁴⁰ This does not require the disclosure of all risks if the physician believes the patient already has some information⁴¹, nor does it call for the disclosure of information which the patient could not reasonably understand.

Truth in disclosure in medicine is crucial to the exemption to the duty to do no harm. It is an opportunity for the patient and the caregiver to grow in mutual trust and cooperation. Although it is sometimes difficult, failure to obtain informed consent is a failure to exercise the doctor/patient trust in good faith. This consent must be in writing, on the record in order to substantiate intent and to allow the opportunity to check for mistakes, at a later time.

Patient confidentiality has been a concern since the time of Hippocrates. "What I may see or hear in the course of treatment or even outside of treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself."⁴² The right to privacy is not absolute. It is generally accepted that patient privacy ends where public peril begins. That is why we report gunshot wounds, some stabbings and some communicable diseases. The Tarasoff Decision establishes the need for disclosure by the physician when an identifiable victim exists. However, the preponderance of cases will require routine announcement of the care plan to the patient, discussion of the care plan and options, the gathering of any necessary consults, and informed consent.

In sum, the declaration criterion asks the questions: have I informed the patient reasonably well about his or her condition, choices of therapy, and gotten permission to treat in accordance with good medical practice and the patient's wishes? Have I maintained confidentiality and protected the public from peril; have I engaged in public discourse; have I gotten any necessary consults; do I have the patient's consent form signed and placed in the record for current and

future accuracy of the intent of the patient; and have I retreated to less invasive or disruptive means if indicated?

The Last Resort

Have I provided an evolutionary care plan? Have I tried less violent means first and failed to meet the just goal with them?

In politics of war, it is the purpose of this criterion to retain the *prima facie* duty to do no harm. It starts with the efforts to avoid war. The last resort recognizes that it is not necessary that "all possible measures have been attempted and exhausted if there is no reasonable expectation that they will be successful."⁴³ For instance, if blockades and negotiations have failed after a reasonable effort has been made, there is no need to have false hope for them to restore just order and provide peace.

The same holds true in medicine. Least drastic means (starting with prevention) are tried first in an evolutionary care plan. In developing a care plan we consider several things from the perspective of both ethics and good standards of medicine: have we determined the goal of treatment with this patient; does the patient know that he or she can forego or withdraw a specific treatment if it seems or becomes too burdensome; have we used technology properly; and is this an evolutionary care plan?

These considerations are all part of routine, evolutionary care plans which include understanding by the patient when cures are easily effected and when treatment plans need repeated modification and change. They require the acknowledgment that at some point the patient will die. An evolutionary plan faces both the tremendous good that medicine can accomplish and the power of nature over our best efforts in the end. Arthur Dyck discusses the need for ideal companionship in *Rights and Responsibilities*.⁴⁴ This should be the end, in good medical care when we can no longer hope for a cure.

Technology presents a double edged sword in many ways. It has, at once, the potential for great good and for great harm. For instance, imaging techniques can confirm diagnoses but cumulative radiation can cause great harm. The jury is still out on the long term affects of multiple ultrasounds and magnetic resonance imagings. Cardiac catheterizations are much less invasive than surgery but more so than imaging. The point is that aggressive treatment may be necessary to save life but the least risky procedures should be considered before resorting to the more or the most risky intervention. Waiting for test results, such as HIV testing, and paying for some extraordinary treatments, such as transplantations or monoclonal antibodies, may pose a morally unacceptable burden for the patient. In areas where there are teaching hospitals and large tertiary facilities we tend to forget that some people find it too burdensome to leave their support networks to avail themselves of the most sophisticated medical treatment. We need to know what the patient's hopes and fears are in order to develop a care plan which minimizes burdens while maximizing realistic hope and well-being. Here we review previous and future treatment with the patient to insure that the least amount of harm will be inflicted, while insuring that we will be a faithful companion throughout. Ongoing treatments are evaluated for efficacy,

tolerability, and for futility; then necessary modifications can be made.

Conclusion

The use of the criteria of the just-war theories provides a comprehensive, simple, formulaic process and algorithm for making sound bioethical decisions at the bedside.

We have demonstrated that the ethical concerns of non-maleficence, autonomy, disclosure, confidentiality, beneficence, justice and good medicine can be considered using the same criteria in the field, the office or in the hospital.

We will remember that we need to exempt ourselves from the *prima facie* duty to do no harm each time we harm or allow harm to be done to ourselves or to another. In medicine we frequently need to do some harm in order to achieve a greater or equal good. We ask eight questions and need favorable responses to proceed. The questions are easily incorporated into routine decision-making. First: *Just Cause*. Do I have a just or worthy reason for this action? Second: *Legitimate Authority*. Do I have legitimate authority? Have I asked the patient and am I qualified, in a qualified setting, to do the task? Third: *Probability of Success*. Is there a likelihood that the intervention which I propose will advance the well-being and good health of this patient? Fourth: *Proportionality*. Is the intervention going to achieve equal or greater good than the harm that it will cause? Fifth: *Declaration*. Have I declared my intentions and gotten appropriate consults, while honoring the patient's right to privacy and safeguarding the public? Is the patient, reasonably well informed? Do I have written consent, if at all possible? Sixth: *Last Resort*. Is this treatment plan evolutionary? Does it propose a course of action that is necessary while trying to care for the patient with the least amount of harm inflicted? Seventh: *Right Intention*. Is my intention to help the patient realize his or her potential for well-being? Are my intentions precisely to achieve a just goal with just means - no more and no less? Eighth: *Just Means*. Are the means which I use morally good acts, omissions and treatments? Are they appropriate for this patient without harming the caregiver or the community?

Case Application

Mrs. Carter presented as an awake and alert, 93 year old, white, Methodist, widow, reported to have been in good health, by her nursing home supervisor. She was admitted to the Norwood Hospital Emergency Room from a local nursing home, with a chief complaint of crushing chest pain. It was accompanied by less severe jaw and left arm pain and shortness of breath. She was cyanotic, cool and diaphoretic. She arrived by basic life support transport in a sitting position and had a non-rebreather mask for oxygen supplementation.

When she arrived she was evaluated while having a 12 lead EKG, a portable chest X-ray, a 22 gauge angiocath inserted (from which blood was obtained for lab work) and a saline lock secured. Cardiac monitor leads were attached which showed elevated T-waves. The diagnosis was made of an inferior myocardial infarct, with congestive failure.

Mrs. Carter was a retired nurse. She grasped the severity of her condition and

was very helpful in making decisions about her care with the healthcare team.

Just Cause

We sought to intervene because Mrs. Carter sought our aid to restore her to health and well-being. She wanted, most of all to be relieved of her chest pain. There was just cause for our intervention.

Legitimate Authority

In this case Mrs. Carter, a retired nurse, was conscious and alert and competent to make decisions about her care. Dialogue with the patient regarding her goal for and choices of treatment was continuous. The physician on duty was a Board Certified Emergency Room Physician, with 15 years experience, working in an accredited emergency room.

Last Resort

The medical intervention in the life of Catherine Carter developed as a part of an evolutionary care plan. The first step was to ask the *patient* what was wrong. Her chest pain and shortness of breath were treated first with supplementary oxygen, then with intravenous Lasix, administered through a small bore IV (accomplished with one stick) and from which blood was drawn for diagnostic tests. Dialogue with Mrs. Carter was continuous. She made it clear that she did not want to be intubated, have external cardiac massage (she was DNR on admission to the hospital) or to be treated aggressively with cardiotoxic drugs. She wanted to be relieved of severe chest pain.

Declaration

Mrs. Carter understood the severity of her condition. She was offered Morphine with an explanation of its benefits and burdens. She chose to have Lasix, oxygen, and Morphine in addition to the diagnostic tests which were performed.

Reasonable Hope for Success

As we stated above, the reasonable hope is to restore the reasonable health and well-being of the patient in light of her telos and good medical practice. Mrs. Carter did not want aggressive treatment, nor would it have been good medical practice. The treatment she was given was consistent with what she wanted and with what the health care team could reasonably provide.

Just Intention

Our intention was just because it was to restore the patient to a state of reasonable health and well-being (to be free of unreasonable pain) through the use of good and just means. The verification of this statement is treated under the just means criterion.

Due Proportion

Here, the burden of the treatment (oxygen, EKG, cardiac monitor, portable

chest X-ray, #22 angiocath, Lasix, Morphine 2 mgms. IV, and human companionship) was in due or reasonable proportion to the pain control Mrs. Carter realized.

Just Means

The means used were consistent with good medical practice and with the wishes of the patient. They also verified our just intent, helping the patient to realize good health, to the best of our ability, in the face of Nature. To review, the means used were not too painful. The oxygen mask was adjusted for comfort and when breathing became comfortable for her a nasal prong administration set was used. The cardiac monitor leads and tracing were accomplished with no pain inflicted. A small IV was placed with one venipuncture, diagnostic blood samples were drawn from the same site, and medications were administered through the line. The portable X-ray was somewhat disruptive but in keeping with the need to make the diagnosis. Further, the means were not too inconvenient. Once the patient was in the Emergency Room, the means were all readily available. The cost of treatment for the patient, as well as for the third party payer, was low. Some interventions for this disease are very expensive and when those treatments are clinically indicated, the outcomes should be evaluated.⁴⁵ Finally, the means were not too burdensome in light of Mrs. Carter's desire for treatment.

Did the means verify the just intent? There were questions raised about the use of analgesic Morphine. The dose of 2mgms. IV, was appropriate for the age, weight, and condition of the patient.⁴⁶ A dose of this size would not have been appropriate for a newborn, nor would it have verified the intent to relieve the pain of a 30 year old patient who had been getting 800mgms., of Morphine IV every hour for the prolonged pain control of bone cancer. It is an important feature of this method of moral reasoning to verify the means used with the stated, just intent.

Mrs. Carter received pain relief from her treatment which was verified by her own admission and by her ability to engage in light conversation about her life as a nurse and wife. She was both gracious and grateful for her care. She was especially grateful that the health care team did not leave her unattended during her brief stay in the emergency room. Mrs. Carter died peacefully, holding the hand of her caregiver. Nature had taken its course.

We add this true and realistic conclusion, in order not to pretend that ethical reasoning will provide an easy path to the practice of medicine. Rather, ethical reasoning will provide the caregiver the assurance that he or she made a reasoned, informed decision by using a comprehensive formulaic process of ethical reasoning.

*I wish to thank my advisor, Professor Arthur Dyck, for reading this manuscript, making helpful suggestions, and for providing the challenge necessary to complete this endeavor.

References

1. The just thing is what we owe one another morally, i.e. our duties to one another.

2. J. Bryan Hehir, "Religious Pluralism and Social policy" in E. Pellegrino [ed] *Catholic Perspectives on Medical Morals*. Dodrecht: Kluwer Academic Publishers, 1989. p209

3. Ralph B. Potter, Lecture, Harvard Divinity School, Fall, 1992.

4. J. Childress, "Just-War Theories: The bases, Interrelations, Priorities, and Functions of Their Criteria", *Theological Studies* 39 1978. pp427-455. Moral reasoning in the taking up of arms and self defense has a tradition which can be found as long ago as the writings of St. Augustine and St. Thomas Aquinas. Others giving comprehensive consideration to the just-war theories are the National Conference of Catholic Bishops, *The Challenge of Peace*. Washington: USCC, 1983. And Ralph Potter, "The Moral Logic of War", *McCormick Quarterly* 23 1970. pp203-233.

5. W.D. Ross, *The Right and the Good*. (London: Oxford University Press) 1930. pp19-20. Ross defines a *prima facie* (literally the first face) duty as "the characteristic (quite distinct from that of being a proper duty) which an act has, in virtue of being a certain kind (e.g. the keeping of a promise), of being an act which would be a duty proper if it were not at the same time of another kind which is morally significant. Whether an act is a duty proper or an actual duty depends on all the morally significant kinds it is an instance of."

6. Childress, p435.

7. J. Childress, *Theological Studies* 39.

8. A.J. Dyck, "Ethics in Medicine". *Unpublished manuscript*. p13.

9. Childress, p436

10. Childress, p436

11. Ibid

12. The recent legal shift to the patient's right to self determination is neither settled nor absolute. A recent case in Massachusetts illustrates this point. "The right to refuse medical treatment in life threatening situations is not absolute; Countervailing interests include preservation of life, the prevention of suicide, maintenance of the ethical integrity of the medical profession, and the protection of innocent third parties." *Munoz v. Norwood Hospital*, 564Mass.

13. Miss Quinlan was a 21 year old woman who lapsed into a coma in 1976. Her parents petitioned the court to allow the ventilator which was supporting her respirations to be withdrawn. It was a nationally watched process and drew attention to the process of allowing patients to forgo and withdraw treatment which they find burdensome and to make decisions for themselves and through surrogates.

14. Pope Pius XII, "Prolongation of Life" November 24, 1957, in *Issues in Ethical Decision Making* G. Atkinson, [ed] (St. Louis: Pope John XXIII Medical Moral and Education Center, 1976).

15. See V. Erlichman, "The 1990Health Care Proxy Law" *Massachusetts Law Review* September 1991, pp145-156.

16. Saikewicz 373 Mass

17. Candura 6 Mass

18. O'Brien 154 Mass

19. Saikewicz 373 Mass

20. W. May, *The Patient Ordeal*. (Bloomington: Indiana University Press)

21. Childress, p436.

22. See Childress, p436 and J. Johnson, "Threats, Values and Defense" *Parameters [Spring 1985]*, M. Walzer, "Perplexed: Moral Ambiguities in the Gulf Crisis", *The New Republic*, January 28, 1991, and *The Challenge of Peace*, NCCB, Washington: USCC; 1983, for a more thorough understanding of this criterion in war.

23. Childress, p437.

24. Z. Brzezinski, *Testimony to the Senate Foreign Relations Committee*, December 5, 1990

25. NCCB, *The Challenge of Peace*, p. 30.

26. See D. Callahan, *The Troubled Dream of Life*. (New York: Simon & Schuster, 1993. pp212-219.) for an excellent discussion of the uses and the overuses of technology in modern medicine. Callahan observes that in the practical realm, the division between futile and beneficial interventions is not necessarily along technical lines. Rather, it is contained in the notion of "useful" treatment. Rejected in this understanding, is treatment which prolongs both metabolism and the dying process but provides no hope for recovery or cure.

27. Tomlinson and Brady, "Ethics and Communication in Do-Not-Resuscitate Orders" *JAMA* 315, Jan. 7, 1988 pp 43-46.
 28. L. Blackhall, Must We Always Use CPR?" *New England Journal of Medicine* 37, November 12, 1987. p. 11.
 29. See D. Kelly, *Critical Care Ethics*. (Kansas City: Sheed and Ward, 1991) pp 60-61.
 30. Childress, p. 438.
 31. NCCB *Peace*, p. 30.
 32. To review briefly, the principle of double-effect needs two pre-conditions and three conditions to be properly used. The pre-conditions are: 1) the means used in the act must be morally good or indifferent [I will not take up the question of whether or not there are any morally indifferent acts here]; and 2) the act presents both a good and evil effect. Then there are three conditions to be met if an act is to qualify for the application of the principle. They are: 1) the good is intended, 2) bad or evil cannot be done to achieve good, and 3) the good achieved by the act must be equal to or greater than the harm predicted. See A. Jonesen & S. Toumlin, *The Abuse of Casuistry: A History of Moral Reasoning*. Berkeley: University of California Press, 1988 and J. Keenan, "The Function of the Principle of Double-Effect" *Theological Studies* 54, 1993.
 33. Childress, pp 437-438.
 34. See David Kinzer, the first of Eight Great and Transcendental Truths about Healthcare quoted in "Providing Healthcare for the Indigent" in *Scarce Medical Resources and Justice*. (Braintree, Mass: The Pope John Center, 1987.) p 69.
 35. Although there is in American constitutional law no duty to rescue, health care providers do have a responsibility, both ethically and legally to respond to the plight of those who seek care. This may be provided with active intervention such as sutures, medications, and resuscitative measures or by loyal companionship in the face of the power of Nature over the best efforts modern technology can provide.
 36. Childress, pp 438-441.
 37. J. Ford, "The Morality of Obliteration Bombing" *Theological Studies* 20 1959 pp 261-309.
 38. Telos is the end point. The telos of human life, according to Thomas Aquinas, in considering the moral measure of activity is: does it lead to God as the final end?
 39. Childress, p. 347.
 40. Munoz, 409 Mass.
 41. Harnish, 387 Mass.
 42. L. Edelstein, "The Hippocratic Oath: Text, Translation and Interpretation." *Bulletin of the History of Medicine. Supplement 1* (Baltimore: John's Hopkins Press, 1943) p. 3.
 43. Childress, p. 436.
 44. See A. Dyck, *Rethinking Rights and Responsibilities*. (Cleveland: Pilgrim Press, 1994) Chapters 8 & 9, for an informed explanation of the concept of ideal companionship.
 45. For instance, in the TPA/Streptokinase debate it has been found that although TPA has an initial cost which is very high the outcomes demonstrate that the Streptokinase has a higher, true, overall cost.
 46. See Pope Pius XII "Prolongation of Life," (November 24, 1957) in *Issues in Ethical Decision Making* G. Atkinson [ed] (St. Louis: Pope John XXIII Medical and Moral Education Center) 1976.
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