Physicians' Professionally Responsible Power: A Core Concept of Clinical Ethics

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The gathering of power unto themselves by physicians, a process supported by evidence-based practice, clinical guidelines, licensure, organizational culture, and other social factors, makes the ethics of power—the legitimation of physicians' power—a core concept of clinical ethics. In the absence of legitimation, the physician's power over patients becomes problematic, even predatory. As has occurred in previous issues of the Journal, the papers in the 2016 clinical ethics issue bear on the professionally responsible deployment of power by physicians. This introduction explores themes of physicians' power in papers from an international group of authors who address autonomy and trust, the virtues of perinatal hospice, conjoined twins in ethics and law, addiction and autonomy in clinical research on addicting substances, euthanasia of patients with dementia in Belgium, and a pragmatic approach to clinical futility.

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I. INTRODUCTION

Themes concerning physicians' power and its professionally responsible deployment have surfaced in previous clinical ethics issues of the *Journal* (McCullough, 1999, 2010, 2015). Power comprises two capacities, the first cognitive and the second executive. First, one forms one's will, that is, makes a decision. Second, one carries one's will into effect, that is, implements one's decision either oneself or through others. Power, of course, is held and exercised over others, as well as oneself. Power can be limited by ethical obligations to others or by prudence or

be unconstrained by either obligations or prudence. The latter is known as absolute power.

In the clinical setting, physicians (but not only physicians) have considerable power over patients. Physicians formulate diagnoses or differential diagnoses after taking a history and performing a physical examination. Physicians confirm diagnoses or refine differential diagnoses by ordering imaging and laboratory analysis. In discharging these professional responsibilities, physicians make a myriad of “silent decisions” (Whitney and McCullough, 2007) and implement them. Physicians decide what information to provide to patients about conditions, diseases, disabilities, and injuries and the clinical alternatives for managing conditions, diseases, disabilities, and injuries. Physicians influence the decisions of patients and surrogate decision makers subtly, by how information is presented and emphasized, and overtly, by making evidence-based recommendations. Physicians’ power in the clinical setting is comprehensive in its scope and consequences for the patient’s interests, rights, and well-being.

The gathering of power unto themselves by physicians, a process supported by evidence-based practice, clinical guidelines, licensure, and organizational culture (to name only four of many social factors), makes the ethics of power—especially the legitimation of physicians’ power—a core concept of clinical ethics. In the absence of legitimation, the physician’s power—and by extension the healthcare organization’s—over patients becomes problematic. This is especially the case when patients are vulnerable, in the sense of having limited capacity or opportunity to exercise their own power. Patients are then, to varying degrees, subject to the power of physicians. In the absence of legitimation of such power, the physician’s power is at risk for becoming predatory on the interests, rights, and well-being of patients.

The existence and abuse of predatory power in the contractual model of medical practice that shaped the history of Western medicine for the preceding centuries prompted two 18th-century British physicians, the Scotsman John Gregory (1724–1773) and the Englishman Thomas Percival (1740–1804), to create the ethical concept of medicine as an antidote (McCullough, 1998, 2015). By making and sustaining three commitments—to the evidence-based practice of medicine, to the primacy of the patient’s interests, and to medicine as a public trust rather than a self-interested merchant guild—physicians transform predatory power into professionally responsible power (McCullough, 2006). Each of the papers in this “Clinical Ethics” number of the *Journal* sheds interesting light on this core concept of clinical ethics.

II. AUTONOMY AND TRUST

Thomas Nys (2016) explores the relationship between autonomy and trust and the implications for how that relationship might usefully be understood

for medical ethics. Trust has several related components: holding between individuals, generating the expectation that another will act in one's interest, and assuming the competence of that other to do so. Trust is open-ended in that it allows for discretion in judgment of that other about what is in one's interest. Trust thus understood becomes an antidote to vulnerability, especially to the power over oneself of that other. A key component of trust is self-trust: the confidence in one's judgments and decisions and actions based on them that derives from sustained dependence in "decent caring relationships" (Nys, 2016, 12). Part of mastering self-trust is being trusted by others. Another key component is that one can consider others to be trustworthy when their primary concern is with one's interests and not their own. This disinterested commitment to the protection and promotion of the interests of others, especially others subordinate to one's power, is a form of love, Nys convincingly argues. "Love" in this account names a competent and sustained commitment to protect and promote the interests of another as one's primary concern and motivation, especially when one is in a position of power vis-à-vis the other. One then displays trust: one shows oneself to be someone who can be counted on by the other, who is vulnerable to one's power, to protect and promote the other's interest, rights, and well-being.

Physicians become trustworthy, thus understood, when they make and sustain the three commitments that define the ethical concept of medicine as a profession that is the extraordinary legacy of Gregory and Percival to us. Trustworthy power, thus understood, is legitimated power. Power thus legitimated becomes professionally responsible power.

III. VIRTUES OF PERINATAL HOSPICE

As the capacity to identify fetal anomalies has grown increasingly more sophisticated, the capacity to predict with confidence which fetuses with gestational ages greater than 24 weeks have a very low probability of survival or of survival with at least some developmental capacity (Chervenak and McCullough, 2014) has increased. Planning the perinatal management of such pregnancies now includes planning for nonaggressive obstetric management (e.g., no fetal monitoring, cesarean delivery only for maternal indications) and in the event of live birth nonaggressive neonatal management (no resuscitation, no intubation and mechanical ventilation). This planning includes perinatal hospice.

Aaron Cobb (2016) undertakes to show that "perinatal hospice manifests and facilitates virtues essential to living well with human dependency and vulnerability" (Cobb, 2016, 25). His aim is to identify the distinctly ethical dimensions of perinatal hospice, distinct from political support for perinatal hospice as an alternative to abortion. He does so because the "goods internal to perinatal hospice are not reducible to the fact that they offer an alternative

to abortion” (Cobb, 2016, 26). These goods concern principally the virtues that we ought to cultivate—in healthcare and in new parents supported by communities—in response to one of the most profound forms of human vulnerability: a medical condition that will take the life of a newborn infant and for which the withholding of life-sustaining treatment is ethically permissible. Appealing to MacIntyre (1999), Cobb identifies “virtues of acknowledged dependence” (Cobb, 2016, 25) that will help parents to cope with “a tormenting psychological ordeal” (Cobb, 2016, 35).

The upshot of Cobb’s argument is that proponents of legislation supporting perinatal hospice and opponents of such legislation both fail to promote an important social practice, the ethical dimensions of which make it worth supporting independently of the political process and state power. Indeed, Cobb’s argument provides a corrective to state power in the regulation of perinatal medicine, nursing, social work, and chaplaincy. Without invoking the precedent, Cobb echoes Thomas Percival’s claim in the later sections of his *Medical Ethics* (Percival, 1803) that the profession of medicine takes its intellectual and moral authority from the three commitments that define the ethical concept of medicine as a profession, none of which commitments include reference to state power. This underscores an important function of clinical ethics vis-à-vis state power: the critical appraisal of it from the perspective of professional medical ethics. Undertaking this function assumes that professional medical ethics is autonomous from state power. Cobb’s paper identifies important implications of this professional autonomy.

IV. CONJOINED TWINS, ETHICS, AND LAW

Julian Savulescu (2016) provides an ethical analysis of the clinical management of conjoined twins. His approach invokes issues of individual and personal identity (not to be conflated with each other), biological and mental existence, sacrificing one twin to save the other, the connection between organ transplantation and separating conjoined twins, and who should serve as the decision maker about surgical and other clinical management of conjoined twins. Savulescu’s approach takes into account the biopsychosocial (Engel, 1960) variation of conjoined twins and the implications of the five components of his approach for the responsible management of that variation.

In the United Kingdom, decision making about conjoined twins has come under state power, as courts have become involved in resolving differences among parents, surgical teams, and hospitals. Savulescu identifies what he characterizes as the resulting “bizarre situation” in which the reasoning of the court does not, in Savulescu’s judgment, withstand close philosophical scrutiny. He goes on to criticize legal constraints on permissible transplantation that originate in the “dead donor” rule.

One implication of Savulescu's argument is that courts of law may be no more capable of responsible judgments about the management of conjoined twins than parents, surgical teams, and hospitals. His survey of the arguments for separating conjoined twins demonstrates, if it demonstrates anything, how vexed, indeed contended, is the ethics of managing conjoined twins, especially when we add to the mix the powerful bias originating in "stereotypes of human existence" (Savulescu, 2016, 53).

Conjoined twins result from the errors of human reproduction (not the sins of intercourse that resulted in the birth of "monsters," signs, or portents sent by the gods or God in punishment for those sins [McCullough, 1998]) and thus fall within observed (and in this sense, normal) biopsychosocial variations of human phenotypes. Ordinarily, the responsible management of such variation in fetuses and newborn children comes under evidence-based professional judgment that guides the professionally responsible exercise of power by perinatal and pediatric clinical care teams and parents. That there happens to be disagreement about clinical management does not, by itself, justify resort to courts of law. Indeed, the Texas Advance Directives Act (Texas Health and Safety Code; Chapter 166.046) excludes professionally responsible end-of-life decision making under the provisions of the statute from court scrutiny. Perhaps the scope of autonomy for physicians' professionally responsible power should be re-thought. For example, absent court review, what confidence should we have that physicians' power about the surgical management of conjoined twins will be responsibly deployed when that power is shaped, or even motivated, by the stereotypes of human existence against the influence of which Savulescu cautions?

V. ADDICTION AND AUTONOMY

Neil Levy (2016) addresses the conceptual and ethical challenges at the intersection of autonomy and addiction. The nub of the latter, as Levy concisely puts it, is that "it is characteristic of addiction to adversely impact on addicts' ability to make autonomous decisions" (Levy, 2016). Levy goes on, however, to show that the view that addiction always "hijacks" the brain is false. However, this conclusion does not clear the way to endorsing the presumption of autonomy for every addicted patient, because "If we know anything about addiction at all, it is that it impairs autonomy" (Levy, 2016, 59).

Levy considers both decisional and executive autonomy and argues that addiction impairs both. He grounds this argument in a detailed account of the effects of addiction on the neurophysiology of decisional and executive autonomy. This physiology sets up the addict to tread the "garden path" of addiction, down which it becomes progressively more difficult to say "no" to the next exposure of the brain to addicting substances. But it is not impossible. It is therefore possible to design clinical trials on addiction in such a way

as to manage the propensity to say “yes” to such exposure. Such trials are crucial for improving the clinical management of addiction and thus mitigating or even preventing (if only for a time) its biopsychosocial consequences for individuals, families, communities, commerce and education, and government at all levels. Thus designed trials exercise professionally responsible power to limit access to clinical trials by patients with impaired decisional and executive autonomy. This is of a piece with the professionally responsible power of clinical investigators to identify and implement scientifically, clinically, and ethically justified inclusion and exclusion criteria.

VI. EUTHANASIA OF PATIENTS WITH DEMENTIA

In Belgium, it is currently legally permissible to perform euthanasia—the direct killing of a patient by introducing a lethal pathology into the patient’s body—for patients with terminal illness and with dementias. Explicit consent of the patient is a requirement. Raphael [Cohen-Almagor \(2016\)](#) provides a critical appraisal of this legally sanctioned clinical practice. The Belgian laws exclude euthanasia as unlawful provided that specific conditions are met, including that the patient is an adult and capable, and has made a “voluntary” and “well-considered and repeated” request ([Cohen-Almagor, 2016, 75–76](#)). Cohen-Almagor cites reports to document that patients have been euthanized without consent and that patients with Alzheimer’s dementia have been euthanized. Euthanizing patients with dementia, Cohen-Almagor argues is “morally problematic” (2016, 77).

Cohen-Almagor appeals to Dworkin’s account of human dignity as a secular concept that contrasts with the theological concept of the sacredness of human life. Dworkin’s account of human dignity appeals to experiential interests (pleasure and enjoyment) and critical interests (living a worthwhile life). Human dignity applies to an individual’s life considered as a whole and thus not cross-sectionally. Cohen-Almagor goes on to provide an analysis of the stages of dementia in terms of capacity for consent, suffering, and required care. For all three stages, he concludes, euthanasia of patients with dementia is at best ethically problematic and therefore not routinely ethically permissible. He identifies the implications of this conclusion for health policy: “The liberal state has an obligation to protect all people, especially the vulnerable” ([Cohen-Almagor, 2016, 85](#)).

There is a strong presumption against euthanasia in professional medical ethics. It should be noted that one of the inventors of professional medical ethics endorsed physician-assisted suicide but the context of his remarks on this subject seem clear that the capacity to exercise one’s rights is an essential component ([McCullough, 1998](#)). This strong presumption puts the burden of proof on physicians and the burden of proof is heavy. The force of Cohen-Almagor’s argument is that for patients with dementia of any stage,

the burden is not met. In such circumstances, however disguised in the discourses of care and compassion, the power of physicians to euthanize patients becomes predatory. In such circumstances, the exercise of state power becomes necessary precisely in order to preserve the three commitments that define medicine as a profession and thus physicians' professionally responsible power over patients.

VII. FUTILE TREATMENT

The ethics of the clinical judgment that initiating or continuing life-sustaining and other forms of treatment is futile (with a very high probability not expected to result in its intended outcome) invokes professional integrity as a justified limit on physicians' provision of such treatment as well as on the requests of patients or their surrogate decision makers for such treatment (Brett and McCullough, 1986, 2012). This limit is enforced by the physician not providing such treatment. In the United States (where the practice of medicine is regulated by the several states), Texas, for example, sanctions the exercise of professionally responsible power in response to medically inappropriate treatment decisions or advance directives (Texas Health and Safety Code; Chapter 166.046), which legislation was influenced by pioneering work by Halevy and Brody (1996) in the Texas Medical Center in Houston, Texas.

Cheryl Misak, Douglas White, and Robert Truog (2016) aim to shift the "futility debate" away from the question, "Who decides?", to an ethically justified policy to manage the diverse values and conflicts among them that have shaped the futility debate. They propose this shift because of their commitment to the view that "decisions about whether to offer or withhold treatments for critically ill patients must be based on reasons that appeal to standards and norms embedded in medical practice and society at large, including norms about the role of the patient, family, and physician in decision making" (Misak, White, and Truog, 2016, 91–92). By "norms of practice," they mean "the best standards that currently exist" (Misak, White, and Truog, 2016, 92), including guidelines and statements from professional associations of physicians.

Misak, White, and Truog propose a pragmatic approach, rooted in the work of Pierce and Lewis, in which "we begin with an inherited set of beliefs, theories, principles, policies, and practices" (Misak, White, and Truog, 2016, 96). The goal is the creation of a reliable approach to ethical challenges, drawing broadly on experience and reflection about beliefs, theories, principles, policies, and practices rather than the deployment of a fully realized moral theory that produces infeasible judgments. They invoke Rawls and Dworkin as exemplars of the intellectual tradition within which they are working. The outcome is the management of persistent ethical disagreement

and conflicting values rather than a final resolution that settles such disagreement and conflict once and for all.

Inappropriate treatment policies should respond to the clinical and ethical variation of what has been labeled “futility” in the clinical setting. The result can be characterized as a kind of “pragmatic casuistry,” based on a typology of cases that is meant to be useful in reaching reliable policies to guide clinical judgment and decision making with patients and family members. The typology includes straightforward un-negotiated cases, straightforward negotiated cases, and grey zone cases. They urge iterative, well reasoned, and deliberative engagement of clinicians with each other and then with the patient’s decision maker to foster trust in the resulting judgments and treatment plans based on them. Physicians’ authority and resulting power are considerable in this process but not decisive, especially in the second and third types of cases.

Misak, White, and Truog emphasize that deference to physician authority and power should not be “submissive” (Misak, White, and Truog, 2016, 110). The resulting nonauthoritarian approach that physicians should take can be understood as an antidote to self-serving power of physicians and healthcare organizations, of just the kind that motivated Gregory and Percival to write their professional medical ethics in the 18th century. The proposed approach to futility policy systematically constrains physicians’ power and thus can be read as supporting an important variant of professionally responsible power.

VIII. CONCLUSION

These six papers nicely illustrate the pervasiveness of the exercise of physicians’ power in the clinical setting. That power interacts with—and, as a consequence, may be strengthened or weakened by—the power of healthcare organizations and the state. These six papers also echo, without appreciating its historical source, the concept of the autonomy of physicians’ professionally responsible power from state power. Physicians’ professionally responsible power, understood in the context of the history of medical ethics and in relationship to organizational and state power, constitutes one of the core, enduring topics of clinical ethics.

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