There has been discussion on how various theories of ethics are similar, how they are different, and how each should be applied. Ethical theory, in general, has been presented in opposition to situation-based ethics and the ethical comportment found in socially based practices. Etiquette is one concept that has entered these debates, only peripherally, as a negative example of what healthcare practice was left with before the development of bioethics theories or as part of a discussion of medical history. In contrast to these limited discussions, etiquette can be seen as a way to bring theories of ethics and ethical comportment into dialogue rather than opposition.

Because it is such a familiar requirement, informed consent can be used to illustrate some intersecting ideas about theories of ethics, etiquette, and ethical comportment. Before initiating certain medical procedures, enrolling a patient as a subject in a research study, or procuring organs for transplantation, nurses and/or physicians are required to obtain each patient’s informed consent. In the process of obtaining consent, the healthcare practitioner presents information about all reasonable options to the patient or the patient’s surrogate, and the patient or patient’s surrogate decides on the best option. Giving informed consent means the patient or the patient’s surrogate has rationally evaluated the options and has chosen the course of action that best suits the patient’s needs and desires.

Theories of ethics, like any rationalist endeavor, are built of axioms and principles that provide a formalized structure in which decisions about the rightness or wrongness of actions can be made. The theory that supports the patient’s right to choose and that more generally supports the “doctrine of informed consent,” includes the concept of respect for persons as ends in themselves. This is further developed in principle-based ethics theory in a discussion of autonomy. Asking consent from a patient or from the patient’s surrogate is one way that healthcare providers show respect for persons and for the importance of individual autonomy.

According to the tenets of principle-based ethics, for consent to be valid it must be informed and voluntary. There is debate in the bioethics and medical literature regarding whether this standard must be upheld in all circumstances, but the debate generally takes another form: How do we make sure the patient or the patient’s surrogate is making an adequately informed choice that is truly voluntary? The pressing questions about informed consent address the amount and quality of information provided and the nature of the situation in which the discussion about consent takes place.

Theories are often presented as foundational in that they are said to provide the groundwork from which action arises. It has long been held that action is most rational when based on theory and when defined as following the rules derived from a theory. In the example of informed consent, we obtain informed consent because the rules of ethics demand it. In this view, the rules of theory are foundational concepts that practice then follows.

Rule following as foundational to practice, however, has come into serious question. Formalized rules, no matter how foundational they seem, always require background knowledge before they can be interpreted or applied. Understanding and following a rule require background understandings by which we interpret the rule and that allow us to recognize the huge variety of possible situations in which the rule can be applied. For example, the rule that consent be informed and voluntary requires a high level of interpretation before it can be applied in any real situation. To start, we need a set of rules that allow us to recognize each situation in which informed consent is required. Once we decide that informed consent is required, we need definitions of “informed” and
that demonstrate this respect. These practices are part of everyday ethical comportment. Ethical comportment is a prereflective, socially embedded practical knowledge that is rational, even though it is not based on rational calculation (ie, based on formal criteria). Unlike theoretical reasoning, comportment cannot be formalized. The prereflective nature of comportment means that comportment is lived and embodied in practices that are not based on formal theoretical precepts. Because it is socially embedded, ethical comportment requires engagement in a situation and a sense of membership in the relevant social group. Comportment develops in dialogue with others and is based on, or constituted by, the background understandings that make it possible for us to develop the axioms and rules involved in ethical theories.

The embodied practices involved in ethical comportment cannot rely on theoretical representations of rules to drive them since the practices and the shared meanings of which they are a part precede the rules. The practices demonstrate a flexibility and innovation in enactment and combination far beyond what would be possible by adherence to a set of rules. This means that rules like respect for autonomy can point to, and remind us, of what our practices are about in a limited, objective sense, but the rules cannot act as the foundation for the practice. Rather, the practice, and its attendant shared meanings, precedes and is the necessary basis for understanding the rules at all. In this view, we do not respect persons because we have a rule telling us to do so. Rather, we have developed the rule because respect for persons is already part of our background practices. We are already acting with respect for individual, personal autonomy in complex, relational, and responsive ways that can never be fully captured in a rule.

Etiquette is related to both formalized ethics theory and ethical comportment in that it is a system of socially derived rules that can be flexibly applied to real situations. Despite its potential as a point of connection between theory and comportment, etiquette has been presented in less than favorable light. In contrasting medical etiquette with medical ethics, Loewy describes a progression from concern with outward performance (etiquette) to a more sophisticated concern with internal intentions (ethics). According to Loewy, etiquette fosters the practitioner’s concerns with how his or her behavior is perceived by others and draws the practitioner’s attention to concern with developing the social and material status of the profession. Ethics, on the other hand, offers guidance on more important questions of the practitioner’s inwardly acknowledged duties to patients. In this view, what seem to be the outward manifestations of good intent displayed in a person’s manners are suspect since good manners and a sharp appearance may be an attempt at marketing a person’s trustworthiness, because such trustworthiness does not actually exist.

Similar to Loewy’s view of etiquette, the 18th-century Scottish philosopher and physician John Gregory’s view of medical etiquette, as described by Maio, includes a warning about potentially deceptive appearances. The physician’s manners and attention to aesthetics may be used to cover up his lack of skill. In Gregory’s time, as is true today, some healthcare practitioners possessing questionable medical skills were adept at selling their services by use of deceptive manners. But unlike Loewy, Gregory’s description of etiquette does not stop with a discussion of the ways etiquette has been misused. Etiquette can also be described as the external manifestation of morally sound intent. Both of these ideas of etiquette can help show how formalized theories of ethics and ethical comportment mutually influence one another and can be brought into a public dialogue.

Etiquette, whether it is used to disguise a corrupt intent or to display a good intent, is the act that opens a social space. As such, etiquette provides a way to open the possibility of involvement between the healthcare provider and the patient/client. In the example of informed consent, the questions of how much information to provide, how to provide it, and how to ensure that the patient’s decision is voluntary cannot come before a relationship is formed in which these questions make sense (L.D., unpublished data, 1999). Etiquette sets up the possibility of this relationship.

As Gregory and Loewy both point out, there is a tension between the two ways that etiquette can be taken up as a social practice. As an instrumental means to attaining some external good, like more fees for services, more organs for transplantation, or more subjects for a research project, etiquette can be used to deceive the patient or client. Maio gives the example of physicians who pay close attention to their dress and manners in order to expand their client base and thereby establish a successful and lucrative practice. For these physicians, etiquette is a means to career advancement. Manners and appearance are important as a means to material gain.
Etiquette is a calculated attempt to present oneself as well-bred and therefore worthy of respect and authority. In contrast to this calculated attention to etiquette as a means to material gain, the ethical practitioner’s etiquette folds into his or her comportment. Manners become part of a prereflective approach to opening a social and moral space in which to meet the other.

Using etiquette as an instrumental technique in the interest of personal gain is not in keeping with either the ethical comportment or the formal ethics of nursing or medical practice. When we run across a fellow practitioner who is using etiquette as subterfuge or as a means to an end, we recognize this as a case of breakdown in ethical comportment, much as Gregory did in the 18th century. This recognition of the instrumental use of manners as breakdown shows how comportment is in dialogue with theories of ethics and demonstrates the way in which theories of ethics have a reciprocal relationship to etiquette and to ethical comportment. The theory both informs and is informed by etiquette, and etiquette forms a bridge between formal ethics and ethical comportment by putting ethics into action (L.D., unpublished data, 1999).

These connections between formal theories of ethics, etiquette, and ethical comportment can be illustrated more clearly by returning to the example of informed consent. In obtaining informed consent for organ donation, the nurse or physician approaches the family in a particular way. The ethical rule about obtaining informed consent for organ donation forbids the use of undue influence, manipulation, and/or coercion, and requires that the donation option be presented as a choice for the family to make based on the wishes of their deceased loved one. The etiquette of this approach is influenced by cultural and social practices surrounding death, bereavement, and the hospital environment, more specifically the environment of the intensive care unit (ICU). Certain behaviors are appropriate, while others are not. Ethical comportment, or the background practices in place in this particular situation, opens certain possibilities for the nurse or physician. The practitioner’s response to the family depends on the interplay of rules, etiquette, and comportment.

The following quote is from an interview with a nurse who was working for an organ procurement organization (OPO); her job involved approaching family members to offer the option of organ donation. The research of which this excerpt is a part has been reported elsewhere. In this excerpt, the nurse describes a situation in which she had been called to a hospital to evaluate a child as a potential organ donor.

It was one of those situations where you couldn’t help but step in because nobody was there to help this family to understand what was happening with the little girl. And I had quite a bit of contact and I think that [the family] just assumed that I was with the hospital or something like that. And actually, it came down to the mother came to me and said, ‘Well, if she really is dead, then we’d like to donate.’ Then I thought, well, I should let them know who I am so if they have other questions... So I gave her my card, and she was fine with it. But the grandmother who had been there quite a bit was not fine with it, and she was chasing me around the ICU yelling, ‘You just wanted her organs, that’s all you wanted. That was the only reason that you were talking to us.’ I was quite new at the time. I don’t think I’d been more than six months or so and I remember sitting in the ICU just crying. I was so upset because it wasn’t my intention, nothing she said was true, but it was still really painful.

This excerpt describes a situation in which an error in etiquette lead to a breakdown in comportment that rendered formal ethics irrelevant. The nurse concealed her identity as an employee of the OPO. The etiquette of this makes sense as a prereflective gesture. Identifying herself as an employee of an OPO upon first encountering the family would have opened a different sort of social space that would have set up the possibility of a different relationship with the family. The nurse perceives herself as first caring about the family and primarily wanting to help them to understand the situation. Given this, initially presenting herself as an OPO employee did not appear as an option to her. The error in etiquette becomes apparent when the grandmother reacts negatively to the revelation of what she perceives to be the nurse’s true motive: obtaining organs. To the grandmother, the nurse’s manners were not a demonstration of the nurse’s ethically sound intent of wanting to open a social space in which the family could choose but rather a mask covering the nurse’s corrupt intent to manipulate the family into donating. The nurse’s original response to the family, which did not include identifying herself as a representative of an OPO, now becomes defined as a failure of etiquette.

As it redefines the situation as one of a failure of etiquette, the grandmother’s interpretation disrupts the nurse’s ethical comportment; the nurse had developed a rapport with the family based on shared understandings that, in the case of the grandmother at least, proved to be untrue. At this point of breakdown, the formal ethical theory from which informed consent is derived becomes irrelevant because the grandmother and the nurse have no common understanding from which to continue the conversation. The failure of etiquette has...
effectively prevented organ donation as appearing as an option for the grandmother. In this case of breakdown, the intersection of ethics, etiquette, and comportment has been demonstrated, and the place of etiquette as a practice that opens a social space becomes clearer.

REFERENCES
