Clinical bioethics has focused largely on individual clinical case dilemmas. Less attention has been given to the everyday ethics of being good healthcare practitioners, physicians, nurses, social workers, respiratory therapists, and physical therapists. Rapid scientific and technical advances push for public and professional ethical concerns focused on science and technology. Consequently, scientific protocols and technologies receive more attention in ethical discourse than everyday ethical comportment and relationships between patients and healthcare providers. Yet, technical and scientific aspects of practice would be ineffective without good patient-healthcare provider relationships. Many ethicists are calling for broader concerns to be addressed in professional ethics.

Meeting patients and their families and recognizing their concerns about healthcare comprise the everyday ethical comportment of the practitioner. Patients and families, while encouraged to become empowered and take more responsibility for their health, are often vulnerable due to lack of knowledge of healthcare or due to crisis and reduced capacities. Therefore, patients rely on healthcare workers to have a fiduciary relationship with them. That is, ethically and legally, healthcare workers are expected to act in the best interests of patients. This requires that commercial or research interests, or any other sources of conflict of interest, not triumph over a patient’s best interests. Being faithful to a patient’s best interests also requires advocacy for patients and their families in complex healthcare settings. Bioethics needs to focus on more than clinical case dilemmas and ethical issues at the individual level. Advocacy for good everyday ethical comportment, and social ethics and public policy that address social inequities are also essential to ensuring that healthcare is a right and fulfills notions of good essential to a healthy society.

It is a broad social inequity that more than 40 million uninsured Americans have little or no access to healthcare. Even the insured may experience delays and refusals of coverage for certain medical and psychiatric services. These access problems are compounded by the fact that social problems are medicalized, causing social and essential caring services to be legitimized and attended to through entry into the medical system. Visiting nurses have to legitimate needed care support and monitoring by officially attending to specified medical conditions. Elderly patients whose system of home care breaks down can be admitted to the hospital for “medical” reasons only. A narrow clinical bioethics cannot address these larger social issues.

Bioethics needs the moral sources of external critique and norms, including social and public policy critiques and internal notions of good within the profession. Bioethicists such as Edmund Pellegrino and David Thomasma have worked on articulating the notions of good within the profession. Charles Taylor points out that behind every “right” there is a notion of good to motivate and inspire it. As moral agents, clinicians are required to learn from their experience in order to develop better judgment and character over time. Experience, as Gadamer points out, is not just the passage of time, but rather the turning around of expectations, confronting counter evidence for one’s beliefs or the adding of nuance to one’s understanding.

Good fiduciary practice requires that the practitioner learn from experience so that he or she acquires habits, dispositions, discernment, skills, and emotional responses of excellent practice. To qualify as a living practice and not just a waning tradition, the practice must be self-improving. The forms of improvement...
are varied, including new science and technology, experiential learning of practitioners, and new societal demands upon the practice. More needs to be done to make the experiential learning of individual practitioners public, accessible to other clinicians, and extended through articulation and scientific study, as well as ethical evaluation.

Charles Taylor notes that our sense of moral obligation depends on a broader and more fundamental sense of what it is good to be:

...But ethics involves more than what we are obligated to do. It also involves what it is good to be. This is clear when we think of considerations other than those arising from our obligations to others. The sense that such and such is an action we are obligated by justice to perform cannot be separated from a sense that being just is a good way to be. If we had the first without any hint of the second, we would be dealing with a compulsion, like the neurotic necessity to wash one's hands or to remove stones from the road. A moral obligation comes across as moral because it is part of a broader sense which includes the goodness, perhaps the nobility or admirability, of being someone who lives up to it. . . .

If we give the full range of ethical meanings their due, we can see that the fullness of ethical life involves not just doing, but also being; and not just these two but also loving (which is short-hand here for being moved by, being inspired by) what is constitutively good. It is a drastic reduction to think that we can capture the moral by focusing only on obligated action as though it were of no ethical moment what you are and what you love. These are the essence of the ethical life.7

To ask ourselves what it means to be a “good” practitioner entails more than asking about our moral obligations, more than just examining patients’ rights, and more than justifying our past actions. Being a good practitioner requires that we are moved by the patient’s plight and that we respond to the patient as a person. Notions of good are more fragile and more pluralistic than ethical and legal rights, and they come with risks of not doing or not being good in a particular situation.8 It is usually easier to guarantee rights than it is to ensure personal and communal fidelity to the good in particular situations. Practical reasoning (ie, clinical reasoning—reasoning about the particular across time through changes in the patient’s condition or concerns, and through changes in the patient’s condition) is underdetermined and has a broader range than what can be reduced to logarithms or prognostic scores. Practical reasoning about a patient’s rapidly changing condition (eg, sepsis, pulmonary edema) or about facing death and providing comfort and dignity cannot be reduced to rights alone. They must be inspired by the notions of good inherent in these ends of practice:

Many more particular life goods are at stake [at end-of-life care] than choice: for example the art of holding open a life so that social death does not occur before physical death; so that leave-taking rituals and the human task of facing death are possible. These are the fragile goods that require connection and discernment. They cannot be guaranteed, but they can be nurtured by telling our practice stories where the good is actualized, and by creating work environments that support and encourage caring practices between practitioners and patients. Rights are essential and remedial, but not the end of ethical concerns, and they must always be animated by the notions of good that constitute them.9

To broaden the public and clinical agendas of bioethics, we will need to include the moral visions provided by notions of the good as well as strong notions of patients’ rights and entitlement to healthcare. It is probably not an exaggeration to say that in every clinical encounter there are ethical issues at the personal, provider, and social levels. Our fiduciary relationship to patients extends to social justice and preventive public health measures to reduce human suffering and vulnerability.

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AMERICAN JOURNAL OF CRITICAL CARE, July 2003, Volume 12, No. 4 375
Enhancing Patient Advocacy and Social Ethics
Patricia Benner

Am J Crit Care 2003;12 374-375
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