An introduction to dental ethics Part 4 – The four principles of biomedical ethics. Part 1

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examines autonomy, beneficence, non-maleficence and justice in more detail.

Introduction

In this part of the series, the four principles of biomedical ethics as proposed by Beauchamp and Childress will be discussed.[1] These principles – autonomy, beneficence, non-maleficence and justice – have been the foundation of medical and dental ethics for the last 40 years. In this section of the series, along with the final section, we will discuss these principles in more detail before considering them in some applied examples.

Autonomy

Autonomy, literally meaning self-legislation, is the cornerstone of ethics in healthcare with its importance extending to politics, moral philosophy, and many other disciplines.

Dental ethics

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Philosophers consider autonomy to be a capacity to develop one's own desires and to act in accordance with what we determine to be our own best interests.

For example, Dworkin defines autonomy as the second order capacity to reflect upon one's first order preferences and wishes.[2] Furthermore, he argues that an autonomous decision is one which is free of coercion, manipulation, and deceit.[3] In other words, our choices and actions must be of our own accord. Joseph Raz portrays a similar conception of autonomy stating that: 'Autonomy is opposed to a life of coerced choices. It contrasts to a life of no choices, or of drifting through life without ever exercising one's capacity to choose.'[4]

In healthcare, autonomy is of paramount importance. In the past, a paternalistic model in which the doctor or dentist knew best was adopted. Over the last 50 years, this has been replaced with an approach in which the patient determines their own best interests and works in partnership with their dentist to make decisions on their treatment. The value of autonomy is therefore tied to the concept of informed, valid consent.

Informed, valid consent has three elements. Firstly, it must be informed. In other words, the patient must have all the relevant information required to make the decision including, but not limited to, alternative treatment options, risks, benefits, costs and likely prognosis. Beauchamp and Childress refer to this condition of consent being informed using the term 'understanding'. According to which they claim that 'an action is not autonomous if the actor does not adequately understand it'.[1]

Secondly, it must be voluntary. In other words, in accordance with Dworkin's conception of autonomy, it must be the patient's own decision and not unduly influenced by the clinician or anyone else.

Finally, the patient must have the capacity to make the specific decision being asked of them. The Mental Capacity Act 2005 defines capacity as:

'For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'[5]

For valid, informed consent, all three of these conditions need to be met. This, broadly speaking, means that the patient has made an autonomous decision regarding their treatment.

Beneficence and non-maleficence

One of the most well-known phrases in healthcare ethics is: 'first do no harm'. This foundational principle is encapsulated in the value of non-maleficence which dictates that we must do all we can not to harm our patients (whether intentionally or not). It is closely related to the principle of beneficence which states that we must 'do good' and help our patients.

Whilst the two principles appear similar in nature there are subtle and yet vital differences between them. I will illustrate this in the form of a well-known thought experiment. Let us imagine that Person A is walking past a lake, and they notice their colleague, Person B drowning. Person A, who is a competent swimmer knows that Person B cannot swim. However, instead of helping their colleague, they leave them to drown. In this case, we would say that Person A could have intervened to help save Person B, but they did not. In not helping and not acting in such a way to help Person B, we would say that Person A has acted immorally.

Ethicists, in this case, would say that we have a positive duty to act in such a way that would help someone else. There are of course limits to this. For example, we would not be expected to run into a burning building to save someone as it would likely cost us our lives. Therefore, whilst it may be morally praiseworthy, we would not be blamed from refraining from this action.

In a similar way, as dental professionals we have a positive duty to help our patients. This requires us to perform an action, or in this case a treatment or intervention which helps them. An example of this is getting a patient out of pain during an emergency appointment. Another would be attending to a patient who is having a medical emergency in the surgery.

Let us now reformulate the scenario. Imagine Person A is walking past a lake and notices that Person B is standing on the edge. They know that Person B cannot swim, and that the lake is so deep that, were they to fall in, they would drown. Person A then pushes Person B into the lake and they drown. In this example, we say that Person A has acted immorally as they have taken an action which has harmed another individual. This is an action which they should have not taken and refrained from. In this case, Person A has a negative duty to not do something which will harm their colleague.

Similarly, if a dental professional takes an action which harms a patient they have been said to have acted immorally (this does not include accidents although there is still culpability on the side of the clinician). We, as dental professionals, have a negative duty not to take actions which harm others. This relates to the duty of non-maleficence in which we have a duty to 'do no harm'.

In summary, beneficence relates to our positive duty to take actions which benefit our patients. In contrast, non-maleficence demands that we refrain from acting in a way which harms our patients – this is a negative duty.

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Justice

The principle of justice claims that individuals should have fair and equitable access to healthcare. This relates to how healthcare resources are allocated and accessed which is known as distributive justice. Most societies, including our own, are constrained by factors such as finance, politics and access to services. This is a particularly active conversation when it comes to dentistry which is gaining a lot of media attention due to issues with accessing NHS dental care.

NHS dentistry differs from the rest of the National Health Service as it is not free at the point of access. Furthermore, there is a much larger private sector. In recent years, there has been increasing difficulty for patients to access NHS dentistry with the number of dentists providing this service rapidly decreasing. A recent survey by the British Dental Association (BDA) highlighted this issue.[6] It reported that half of dentists have reduced their NHS commitment since the pandemic.

Furthermore, 43% of dentists surveyed indicated that they are likely to move into private practice. This is a stark warning that the number of dentists providing NHS care is set to decrease even more. Regardless of any investment in NHS dentistry, if there are no dentists to provide it the issue will not be solved. Even if care is made available another vital part of providing care is making sure that it can be accessed. For example, some elderly patients may not be able to make it into the practice and require domiciliary care.

Ultimately, it is government policy which results in meaningful change. Whilst there have been pledges from the government to reform NHS dentistry and increase access to it, very little change has materialised.

Conclusion

The four principles of biomedical ethics are the most well-known and ubiquitous ethical principles in dentistry. They are easy to apply and straightforward. This means that they can be applied by clinicians in practice to help us make decisions when faced with an ethical dilemma. In the final section of this series, we will look at these ethical principles in applied examples and consider the benefits and drawbacks of the four principles further.

Read more about Keerut in our 'Meet the author' article this January.

References

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