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THE PROMISE OF THE BENEFICENCE MODEL FOR MEDICAL ETHICS

*Tom L. Beauchamp**

Many writings in ancient, medieval, and modern medicine contain a storehouse of information about medical ethics. Throughout these periods the health professional's obligations and virtues, as expressed in codes and didactic writings on ethics, have been conceived through professional commitments to provide care, which may be expressed in ethical terms as fundamental obligations of beneficence. In recent years, however, the idea has emerged that the proper model of the physician's moral responsibility should be understood not in terms of beneficence but in terms of the rights of patients, including rights to truthfulness, confidentiality, privacy, disclosure, and consent.

This challenge has jolted medicine from its traditional preoccupation with a beneficence-based model of medical ethics in the direction of an autonomy model. Rather than perceiving the physician-patient relationship in terms of the patient's submission to the physician's professional forms of care, the autonomy model views the relationship within a wider social framework, emphasizing that patients have decisionmaking rights and should be enabled to define the boundaries of the patient-physician relationship to fit their own ends.

More recently, particularly through the work of Edmund D. Pellegrino, there has been an attempt to restore the beneficence model to its former preeminent position in the profession of medicine. The proper role of the beneficence model, the autonomy model, and the reconstructed beneficence model proposed by Pellegrino is the subject of this Article. While critical of his beneficence model as conceptually inadequate, this Article should be taken in the spirit of a philosophical tribute to a leading figure with whom all in bioethics have had to contend. This paper is not a repudiation of Pellegrino's general contribution to bioethics. To the contrary, no one in contemporary bioethics has equalled the sustained contribution he has made to the field over the past thirty years.

This Article traces the history of the beneficence and autonomy models,

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concluding with the contemporary problem of their conflict. A conceptual section that explains the difference between these two models and briefly explicates the moral principles on which they rest follows. Next, the two forms of justification underlying the models are presented. Finally, the nature of Pellegrino's contribution to the discussion is considered and critically evaluated.

I. MEDICAL ETHICS FROM HIPPOCRATES TO MODERN TIMES

A primary historical source for our understanding of the physician's responsibility for the patient derives from the Hippocratic physicians in ancient Greece. The *Corpus Hippocraticum* fails to address today's problems of the autonomy of patients. Rather, it bluntly advises physicians of the wisdom of "concealing most things from the patient, while you are attending to him . . . turning his attention away from what is being done to him; . . . revealing nothing of the patient's future or present condition."¹ In these writings the physician is generally portrayed as one who commands and decides, while patients are conceived as persons who must place themselves in the physician's hands and obey commands.

The purpose of medicine expressed in this tradition is that of benefiting the sick and keeping them from harm and injustice. This medical beneficence is the proper goal of medicine, and professional dedication to it makes one a physician. Skilled communication in care and deference to the patient's preferences are foreign ideas, except insofar as dialogue could be used to instill confidence and persuade of a therapeutic regimen for purposes of a health benefit to the patient. The Hippocratic tradition also features the overriding importance of authority. It shows little appreciation of patient needs apart from medicine's conception of the patient's medical needs. This "Hippocratic beneficence" involves a conception of responsible medical behavior that rests entirely on acting for the patient's medical best interest.

The Hippocratic tradition was carried forward from medieval to modern medicine as an ideal of moral commitment and behavior. Medical schools were quick to train students in Hippocratic principles, despite their increasingly archaic form. Many prominent figures played a role in transmitting parts of the medical ethics of this tradition, even if in a modified form. In the United States, for example, Benjamin Rush, a committed revolutionary and signer of the American Declaration of Independence affectionately re-

1. *Decorum* XVI, in 2 HIPPOCRATES 297-99 (W. Jones trans. 1923). The most celebrated expression of beneficence as the core principle in medicine is found in the Hippocratic work, *Epidemics*: "As to diseases, make a habit of two things—to help, or at least to do no harm." *Epidemics* I, XI, in 1 HIPPOCRATES 165 (W. Jones trans. 1923) (emphasis added).

ferred to as the "American Hypocrates," wrote and lectured on medical ethics.² Although he appreciated the importance of reflecting on the patient's point of view much more than did Hippocratic physicians, he, like virtually all others in the history of medicine, yielded to the authority of the beneficence model on all tough moral questions.³ From the perspective of the English-speaking world, it remained to Thomas Percival to give the first well-shaped doctrine of medical ethics. Perhaps the most influential writer in medical ethics during the modern period, Percival published his landmark *Medical Ethics* in 1803.⁴ This book makes a pointed appeal to beneficence and contains a short list of recommended virtues that are associated with benevolence and special responsibility. The work made no more mention, however, of obtaining permission from patients or respect for decisionmaking by patients than had previous codes and treatises. Like the Hippocratic physicians, Percival moved from the premise of the patient's best medical interest being the proper goal of the physician's actions to descriptions of the physician's proper deportment, including traits of character that maximize the patient's welfare.⁵ Authority directs the physician to role responsibilities, dictated by the profession's understanding of its obligations. These obligations are invariably beneficence-based in Percival's work. For example, the physician is encouraged in difficult circumstances to manipulate the truth if it is in the best medical interests of the patient.⁶

Percival recognized that the patient's right to the truth clashed with his recommendation of benevolent deception in medicine, but rights never achieved the same status as virtues in his ethics, where he looked to the "characteristic excellence of the virtuous man."⁷ Percival held that the physician does not actually lie in acts of deception and falsehood, as long as the objective is to give hope to the dejected or sick patient. The role of the physician, after all, is primarily to "be the minister of hope and comfort."⁸

Percival's work served as the model for the American Medical Association's (AMA) first Code of Medical Ethics in 1847.⁹ Many whole passages

2. W. GOODMAN, BENJAMIN RUSH: PHYSICIAN AND CITIZEN 141 (1934).

3. See generally B. Rush, *Travels Through Life*, in THE AUTOBIOGRAPHY OF BENJAMIN RUSH (G. Corner ed. 1948).

4. T. PERCIVAL, MEDICAL ETHICS; OR, A CODE OF INSTITUTES AND PRECEPTS ADAPTED TO THE PROFESSIONAL CONDUCT OF PHYSICIANS AND SURGEONS (E. Pellegrino ed. 1985). Dr. Pellegrino is the John Carroll Professor of Medicine and Medical Humanities and Director of the Center for the Advanced Study of Ethics at Georgetown University, Washington, D.C.

5. *Id.* at 30-52.

6. *Id.* at 162.

7. *Id.* at 166.

8. *Id.* at 156.

9. ACADEMY OF MEDICINE, CODE OF MEDICAL ETHICS (1848). This Code was

were taken verbatim from Percival. Much more than Percival's language survived in America: His viewpoint on medical ethics gradually became the creed of professional conduct in the United States.

However, shortly after the middle of the twentieth century, a major transformation began to take place: Forces in ethics and health policy with roots external to the professional concerns of physicians began to be influential. Of these influences, courts and other legal sources were most important. In the 1960s, problems of medical ethics were viewed in health care circles primarily as legal issues. New terms like "bioethics" had not yet been invented in the 1950s and early 1960s.

It seems likely that both increased legal interest and increased ethical interest in the professional-patient relationship were but instances of a new civil-rights orientation that various social movements of the last 30 years introduced into American society. The issues raised by minority rights, women's rights, the consumer movement, and the rights of prisoners and the mentally ill often included health care components such as reproductive rights, rights of access to abortion and contraception, the right to health care information, access to care, and rights to be protected against unwarranted human experimentation. These urgent societal concerns helped reinforce public acceptance of the notion of rights as applied to health care.

It is doubtful that the lines of influence between medical ethics and the social movements of the 1960s and 1970s can be easily untangled. However, this much is clear: Once the flood was flowing in the direction of a new medical ethics there seemed no way to stop it. A massive tangle of problems with special literatures emerged on informed consent, abortion, medical confidentiality, euthanasia and the prolongation of life, the use of behavior control techniques, and the like. In the decade from 1962 to 1972, the old ideas of medical ethics began to crumble and the new emerged with vigor—so much so that terms like "bioethics," "moral problems in medicine," and "biomedical ethics" drowned the term "medical ethics," as if to signal the dawning of a new subject matter in a new era.

Various assumptions surrounding the historical primacy of the obligation of beneficence have been seriously challenged through these movements. In this light, the arrival of a patient-centered medical ethics emphasizing autonomy rights is not surprising. One result of these developments has been to introduce both confusion and constructive change in American medicine, which continues as a profession to struggle with unprecedented challenges to its authority in the control and treatment of patients.

adopted by the American Medical Association in May, 1847 and by the New York Academy of Medicine in October, 1847.

II. THE TWO MODELS OF MEDICAL ETHICS

“Models” of medical ethics (or of physician responsibility in providing health care) give shape to what is only inchoate and unsystematically formed in the history of medical practice and medical ethics.¹⁰ As used in this Article, the “autonomy model” refers to the view that the physician’s responsibilities to the patient of disclosure, confidentiality, privacy, and consent-seeking are established primarily, perhaps exclusively, by the moral principle of respect for autonomy. This principle may be stated as follows: Autonomy of action should not be subject to controlling constraint by others.

The conflict between this principle and the principle of benevolence, which underlies the “benevolence model,” can be expressed as follows: The physician’s responsibilities are conceived traditionally in terms of the physician’s primary obligation to provide medical benefits. The management of information is understood, on the latter model, in terms of the management of patients (“due care”) generally. That is, the physician’s primary obligation in handling information and in making recommendations is understood in terms of maximizing the patient’s medical benefits. The central problem of authority in these discussions has become whether an autonomy model of medical practice should be given practical priority over the benevolence model. A typical handling of the problem between these two models is demonstrated in the following statement by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research:

The primary goal of health care in general is to maximize each patient’s well-being. However, merely acting in a patient’s best interests without recognizing the individual as the pivotal decisionmaker would fail to respect each person’s interest in self-determination. . . . When the conflicts that arise between a competent patient’s self-determination and his or her apparent well-being remain unresolved after adequate deliberation, a competent patient’s self-determination is and usually should be given greater weight than other people’s views on that individual’s well-being.¹¹

The Commission clearly emphasizes the role of the patient in decisionmaking. “Respect for the self-determination of competent patients is of special importance . . . the patient [should have] the final authority to decide.”¹²

The two models can and should be understood as polar opposites,

10. See T. BEAUCHAMP & L. MCCULLOUGH, *MEDICAL ETHICS* 26-27 (1984).

11. PRESIDENT’S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE SUSTAINING TREATMENT* 26-27 (1983).

12. *Id.* at 44.

although one might adopt a piece of one model and a piece of the other without resultant inconsistency. Typically, professionals and patients alike view the authority for some decisions as properly the patient's and authority for other decisions as primarily the professional's. It is widely agreed, for example, that elective surgery involving significant risk is properly the patient's but that decisions about whether and under what conditions to administer a sedative to a frightened patient screaming in an emergency room is properly the physician's. Many cases, however, are more ambiguous as to proper decisionmaking authority—for instance, who should decide which aggressive therapy, if any, to administer to a cancer victim, how refusal of treatment cases should be handled, and who should decide about access to confidential medical records.

III. DIFFERENT JUSTIFICATIONS IN THE MODELS

From the perspective of ethical theory, the difference between these two models can be understood in terms of the *justifications* the models provide. The premise that authority rests with patients or subjects should be justified, according to proponents of the autonomy model, by the principle of respect for autonomy. It should *not* be justified by arguments from beneficence to the effect that decisional autonomy by patients enables them to survive, heal, or otherwise improve their own health. Similarly in research settings, a proponent of the autonomy model holds that requiring the consent of subjects must be based on the principle of respect for autonomy, and never solely on the premise that consent protects subjects from risks. (Consent requirements first appeared in research codes and guidelines for the purpose of protecting subjects welfare—the wrong motivation and justification, from this perspective.)

Even judgments that favor respecting a patient's decision have not traditionally been justified in medicine by a principle of respect for autonomy; these judgments have commonly rested on the principle that the patients' *welfare* is maximized by allowing them to be decisionmakers. These arguments range from the simple contention that making one's own decisions promotes one's psychological well-being to the more controversial observation that patients generally know themselves well enough to be the best judges, ultimately, of what is most beneficial for them. A defender of the autonomy model believes that the problem with using these welfare-based premises to protect autonomous choice for patients and subjects is that autonomy is valued only extrinsically for the sake of health, rather than intrinsically for its own sake.

IV. THE PELLEGRINO-THOMASMA BENEFICENCE MODEL

So influential is the autonomy model in contemporary biomedical ethics that it has become difficult to find clean and clear commitments to the traditional beneficence model. The exception is Edmund Pellegrino's reconstruction of the traditional beneficence model, with the intent of accommodating some concerns of the autonomy model. He promotes the preeminence of beneficence—in a book coauthored by David Thomasma—as follows:

We will contend that beneficence remains the central moral principle of the ethics of medicine. . . . Our aim is to redefine, and refine, the notion of beneficence in terms of the new practicalities and dimensions of the physician-patient relationship today. With the recent emergence in the medical ethics of the principle of autonomy, it seems necessary to strike a new balance between autonomy and beneficence, which to some ethicists seem to be in conflict.¹³

In their interpretation, neither contemporary law nor contemporary medical ethics provides sufficient reason to hold that autonomy takes priority over beneficence in medical ethics:

None of [the court cases favoring patient autonomy] can be seen as an objection to the beneficence model. It might be tempting to think that these cases give precedence to patient wishes or presumed wishes over physician paternalism, but that is not so. Instead, they emphasize patient wishes . . . as a means for protecting the patient's best interests. This is a critical point. While autonomy is not a clear winner in these cases, neither is paternalism. Rather, the best interests of the patients are intimately linked with their preferences. From these are derived our primary duties toward them.¹⁴

The "beneficence" model, as presented in this passage, seems merely a disguised defense of one form of the autonomy model. If the content of the physician's obligation to be beneficent is determined entirely by the patient's *preferences* (including choices), the principle of autonomy is overriding, and the autonomy model prevails. However, Pellegrino and Thomasma ul-

13. E. PELLEGRINO & D. THOMASMA, FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTH CARE 11-36 (1988) [hereinafter FOR THE PATIENT'S GOOD].

14. *Id.* at 29. The famous court cases referenced include *Bartling v. Glendale Adventist Medical Center*, 184 Cal. App. 3d 961, 229 Cal. Rptr. 360 (1986); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *In the Matter of Claire C. Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417 (1977); *In the Matter of Karen Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, *Garger v. New Jersey*, 429 U.S. 922 (1976).

mately reject an autonomy-based rationale for their conclusions. Their thesis is expanded as follows:

[B]oth autonomy and paternalism are superseded by the obligation to act beneficently; that is to say, the choice of whether one acts to foster autonomy or instead acts paternalistically should be based on what most benefits the patient and not on the intellectual convictions or moral impulses of the physician. . . . [A]ny critical reflection on beneficence must include limitations on autonomy. There are too many clinical situations in which freedom—either the physician's or the patient's—must be curtailed. In the real world of clinical medicine, there are no absolute moral principles except the injunction to act in the patient's best interest.¹⁵

Here is a bona fide denial of the preeminence of an autonomy model and an assertion of the preeminence of the beneficence model. In order to understand this argument, the background of the Pellegrino-Thomasma conception of models and their competition must be provided. The Pellegrino-Thomasma treatise argues that the models, as defined by this author and Laurence McCullough, have been treated too simplistically through the contrast of the beneficence and autonomy models and by the belief that these models, as the only two alternatives, are fundamentally different.¹⁶ The Pellegrino-Thomasma proposal, instead, states that there are three models: autonomy, paternalism, and beneficence. A sharp, polar contrast is found between an autonomy model and a paternalism model. The beneficence model is portrayed as a mediating model that captures the best of the other two. In a paternalism model, a medical decision to benefit a patient is (by definition) taken without full consent of the patient;¹⁷ by contrast, in an autonomy model there must (by definition) be full consent by the patient to any medical decision to benefit the patient. The paternalism model is rejected by Pellegrino and Thomasma as overly authoritarian; the autonomy model is rejected on the grounds that it shifts too much of the decisionmaking locus from the physician to the patient and does not give "sufficient attention to the impact of disease on the patient's capacities for autonomy."¹⁸

At this point a criticism is in order of both definitions and basic premises of the Pellegrino-Thomasma model. Their argument harbors a common confusion over the nature of the autonomy model, because it is applied to "people who are incapacitated by disease or trauma [and who would by the conditions of the model be] abandoned to their autonomy, that is, merely

15. *Id.* at 32, 46.

16. *Id.* at 57; *cf.* at 157.

17. *Id.* at 10, 57.

18. *Id.* at 14.

given the 'facts' and asked to make a decision."¹⁹ Defenders of the autonomy model have never said that a person of sharply diminished autonomy who expresses a preference falls under the autonomy model, so as to protect the patient from the decisions of a caring physician. To the contrary, virtually everyone acknowledges—under any model—that a person who is non-autonomous or significantly defective in autonomy is highly dependent on others, does not properly fall under the autonomy model, and therefore should be protected under the beneficence model. Pellegrino and Thomasma falter on this important point by holding that the beneficence model should protect such patients by not abandoning them to their "autonomy" and by not acting without their consent. The operative concept in their beneficence model is called "beneficence-in-trust," meaning that physicians and patients hold in trust "the goal of acting in the best interests of one another in the relationship."²⁰ The trust aspect is the cement of the relationship, and what makes the beneficence model preferable to the other two.

However, this fascinating attempt to mediate the conflict between physician interests in paternalism and patient interests in autonomy is bound to fail precisely because it does not properly conceive the true nature of the conflict between the autonomy model and the beneficence model as previously analyzed. To see why, consider Pellegrino and Thomasma's presentation of the circumstances in which medical beneficence overrides respect for patient autonomy, where patients have made what they label "irresponsible choices." Here are two cases:

Autonomy would be wrongly exercised if [the patient] rejected penicillin treatment for pneumococcal or meningococcal meningitis. Both infections are life threatening and possess a high potential for central nervous system damage if the patient does recover. The same would be true of rejecting surgery for a ruptured spleen, appendicitis, or a subdural hematoma. Here the capabilities of medicine are both effective and beneficial.²¹

In these cases the patient, according to Pellegrino and Thomasma, has made an irresponsible choice that a caring physician would disallow on grounds of beneficence. This way of framing the problem is tantamount to a paternalism model, even under their definitions.

The defense of the Pellegrino-Thomasma beneficence model, as stated by

19. *Id.* at 17-18.

20. *Id.* at 54-55. The philosophical basis for this view of medical morality was developed in their first book, especially chapter 9. E. PELLEGRINO & D. THOMASMA, *A PHILOSOPHICAL BASIS OF MEDICAL PRACTICE* (1981). See also Pellegrino, *Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness*, 4 *J. MED. & PHIL.* 32 (1979).

21. *Id.* at 47.

its authors, is not one in which beneficence *necessarily* overrides respect for autonomy. As previously demonstrated, the principle that physicians should "act in the patient's best interest" is construed as *absolute*²²—rather than *prima facie* overriding. By following this absolute rule, the physician will not necessarily act on what the patient prefers, because the patient may prefer what is not in his or her best interest. If the question is posed as to why this position is not straightforwardly paternalistic, their reply is ready: Physicians and patients have mutually agreed to hold in trust "the goal of acting in the best interests of one another in the relationship."²³ Thus, there is a prior arrangement involving negotiation and mutual acknowledgment to the effect that the patient's best interests in the long run override immediate preferences expressed in a particular situation.²⁴ That there may at times, although not always,²⁵ be justified coercion of the patient is a premise Pellegrino and Thomasma are prepared to accept.²⁶

This model cannot, in the end, escape collapse into some version of the paternalism model.²⁷ The definition of paternalism preferred by this author is the following strong interpretation: A paternalistic action *infringes autonomous choice* on grounds of beneficence. Also widely accepted is a weaker definition of paternalism: the overriding of a person's wishes or intentional actions (whether autonomous or not) for beneficent reasons. On either definition, the Pellegrino-Thomasma model is paternalistic. The model does, of course, avoid prescribing paternalism in *every* circumstance of a conflict between medical beneficence and patient autonomy, because Pellegrino and Thomasma accept the view that neither the principle of respect for autonomy nor a general principle of medical best interest is absolute in a situation of conflict.

The Pellegrino-Thomasma position is vexing, although not because of paternalism, which is acceptable when properly qualified. Rather, it is vexing due to their related belief that there is no conflict between *beneficence* and autonomy because there is only a conflict between *paternalism* and autonomy. The grounds of the physician's actions in the cases cited above is purely medical beneficence; and this beneficence conflicts with the patient's choice (which appears to be an autonomous choice), eventuating in paternal-

22. *Id.* at 32, 25, 46.

23. *Id.* at 54-55.

24. *Id.* at 55.

25. Note the autonomy-oriented discussion of the Bouvia case. *Id.* at 200.

26. For a general defense of the claim that there can be "a moral use of coercion" based on the protection of "health as a moral value," see Pellegrino, *Autonomy and Coercion in Disease Prevention and Health Promotion*, 5 THEORETICAL MED. 83-91 (1984).

27. For a discussion of this problem, see FOR THE PATIENT'S GOOD, *supra* note 13, at 12-13, 29, 35-36, 49.

istic action. It is precisely because of the difficulties presented by beneficence in conflict with autonomy in these cases that contemporary biomedical ethics has become polarized over the relative merits of beneficence and autonomy, and consequently so rivetted to the problems of paternalism.

It is unlikely that the general problem of which principle—beneficence or autonomy—should be overriding in medical ethics is amenable to solution by defending one principle against the other principle. No more likely is it that the problems of medical ethics under discussion today are resolvable by defending one model against another model. There is no premier and overriding authority in either the patient or the physician and no preeminent principle or model in biomedical ethics. The admonition to “act in the patient’s best interest” and the model that flows from it are no exceptions.²⁸ This conclusion is tantamount to denying that Pellegrino and Thomasma have achieved “The Restoration of Beneficence in Health Care” (an overriding beneficence model) that forms the subtitle of their book (although it is not tantamount to rejecting the moral claims of beneficence defended in that book).

Pellegrino’s moral viewpoint in bioethics, and with it the views of most contemporary defenders of the beneficence model, seem morally correct while at the same time conceptually incorrect. The moral correctness is located in the statement quoted above that “the best interests of the patients are intimately linked with their preferences. From these are derived our primary duties toward them.”²⁹ The conceptual incorrectness comes in the thesis that this claim is beneficence-based rather than autonomy-based. This is a misunderstanding of the import of both the principle of respect for autonomy and the principle of beneficence.

This Article submits that the debate over which model should prevail has been confused by the failure of Pellegrino and Thomasma to distinguish between a principle of beneficence that *competes* with a principle of respect for autonomy and a principle of beneficence that *includes* respect for patient autonomy. That this competition is sometimes present should be clear from the above argument. When the conflict occurs, no beneficence model of the sort proposed by Pellegrino and Thomasma can mediate the conflict. Unfortunately, it has never been successfully shown that *any* model is capable of mediating the conflict.

28. For a defense of this general viewpoint, see T. BEAUCHAMP & J. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS ch. 5 (1989).

29. FOR THE PATIENT’S GOOD, *supra* note 13, at 29.

