The Principles of the Belmont Report Revisited

How Have Respect for Persons, Beneficence, and Justice Been Applied to Clinical Medicine?

by ERIC J. CASSELL

Although written primarily for medical research, the Belmont principles have permeated clinical medicine as well. In fact, they are part of a broad cultural shift that has dramatically reworked the relationship between doctor and patient. In the early 1950s, medicine was about making the patient better and maintaining optimism when the patient could not get better. By the 1990s, medicine was about the treatment of specific physiological systems, as directed by the patient, but as limited by the society's concern for justice.

In 1954 a man in his fifties was admitted to a teaching hospital with a heart attack of a few hours' duration. He was to be the first subject of an innovative treatment (intravenous streptokinase and streptodornase) to dissolve the thrombosis in his coronary artery.

The patient was chosen because he was a derelict with no living relatives. In the fashion of the day, he was not told what was to be done and no consent was requested or obtained. An attending physician, resident, and medical student were in constant attendance. After a number of hours of receiving the new medication, an irregularity of his heart rhythm developed. The treatment was stopped out of fear for his safety.

In 1997 a thirty-eight-year-old woman with stage IV (metastatic) cancer of the breast received high-dose chemotherapy followed by a bone marrow stem-cell transplant at a major western medical center, after almost three years of continuous disease and multiple treatments. Months later a routine CT scan revealed what appeared to the transplant oncologist to be recurrent cancer in the spine. The implication was that the chemotherapy and bone marrow transplant had failed.

The transplant oncologist sent the following letter to the patient, her radiation oncologist, and the chief of the breast service at a major cancer center in the patient's home city:

> Dear Olga [the patient], Cheryl, and Jimmy:
>
> Enclosed is the relevant bone window from Olga's 11-12-97 CT Scan (as well as the formal reading) demonstrating the new sclerotic focus in the left pedicle of L2. I have circled it in red. It looks real to me and I would have Cheryl buzz [radiate] that area.
>
> Olga, this is our only copy so will you send that one sheet back to us for our files? Hope all is well with the three of you. Talk to you soon.
>
> Sincerely
>
> [Signed]
>
> Associate Director,
> Bone Marrow Transplant Program

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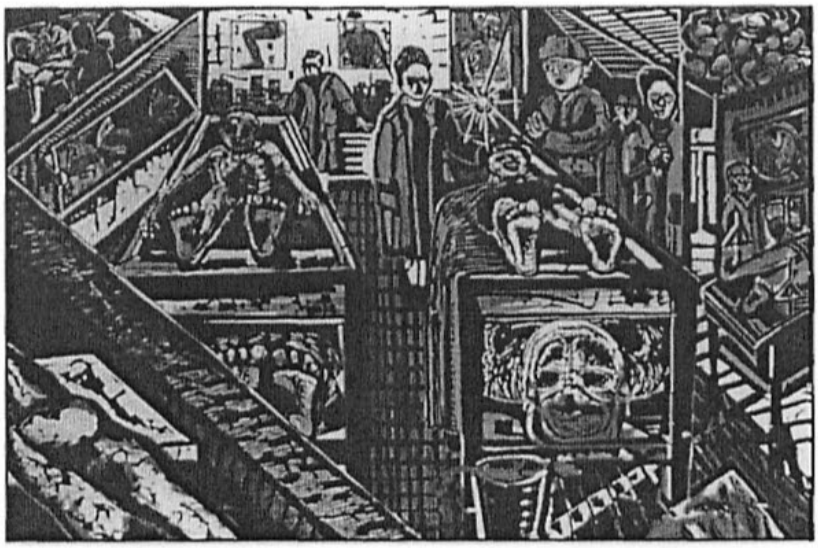
In the forty-three years between these cases both medicine and the society around it have changed significantly under the influence of complex and intertwining forces. Scientific and technological advance have come to drive medical practice; the organization and financing of medical services have been remodeled in response both to new therapeutic capabilities and to the increasing costs of those therapies; chronic disease has displaced infectious and other acute diseases as the leading reason for seeking medical care and the leading cause of death; and the relationship between the patient and the physician has shifted not only toward "patient-centered" care but equally toward consumerism.

American society, of course, has undergone equally deep changes as government and authority were challenged in the social unrest of the '60s and '70s, rights movements of all kinds (civil rights, women's rights, patients' rights, gay rights, disability rights, and others) have gained prominence, individualism and pride in ethnicity have superceded the metaphor of the American "melting pot," and information technologies and financial and economic forces have captured the social imagination, allowing an ever-widening gap to open between rich and poor.

Like the wider society, neither the profession of medicine nor medical education is what it was a scant four decades ago.

Just about midway through these forty years of transformation, in 1978, the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research published the *Belmont Report*, introducing the principles of respect for persons, beneficence, and justice into research with human subjects—and foreclosing scenarios like the opening case. The Belmont principles have permeated clinical medicine as well. For example, recognition of the importance of freedom of choice as an aspect of respect for persons is now instantiated in informed consent documents, laws, and court rulings. Similarly, the principles of respect for persons and beneficence are institutionalized in hospital functions that monitor quality of care, such as the tissue committees that insure that surgical procedures are appropriate. Patterns of practice, professional ideals, and the everyday behavior of both doctors and patients also demonstrate the definitions and application of the principles. They show what patients expect or demand and what physicians feel obligated to do. But what the principles mean is closely bound up with the changes in medicine and the social context in which medicine is practiced.



Eric Avery, ***As It Is***, 1987, five-color lithograph with woodcut overprint, courtesy of the artist.

Beneficence

I begin with the principle of beneficence because the place of respect for persons and justice in clinical practice is easier to understand when one becomes aware of the changes since the 1950s in what counts as beneficence in medicine. Beneficent (or benevolent) actions or behaviors are those that actively do good or that actively protect from harm. Initially, the idea of doing good and avoiding harm was seen as resulting from both physicians' personal characteristics and medical effectiveness. The former, if ideal, would be devoid of overweening pride, venality, impure motives, untrustworthiness, and carelessness. The latter was a function of technical knowledge and proficiency. The physicians of the derelict with the heart attack suffered both moral and technical inadequacies of which they were largely unaware. They were, however, unquestionably aware of the dangers and fearful of harming him.

The intervening period in medicine has seen an explosion of technical capacity and a great increase in moral awareness, but the concept of benevolence has shrunk pari passu. The personal characteristics of physicians that served beneficence and were believed to be of great importance in previous generations now serve nostalgia more than clinical medicine.

In the early 1950s, being made better was often defined as having the burdens of disease lifted. Benevolence had to do with making patients better. During my training and early years of medical practice, disease manifestations were treated because they were there. Hernias, hemorrhoids that made any trouble, and most varicose veins of the legs were surgically removed, as were many superficial tumors and abnormalities. By the late 1950s, psychological de-