UNIT 3

Contents:

Introduction

Research scientists are obliged to follow certain values and principles. Values such as these do not give answers as to how to handle a particular situation, but provide a useful framework for understanding conflicts. Sometimes, no good solution to a dilemma in medical ethics exists, and occasionally, the values of the medical community (i.e., the hospital and its staff) conflict with the values of the individual patient, family, or larger non-medical community. These values are the basis of the ARRT code of ethics which is strictly enforced.

HISTORY OF MEDICAL ETHICS

Historically, Western medical ethics may be traced to guidelines on the duty of physicians in antiquity, such as the Hippocratic Oath, and early Christian teachings. The first code of medical ethics, Formula Comitis Archiatrorum, was published in the 5th century, during the reign of the Ostrogothic king Theodoric the Great. In the medieval and early modern period, the field is indebted to Islamic scholarship such as Ishaq ibn Ali al-Ruhawi (who wrote the Conduct o/a Physician, the first book dedicated to medical ethics), Avicenna's Canon of Medicine and Muhammad ibn Zakariya ar-Razi (known as Rhazes in the West), Jewish thinkers such ms Maimonides, Roman Catholic scholastic thinkers such as Thomas Aquinas, and the

case-oriented analysis (casuistry) of Catholic moral theology. These intellectual traditions continue in Catholic, Islamic and Jewish medical ethics.

By the 18th and 19th centuries, medical ethics emerged as a more self-conscious discourse. In England, Thomas Percival, a physician and author, crafted the first modern code of medical ethics. He drew up a pamphlet with the code in 1794 and wrote an expanded version in 1803, in which he coined the expressions "medical ethics" and "medical jurisprudence". However, there are some who see Percival's guidelines that relate to physician consultations as being excessively protective of the home physician's reputation. Jeffrey Berlant is one such critic who considers Percival's codes of physician consultations as being an early example of the anti-competitive, "guild"-like nature of the physician community. In 1 815, the Apothecaries Act was passed by the Parliament of the United Kingdom. It introduced compulsory apprenticeship and formal qualifications for the apothecaries of the day under the license of the Society of Apothecaries. This was the beginning of regulation of the medical profession in the UK. In 1847, the American Medical Association adopted its first code ofethics, with this being based in large part upon Percival's work. While the secularized field borrowed largely from Catholic medical ethics, in the 20th century a distinctively liberal Protestant approach was articulated by thinkers such as Joseph Fletcher. In the 1960s and 1970s, building upon liberal theory and procedural justice, much of the discourse of medical ethics went through a dramatic shift and largely reconfigured itself into bioethics.

Since the 1970s, the growing influence of ethics in contemporary medicine can be seen in the increasing use of Institutional Review Boards to evaluate experiments on human subjects, the establishment of hospital ethics committees, the expansion of the role of clinician ethicists, and the integration of ethics into many medical school curricula.

VALUES IN MEDICAL ETHICS

A common framework used in the analysis of medical ethics is the "four principle values" approach postulated by Tom Beauchamp and James Childress in their textbook Principles of biomedical ethics. It recognizes four basic moral principles, which are to be judged and weighed against each other, with attention given to the scope of their application. The four principle values in medical ethics are:

- **Respect for autonomy** – the patient has the right to refuse or choose their treatment. (Voluntas aegroti suprema lex.)
- **Beneficence** – a practitioner should act in the best interest of the patient. (Salus aegroti suprema lex.)
- **Non-maleficence** – "first, do no harm" (primum non nocere).
- **Justice** – concerns the distribution of scarce health resources, and the decision of who gets what treatment (fairness and equality).

Other values which are sometimes discussed include:

- **Respect for persons** – the patient (and the person treating the patient) have the right to be treated with dignity.

- **Truthfulness and honesty** – the concept of informed consent has increased in importance since the historical events of the Doctors' Trial of the Nuremberg trials and Tuskegee syphilis experiment.

When moral values are in conflict, the result may be an ethical dilemma or crisis. Conflicts can also arise between health care providers, or among family members. Some argue for example, that the principles of autonomy and beneficence clash when patients refuse blood transfusions, considering them life-saving; and truth-telling was not emphasized to a large extent before the time of HIV.

AUTONOMY

The principle of autonomy recognizes the rights of individuals to self-determination. This is rooted in society's respect for individuals' ability to make informed decisions about personal matters. Autonomy has become more important as social values have shifted to define medical quality in terms of outcomes that are important to the patient rather than medical professionals. The increasing importance of autonomy can be seen as a social reaction to a "paternalistic" tradition within healthcare. Some have questioned whether the backlash against historically excessive paternalism in favor of patient autonomy has inhibited the proper use of soft paternalism to the detriment of outcomes for some patients. Respect for autonomy is the basis for informed consent and advance directives. Autonomy is a general indicator of health. Many diseases are characterized by loss of autonomy, in various manners. This makes autonomy an indicator for both personal wellbeing, and for the well-being of the profession. This has implications for the consideration of medical ethics: "is the aim of health care to do good, and benefit from it?" or "is the aim of health care to do good to others, and have them and society, benefit from this?" (Ethics – by definition – tries to find a beneficial balance between the activities of the individual and its effects on a collective.) By considering autonomy as a gauge parameter for (self) health care, the medical and ethical perspective both benefit from the implied reference to health. Psychiatrists and clinical psychologists are often asked to evaluate a patient's capacity for making life-and-death decisions at the end of life. Persons with a psychiatric condition such as delirium or clinical depression may not have the capacity to make end-of-life decisions. Therefore, for these persons, a request to refuse treatment may be taken in consideration of their condition and not followed. Unless there is a clear advance directive to the contrary, persons who lack mental capacity are generally treated according to their best interests. On the other hand, persons who have the mental capacity to make end-of-life decisions have the right to refuse treatment and choose an early death if that is what they truly want. In such cases, psychiatrists and psychologists are typically part of protecting that right.

BENEFICENCE

The term beneficence refers to actions that promote the well being of others. In the medical context, this means taking actions that serve the best interests of patients. However, uncertainty surrounds the precise definition of which practices do in fact help patients. James Childress and Tom Beauchamp in Principle of Biomedical Ethics (1978) identify beneficence as one of the core values of healthcare ethics. Some scholars, such as Edmund Pellegrino, argue that

beneficence is the only fundamental principle of medical ethics. They argue that healing should be the sole purpose of medicine, and that endeavors like cosmetic surgery, contraception and euthanasia fall beyond its purview.

NON-MALEFICENCE

The concept of non-maleficence is embodied by the phrase, "first, do no harm," or the Latin, primum non nocere. Many consider that should be the main or primary consideration (hence primum): that it is more important not to harm your patient, than to do them good. This is partly because enthusiastic practitioners are prone to using treatments that they believe will do good, without first having evaluated them adequately to ensure they do no (or only acceptable levels of) harm. Much harm has been done to patients as a result, as in the saying, "The treatment was a success, but the patient died." Itis not only more important to do no harm than to do good; it is also important to know how likely it is that your treatment will harm a patient. So for example, a physician should go further than not prescribing medications they know to be harmful – he or she should not prescribe medications (or otherwise treat the patient) unless s/he knows that the treatment is unlikely to be harmful; or at the very least, that patient understands the risks and benefits, and that the likely benefits outweigh the likely risks. In practice, however, many treatments carry some risk of harm. In some circumstances, e.g. in desperate situations where the outcome without treatment will be grave, risky treatments that stand a high chance of harming the patient will be justified, as the risk of not treating is also very likely to do harm. So the principle of non-maleficence is not absolute, and balances against the principle of beneficence (doing good), as the effects of the two principles together often give rise to a double effect (further described in next section). Depending on the cultural consensus conditioning (expressed by its religious, political and legal social system) the legal definition of non-maleficence differs. Violation of nonmaleficence is the subject of medical malpractice litigation. Regulations therefore differ over time, per nation.

DOUBLE EFFECT

Double effect refers to two types of consequences which may be produced by a single action, and in medical ethics it is usually regarded as the combined effect of beneficence and non-maleficence. A commonly cited example of this phenomenon is the use of morphine or other analgesic in the dying patient. Such use of morphine can have the beneficial effect of easing the pain and suffering of the patient, while simultaneously having the maleficent effect of hastening the death of the patient through suppression of the respiratory system.

CONFLICTS BETWEEN AUTONOMY AND BENEFICENCE AND NON-MALEFICENCE

Autonomy can come into conflict with beneficence when patients disagree with recommendations that health care professionals believe are in the patient's best interest. When the patient's interests conflict with the patient's welfare, different societies settle the conflict in a

wide range of manners. Western medicine generally defers to the wishes of a mentally competent patient to make his own decisions, even in cases where the medical team believes that he is not acting in his own best interests. However, many other societies prioritize beneficence over autonomy. Examples include when a patient does not want a treatment because of, for example, religious or cultural views. In the case of euthanasia, the patient, or relatives of a patient, may want to end the life of the patient. Also, the patient may want an unnecessary treatment, as can be the case in hypochondria or with cosmetic surgery; here, the practitioner may be required to balance the desires of the patient for medically unnecessary potential risks against the patient's informed autonomy in the issue. A doctor may want to prefer autonomy because refusal to please the patient's will would harm the doctor-patient relationship. An individual's capacity for informed decision making may come into question during resolution of conflicts between autonomy and beneficence. The role of surrogate medical decision makers is an extension of the principle of autonomy. Autonomy and non-maleficence may also overlap. For example, a breach of patients' autonomy may cause a decrease in confidence for medical services in the population and subsequently the population might be less willingness to seek medical help. The principles of conflict between autonomy and beneficence or non-maleficence may also be expanded to include effects on the relatives of patients or even the medical practitioners, the overall population and economic issues when making medical decisions.

EUTHANASIA

There is disagreement among American healthcare providers as to whether the nonmaleficence principle should exclude the practice of euthanasia. An example of a doctor who did not believe euthanasia should be excluded was Dr. Jack Kevorkian, who was convicted of second-degree homicide in Michigan in 1998 after demonstrating active euthanasia on the TV news show 60 Minutes. In some countries, such as the Netherlands, euthanasia is an accepted medical practice under certain conditions. Legal regulations assign this to the medical profession. In such nations, the aim is to alleviate the suffering of patients from diseases known to be incurable by the methods known in that culture. In that sense, the "Primum no Nocere" is based on the belief that the inability of the medical expert to offer help, creates a known great and ongoing suffering in the patient.

INFORMED CONSENT

Informed consent in medical ethics usually refers to the idea that a patient must be fully informed about and understand the potential benefits and risks of their choice of treatment. An uninformed person is at risk of mistakenly making a choice not reflective of his or her values or wishes. It does not specifically mean the process of obtaining consent, nor the specific legal requirements, which vary from place to place, for capacity to consent. Patients can elect to make their own medical decisions, or can delegate decision-making authority to another party. If the patient is incapacitated, laws around the world designate different processes for obtaining informed consent, typically by having a person appointed by the patient or their next of kin make decisions for them. The value of informed consent is closely related to the values of autonomy and truth telling. A correlate to "informed consent" is the concept of informed refusal.

CONFIDENTIALITY

Confidentiality is commonly applied to conversations between healthcare providers and patients. Legal protections prevent healthcare providers from revealing their discussions with patients, even under oath in court. Patient confidentiality is mandated in America by laws stemming from the Health Information Portability and Accountability Act (HIPAA), specifically the Privacy Rule, and various state laws, some more rigorous than HIPAA. However, numerous exceptions to the rules have been carved out over the years. For example, many states require healthcare providers to report gunshot wounds to the police and impaired drivers to the Department of Motor Vehicles. Confidentiality is also challenged in cases involving the diagnosis of a sexually transmitted disease in a patient who refuses to reveal the diagnosis to a spouse, and in the termination of a pregnancy in an underage patient, without the knowledge of the patient's parents. Many states in the U.S. have laws governing parental notification in underage abortion. Traditionally, medical ethics has viewed the duty of confidentiality as a relatively nonnegotiable tenet of medical practice. More recently, critics like Jacob Appel have argued for a more nuanced approach to the duty that acknowledges the need for flexibility in many cases. Confidentiality is an important issue in primary care ethics, where healthcare providers care for many patients from the same family and community, and where third parties often request information from the considerable medical database typically gathered in primary health care.

CRITICISMS OF ORTHODOX MEDICAL ETHICS

It has been argued that mainstream medical ethics is biased by the assumption of a framework in which individuals are not simply free to contract with one another to provide whatever medical treatment is demanded, subject to the ability to pay. Because a high proportion of medical care is typically provided via the welfare state (ie. Medicare), and because there are legal restrictions on what treatment may be provided and by whom, an automatic divergence may exist between the wishes of patients and the preferences of medical practitioners and other parties.

IMPORTANCE OF COMMUNICATION

Many so-called "ethical conflicts" in medical ethics are traceable back to a lack of communication. Communication breakdowns between patients and their healthcare team, between family members, or between members of the medical community, can all lead to disagreements and strong feelings. These breakdowns should be remedied, and many apparently insurmountable "ethics" problems can be solved with open lines of communication.

CONTROL AND RESOLUTION

To ensure that appropriate ethical values are being applied within hospitals, effective hospital accreditation requires that ethical considerations are taken into account, for example with respect to healthcare provider integrity, conflict of interest, research ethics and organ transplantation ethics.

GUIDELINES

There are various ethical guidelines. For example, the Declaration of Helsinki is regarded as authoritative in human research ethics. In the United Kingdom, General Medical Council provides clear overall modern guidance in the form of its 'GoodMedical Practice' statement. Other organizations, such as the Medical Protection Society and a number of university departments, are often consulted by British doctors regarding issues relating to ethics. The ARRT is an example of an organization which requires it's members to adhere to a specific ethical code of conduct.

ETHICS COMMITTEES

Often, simple communication is not enough to resolve a conflict, and a hospital, or organization's ethics committee must convene to decide a complex matter. These bodies are composed primarily of health care professionals, but may also include philosophers, lay people, and clergy – indeed, in many parts of the world their presence is considered mandatory in order to provide balance. The ARRT ethics committee is such a body which resolves conflicts pertaining to its members.

MEDICAL ETHICS IN AN ONLINE WORLD

Increasingly, medical researchers are researching activities in online environments such as discussion boards and bulletin boards, and there is concern that the requirements of informed consent and privacy are not as stringently applied as they should be, although some guidelines do exist. The delivery of diagnosis online leads patients to believe that doctors in some parts of the country are at the direct service of drug companies. Finding diagnosis as convenient as what drug still has patent rights on it. Physicians and drug companies are found to be competing for top ten search engine ranks to lower costs of selling these drugs with little to no patient involvement. Another issue that has arisen, however, is the disclosure of information. While researchers wish to quote from the original source in order to argue a point, this can have repercussions. The quotations and other information about the site can be used to identify the site, and researchers have reported cases where members of the site, bloggers and others have used this information as 'clues' in a game in an attempt to identify the site. Some researchers have employed various methods of "heavy disguise," including discussing a different condition from that under study, or even setting up bogus sites (called 'Maryut sites') to ensure that the researched site is not discovered. The term "Maryut site" is a reference to the story of the creation of a decoy site at Maryut Lake to prevent Alexandria Harbor's being bombed during World War II. The process of using a Maryut site would be the following: The researcher creates a fake (or "Maryut") web site that has astructure similar to the research site. The researcher then populates the Maryut site with plausible information. In the research paper, amongst the real information listed, the researcher lists the fake information that is found only in the Maryut site.

CULTURAL CONCERNS

Culture differences can create difficult medical ethics problems. Some cultures have spiritual or magical theories about the origins of disease, for example, and reconciling these beliefs with the tenets of Western medicine can be difficult. This will be discussed in detail in later chapters.

TRUTH TELLING

Some cultures do not place a great emphasis on informing the patient of the diagnosis, especially when cancer is the diagnosis. American culture rarely used truth-telling especially in medical cases, up until the 1970s. In American medicine, the principle of informed consent now takes precedence over other ethical values, and patients are usually at least asked whether they want to know the diagnosis.

ONLINE BUSINESS PRACTICES

Healthcare websites have the responsibility to ensure that the private medical records of their online visitors are secure from being marketed and monetized into the hands of drug companies, occupation records, insurancers. The delivery of diagnosis online leads patients to believe that doctors in some parts of the country are at the direct service of drug companies, finding diagnosis as convenient as what drug still has patent rights on it. Physicians and drug companies are found to be competing for top ten search engine ranks to lower costs of selling these drugs with little to no patient involvement. With the expansion of internet healthcare platforms, online practitioner legitimacy and privacy accountability face unique challenges such as e-paparazzi, online information brokers, industrial spies, unlicensed information providers that work outside of traditional medical codes for profit. The American Medical Association (AMA) states that medical websites have the responsibility to ensure the health care privacy of online visitors and protect patient records from being marketed and monetized into the hands of insurance companies, employers, and marketers. With the rapid unification of healthcare, business practices, computer science and e-commerce to create these online diagnostic websites, efforts to maintain health care system's ethical confidentiality standard need to keep up as well. Over the next few years, the Department of Health and Human Services have stated that they will be working towards lawfully protecting the online privacy and digital transfers of patient Electronic Medical Records (EMR) under The Health Insurance Portability and Accountability Act (HIPAA).

CONFLICTS OF INTEREST

Healthcare providers should not allow a conflict of interest to influence medical judgment. In some cases, conflicts are hard to avoid, and doctors have a responsibility to avoid entering such situations. Unfortunately, research has shown that conflicts of interests are very common among both academic healthcare providers and healthcare providers in practice. The Pew Charitable

Trusts has announced the Prescription Project for "academic medical centers, professional medical societies and public and private payers to end conflicts of interest resulting from the $12 billion spent annually on pharmaceutical marketing"

REFERRALS

Doctors who receive income from referring patients for medical tests have been shown to refer more patients for medical tests which could lead to unneeded and excessive testing.This practice is forbidden by the American College of Physicians. Fee splitting and the payments of commissions to attract referrals of patients is considered unethical and unacceptable in most parts of the world.

VENDOR RELATIONSHIPS

Studies show that doctors can be influenced by drug company inducements, including gifts and food. There is concern that industry-sponsored Continuing Medical Education (CME) programs may influence the behavior patterns of healthcare providers. Many patients surveyed in one study agreed that physician gifts from drug companies influence prescribing practices. A growing movement among physicians is attempting to diminish the influence of pharmaceutical industry marketing upon medical practice, as evidenced by Stanford University's ban on drug company-sponsored lunches and gifts. Other academic institutions that have banned pharmaceutical industry-sponsored gifts and food include the Johns Hopkins Medical Institutions, University of Michigan, University of Pennsylvania, and Yale University.

TREATMENT OF FAMILY MEMBERS

Many healthcare providers treat their family members. Healthcare providers who do so must be vigilant not to create conflicts of interest or treat inappropriately.

SEXUAL RELATIONSHIPS

Sexual relationships between healthcare providers and patients can create ethical conflicts, since sexual consent may conflict with the fiduciary responsibility of the healthcare provider. Healthcare providers who enter into sexual relationships with patients in some cases can face the threats of deregistration and prosecution. Sexual relationships between healthcare providers and patients' relatives may also be prohibited in some jurisdictions, although this prohibition is highly controversial.

FUTILITY

The concept of medical futility has been an important topic in discussions of medical ethics. What should be done if there is no chance that a patient will survive but the family members

insist on advanced care? Previously, some articles defined futility as the patient having less than a one percent chance of surviving. Some of these cases wind up in the courts. In some hospitals, medical futility is referred to as “non-beneficial care.” Advanced directives include living wills and durable powers of attorney for health care. Such directives include Do Not Resuscitate or DNR orders. In many cases, the “expressed wishes” of the patient are documented in these directives, and this provides a framework to guide family members and health care professionals in the decision making process when the patient is incapacitated. Undocumented expressed wishes can also help guide decisions in the absence of advanced directives. “Substituted judgment” is the concept that a family member can give consent for treatment if the patient is unable (or unwilling) to give consent themselves. The key question for the decision making surrogate is not, “What would you like to do?”, but instead, “What do you think the patient would want in this situation?” Courts have supported family’s arbitrary definitions of futility to include simple biological survival, as in the Baby K case (in which the courts ordered a child born with only a brain stem instead of a complete brain to be kept on a ventilator based on the religious belief that all life must be preserved). The Baby Doe Law or Baby Doe Amendment is the name of an amendment to the Child Abuse Law passed in 1984 in the United States that sets forth specific criteria and guidelines for the treatment of seriously ill and/or disabled newborns, regardless of the wishes of the parents. The Baby Doe Law establishes state protection for a disabled child’s right to life, ensuring that this right is protected even over the wishes of parents or guardians in cases where they want to withhold treatment. The Baby Doe Law or Baby Doe Amendment is the name of an amendment to the Child Abuse Law passed in 1984 in the United States that sets forth specific criteria and guidelines for the treatment of seriously ill and/or disabled newborns, regardless of the wishes of the parents. The Baby Doe Law mandates that states receiving federal money for child abuse programs develop procedures to report medical neglect, which the law defines as the withholding of treatment unless a baby is irreversibly comatose or the treatment is “virtually futile” in terms of the newborn’s survival. Assessments of a child’s quality of life are not valid reasons for withholding medical care