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Medical Ethics: A Review

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ABSTRACT

Getting to the heart of the often-impossible moral dilemmas and persistent ethical problems which confront medical staff, this article aims to help the aid workers and health practitioners alike understand why principles matter more than ever and how they can be used to make better choices. In light of ongoing Coronavirus pandemics, the ethical dilemmas are at cornerstone of health practitioners' day-to-day realities across the globe. A much-needed moral compass needs to be developed to help health workers to navigate tensions between principle and practice. I hope that this contribution is sees as an invaluable tool that helps penetrate the fundamental moral and ethical questions of health providers, accessible both for scholars and practitioners.

***Key words**: scholars and practitioners, fundamental moral and ethical questions of health providers*

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INTRODUCTION

Medical ethics is a system of moral principles that apply values to the practice of clinical medicine and in scientific research. Medical ethics is based on a set of values that professionals can refer to in the case of any confusion or conflict. These values include the respect for autonomy, non-maleficence, beneficence, and justice

Such tenets may allow doctors, care providers, and families to create a treatment plan and work towards the same common goal. It is important to note that these four values are not ranked in order of importance or relevance and that they all encompass values pertaining to medical ethics. However, a conflict may arise leading to the need for hierarchy in an ethical system, such that some moral elements overrule others with the purpose of applying the best moral judgement to a difficult medical situation.

Medical ethics involves examining a specific problem, usually a clinical case, and using values, facts, and logic to decide what the best course of action should be. Some ethical problems are fairly straightforward, such as determining right from wrong. But others can also be more perplexing, such as deciding between two "rights"—two values that are in conflict with each other—or deciding between two different value systems, such as the patient's versus the doctor's.

Doctors may deal with a great variety of perplexing ethical problems even in a small medical practice. Here are some common problems identified in a 2016 Medscape survey, where at least some physicians held different opinions:

- ✓ Accepting money from pharmaceutical or device manufacturers;
- ✓ Upcoding to get treatment covered;
- ✓ Getting romantically involved with a patient or family member;
- ✓ Covering up a mistake;
- ✓ Reporting an impaired colleague;
- ✓ Cherry-picking patients;
- ✓ Withholding treatment to meet an organization's budget, or because of insurance policies;
- ✓ Prescribing a placebo;
- ✓ Practicing defensive medicine to avoid malpractice lawsuits;
- ✓ Dropping insurers;
- ✓ Breaching patient confidentiality owing to a health risk.
- ✓ Withdrawal of ventilation in a dying patient
- ✓ Treatment of patients with self-inflicted disease
- ✓ Termination of pregnancy
- ✓ Management and treatment of people with dementia
- ✓ Use of highly expensive treatments for rare diseases

- ✓ Use of animals in clinical trials
- ✓ Use of humans in clinical trials
- ✓ Euthanasia
- ✓ Should we be carrying out bariatric surgery?
- ✓ Should doctors ever go on strike?

Professional standards are a way to provide some guidance on ethical problems, but they cannot address every issue, and they may not address troubling nuances, such as reconciling two conflicting values.

MATERIAL AND METHODS

Many professional ethicists recommend using four basic values, or principles, to decide ethical issues:

1. Autonomy: Patients basically have the right to determine their own healthcare.
2. Justice: Distributing the benefits and burdens of care across society.
3. Beneficence: Doing good for the patient.
4. Non-malfeasance: Making sure you are not harming the patient.

However, ethical values are not limited to just these four principles. There are other important values to consider, such as truth-telling, transparency, showing respect for patients and families, and showing respect for patients' own values.

In addition, medical ethics is not just a thought process. It also involves people skills, such as gathering the facts needed to make a decision and presenting your decision in a way that wins over the confidence of all parties.

Ethics is often seen as a proscriptive activity—telling you what you cannot do. But in many cases, it can be very freeing. It can affirm that you are doing the right thing.

Listening skills are an essential part of medical ethics. Quite often, ethical disputes result from not knowing all the facts, or not providing all the facts to patients. Tactfulness and respect are also important. A well-constructed ethical decision could be ignored if you have not won the patient's confidence.

Ethics is often seen as a proscriptive activity—telling you what you cannot do. But in many cases, it can be very freeing. It can affirm that you are doing the right thing. If you go through the proper ethical thought process, you'll have greater certainty that what you're doing is the right thing. Relieved of nagging doubts, you will be able to proceed more directly and more vigorously with your care plan.

As the health system evolves, ethical decisions could become more challenging.

For example, mounting difficulties in finding affordable insurance prompt patients to forgo the care they need, and this affects the clinician's care plan.

There are several codes of conduct.

The Hippocratic Oath discusses basic principles for medical professionals. This document dates back to the fifth century BCE. Both The Declaration of Helsinki (1964) and The Nuremberg Code (1947) are two well-known and well respected documents contributing to medical ethics. Other important markings in the history of Medical Ethics include *Roe v. Wade* in 1973 and the development of Hemodialysis in the 1960s. More recently, new techniques for gene editing aiming at treating, preventing and curing diseases utilizing gene editing, are raising important moral questions about their applications in medicine and treatments as well as societal impacts on future generations.

As this field continues to develop and change throughout history, the focus remains on fair, balanced, and moral thinking across all cultural and religious backgrounds around the world. Medical ethics encompasses a practical application in clinical settings as well as scholarly work on its history, philosophy, and sociology. Medical ethics encompasses beneficence, autonomy, and justice as they relate to conflicts such as euthanasia, patient confidentiality, informed consent, and conflicts of interest in healthcare. In addition, medical ethics and culture are interconnected as different cultures implement ethical values differently, sometimes placing more emphasis on family values and downplaying the importance of autonomy. This leads to an increasing need for culturally sensitive physicians and ethical committees in hospitals and other healthcare settings.

Doctors exposed at he frontline of Hippocratic oath daily navigate ethical minefields and this brief analytical piece aims at lucidly exploring moral complexities.

'Primum non nocere – First do no harm, vowed by *I will abstain from all intentional wrong doings.*

The Hippocratic oath has been eclipsed as a document of professional ethics, providing a comprehensive overview of the obligations and professional behaviour of a doctor to the patients and wider society.

Though there is no direct punishment for breaking the Hippocratic Oath, in a modern world so called medical malpractice carries a wide range of punishments from legal actions to civil penalties. Some court decisions have made reference to the Oath, either upholding or dismissing its bounds for medical ethics.

A common framework used in the analysis of medical ethics is the "four principles" 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 principles are:

- Respect for autonomy – the patient has the right to refuse or choose their treatment.
- Beneficence – a practitioner should act in the best interest of the patient.
- Non-maleficence – to not be the cause of harm. Also, "Utility" - to promote more good than harm
- Justice – concerns the distribution of scarce health resources, and the decision of who gets what treatment.

RESULTS AND DISCUSSIONS

The principle of autonomy, broken down into "autos" (self) and "nomos (rule), views the rights of an individual to self-determination. This is rooted in society's respect for individuals' ability to make informed decisions about personal matters with freedom. Autonomy has become more important as social values have shifted to define medical quality in terms of outcomes that are important to the patient and their family rather than medical professionals. The increasing importance of autonomy can be seen as a social reaction against the "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.

The definition of autonomy is the ability of an individual to make a rational, uninfluenced decision. Therefore, it can be said that autonomy is a general indicator of a healthy mind and body. The progression of many terminal diseases are characterized by loss of autonomy, in various manners and extents. For example, dementia, a chronic and progressive disease that attacks the brain can induce memory loss and cause a decrease in rational thinking, almost always results in the loss of autonomy.

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 lack capacity to make end-of-life decisions. For these persons, a request to refuse treatment may be taken in the context of their condition. Unless there is a clear advance directive to the contrary, persons lacking mental capacity are treated according to their best interests. This will involve an assessment involving people who know the person best to what decisions the person would have made had they not lost capacity. Persons with the mental capacity to make end-of-life decisions may refuse treatment with the understanding that it may shorten their life. Psychiatrists and psychologists may be involved to support decision making.

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 and their families. However, uncertainty surrounds the precise definition of which practices do in fact help patients.

Informed consent in ethics usually refers to the idea that a person must be fully informed about and understand the potential benefits and risks of their choice of treatment. A correlate to "informed consent" is the concept of informed refusal. 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, or 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.

Confidentiality is commonly applied to conversations between doctors and patients. This concept is commonly known as patient-physician privilege. Legal protections prevent physicians from revealing their discussions with patients, even under oath in court.

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.

Traditionally, medical ethics has viewed the duty of confidentiality as a relatively non-negotiable 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 physicians 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.

In increasing frequency, 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 applied, although some guidelines do exist.

One 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 when the identity of the patient is not kept confidential. The quotations and other information about the site can be used to identify the patient, 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.

Healthcare institutions' 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, and insurance companies. 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. 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.

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 physician integrity, conflict of interest, research ethics and organ transplantation ethics.

There is much documentation of the history and necessity of the Declaration of Helsinki. The first code of conduct for research including medical ethics was the Nuremberg Code. This document had large ties to Nazi war crimes, as it was introduced in 1947, so it didn't make much of a difference in terms of regulating practice. This issue called for the creation of the Declaration. There are some stark differences between the Nuremberg Code and the Declaration of Helsinki, including the way it is written. Nuremberg was written in a very concise manner, with a simple explanation. The Declaration of Helsinki is written with a thorough explanation in mind and including many specific commentaries.

In the United Kingdom, General Medical Council provides clear overall modern guidance in the form of its 'Good Medical 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.

One concern regarding the intersection of medical ethics and humanitarian medical aid is how medical assistance can be as harmful as it is helpful to the community being served. One such example being how political forces may control how foreign humanitarian aid can be utilized in the region it is meant to be provided in. This would be congruous in situations where political strife could lead such aid being used in favor of one group over another. Another example of how foreign humanitarian aid can be misused in its intended community includes the possibility of dissonance forming between a foreign humanitarian aid group and the community being served. Examples of this could include the relationships being viewed between aid workers, style of dress, or the lack of education regarding local culture and customs.

Humanitarian practices in areas lacking optimum care can also pause other interesting and difficult ethical dilemmas in terms of beneficence and non-maleficence. Humanitarian practices are based upon providing better medical equipment and care for communities whose country does not provide adequate healthcare. The issues with providing healthcare to communities in need may sometimes be religious or cultural backgrounds keeping people from performing certain procedures or taking certain drugs. On the other hand, wanting certain procedures done in a specific manner due to religious or cultural belief systems may also occur. The ethical dilemma stems from differences in culture between communities helping those with medical disparities and the societies receiving aid. Women's rights, informed consent and education about health become controversial, as some treatments needed are against societal law, while some cultural traditions involve procedures against humanitarian efforts. Examples of this are female genital mutilation (FGM), aiding in re-infibulation, providing sterile equipment in order to perform procedures such as FGM, as well as informing patients of their HIV positive testing. The latter is controversial because certain communities have in the past outcast or killed HIV positive individuals.

Leading causes of death around the world are highly related to behavioral consequences over genetic or environmental factors. This leads some to believe true healthcare reform begins with cultural reform, habit and overall lifestyle. Lifestyle, then, becomes the cause of many illnesses and the illnesses themselves are the result or side-effect of a larger problem. Some people believe this to be true and think that cultural change is needed in order for developing societies to cope and dodge the negative effects of drugs, food and

conventional modes of transportation available to them. In 1990, tobacco use, diet, and exercise alone accounted for close to 80 percent of all premature deaths and continue to lead in this way though the 21st century. Heart disease, stroke, dementia, and diabetes are some of the diseases that may be affected by habit forming patters throughout our life. Some believe that medical lifestyle counseling and building healthy habits around our daily lives is one way to tackle health care reform.

Buddhist ethics and medicine are based on religious teachings of compassion and understanding of suffering and cause and effect and the idea that there is no beginning or end to life, but that instead there are only rebirths in an endless cycle. In this way, death is merely a phase in an indefinitely lengthy process of life, not an end. However, Buddhist teachings support living ones life to the fullest so that through all the suffering which encompasses a large part of what is life, there are no regrets. Buddhism accepts suffering as an inescapable experience, but values happiness and thus values life. Because of this suicide, and euthanasia, are prohibited. However, attempts to rid oneself of any physical or mental pain and suffering are seen as good acts. On the other hand, sedatives and drugs are thought to impair consciousness and awareness in the dying process, which is believed to be of great importance, as it is thought that one's dying consciousness remains and affects new life. Because of this, analgesics must not be part of the dying process, in order for the dying person to be present entirely and pass on their consciousness wholesomely. This can pose significant conflicts during end of life care in Western medical practice.

In traditional Chinese philosophy, human life is believed to be connected to nature, which is thought of as the foundation and encompassing force sustaining all of life's phases. Passing and coming of the seasons, life, birth and death are perceived as a cyclic and perpetual occurrences that are believed to be regulated by the principles of When one dies, the life-giving material force referred to as *ch'i*, encompassing both body and spirit, rejoins the material force of the universe and cycles on with respect to the rhythms set forth by *yin* and *yang.*

Because many Chinese people believe that circulation of both physical and 'psychic energy' is important to stay health, procedures which require surgery as well as donations and trans-plantations of organs are seen as a loss of *ch'i* , resulting in the loss of someone's vital energy supporting their consciousness and purpose in their lives. Furthermore, a person is never seen as a single unit but rather as a source of relationship, interconnected in a social web. Thus, it is believed that what makes a human one of us is relatedness and communication and family is seen as the basic unit of a community. This can greatly affect the way medical decisions are made among family members, as diagnoses are not always expected to be announced to the dying or sick, the elderly are expected to be cared for and represented by their children and physicians are expected to act in a paternalistic way. In short, informed consent as well as patient privacy can be difficult to enforce when dealing with Confucian families.

Furthermore, some Chinese people may be inclined to continue futile treatment in order to extend life and allow for fulfillment of the practice of benevolence and humanity. In contrast, patients with strong beliefs may see death as an obstacle and dying as a reunion with nature that should be accepted, and are therefore less likely to ask for treatment of an irreversible condition.

Some believe Islamic medical ethics and framework remain poorly understood by many working in healthcare. It is important to recognize that for people of Islamic faith, Islam envelops and affects all aspects of life, not just medicine. Because many believe it is faith and a supreme deity that hold the cure to illness, it is common that the physician is viewed merely as help or intermediary player during the process of healing or medical care.

In addition to Chinese culture's emphasis on family as the basic unit of a community intertwined and forming a greater social construct, Islamic traditional medicine also places importance on the values of family and the well-being of a community. Many Islamic communities uphold paternalism as an acceptable part of medical care. However, autonomy and self-rule is also valued and protected and, in Islamic medicine, it is particularly upheld in terms of providing and expecting privacy in the healthcare setting. An example of this is requesting same gender providers in order to retain modesty. Overall, Beauchamp's principles of beneficence, non-maleficence and justice are promoted and upheld in the medical sphere with as much importance as in Western culture. In contrast, autonomy is important but more nuanced. Furthermore, Islam also brings forth the principles of jurisprudence, and legal maxims, which also allow for Islam to adapt to an ever-changing medical ethics framework.

Adherence to the interests of the patient is one of the most important keywords in current medical ethics literature. In different parts of his recommendations, Avicenna has advised physicians to care for the patients' interest and has highlighted this issue in differing orders. He considers confidentiality as one of the physician's duties; he explicitly states that "the physician ought to protect the patient's secrets and should not express patient diseases such as hemorrhoids and diseases of women except in the cases of necessity and (only) to the people who should know".

In another section, Avicenna has discussed the physician-pharmacist relation. He considers physician's knowledge on different drugs as a warranty for patient's interest in dealing with pharmacist. He states that it is because of the physician's ability to inhibit the fraudulent activities of a pharmacist when the pharmacist offers expensive drugs to patients, considering his own profit without measuring the potential damages. In fact, Avicenna gives priority to patient's interests in the relationship among patient, physician and pharmacist. In this part, Avicenna has indirectly mentioned the subject of health care provider's conflict of interest. Another issue repeatedly cited in the recommendation of Avicenna is consideration of patient's interests in diagnostic and therapeutic function of physician. According to Avicenna's view, a physician should consider patient's interests and conditions in all of his/her decisions about patient care. In the selection of specific treatment, he should start with the simplest and least aggressive treatments: he needs to avoid prescribing potentially harmful drugs as much as possible. Avicenna explicitly says that the choice of treatment by physician should be based on patient's interest: "He should not prescribe therapeutics unaffordable for patient." He believes that all physicians' behaviors must be based on patient's interests, and this must not be excluded even in regards with examination. One of the outstanding points of Avicenna recommendations is the strong emphasis on avoiding any action that may cause harm to the patient: "Physicians should not recommend the use of poison, lethal drugs and abortive medications; they are not to talk about these materials except when they want to prevent harm or when it benefits the patient". He also states that if the physician causes any harm to the patient or happens to miss one of his/her interests, he should compensate. To summarize, from the viewpoint of Avicenna, respecting patient's interest should dominate all aspects of physicians' relations and decisions.

CONCLUSION

In various parts of his recommendations, Avicenna refers to patient-physician relationship. He believes that physician's professional behavior must be eligible for moderation and be "away from extremes of intimacy or arrogance; because excessive intimacy and jesting harm the dignity of physician while arrogance or any harshness could harm the patient-physician relationship". He also describes in detail how to communicate with patient, when Avicenna says: "… upon visiting of a patient, the physician should sit next to him in a way that is in front of him so that he could see his face and listen to him well. He should only ask the questions that provide necessary information for his diagnosis and treatment: the physician ought to avoid extraneous and unnecessary questions. Moreover, the physicians should avoid prolonging the time of his visit even if the patient wants his companion. The physician should limit the visiting time to the required length in a compassionate and respectful manner." According to Avicenna's view, one of the duties of a physician is to increase the patient's hope to the good prognosis of his disease, but he should condition it to complete compliance with the physician's recommendations: "The physician should also be calm and dignified in his behavior, associated with patience, gentleness and tolerance; he must listen well to the patient's complaints, explain the information he needs according to the patient's understanding, and avoid using difficult words in the conversation with the patient".

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