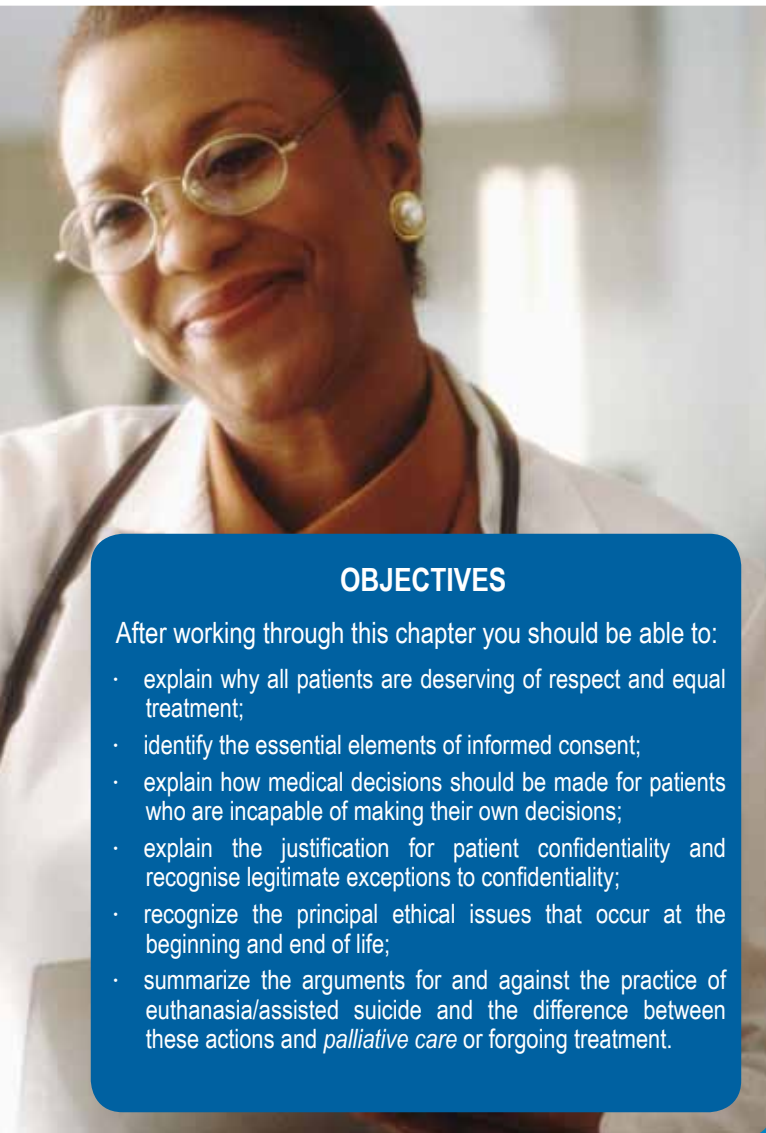


CHAPTER TWO – PHYSICIANS AND PATIENTS



Compassionate doctor

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OBJECTIVES

After working through this chapter you should be able to:

- explain why all patients are deserving of respect and equal treatment;
- identify the essential elements of informed consent;
- explain how medical decisions should be made for patients who are incapable of making their own decisions;
- explain the justification for patient confidentiality and recognise legitimate exceptions to confidentiality;
- recognize the principal ethical issues that occur at the beginning and end of life;
- summarize the arguments for and against the practice of euthanasia/assisted suicide and the difference between these actions and *palliative care* or forgoing treatment.

CASE STUDY #1

Dr. P, an experienced and skilled surgeon, is about to finish night duty at a medium-sized community hospital. A young woman is brought to the hospital by her mother, who leaves immediately after telling the intake nurse that she has to look after her other children. The patient is bleeding vaginally and is in a great deal of pain. Dr. P examines her and decides that she has had either a miscarriage or a self-induced abortion. He does a quick dilatation and curettage and tells the nurse to ask the patient whether she can afford to stay in the hospital until it is safe for her to be discharged. Dr. Q comes in to replace Dr. P, who goes home without having spoken to the patient.

WHAT'S SPECIAL ABOUT THE PHYSICIAN-PATIENT RELATIONSHIP?

The physician-patient relationship is the cornerstone of medical practice and therefore of medical ethics. As noted above, the **Declaration of Geneva** requires of the physician that "The health of my patient will be my first consideration," and the **International Code of Medical Ethics** states, "A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her." As discussed in Chapter One, the traditional interpretation of the physician-patient relationship as a paternalistic one, in which the physician made the decisions and the patient submitted to them, has been widely rejected in recent years, both in ethics and in law. Since many patients are either unable or unwilling to make decisions about their medical care, however, patient autonomy

is often very problematic. Equally problematic are other aspects of the relationship, such as the physician's obligation to maintain patient confidentiality in an era of computerized medical records and managed care, and the duty to preserve life in the face of requests to hasten death.

This section will deal with six topics that pose particularly vexing problems to physicians in their daily practice: respect and equal treatment; communication and consent; decision-making for incompetent patients; confidentiality; beginning-of-life issues; and end-of-life issues.

“The health of my patient will be my first consideration”

RESPECT AND EQUAL TREATMENT

The belief that all human beings deserve respect and equal treatment is relatively recent. In most societies disrespectful and unequal treatment of individuals and groups was accepted as normal and natural. Slavery was one such practice that was not eradicated in the European colonies and the USA until the 19th century and still exists in some parts of the world. The end of institutional discrimination against non-whites in countries such as South Africa is much more recent. Women still experience lack of respect and unequal treatment in most countries. Discrimination on the basis of age, disability or sexual orientation is widespread. Clearly, there remains considerable resistance to the claim that all people should be treated as equals.

The gradual and still ongoing conversion of humanity to a belief in human equality began in the 17th and 18th centuries in Europe and North America. It was led by two opposed ideologies: a new interpretation of Christian faith and an anti-Christian rationalism. The former inspired the American Revolution and Bill of Rights;

the latter, the French Revolution and related political developments. Under these two influences, democracy very gradually took hold and began to spread throughout the world. It was based on a belief in the political equality of all men (and, much later, women) and the consequent right to have a say in who should govern them.

In the 20th century there was considerable elaboration of the concept of human equality in terms of human rights. One of the first acts of the newly established United Nations was to develop the **Universal Declaration of Human Rights** (1948), which states in article 1, "All human beings are born free and equal in dignity and rights." Many other international and national bodies have produced statements of rights, either for all human beings, for all citizens in a specific country, or for certain groups of individuals ('children's rights', 'patients' rights', 'consumers' rights', etc.). Numerous organizations have been formed to promote action on these statements. Unfortunately, though, human rights are still not respected in many countries.

The medical profession has had somewhat conflicting views on patient equality and rights over the years. On the one hand, physicians have been told not to "permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient" (**Declaration of Geneva**). At the same time physicians have claimed the right to refuse to accept a patient, except in an emergency. Although the legitimate grounds for such refusal include a full practice, (lack of) educational qualifications and specialization, if physicians do not have to give any reason for refusing a patient, they can easily practise discrimination without being held accountable. A physician's conscience, rather than the law or disciplinary authorities, may be the only means of preventing abuses of human rights in this regard.

Even if physicians do not offend against respect and human equality in their choice of patients, they can still do so in their attitudes

towards and treatment of patients. The case study described at the beginning of this chapter illustrates this problem. As noted in Chapter One, compassion is one of the core values of medicine and is an essential element of a good therapeutic relationship. Compassion is based on respect for the patient's dignity and values but goes further in acknowledging and responding to the patient's vulnerability in the face of illness and/or disability. If patients sense the physician's compassion, they will be more likely to trust the physician to act in their best interests, and this trust can contribute to the healing process.

The trust that is essential to the physician-patient relationship has generally been interpreted to mean that physicians should not desert patients whose care they have undertaken. The WMA's **International Code of Medical Ethics** implies that the only reason for ending a physician-patient relationship is if the patient requires another physician with different skills: "A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her.

“...in ending a physician-patient relationship... physicians... should be prepared to justify their decision, to themselves, to the patient and to a third party if appropriate.”

Whenever an examination or treatment is beyond the physician's capacity, he/she should consult with or refer to another physician who has the necessary ability." However, there are many other reasons for a physician wanting to terminate a relationship with a patient, for example, the physician's moving or stopping practice, the patient's refusal or inability to pay for the physician's services, dislike of the patient and the physician for each other, the patient's refusal to comply with the physician's recommendations, etc. The reasons may be entirely legitimate, or they may be unethical. When considering such an action, physicians should consult their Code of

Ethics and other relevant guidance documents and carefully examine their motives. They should be prepared to justify their decision, to themselves, to the patient and to a third party if appropriate. If the motive is legitimate, the physician should help the patient find another suitable physician or, if this is not possible, should give the patient adequate notice of withdrawal of services so that the patient can find alternative medical care. If the motive is not legitimate, for example, racial prejudice, the physician should take steps to deal with this defect.

Many physicians, especially those in the public sector, often have no choice of the patients they treat. Some patients are violent and pose a threat to the physician's safety. Others can only be described as obnoxious because of their antisocial attitudes and behaviour. Have such patients forsaken their right to respect and equal treatment, or are physicians expected to make extra, perhaps even heroic, efforts to establish and maintain therapeutic relationships with them? With such patients, physicians must balance their responsibility for their own safety and well-being and that of their staff with their duty to promote the well-being of the patients. They should attempt to find ways to honour both of these obligations. If this is not possible, they should try to make alternative arrangements for the care of the patients.

Another challenge to the principle of respect and equal treatment for all patients arises in the care of infectious patients. The focus here is often on HIV/AIDS, not only because it is a life-threatening disease but also because it is often associated with social prejudices. However, there are many other serious infections including some that are more easily transmissible to healthcare workers than HIV/AIDS. Some physicians hesitate to perform invasive procedures on patients with such conditions because of the possibility that they, the physicians, might become infected. However, medical codes of ethics make no exception for infectious patients with regard to the

physician's duty to treat all patients equally. The WMA's **Statement on HIV/AIDS and the Medical Profession** puts it this way:

Unfair discrimination against HIV/AIDS patients by physicians must be eliminated completely from the practice of medicine.

All persons infected or affected by HIV/AIDS are entitled to adequate prevention, support, treatment and care with compassion and respect for human dignity.

A physician may not ethically refuse to treat a patient whose condition is within his or her current realm of competence, solely because the patient is seropositive.

A physician who is not able to provide the care and services required by patients with HIV/AIDS should make an appropriate referral to those physicians or facilities that are equipped to provide such services. Unless or until the referral can be accomplished, the physician must care for the patient to the best of his or her ability.

“A person who is afflicted with AIDS needs competent, compassionate treatment.”

אתיקה רפואית

The intimate nature of the physician-patient relationship can give rise to sexual attraction. A fundamental rule of traditional medical ethics is that such attraction must be resisted. The Oath of Hippocrates includes the following promise: “Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons....” In recent years many medical association have restated this prohibition of sexual relations between physicians and their patients. The reasons for this are as valid today as they were in Hippocrates' time, 2500 years ago. Patients are vulnerable and put their trust in physicians to

treat them well. They may feel unable to resist sexual advances of physicians for fear that their treatment will be jeopardized. Moreover, the clinical judgment of a physician can be adversely affected by emotional involvement with a patient.

This latter reason applies as well to physicians treating their family members, which is strongly discouraged in many medical codes of ethics. However, as with some other statements in codes of ethics, its application can vary according to circumstances. For example, solo practitioners working in remote areas may have to provide medical care for their family members, especially in emergency situations.

COMMUNICATION AND CONSENT

Informed consent is one of the central concepts of present-day medical ethics. The right of patients to make decisions about their healthcare has been enshrined in legal and ethical statements throughout the world. The WMA **Declaration on the Rights of the Patient** states:

The patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of his/her decisions. A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make his/her decisions. The patient should understand clearly what is the purpose of any test or treatment, what the results would imply, and what would be the implications of withholding consent.

A necessary condition for informed consent is good communication between physician and patient. When medical paternalism was normal, communication was relatively simple; it consisted of the

physician's orders to the patient to comply with such and such a treatment. Nowadays communication requires much more of physicians. They must provide patients with all the information they need to make their decisions. This involves explaining complex medical diagnoses, prognoses and treatment regimes in simple language, ensuring that patients understand the treatment options, including the advantages and disadvantages of each, answering any questions they may have, and understanding whatever decision the patient has reached and, if possible, the reasons for it. Good communication skills do not come naturally to most people; they must be developed and maintained with conscious effort and periodic review.

Two major obstacles to good physician-patient communication are differences of language and culture. If the physician and the patient do not speak the same language, an interpreter will be required. Unfortunately, in many settings there are no qualified interpreters and the physician must seek out the best available person for the task. Culture, which includes but is much broader than language, raises additional communication issues. Because of different cultural understandings of the nature and causes of illness, patients may not understand the diagnosis and treatment options provided by their physician. In such circumstances physicians should make every reasonable effort to probe their patients' understanding of health and healing and communicate their recommendations to the patients as best they can.

If the physician has successfully communicated to the patient all the information the patient needs and wants to know about his or her diagnosis, prognosis and treatment options, the patient will then be in a position to make an informed decision about how to proceed. Although the term 'consent' implies acceptance of treatment, the concept of informed consent applies equally to refusal of treatment or to choice among alternative treatments. Competent patients have

“Competent patients have the right to refuse treatment, even when the refusal will result in disability or death.”

the right to refuse treatment, even when the refusal will result in disability or death.

Evidence of consent can be explicit or implicit (implied). Explicit consent is given orally or in writing. Consent is implied when the patient indicates

a willingness to undergo a certain procedure or treatment by his or her behaviour. For example, consent for venipuncture is implied by the action of presenting one's arm. For treatments that entail risk or involve more than mild discomfort, it is preferable to obtain explicit rather than implied consent.

There are two exceptions to the requirement for informed consent by competent patients:

- Situations where patients voluntarily give over their decision-making authority to the physician or to a third party. Because of the complexity of the matter or because the patient has complete confidence in the physician's judgement, the patient may tell the physician, "Do what you think is best." Physicians should not be eager to act on such requests but should provide patients with basic information about the treatment options and encourage them to make their own decisions. However, if after such encouragement the patient still wants the physician to decide, the physician should do so according to the best interests of the patient.
- Instances where the disclosure of information would cause harm to the patient. The traditional concept of 'therapeutic privilege' is invoked in such cases; it allows physicians to withhold medical information if disclosure would be likely to result in serious physical, psychological or emotional harm to the patient, for example, if the patient would be likely to commit suicide if the

diagnosis indicates a terminal illness. This privilege is open to great abuse, and physicians should make use of it only in extreme circumstances. They should start with the expectation that all patients are able to cope with the facts and reserve nondisclosure for cases in which they are convinced that more harm will result from telling the truth than from not telling it.

In some cultures, it is widely held that the physician's obligation to provide information to the patient does not apply when the diagnosis is a terminal illness. It is felt that such information would cause the patient to despair and would make the remaining days of life much more miserable than if there were hope of recovery. Throughout the world it is not uncommon for family members of patients to plead with physicians not to tell the patients that they are dying. Physicians do have to be sensitive to cultural as well as personal factors when communicating bad news, especially of impending death. Nevertheless, the patient's right to informed consent is becoming more and more widely accepted, and the physician has a primary duty to help patients exercise this right.

In keeping with the growing trend towards considering healthcare as a consumer product and patients as consumers, patients and their families not infrequently demand access to medical services that, in the considered opinion of physicians, are not appropriate. Examples of such services range from antibiotics for viral conditions to intensive care for brain-dead patients to promising but unproven drugs or surgical procedures. Some patients claim a 'right' to any medical service that they feel can benefit them, and often physicians are only too willing to oblige, even when they are convinced that the service can offer no medical benefit for the patient's condition. This problem is especially serious in situations where resources are limited and providing 'futile' or 'nonbeneficial' treatments to some patients means that other patients are left untreated.

Futile and **nonbeneficial** can be understood as follows. In some situations a physician can determine that a treatment is 'medically' futile or nonbeneficial because it offers no reasonable hope of recovery or improvement or because the patient is permanently unable to experience any benefit. In other cases the utility and benefit of a treatment can only be determined with reference to the patient's subjective judgement about his or her overall well-being. As a general rule a patient should be involved in determining futility in his or her case. In exceptional circumstances such discussions may not be in the patient's best interests. The physician has no obligation to offer a patient futile or nonbeneficial treatment.

“The physician has no obligation to offer a patient futile or nonbeneficial treatment.”

medical ethics

The principle of informed consent incorporates the patient's right to choose from among the options presented by the physician. To what extent patients and their families have a right to services not recommended by physicians is becoming a major topic of controversy in ethics, law and public policy. Until this matter is decided by governments, medical insurance providers and/or professional organisations, individual physicians will have to decide for themselves whether they should accede to requests for inappropriate treatments. They should refuse such requests if they are convinced that the treatment would produce more harm than benefit. They should also feel free to refuse if the treatment

Do patients have a right to services not recommended by physicians?

is unlikely to be beneficial, even if it is not harmful, although the possibility of a placebo effect should not be discounted. If limited resources are an issue, they should bring this to the attention of whoever is responsible for allocating resources.

DECISION-MAKING FOR INCOMPETENT PATIENTS

Many patients are not competent to make decisions for themselves. Examples include young children, individuals affected by certain psychiatric or neurological conditions, and those who are temporarily unconscious or comatose. These patients require substitute decision-makers, either the physician or another person. Ethical issues arise in the determination of the appropriate substitute decision-maker and in the choice of criteria for decisions on behalf of incompetent patients.

When medical paternalism prevailed, the physician was considered to be the appropriate decision-maker for incompetent patients. Physicians might consult with family members about treatment options, but the final decisions were theirs to make. Physicians have been gradually losing this authority in many countries as patients are given the opportunity to name their own substitute decision-makers to act for them when they become incompetent. In addition, some states specify the appropriate substitute decision-makers in descending order (e.g., husband or wife, adult children, brothers and sisters, etc.). In such cases physicians make decisions for patients only when the designated substitute cannot be found, as often happens in emergency situations. The WMA **Declaration on the Rights of the Patient** states the physician's duty in this matter as follows:

If the patient is unconscious or otherwise unable to express his/her will, informed consent must be obtained, whenever possible, from a legally entitled representative. If a legally entitled representative is not available, but a medical intervention is urgently needed, consent of the patient may be presumed, unless it is obvious and beyond any doubt on the basis of the patient's previous firm

expression or conviction that he/she would refuse consent to the intervention in that situation.

Problems arise when those claiming to be the appropriate substitute decision-makers, for example different family members, do not agree among themselves or when they do agree, their decision is, in the physician's opinion, not in the patient's best interests. In the first instance the physician can serve a mediating function, but if the disagreement persists, it can be resolved in other ways, for example, by letting the senior member of the family decide or by voting. In cases of serious disagreement between the substitute decision-maker and the physician, the **Declaration on the Rights of the Patient** offers the following advice: "If the patient's legally entitled representative, or a person authorized by the patient, forbids treatment which is, in the opinion of the physician, in the patient's best interest, the physician should challenge this decision in the relevant legal or other institution."

The principles and procedures for informed consent that were discussed in the previous section are just as applicable to substitute decision-making as to patients making their own decisions. Physicians have the same duty to provide all the information the substitute decision-makers need to make their decisions. This involves explaining complex medical diagnoses, prognoses and treatment regimes in simple language, ensuring that the decision-makers understand the treatment options, including the advantages and disadvantages of each, answering any questions they may have, and understanding whatever decision they reach and, if possible, the reasons for it.

The principal criteria to be used for treatment decisions for an incompetent patient are his or her preferences, if these are known. The preferences may be found in an *advance directive* or may have

been communicated to the designated substitute decision-maker, the physician or other members of the healthcare team. When an incompetent patient's preferences are not known, treatment decisions should be based on the patient's best interests, taking into account: (a) the patient's diagnosis and prognosis; (b) the patient's known values; (c) information received from those who are significant in the patient's life and who could help in determining his or her best interests; and (d) aspects of the patient's culture and religion that would influence a treatment decision. This approach is less certain than if the patient has left specific instructions about treatment, but it does enable the substitute decision-maker to infer, in light of other choices the patient has made and his or her approach to life in general, what he or she would decide in the present situation.

Competence to make medical decisions can be difficult to assess, especially in young people and those whose capacity for reasoning has been impaired by acute or chronic illness. A person may be competent to make decisions regarding some aspects of life but not others; as well, competence can be intermittent -- a person may be lucid and oriented at certain times of the day and not at others. Although such patients may not be legally competent, their preferences should be taken into account when decisions are being made for them. The **Declaration on the Rights of the Patient** states the matter thus: "If a

patient is a minor or otherwise legally incompetent, the consent of a legally entitled representative is required in some jurisdictions. Nevertheless the patient must be involved in the decision-making to the fullest extent allowed by his/her capacity."

"...the patient must be involved in the decision-making to the fullest extent allowed by his/her capacity"

Not infrequently, patients are unable to make a reasoned, well thought-out decision regarding different treatment options due to the discomfort and distraction caused by their disease. However, they may still be able to indicate their rejection of a specific intervention, an intravenous feeding tube, for example. In such cases, these expressions of dissent should be taken very seriously, although they need to be considered in light of the overall goals of their treatment plan.

Patients suffering from psychiatric or neurological disorders who are judged to pose a danger to themselves or to others raise particularly difficult ethical issues. It is important to honour their human rights, especially the right to freedom, to the greatest extent possible. Nevertheless, they may have to be confined and/or treated against their will in order to prevent harm to themselves or others. A distinction can be made between involuntary confinement and involuntary treatment. Some patient advocates defend the right of these individuals to refuse treatment even if they have to be confined as a result. A legitimate reason for refusing treatment could be painful experience with treatments in the past, for example, the severe side effects of psychotropic medications. When serving as substitute decision-makers for such patients, physicians should ensure that the patients really do pose a danger, and not just an annoyance, to others or to themselves. They should try to ascertain the patients' preferences regarding treatment, and the reasons for these preferences, even if in the end the preferences cannot be fulfilled.

CONFIDENTIALITY

The physician's duty to keep patient information confidential has been a cornerstone of medical ethics since the time of Hippocrates. The Hippocratic Oath states: "What I may see or hear in the course

“In certain limited circumstances it is not unethical to disclose confidential information.”

Læknisfræðileg siðfræði

of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.” The Oath, and some more recent versions, allow no exception to this duty of confidentiality. However, other codes reject this absolutist approach to confidentiality. For example, the WMA’s **International Code of Medical Ethics** states, “It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality.” That breaches of confidentiality are sometimes justified calls for clarification of the very idea of confidentiality.

The high value that is placed on confidentiality has three sources: autonomy, respect for others and trust. Autonomy relates to confidentiality in that personal information about an individual belongs to him or her and should not be made known to others without his or her consent. When an individual reveals personal information to another, a physician or nurse for example, or when information comes to light through a medical test, those in the know are bound to keep it confidential unless authorized to divulge it by the individual concerned.

Confidentiality is also important because human beings deserve respect. One important way of showing them respect is by preserving their privacy. In the medical setting, privacy is often greatly compromised, but this is all the more reason to prevent further unnecessary intrusions into a person’s private life. Since individuals differ regarding their desire for privacy, we cannot assume that everyone wants to be treated as we would want to

be. Care must be taken to determine which personal information a patient wants to keep secret and which he or she is willing to have revealed to others.

Trust is an essential part of the physician-patient relationship. In order to receive medical care, patients have to reveal personal information to physicians and others who may be total strangers to them---information that they would not want anyone else to know. They must have good reason to trust their caregivers not to divulge this information. The basis of this trust is the ethical and legal standards of confidentiality that healthcare professionals are expected to uphold. Without an understanding that their disclosures will be kept secret, patients may withhold personal information. This can hinder physicians in their efforts to provide effective interventions or to attain certain public health goals.

The WMA **Declaration on the Rights of the Patient** summarises the patient's right to confidentiality as follows:

- All identifiable information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind, must be kept confidential, even after death. Exceptionally, the descendents may have a right of access to information that would inform them of their health risks.
- Confidential information can only be disclosed if the patient gives explicit consent or if expressly provided for in the law. Information can be disclosed to other healthcare providers only on a strictly "need to know" basis unless the patient has given explicit consent.
- All identifiable patient data must be protected. The protection of the data must be appropriate to the manner of its storage. Human substances from which identifiable data can be derived must be likewise protected.

As this WMA Declaration states, there are exceptions to the requirement to maintain confidentiality. Some of these are relatively non-problematic; others raise very difficult ethical issues for physicians.

Routine breaches of confidentiality occur frequently in most healthcare institutions. Many individuals – physicians, nurses, laboratory technicians, students, etc. – require access to a patient's health records in order to provide adequate care to that person and, for students, to learn how to practise medicine. Where patients speak a different language than their caregivers, there is a need for interpreters to facilitate communication. In cases of patients who are not competent to make their own medical decisions, other individuals have to be given information about them in order to make decisions on their behalf and to care for them. Physicians routinely inform the family members of a deceased person about the cause of death. These breaches of confidentiality are usually justified, but they should be kept to a minimum and those who gain access to confidential information should be made aware of the need not to spread it any further than is necessary for descendents benefit. Where possible, patients should be informed that such breaches occur.

Another generally accepted reason for breaching confidentiality is to comply with legal requirements. For example, many jurisdictions have laws for the mandatory reporting of patients who suffer from designated diseases, those deemed not fit to drive and those suspected of child abuse. Physicians should be aware of the legal requirements for the disclosure of patient information where they work. However, legal requirements

“...physicians should view with a critical eye any legal requirement to breach confidentiality and assure themselves that it is justified before adhering to it.”

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can conflict with the respect for human rights that underlies medical ethics. Therefore, physicians should view with a critical eye any legal requirement to breach confidentiality and assure themselves that it is justified before adhering to it.

If physicians are persuaded to comply with legal requirements to disclose their patients' medical information, it is desirable that they discuss with the patients the necessity of any disclosure before it occurs and enlist their co-operation. For example, it is preferable that a patient suspected of child abuse call the child protection authorities in the physician's presence to self-report, or that the physician obtain his or her consent before the authorities are notified. This approach will prepare the way for subsequent interventions. If such co-operation is not forthcoming and the physician has reason to believe any delay in notification may put a child at risk of serious harm, then the physician ought to immediately notify child protection authorities and subsequently inform the patient that this has been done.

In addition to those breaches of confidentiality that are required by law, physicians may have an ethical duty to impart confidential information to others who could be at risk of harm from the patient. Two situations in which this can occur are when a patient tells a psychiatrist that he intends to harm another person and when a physician is convinced that an HIV-positive patient is going to continue to have unprotected sexual intercourse with his spouse or other partners.

Conditions for breaching confidentiality when not required by law are that the expected harm is believed to be imminent, serious (and irreversible), unavoidable except by unauthorised disclosure, and greater than the harm likely to result from disclosure. In determining the proportionality of these respective harms, the physician needs to assess and compare the seriousness of the harms and the

likelihood of their occurrence. In cases of doubt, it would be wise for the physician to seek expert advice.

When a physician has determined that the duty to warn justifies an unauthorised disclosure, two further decisions must be made. Whom should the physician tell? How much should be told? Generally speaking, the disclosure should contain only that information necessary to prevent the anticipated harm and should be directed only to those who need the information in order to prevent the harm. Reasonable steps should be taken to minimize the harm and offence to the patient that may arise from the disclosure. It is recommended that the physician should inform the patient that confidentiality might be breached for his or her own protection and that of any potential victim. The patient's co-operation should be enlisted if possible.

In the case of an HIV-positive patient, disclosure to a spouse or current sexual partner may not be unethical and, indeed, may be justified when the patient is unwilling to inform the person(s) at risk. Such disclosure requires that all of the following conditions are met: the partner is at risk of infection with HIV and has no other reasonable means of knowing the risk; the patient has refused to inform his or her sexual partner; the patient has refused an offer of assistance by the physician to do so on the patient's behalf; and the physician has informed the patient of his or her intention to disclose the information to the partner.

The medical care of suspected and convicted criminals poses particular difficulties with regard to confidentiality. Although physicians providing care to those in custody have limited independence, they should do their best to treat these patients as they would any others. In particular, they should safeguard confidentiality by not revealing details of the patient's medical condition to prison authorities without first obtaining the patient's consent.

BEGINNING-OF-LIFE ISSUES

Many of the most prominent issues in medical ethics relate to the beginning of human life. The limited scope of this Manual means that these issues cannot be treated in detail here but it is worth listing them so that they can be recognized as ethical in nature and dealt with as such. Each of them has been the subject of extensive analysis by medical associations, ethicists and government advisory bodies, and in many countries there are laws, regulations and policies dealing with them.

- **CONTRACEPTION** – although there is increasing international recognition of a woman's right to control her fertility, including the prevention of unwanted pregnancies, physicians still have to deal with difficult issues such as requests for contraceptives from minors and explaining the risks of different methods of contraception.
- **ASSISTED REPRODUCTION** – for couples (and individuals) who cannot conceive naturally there are various techniques of assisted reproduction, such as artificial insemination and in-vitro fertilization and embryo transfer, widely available in major medical centres. *Surrogate or substitute gestation* is another alternative. None of these techniques is unproblematic, either in individual cases or for public policies.
- **PRENATAL GENETIC SCREENING** – genetic tests are now available for determining whether an embryo or foetus is affected by certain genetic abnormalities and whether it is male or female. Depending on the findings, a decision can be made whether or not to proceed with pregnancy. Physicians need to determine when to offer such tests and how to explain the results to patients.

- **ABORTION** – this has long been one of the most divisive issues in medical ethics, both for physicians and for public authorities. The WMA **Statement on Therapeutic Abortion** acknowledges this diversity of opinion and belief and concludes that “This is a matter of individual conviction and conscience that must be respected.”
- **SEVERELY COMPROMISED NEONATES** – because of extreme prematurity or congenital abnormalities, some neonates have a very poor prognosis for survival. Difficult decisions often have to be made whether to attempt to prolong their lives or allow them to die.
- **RESEARCH ISSUES** – these include the production of new embryos or the use of ‘spare’ embryos (those not wanted for reproductive purposes) to obtain stem cells for potential therapeutic applications, testing of new techniques for assisted reproduction, and experimentation on fetuses.

END-OF-LIFE ISSUES

End-of-life issues range from attempts to prolong the lives of dying patients through highly experimental technologies, such as the implantation of animal organs, to efforts to terminate life prematurely through euthanasia and medically assisted suicide. In between these extremes lie numerous issues regarding the initiation or withdrawing of potentially life-extending treatments, the care of terminally ill patients and the advisability and use of advance directives.

Two issues deserve particular attention: euthanasia and assistance in suicide.

- **EUTHANASIA** means knowingly and intentionally performing an act that is clearly intended to end another person’s life and that includes the following elements: the subject is a competent,

informed person with an incurable illness who has voluntarily asked for his or her life to be ended; the agent knows about the person's condition and desire to die, and commits the act with the primary intention of ending the life of that person; and the act is undertaken with compassion and without personal gain.

- **ASSISTANCE IN SUICIDE** means knowingly and intentionally providing a person with the knowledge or means or both required to commit suicide, including counselling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs.

Euthanasia and assisted suicide are often regarded as morally equivalent, although there is a clear practical distinction, and in some jurisdictions a legal distinction, between them.

Euthanasia and assisted suicide, according to these definitions, are to be distinguished from the withholding or withdrawal of inappropriate, futile or unwanted medical treatment or the provision of compassionate palliative care, even when these practices shorten life.

Requests for euthanasia or assistance in suicide arise as a result of pain or suffering that is considered by the patient to be intolerable. They would rather die than continue to live in such circumstances. Furthermore, many patients consider that they have a right to die if they so choose, and even a right to assistance in dying. Physicians are regarded as the most appropriate instruments of death since they have the medical knowledge and access to the appropriate drugs for ensuring a quick and painless death.

Physicians are understandably reluctant to implement requests for euthanasia or assistance in suicide because these acts are illegal in most countries and are prohibited in most medical codes

of ethics. This prohibition was part of the Hippocratic Oath and has been emphatically restated by the WMA in its **Declaration on Euthanasia**:

Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness.

The rejection of euthanasia and assisted suicide does not mean that physicians can do nothing for the patient with a life-threatening illness that is at an advanced stage and for which curative measures are not appropriate. In recent years there have been great advances in palliative care treatments for relieving pain and suffering and improving quality of life. Palliative care can be appropriate for patients of all ages, from a child with cancer to a senior nearing the end of life. One aspect of palliative care that needs greater attention for all patients is pain control. All physicians who care for dying patients should ensure that they have adequate skills in this domain, as well as, where available, access to skilled consultative help from palliative care specialists. Above all, physicians should not abandon dying patients but should continue to provide compassionate care even when cure is no longer possible.

“...physicians should not abandon dying patients but should continue to provide compassionate care even when cure is no longer possible.”

The approach of death presents many other ethical challenges for patients, substitute decision-makers and physicians. The possibility of prolonging life through recourse to drugs, resuscitative interventions, radiological procedures and intensive care requires

decisions about when to initiate these treatments and when to withdraw them if they are not working.

As discussed above in relation to communication and consent, competent patients have the right to refuse any medical treatment, even if the refusal results in their death. Individuals differ greatly with regard to their attitude towards dying; some will do anything to prolong their lives, no matter how much pain and suffering it involves, while others so look forward to dying that they refuse even simple measures that are likely to keep them alive, such as antibiotics for bacterial pneumonia. Once physicians have made every effort to provide patients with information about the available treatments and their likelihood of success, they must respect the patients' decisions about the initiation or continuation of any treatment.

End-of-life decision-making for incompetent patients presents greater difficulties. If patients have clearly expressed their wishes in advance, for example in an advance directive, the decision will be easier, although such directives are often very vague and need to be interpreted with respect to the patient's actual condition. If patients have not adequately expressed their wishes, the appropriate substitute decision-maker must use another criterion for treatment decisions, namely, the best interests of the patient.

BACK TO THE CASE STUDY

According to the analysis of the physician-patient relationship presented in this chapter,

Dr. P's conduct was deficient in several respects: (1) COMMUNICATION – he made no attempt to communicate with the patient regarding the cause of her condition, treatment options or her ability to afford to stay in the hospital while she recovered;

(2) CONSENT – he did not obtain her informed consent to treatment:

(3) COMPASSION – his dealings with her displayed little compassion for her plight.

His surgical treatment may have been highly competent and he may have been tired at the end of a long shift, but that does not excuse the breaches of ethics.