

CHAPTER ONE – PRINCIPAL FEATURES OF MEDICAL ETHICS



A Day in the Life of a French General Practitioner
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OBJECTIVES

After working through this chapter you should be able to:

- explain why ethics is important to medicine
- identify the major sources of medical ethics
- recognize different approaches to ethical decision-making, including your own.

WHAT'S SPECIAL ABOUT MEDICINE?

Throughout almost all of recorded history and in virtually every part of the world, being a physician has meant something special. People come to physicians for help with their most pressing needs – relief from pain and suffering and restoration of health and well-being. They allow physicians to see, touch and manipulate every part of their bodies, even the most intimate. They do this because they trust their physicians to act in their best interests.

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The status of physicians differs from one country to another and even within countries. In general, though, it seems to be deteriorating. Many physicians feel that they are no longer as respected as they once were. In some countries, control of healthcare has moved steadily away from physicians to professional managers and bureaucrats, some of whom tend to see physicians as obstacles to rather than partners in healthcare reforms. Patients who used to accept physicians' orders unquestioningly sometimes ask physicians to defend their recommendations if these are different from advice obtained from other health practitioners or the Internet. Some procedures that formerly only physicians were capable of performing are now done by medical technicians, nurses or paramedics.

Despite these changes impinging on the status of physicians, medicine continues to be a profession that is highly valued by the sick people who need its services. It also continues to attract large numbers of the most gifted, hard-working and dedicated students. In order to meet

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the expectations of both patients and students, it is important that physicians know and exemplify the core values of medicine, especially compassion, competence and autonomy. These values, along with respect for fundamental human rights, serve as the foundation of medical ethics.

WHAT'S SPECIAL ABOUT MEDICAL ETHICS?

Compassion, competence and autonomy are not exclusive to medicine. However, physicians are expected to exemplify them to a higher degree than other people, including members of many other professions.

Compassion, defined as understanding and concern for another person's distress, is essential for the practice of medicine. In order to deal with the patient's problems, the physician must identify the symptoms that the patient is experiencing and their underlying causes and must want to help the patient achieve relief. Patients respond better to treatment if they perceive that the physician appreciates their concerns and is treating them rather than just their illness.

A very high degree of **competence** is both expected and required of physicians. A lack of competence can result in death or serious morbidity for patients. Physicians undergo a long training period to ensure competence, but considering the rapid advance of medical knowledge, it is a continual challenge for them to maintain their competence. Moreover, it is not just their scientific knowledge and technical skills that they have to maintain but their ethical knowledge, skills and attitudes as well, since new ethical issues arise with changes in medical practice and its social and political environment.

Autonomy, or self-determination, is the core value of medicine that has changed the most over the years. Individual physicians have

traditionally enjoyed a high degree of clinical autonomy in deciding how to treat their patients. Physicians collectively (the medical profession) have been free to determine the standards of medical education and medical practice. As will be evident throughout this

THE WORLD MEDICAL ASSOCIATION DECLARATION OF GENEVA

At the time of being admitted as a member of the medical profession:

I SOLEMNLY PLEDGE to consecrate my life to the service of humanity;

I WILL GIVE to my teachers the respect and gratitude that is their due;

I WILL PRACTISE my profession with conscience and dignity;

THE HEALTH OF MY PATIENT will be my first consideration;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL MAINTAIN by all the means in my power, the honour and the noble traditions of the medical profession;

MY COLLEAGUES will be my sisters and brothers;

I WILL NOT 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;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely and upon my honour.

Manual, both of these ways of exercising physician autonomy have been moderated in many countries by governments and other authorities imposing controls on physicians. Despite these challenges, physicians still value their clinical and professional autonomy and try to preserve it as much as possible. At the same time, there has been a widespread acceptance by physicians worldwide of patient autonomy, which means that patients should be the ultimate decision-makers in matters that affect themselves. This Manual will deal with examples of potential conflicts between physician autonomy and respect for patient autonomy.

Besides its adherence to these three core values, medical ethics differs from the general ethics applicable to everyone by being publicly *professed* in an oath such as the World Medical Association **Declaration of Geneva** and/or a code. Oaths and codes vary from one country to another and even within countries, but they have many common features, including promises that physicians will consider the interests of their patients above their own, will not discriminate against patients on the basis of race, religion or other human rights grounds, will protect the confidentiality of patient information and will provide emergency care to anyone in need.

WHO DECIDES WHAT IS ETHICAL?

Ethics is *pluralistic*. Individuals disagree among themselves about what is right and what is wrong, and even when they agree, it can be for different reasons. In some societies, this disagreement is regarded as normal and there is a great deal of freedom to act however one wants, as long as it does not violate the rights of others. In more traditional societies, however, there is greater agreement on ethics and greater social pressure, sometimes backed by laws, to act in certain ways rather than others. In such societies

culture and religion often play a dominant role in determining ethical behaviour.

The answer to the question, “who decides what is ethical for people in general?” therefore varies from one society to another and even within the same society. In liberal societies, individuals have a great deal of freedom to decide for themselves what is ethical, although they will likely be influenced by their families, friends, religion, the media and other external sources. In more traditional societies, family and clan elders, religious authorities and political leaders usually have a greater role than individuals in determining what is ethical.

Despite these differences, it seems that most human beings can agree on some fundamental ethical principles, namely, the basic human rights proclaimed in the United Nations **Universal Declaration of Human Rights** and other widely accepted and officially endorsed documents. The human rights that are especially important for medical ethics include the right to life, to freedom from discrimination, torture and cruel, inhuman or degrading treatment, to freedom of opinion and expression, to equal access to public services in one’s country, and to medical care.

For physicians, the question, “who decides what is ethical?” has until recently had a somewhat different answer than for people in general. Over the centuries the medical profession has developed its own standards of behaviour for its members, which are expressed in codes of ethics and related policy documents. At the global level, the WMA has set forth a broad range of ethical statements that specify the behaviour required of physicians no matter where they live and practise. In many, if not most, countries medical associations have been responsible for developing and enforcing the applicable ethical standards. Depending on the country’s approach to medical law, these standards may have legal status.

The medical profession's privilege of being able to determine its own ethical standards has never been absolute, however. For example:

- Physicians have always been subject to the general laws of the land and have sometimes been punished for acting contrary to these laws.
- Some medical organizations are strongly influenced by religious teachings, which impose additional obligations on their members besides those applicable to all physicians.
- In many countries the organizations that set the standards for physician behaviour and monitor their compliance now have a significant non-physician membership.

The ethical directives of medical associations are general in nature; they cannot deal with every situation that physicians might face in their medical practice. In most situations, physicians have to decide for themselves what is the right way to act, but in making decisions, it is helpful to know what other physicians would do in similar situations. Medical codes of ethics and policy statements reflect a general consensus about the way physicians should act and they should be followed unless there are good reasons for acting otherwise.

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DOES MEDICAL ETHICS CHANGE?

There can be little doubt that some aspects of medical ethics have changed over the years. Until recently physicians had the right and the duty to decide how patients should be treated and there was no obligation to obtain the patient's informed consent. In contrast, the 2005 version of the WMA **Declaration on the Rights of the Patient**

begins with this statement: “The relationship between physicians, their patients and broader society has undergone significant changes in recent times. While a physician should always act according to his/her conscience, and always in the best interests of the patient, equal effort must be made to guarantee patient autonomy and justice.” Many individuals now consider that they are their own primary health providers and that the role of physicians is to act as their consultants or instructors. Although this emphasis on self-care is far from universal, it does seem to be spreading and is symptomatic of a more general evolution in the patient-physician relationship that gives rise to different ethical obligations for physicians than previously.

Until recently, physicians generally considered themselves *accountable* only to themselves, to their colleagues in the medical profession and, for religious believers, to God. Nowadays, they have additional accountabilities – to their patients, to third parties such as hospitals and *managed healthcare* organizations, to medical licensing and regulatory authorities, and often to courts of law. These different accountabilities can conflict with one another, as will be evident in the discussion of dual loyalty in Chapter Three.

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Medical ethics has changed in other ways. Participation in abortion was forbidden in medical codes of ethics until recently but now is tolerated under certain conditions by the medical profession in many countries. Whereas in traditional medical ethics the sole responsibility of physicians was to their individual patients, nowadays it is generally agreed that physicians should also consider the needs of society, for example, in allocating scarce healthcare resources (cf. Chapter Three).

Advances in medical science and technology raise new ethical issues that cannot be answered by traditional medical ethics. Assisted reproduction, genetics, health informatics and life-extending and enhancing technologies, all of which require the participation of physicians, have great potential for benefiting patients but also potential for harm depending on how they are put into practice. To help physicians decide whether and under what conditions they should participate in these activities, medical associations need to use different analytic methods than simply relying on existing codes of ethics.

Despite these obvious changes in medical ethics, there is widespread agreement among physicians that the fundamental values and ethical principles of medicine do not, or at least should not, change. Since it is inevitable that human beings will always be subject to illness, they will continue to have need of compassionate, competent and autonomous physicians to care for them.

DOES MEDICAL ETHICS DIFFER FROM ONE COUNTRY TO ANOTHER?

Just as medical ethics can and does change over time, in response to developments in medical science and technology as well as in societal values, so does it vary from one country to another depending on these same factors. On euthanasia, for example, there is a significant difference of opinion among national medical associations. Some associations condemn it but others are neutral and at least one, the Royal Dutch Medical Association, accepts it under certain conditions. Likewise, regarding access to healthcare, some national associations support the equality of all citizens whereas others are willing to tolerate great inequalities. In some countries there is considerable interest in the ethical issues posed by advanced medical technology whereas in countries that do not

have access to such technology, these ethical issues do not arise. Physicians in some countries are confident that they will not be forced by their government to do anything unethical while in other countries it may be difficult for them to meet their ethical obligations, for example, to maintain the confidentiality of patients in the face of police or army requirements to report 'suspicious' injuries.

Although these differences may seem significant, the similarities are far greater. Physicians throughout the world have much in common, and when they come together in organizations such as the WMA, they usually achieve agreement on controversial ethical issues, though this often requires lengthy debate. The fundamental values of medical ethics, such as compassion, competence and autonomy, along with physicians' experience and skills in all aspects of medicine and healthcare, provide a sound basis for analysing ethical issues in medicine and arriving at solutions that are in the best interests of individual patients and citizens and public health in general.

THE ROLE OF THE WMA

As the only international organization that seeks to represent all physicians, regardless of nationality or specialty, the WMA has undertaken the role of establishing general standards in medical ethics that are applicable worldwide. From its beginning in 1947 it has worked to prevent any recurrence of the unethical conduct exhibited by physicians in Nazi Germany and elsewhere. The WMA's first task was to update the Hippocratic Oath for 20th century use; the result was the **Declaration of Geneva**, adopted at the WMA's 2nd General Assembly in 1948. It has been revised several times since, most recently in 2006. The second task was the development of an **International Code of Medical Ethics**, which was adopted at the 3rd General Assembly in 1949 and revised in 1968, 1983 and 2006. This code is currently undergoing further revision. The next task was to develop ethical guidelines for research on human subjects. This

took much longer than the first two documents; it was not until 1964 that the guidelines were adopted as the **Declaration of Helsinki**. This document has also undergone periodic revision, most recently in 2000.

In addition to these foundational ethical statements, the WMA has adopted policy statements on more than 100 specific issues, the majority of which are ethical in nature while others deal with socio-medical topics, including medical education and health systems. Each year the WMA General Assembly revises some existing policies and/or adopts new ones.

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HOW DOES THE WMA DECIDE WHAT IS ETHICAL?

Achieving international agreement on controversial ethical issues is not an easy task, even within a relatively cohesive group such as physicians. The WMA ensures that its ethical policy statements reflect a consensus by requiring a 75% vote in favour of any new or revised policy at its annual Assembly. A precondition for achieving this degree of agreement is widespread consultation on draft statements,

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careful consideration of the comments received by the WMA Medical Ethics Committee and sometimes by a specially appointed workgroup on the issue, redrafting of the statement and often further consultation. The process can be lengthy, depending on the complexity and/or the novelty of the issue. For example, a recent

revision of the **Declaration of Helsinki** was begun early in 1997 and completed only in October 2000. Even then, outstanding issues remained and these continued to be studied by the Medical Ethics Committee and successive workgroups.

A good process is essential to, but does not guarantee, a good outcome. In deciding what is ethical, the WMA draws upon a long tradition of medical ethics as reflected in its previous ethical statements. It also takes note of other positions on the topic under consideration, both of national and international organizations and of individuals with skill in ethics. On some issues, such as informed consent, the WMA finds itself in agreement with the majority view. On others, such as the confidentiality of personal medical information, the position of physicians may have to be promoted forcefully against those of governments, health system administrators and/or commercial enterprises. A defining feature of the WMA's approach to ethics is the priority that it assigns to the individual patient or research subject. In reciting the **Declaration of Geneva**, the physician promises, "The health of my patient will be my first consideration." And the **Declaration of Helsinki** states, "In medical research involving human subjects, the well-being of the individual research subject must take precedence over all other interests."

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HOW DO INDIVIDUALS DECIDE WHAT IS ETHICAL?

For individual physicians and medical students, medical ethics does not consist simply in following the recommendations of the WMA

or other medical organizations. These recommendations are usually general in nature and individuals need to determine whether or not they apply to the situation at hand. Moreover, many ethical issues arise in medical practice for which there is no guidance from medical associations. Individuals are ultimately responsible for making their own ethical decisions and for implementing them.

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There are different ways of approaching ethical issues such as the ones in the cases at the beginning of this Manual. These can be divided roughly into two categories: non-rational and *rational*. It is important to note that non-rational does not mean irrational but simply that it is to be distinguished from the systematic, reflective use of reason in decision-making.

Non-rational approaches:

- **Obedience** is a common way of making ethical decisions, especially by children and those who work within authoritarian structures (e.g., the military, police, some religious organizations, many businesses). Morality consists in following the rules or instructions of those in authority, whether or not you agree with them.
- **Imitation** is similar to obedience in that it subordinates one's judgement about right and wrong to that of another person, in this case, a role model. Morality consists in following the example of the role model. This has been perhaps the most common way of learning medical ethics by aspiring physicians, with the role models being the senior consultants and the mode of moral learning being observation and assimilation of the values portrayed.

- **Feeling** or **desire** is a subjective approach to moral decision-making and behaviour. What is right is what feels right or satisfies one's desire; what is wrong is what feels wrong or frustrates one's desire. The measure of morality is to be found within each individual and, of course, can vary greatly from one individual to another, and even within the same individual over time.
- **Intuition** is an immediate perception of the right way to act in a situation. It is similar to desire in that it is entirely subjective; however, it differs because of its location in the mind rather than the will. To that extent it comes closer to the rational forms of ethical decision-making than do obedience, imitation, feeling and desire. However, it is neither systematic nor reflexive but directs moral decisions through a simple flash of insight. Like feeling and desire, it can vary greatly from one individual to another, and even within the same individual over time.
- **Habit** is a very efficient method of moral decision-making since there is no need to repeat a systematic decision-making process each time a moral issue arises similar to one that has been dealt with previously. However, there are bad habits (e.g., lying) as well as good ones (e.g., truth-telling); moreover, situations that appear similar may require significantly different decisions. As useful as habit is, therefore, one cannot place all one's confidence in it.

Rational approaches:

As the study of morality, ethics recognises the prevalence of these non-rational approaches to decision-making and behaviour. However, it is primarily concerned with rational approaches. Four such approaches are deontology, consequentialism, principlism and virtue ethics:

- **Deontology** involves a search for well-founded rules that can serve as the basis for making moral decisions. An example of such a rule is, “Treat all people as equals.” Its foundation may be religious (for example, the belief that all God’s human creatures are equal) or non-religious (for example, human beings share almost all of the same genes). Once the rules are established, they have to be applied in specific situations, and here there is often room for disagreement about what the rules require (for example, whether the rule against killing another human being would prohibit abortion or capital punishment).
- **Consequentialism** bases ethical decision-making on an analysis of the likely consequences or outcomes of different choices and actions. The right action is the one that produces the best outcomes. Of course there can be disagreement about what counts as a good outcome. One of the best-known forms of consequentialism, namely **utilitarianism**, uses ‘utility’ as its measure and defines this as ‘the greatest good for the greatest number’. Other outcome measures used in healthcare decision-making include cost-effectiveness and quality of life as measured in QALYs (quality-adjusted life-years) or DALYs (disability-adjusted life-years). Supporters of consequentialism generally do not have much use for principles; they are too difficult to identify, prioritise and apply, and in any case they do not take into account what in their view really matters in moral decision-making, i.e., the outcomes. However, this setting aside of principles leaves consequentialism open to the charge that it accepts that ‘the end justifies the means’, for example, that individual human rights can be sacrificed to attain a social goal.
- **Principlism**, as its name implies, uses ethical principles as the basis for making moral decisions. It applies these principles to particular cases or situations in order to determine what

is the right thing to do, taking into account both rules and consequences. Principlism has been extremely influential in recent ethical debates, especially in the USA. Four principles in particular, respect for autonomy, *beneficence*, *non-maleficence* and *justice*, have been identified as the most important for ethical decision-making in medical practice. Principles do indeed play an important role in rational decision-making. However, the choice of these four principles, and especially the prioritisation of respect for autonomy over the others, is a reflection of Western liberal culture and is not necessarily universal. Moreover, these four principles often clash in particular situations and there is need for some criteria or process for resolving such conflicts.

- **Virtue ethics** focuses less on decision-making and more on the character of decision-makers as reflected in their behaviour. A virtue is a type of moral excellence. As noted above, one virtue that is especially important for physicians is compassion. Others include honesty, prudence and dedication. Physicians who possess these virtues are more likely to make good decisions and to implement them in a good way. However, even virtuous individuals often are unsure how to act in particular situations and are not immune from making wrong decisions.

None of these four approaches, or others that have been proposed, has been able to win universal assent. Individuals differ among themselves in their preference for a rational approach to ethical decision-making just as they do in their preference for a non-rational approach. This can be explained partly by the fact that each approach has both strengths and weaknesses. Perhaps a combination of all four approaches that includes the best features of each is the best way to make ethical decisions rationally. It would take serious account of rules and principles by identifying the ones most relevant to the situation or case at hand and by attempting to implement them to the greatest extent possible. It would also examine the

likely consequences of alternative decisions and determine which consequences would be preferable. Finally, it would attempt to ensure that the behaviour of the decision-maker both in coming to a decision and in implementing it is admirable. Such a process could comprise the following steps:

1. Determine whether the issue at hand is an ethical one.
2. Consult authoritative sources such as medical association codes of ethics and policies and respected colleagues to see how physicians generally deal with such issues.
3. Consider alternative solutions in light of the principles and values they uphold and their likely consequences.
4. Discuss your proposed solution with those whom it will affect.
5. Make your decision and act on it, with sensitivity to others affected.
6. Evaluate your decision and be prepared to act differently in future.

CONCLUSION

This chapter sets the stage for what follows. When dealing with specific issues in medical ethics, it is good to keep in mind that physicians have faced many of the same issues throughout history and that their accumulated experience and wisdom can be very valuable today. The WMA and other medical organizations carry on this tradition and provide much helpful ethical guidance to physicians. However, despite a large measure of consensus among physicians on ethical issues, individuals can and do disagree on how to deal with specific cases. Moreover, the views of physicians can be quite different from those of patients and of other healthcare providers. As a first step in resolving ethical conflicts, it is important for physicians to understand different approaches to ethical decision-making, including their own and those of the people with whom they are interacting. This will help them determine for themselves the best way to act and to explain their decisions to others.

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