Medical Ethics

Ethics is the study of morality and understanding the nature of conflicts arising from moral imperatives and how best we may deal with them (Avasthi et al., 2013).

Morality concerns right and wrong conduct, define rights, duties as well as responsibilities and reflects values which are very important in the practice of medicine (Hagen-Ansert, 2017).

Medical ethics is the principles of proper professional conduct concerning the rights and duties of the physician, patients, and fellow practitioners, as well as the physician’s actions in the care of patients and in relations with their families (Beauchamp and Childress, 2013).

Medical Ethics has been included in the training curriculum of health professional in many countries this may be a reflection of an increased public awareness as well as poor practices within the health care sector. As patients now are more aware of what they expect from health care professionals, when they enter the health care environment (Almoajel, 2012).

Ethics has been an integral part of medicine at least since the time of Hippocrates, the fifth century B.C.E. “Before Common Era” who is regarded as a founder of medical ethics that cautioned his students, “First, do no harm” also his teachings emphasize choosing treatment based on knowledge that would best benefit patients and treating patients as one
would treat his family members, keeping confidentiality and practicing personal piety (*Swailem, 2009*).

Ethical decision-making is based on basic values (moral, personal, religious and legal) that are outside the scope of the medical knowledge base. Therefore, in a clinical situation, the therapeutic option that is ultimately chosen is dependent on clarifying the ethical question, understanding the information gathered and articulating the values and consequences among the alternatives (*Brescia, 2001*).

Basic principles of medical ethics have been incorporated into research regulations, professional codes, and clinical practices all over the world. The ethical codes of different professional groups may differ slightly in definitions, but the basic principles of autonomy, justice, beneficence, non-maleficence, and respect for persons are universal (*Hagen-Ansert, 2017*).

The basic medical ethical principles:

The four basic principles of medical ethics (autonomy, justice, beneficence and non-maleficence) form the foundation and a basic justification for health professionals to guide and decide what practices are ethical in clinical settings (*Adhikari et al., 2016*).

1) **Autonomy**

Autonomy is the most important ethical principle, which supersedes all others. It is based on that every person has intrinsic value that preserves his ability to make informed decisions and justifies any actions arising from him. Autonomy stands for personal liberty where the
individual is free to choose and implement his own decisions free from deceit, duress and constraint. This concept serves well when securing the rights of patients against paternalistic infringement (Varelius, 2006).

An idealized expression of autonomy occurs when a competent adult chooses voluntarily and intelligently from among various options whose relative risks and benefits have been fully explained to him or her by the physicians and other health care professionals “i.e., via a truly informed consent process” (Fanaroff, 2014).

The concept of autonomy in Western culture emphasizes individualism, personal gratification and self-actualization (Marshall and Koenig, 2004).

Consent to treatment

Consent is a core ethical and legal principle in health care. Its roots lie in the ethical principle of personal autonomy, and it embraces the obligation of the health care professional to respect the right of an individual to make health care decisions (Dhai and Payne-James, 2013).

The person’s consent is inferred from his or her actions (or inactions) as if a doctor asks to check a patient’s pulse and he or she offers his/her wrist, then consent is implied. Conversely, refusal to participate in these acts would imply that the patient did not give his or her consent at that time (Rao, 2008).

Most medical practice is conducted under the principle of implied consent where the fact that when a person comes to visit the doctor or asks the doctor to visit him implies his will to be examined or treated as
implied consent does not need to be documented in the clinical record (Richard, 2003).

Implied consent covers only basic clinical methods of examination, such as history taking, observation, palpation and auscultation, it does not extend to intimate examinations such as vaginal and rectal examination (Maurice, 1998).

When the physician is going to perform any medical procedure other than clinical examination, specific permission must be obtained from the patient, this is known as express consent (Lambert and Wood, 2000).

Verbal consent may be simply an extension of implied consent. The physician may ask the patient if it is all right to insert a venous cannula and the patient says yes. At the other extreme, verbal consent may be a very thorough process in which the physician has explained specific risks and benefits of a proposed procedure in great detail and, following some deliberation, the patient agrees verbally (Aitkenhead et al., 2013).

All surgical procedures (especially under anesthesia) and any internal examination (intimate, manual or any form of endoscopies) must follow consent for that particular procedure. Express consent may be written (usually in major procedures) or verbal (better in presence of witness) (Stein and Pincus, 1999).

Informed consent

Informed consent in the medical field is the procedure by which a patient consents to or refuses (informed refusal) a medical intervention
based on the information provided by a health care worker regarding the nature and potential consequences of the suggested treatment regimen. The goal of the informed consent is to respect patient autonomy and enable him to make important rational decisions regarding his medical care (Harish et al., 2015).

Informed consent becomes very important in the present day settings as the doctor-patient relationship is primarily contractual by nature and requires agreement between the parties to the proposed medical intervention. This is based on the physician’s ability to properly explain to the patient his condition and answer all possible queries of the patient to help the patient to make a valid decision (consent/refusal) based on the facts put forward to him (Harish et al., 2012).

Legally, every physician must understand the underpinnings of the common-law analysis of medical informed consent and negligence as medical informed consent is codified into statutory law, and lack of adherence to the statute can lead to negligence claims (Allen et al., 2008).

Many doctors and health care workers tend to override the patient’s autonomous decision in the mistaken belief that their primary duty is the good, healthy outcome for their patient. This is an instance of Medical Paternalism, which, according to Zenbaty Paternalism, is the interference with a patient’s autonomy justified by reasons referring exclusively to welfare good, happiness, needs, interests, or values of the person being constrained (Harish et al., 2015).
There are five requirements for the process of informed consent: disclosure, decisional capacity, patient understanding of the information, voluntariness, and consent (Amer, 2013).

Physician’s explanation and the level of patient’s understanding is directly related to patient satisfaction, treatment adherence and the treatment outcome as improper, partial or faulty explanation may lead to disputes between the two and distrust by patient and his relatives, culminating in allegations of substandard medical care; even if there is no fault in the doctor’s medical judgment or treatment skill (Harish et al., 2012).

To give valid informed consent: the patient must be competent and understand for what he is giving permission and his actions must be voluntary “of free mind and free will.” The patient must not be cognitively impaired by medication, personal emotional stress, or external stress by family members or physicians. For example, a patient who was given a sedative to sleep and subsequently awakened in the middle of the night to give consent for a hernia operation. The court held that the medical consent was invalid because the patient was unlikely to understand what permission he had granted after being awakened from sleep and after taking a sedative (Allen et al., 2008).

In case if the consent is refused, the doctor should obtain an informed refusal from the patient. Failure to inform the risks of declining treatment renders the doctor liable to the same extent as failing to disclose the risks of performing the treatment. The patient must know the risks of leaving the disease or condition untreated, otherwise, a truly informed decision in which the patient can balance the risks and benefits within the
patient’s own psychological framework has not been reached *(Warner et al., 2002)*.

2) **Beneficence (Acting in best interest)**

Persons are treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their wellbeing and welfare. Two general rules have been formulated as complementary expressions of beneficent actions in this sense: 1) do not harm 2) maximize possible benefits and minimize possible harms *(Bhui and Colby, 2008)*.

3) **Non-maleficence (Do no harm)**

The principle of non-maleficence implies an obligation not to inflict harm on others. In balancing beneficence and non-maleficence (benefit versus risk), the clinician must share information with the patient, who can then be helped to make an informed decision *(Fanaroff, 2014)*.

4) **Justice (Doing what is fair)**

The principle of justice implies fair distribution of the resources that are available to the doctor in his health care-delivery system, amongst his patients. It addresses respect for people’s rights and respect for morally acceptable benefit to the patient *(Lawrence, 2007)*.

The principle of justice obliges doctors to equitably distribute benefits, risks, costs, burdens and resources to their patients as each
person has an equal share and urgent cases must be also taken in consideration (Warren and Jahn, 2011).

**Figure (1):** Basic medical ethical principles: Autonomy, Non-maleficence (doing no harm), beneficence (acting in the welfare of the patient) and justice (Chamberlain et al., 2012).

**Medical confidentiality**

The professional obligation of confidentiality has ancient origins in Western medical ethics, dating from the Hippocratic Oath in the 5th century B.C.E. The Oath states that the physician will not reveal any information about his patient, whether that information is learned in the course of clinical care or outside of that context (Jones and McCullough, 2013).

Confidentiality pertains to the information that an individual has disclosed in a relationship of trust and with the expectation that it will not be divulged to others in ways that are inconsistent with the understanding of the original disclosure without permission (Casarett et al., 2000).
The practice of medicine requires strict confidentiality to respect another person's right to choose which aspects of himself or herself to share with others. Also, in the relationship between a physician and a patient, the sacrifice of privacy is voluntary and unilateral, requiring professional protection (Jones and McCullough, 2013).

**Breach of confidentiality**

The Irish Medical Council lists four circumstances where exceptions may be justified to breaches of confidentiality in the absence of permission from the patient, namely: when ordered by a judge in a court of law, also when necessary to protect the interests of the patient, when necessary to protect the welfare of society and when necessary to safeguard the welfare of another individual or patient (Agyapong et al., 2009).

**Disclosure of patient information**

The doctors’ legal obligation of confidentiality is best seen as a public and not a private interest, so when doctors disclose personal information without consent may be justified when failure to do so may expose the patient or others to the risk of death or serious harm (Wood, 2005).

The confidences are those of the patient, not those of the doctor, so if a patient requests or consents to their disclosure, the information may be perfectly and properly disclosed within the terms of the patient’s permissions. Consent to disclose confidential information may be given by the patient in a range of circumstances that include employment or insurance purposes, housing or welfare, testimonials and references or legal proceedings (Palmer, 2005).
In circumstances in which a patient is unable to give consent because of incapacity or immaturity and refused to allow the doctor to speak to other appropriate persons, the doctor may disclose information to other appropriate persons if convinced that it is in the patient's best medical interests. If a doctor believes that a patient is the victim of physical or sexual abuse or neglect, he may disclose relevant information to an appropriate person or statutory agency to prevent further harm to the patient (Palmer, 2005).

In most circumstances, close relatives are told the nature of the patient's illness, especially if they live together and have to care for the patient at home but this disclosure is by no means automatic, and if the patient's request that a relative not be told, then the doctor must abide by that wish, unless he is convinced that some over-riding medical reason exists (such as the need for domiciliary care). Particular caution is required over the disclosure of sexual matters, such as pregnancy, abortion or venereal diseases, as it may cause severe conflict between close relatives, such as husband and wife (Richard, 2003).

Professional Codes of Ethics

Most health professions have specific codes of ethics that are written guidelines using broad base directives that do not provide issue-specific guidelines. This means that the ethical guidelines for most health care professionals are vague, so ethical health professionals are required to apply their professional codes of ethics within a framework of societal moral values and within respect of individual philosophies and beliefs (Tietze, 2012).
Oaths and codes vary from one country to another and even within countries, but they have many common features including promises that physicians 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 (Swailem, 2009).

The medical code of ethics is considered the foundation for ethical behavior in health care, dates to Hippocrates; other codes of ethics are more recent but were often derived from the Hippocratic Oath (Tietze, 2012).

The Hippocratic Oath (about 400 B.C.E.) is of major historical significance as its principles form the framework for many of our current ethical standards (Winau, 1994).

The World Medical Association (WMA) provides an international code of medical ethics that lists out physician's duties in general, to the sick, and to each other (World Medical Association, 1949).

The World Medical Association Declaration of Geneva (1978):

The Geneva declaration for physician's oath at the time of being admitted as a member of the medical profession is as follows: (Payene-James et al., 2011).

- I solemnly pledge myself to consecrate my life to the service of humanity.
- I will give to my teachers the respect and gratitude which is their due.
- I will practice my profession with conscience and dignity.
- The health of my patient will be my first consideration.
I will maintain by all the means in my power, the honor 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 honor.

In the Islamic code of medical ethics, a doctor's oath is as follows: *(Islamic Code of Medical Ethics, 1982).*

*I swear by God the Great:*

- To regard God in carrying out my profession.

- To protect human life in all stages and under all circumstances, doing my utmost to rescue it from death, malady, pain, and anxiety.

- To keep peoples' dignity, cover their privacies and lock up their secrets.

- To be, all the way, an instrument of God's mercy, extending my medical care to near & far, virtuous & sinner and friend and enemy.
To strive in the pursuit of knowledge and harnessing it for the benefit but not the harm of Mankind.

To revere my teacher, teach my junior, and be brother to members of the Medical Profession joined in piety and charity.

To live my Faith in private and in public, avoiding whatever blemishes me in the eyes of God, His apostle and my fellow Faithful.


- A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
- A physician shall uphold the standards of professionalism, and be honest in all professional interactions and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.
- A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- A physician shall respect the rights of patients, colleagues, and other health professionals.
- A physician shall safeguard patient confidences and privacy within the constraints of the law.
- A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the
public, obtain consultation, and use the talents of other health professionals when indicated.

- A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

- A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

- A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

- A physician shall support access to medical care for all people.

**Doctor-patient relationship**

Maintaining good technical as well as interpersonal skills is essential for the doctors to satisfy their patients, especially physicians working in public hospitals (*Chimbindi et al., 2014*).

The physician must have not only the scientific knowledge and technical abilities, but also understanding of human nature. The patient is not just a group of symptoms, damaged organs and altered emotions but he is a human being, at the same time worried, hopeful and search for relief, help and trust. The importance of an intimate relationship between patient and physician can never be overstated because in most cases an accurate diagnosis, as well as an effective treatment, relies directly on the quality of this relationship (*Hellin, 2002*).
In this deeply intimate relationship, when we earn our patients' trust, we must learn about fears and worries that our patients may share them or not to us as they put their lives and well-being in our hands (Kleinman, 2013).

In clinical medicine, the relationship between doctor and patient is not a vehicle through which to deliver care, but it is one of the most important aspects of care itself. Excellent clinical outcomes in patients report high degrees of satisfaction, work effectively with their physicians, adhere to treatment regimens, and proactively manage their lives to promote wellness are more likely to arise from relationships with doctors that are collaborative, and in which patients feel heard, understood, respected, and included in treatment planning (Gordon and Beresin, 2015).

The apparent intrinsic quality of this unique doctor-patient relationship allows two individuals, previously unknown to each other, to feel at ease with variable degree of intimacy. This relationship, in time, may develop to allow the patient to convey highly personal and private matters in a safe and constructive environment (Kaba and Sooriakumara, 2007).

**Doctors Duties to their patients:**

A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for that purpose and when consulted by any patient, he must decide what treatment to be given and the duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient (Harish et al., 2012).
While a doctor cannot be forced to treat any person, he has certain responsibilities for those whom he accepts. It is an implied contract, which is not written. This contract requires that the doctor must continue to treat a patient whom he has accepted with reasonable care, reasonable skill and to keep inviolate his secrets (Parikh, 1995).

Doctor should know his duties regarding general aspects of medical practice: (1) duty to up-to-date his knowledge and skills, (2) duty to attend the patient, (3) duty to special attention to patients of tender ages, duty to proper investigations, (4) duty to proper prescription and instructions, (5) duty to issue the needful certificates, (6) duty to inform the concerned responsible authorities and duty to act in accordance with the law (Singh et al., 2011).

Doctors must demonstrate the ability to communicate effectively, both orally and in writing with patients, their families, patients’ colleagues and others with whom physicians must exchange information in carrying out their responsibilities (Norgaard et al., 2011).

Doctors should be well aware about when they have slightest doubt of medico-legal cases they should send police information as the doctor has not only to play a vital role in struggling to save the patients’ life but also has to fulfill the required minimum formalities on medico-legal aspects in each case. This emphasizes the most frequent dilemma faced by the doctors: which case is to be booked as medico-legal? Doctors also should be aware about laws in relation to medical practices “Legal obligation” (Singh et al., 2011).
Patient Rights and Responsibilities:

Health care patients have rights, which must be acknowledged and protected which include observance of acceptable physical, mental, spiritual and social needs and health care providers are responsible for establishing and maintaining patients' rights (Abedi et al., 2016).

The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician (Boylan, 2014).

- The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives.
- The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.
- The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.
- The patient has the right to confidentiality, so the physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
- The patient has the right to continuity of health care, so the physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient.
The patient has a basic right to have available adequate health care. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should advocate for patients in dealing with third parties when appropriate.

Patients are responsible for providing information about past illness, hospitalization, medications and other matters related to their health status to participate effectively in decision making then inform their physicians if they anticipate problems in following prescribed treatment (Veatch, 2000).

Research ethics:

The system of ethical review of medical research employs to protect the rights and welfare of human participants, ensuring the legal and ethical application of codes of practice of medical research so Investigators are obligated to design research protocols that establish standards of scientific integrity, safeguard ethical and legislative issues of the human subjects with informed consent as a mandatory component of any clinical research (Guraya et al., 2014).

The international code of ethics for biomedical research, Helsinki II 1964: (Beauchamp and Childress, 2001).

1. The design and performance of each experimental procedure including human subjects should conform to existing scientific principles.
2. The design of the study must be clearly mentioned in the experimental protocol which should be forwarded to an independent review committee.

3. The study must be conducted only by persons adept at conducting the study after assuming full responsibility towards any problem arising because of the study.

4. The study should be carried out legitimately.

5. Every biomedical research should be preceded with a carefully conducted study of the biases, effects and the feasibility of the study.

6. The right of the research project to safeguard the privacy of an individual is paramount.

7. Human trials must be conducted only when an investigator is satisfied about the predictability of the side effects, hazards and others.

8. Investigators must preserve the accuracy of the results in the event that the results are published.

9. The subjects must be informed about the aims, objectives and the potential hazards of the study.

10. The consent can be obtained from the subject’s doctor or relatives provided that the subject legally cannot give the consent and if the study is of real use to him.