Medical Ethics — general principles

A peep into history - the genesis of medical ethics

References to medical ethics are to be found in the classic works of all schools of medicine in all cultures. Hippocrates commands the place of eminence amongst Greek physicians insisting on high ethical standards. Of the Roman physicians, Galen (AD 131 -201) stands out as one who commended moral assessment of the human soul and body and exhorted his colleagues to strive to do their best for both.

The ancient Indian science of life, Chinese schools of medicine and philosophy, Arabic and Islamic cultures have also made pertinent references to ethical medical practice.

Across all cultures and over all periods, the concerns have been strikingly similar: to bridle skills and knowledge acquired by the physician to the welfare and dignity of his patients and society and to provide checks against the misuse of the power aquired by the healer. These were requisites for preserving the dignity of the profession.

The need for ethical norms in medicine appears to have originated in the earliest interactions between the healer and the person seeking health or relief from disease.

The practice of medicine was at first a matter of mystery. Supernatural influences were invoked to heal or cure. The medical profession was elitist at its inception, healing being the prerogative of a few. Powers of healing were transferred from tribal witch doctor to the priest of organised religion.

The priest-physician exploited the principle of power derived from a supernatural source. Disease was caused by evil spirits at war with the gods, who were themselves, protectors of man. Since gods arbitrated life and death, men associated with them could reasonably be expected to intervene successfully on behalf of an outsider.

Religion and medicine had parallel objectives - protection against evil which could express itself in spiritual form (as disease of the mind) or material form (as disease of the body). The relatively closed community of priest-physicians learned from each other and benefited from organisation and codification. By virtue of their privileged position as teachers, they attracted students from the upper social strata. Preserving the image of holiness and secularity, the priest-physician acquired considerable superiority.[1]

Atheism and medical ethics

The term moral is often, and incorrectly, linked inseparably with religion. Some philosophical doctrines stimulated thought and gave birth to the ethical concepts we continue to use. Chief amongst them are (a) utilitarianism, which originated in the writings of David Hume (1711-1776), Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873) and (b) deontology, formulated by Immanuel Kant (1734 - 1804). Neither invoked supernatural elements Tom Beauchamp and James Childress have discussed these theories in considerable detail.[2] This paper draws heavily on their volume which is warmly commended.

Criteria for moral and non-moral action

How does one distinguish between moral and non-moral action? What makes some dilemmas and judgements - and not others - moral? By what criteria can we say that any given normative standard is properly moral rather than religious, legal, or political? Beauchamp and Childress[2] discuss three considerations which guide us in distinguishing between moral and non-moral action. The first and second of these are related to the form and the third to the content of the action.

Simply put, these are:

1. Acts accepted by a person, or society as supreme, final, or overriding in judgement. As Beauchamp and Childress[2] point out, this, by itself is not enough to make the action moral. It needs to be associated with the next two conditions.

2. All relevant, similar, cases must be treated in an identical way, leading to universalisation of judgement on the morality of an act.

3. The act must lead to the welfare of others.

Civil societies - laws and ethics.

The relevance of ethics and laws to a civil society is obvious. Whilst laws are designed to regulate society, ethics are intended to regulate oneself. The aim of an ideal society would be to have minimal laws and a freer society. This goal is (and can be) facilitated by a strong adherence to ethical norms by all members of society.

We present a series of essays on various aspects of medical ethics which, taken together, might form a handbook on the subject. We shall print these- on a four-page centrefold which can be pulled out and filed for reference. The second essay deals with general principles and discusses informed consent. These pages are being given separate, sequential centrefold numbers.

Every person, howsoever weak and feeble, remains a source of power. This power can be put to good or bad use. The intent of ethical codes in a society of humans is to generate a humane society by harnessing the powers of its individual members to the dignity and welfare of others in it. With increasing levels of power (bestowed or acquiesced) and concentration of power in groups within the society, the need for stringent implementation of ethical codes becomes even more imperative.

Professional groups, by virtue of their acquired knowledge, skills and opportunities, have increased levels of such power and need a strong ethical base on which they base their professional pursuits. Hence the importance of medical ethics and ethical codes.

Medical Councils, codes of medical ethics and the practice of medicine

Personal beliefs, perceptions and interpretations of supreme, final and overriding judgements could vary between individuals practising medicine with consequent chaotic variance in action. Most societies have set up medical councils and formulated codes to ensure ethical practice of medicine.

The Medical Council of India (and its subsidiaries in various states of the country) has been entrusted with this charge. It is a member of the World Medical Association and a signatory to the International Code of Medical Ethics. It is vested with the powers to register and de-register members as is applicable.

When a doctor registers with the Council, she/he simultaneously agrees to abide by the rules and ethical codes laid down by the Council and, by extension, those decreed by the World Medical Association under the International Code of Medical Ethics.

Even where personal beliefs of the practitioner, registered with the Medical Council of India (or its State subsidiaries), are at variance with those of the Council, it is obligatory for the doctor to abide by the codes of ethics laid down by the Council. For instance, a practitioner with a strong belief in racial discrimination cannot permit such discrimination to influence her/his care of patients.

Principles of medical ethics

Four principles govern the ethical practice of medicine:

1 autonomy of the patient

2 nonmaleficence towards the patient

3 beneficence towards the patient

4 justice

The principle of autonomy

Our present understanding and appreciation of this principle is based on the works of Immanuel Kant and John Stuart Mill. Kant developed the concept of the moral autonomy of the will. Mill, on the other hand, developed the argument that social and political control over individual actions is legitimate only if it is necessary to prevent harm to other individuals.

Respect for autonomy of persons. encourages removal of constraints on them that might disallow a person from making decisions or choosing between one of several courses of action. (We refer the reader to the book by Beauchamp and Childress[2] for fuller details.)

Are all persons to be granted full autonomy? Beauchamp and Childress[2] reiterate that the principle of autonomy does not apply to persons who are not in a position to exercise such autonomy. They provide as examples individuals who are immature, incapacitated, ignorant, coerced or placed in a position in which they can be exploited by others.

The parent or guardian is authorised to act on behalf of the patient who cannot be expected to exercise autonomy. The parent or guardian and the. team of medical professionals must make special efforts to explore all feasible measures to promote conditions likely to promote autonomous responses from the patient. They must also ensure that actions taken on behalf of the incompetent patient are in accordance with those willed by, the patient whilst she/he was competent to make decisions.

Informed consent and respect for autonomy

The act of obtaining consent from the patient for any medical intervention is based on respect for autonomy of the patient. Since medical interventions are, on the one hand, of technical nature not easily understood by non-medical persons and, on the other, can have both beneficial and harmful manifestations, it is especially important to exercise considerable care and do one's best in conveying to the patient the exact nature of the procedure to be carried out or therapy being administered and the risks and dangers that could follow. It is only when the patient has been made aware of the possible harm that may follow and, having understood this, permits the procedure or therapy that the medical attendant can rest satisfied with the informed consent obtained.

Situations demanding informed consent are ubiquitous in day-to-day medical practice and in all clinical

research. And yet, it is common knowledge that, more often than not, the manner in which such informed consent is obtained is cursory, apathetic, halfhearted and unfair to the patient. To avoid failure in our duty to the patient we must, consciously, ensure the following: a) competence of the patient to consent b) disclosure of as much information on the procedure or form of therapy as possible c) comprehension by the patient of the information conveyed and the implications in terms of possible harm d) total absence of any form of coercion or domination by any member of the medical team when the consent is obtained.

Validity of the information disclosed to the patient rests on two main attributes - the veracity of information and the completeness of information. Both these are amenable to objective evaluation and to that extent can be ensured. If the information is true by contemporary scientific and local standards, it is adequate. Comprehension of information can be validated by chatting with the patient and seeking answers to relevant questions.

Deciding the competence of the patient to consent can, on the other hand, pose serious difficulty in obtaining informed consent. The element of competence has two aspects (a) the voluntariness of consent and (b) the competence to consent.

Judgement on the exercise of true volition is especially important in our setting. All- too-often, the husband dominates the wife and forces her to undergo tubal ligation or some other similar form of sterilisation against her will and because he is unwilling to undergo the considerably simpler procedure of vasectomy. In a setting devoid of absolute confidentiality - so common in Indian clinics, where the husband insists on being present all the time during discussions between doctor and patient - the wife does not voice her objection and offers her mute thumbprint on the paper thrust before her. In such circumstances it is incumbent on us to make special effort at learning the will of the patient and acting on it.

Determining competence of the patient to consent is perhaps, the most difficult. Barring extreme cases (as with the completely competent or the totally incompetent), objectivity in assessment can be difficult and judgement, value-laden. Standards of competence have been extensively debated in the West. Courts have disagreed on the properties crucial to determination of competence. The ability to make a decision at all is, obviously, vital. The capacity to reach a reasonable result through a decision has been advocated as a criterion for assessing competence for consent. 'Reasonable' needs qualification and can prove a stumbling block in a court of law. The capacity to harness rational reasons whilst reaching decisions has been generally accepted as the criterion on which judgement of competence can be made.

Given our feudal history, much greater effort is needed to generate conditions that nurture autonomy in every person. Education of the general population on medical matters and constructive demystification of medicine will help. We also need to expose society at large to situations where vital decisions are necessary. Members of the public must be empowered with the tools of logic to enable them to make rational and safe decisions that are in their best interests. Perpetuating the attitude of the shamaan on yore and holding the facts in medicine close to the medicine man's bosom is manifest disrespect of the autonomy of the patient.

The principles of nonmaleficence and beneficence

These are complementary. Simply put, we must strive not to inflict evil or harm on the patient. Instead, we should prevent evil or harm and, where these exist, remove them. Our efforts must be concentrated on promoting good and the welfare of the patient.

These principles form the foundation of medical practice.

It is up to us to introspect on the extent to which we, in India, adhere to them. Sadly, even without straining memory, we can summon up instances where they have been wilfully flouted.

The principle of justice

The material principles of justice[2] are:

-to each person an equal share

-to each person according to individual need

-to each individual according to individual effort

-to each person according to contribution to society

-to each person according to merit,

If we were to tailor these general principles to the assessment of performance by members of the medical and allied professions, we could consider criteria for (a) judging the competence of the practitioner in medical intervention (b) the professional charges levied and (c) the quality of fiduciary relationship. We could pose questions like: Is the intervention medically justified and professionally competent.? Are the fees levied just' and fair? Is there a betrayal of trust between

the doctor and the patient?

It is upto us as professionals to devise means for assessing and monitoring our performances primarily because we are best equipped in terms of medical expertise to do so. Exercises like medical, prescription and social audits may serve as the first step in this direction.

Failure on our part to search our own practices and consciences will, inevitably, invite monitoring and judgement by other agencies and the public at large. Were this to come to pass, our protestations that they are unskilled in medicine will be brushed aside as they do their best to ensure that the medical profession does justice by society.

Medical ethics and everyday practice of medicine

Dilemmas in ethics arise in everyday practice mainly because of conflicting positions on the four principles enunciated above. This has led to the deveopment of a new discipline - philosophical medical ethics.[3] It aims at focussing attention on grey areas in ethics in medicine. In subsequent essays in this series we hope to develop this theme.

For the present we leave you with the process by which a given act can be analysed using the principles discussed above. We use examples familiar to all, from current medical practice. Whilst the blatant violation of medical ethics by each of these practices is obvious, a similar analysis can be made of practices where doubt exists on whether or not they fall within the limits of ethical permissibility.

1. *Fee splitting* The giving or acceptance of commissions for referral of patients is a violation of (a) the principle of nonmaleficence (b) the principle of beneficence (c) fiduciary relationship with patients (d) justice to patients. The fact that money is changing hands for what should be a free service is, in itself, to be censured. When the lure of lucre impels the referring physician to send a patient to a doctor who is not the best expert in the field, the practice can only be condemned.

2. *Over-prescription, advising unnecessary investigations* These violate (a) the principle of justice (lack of professional competence) (b) principle of nonmaleficence and beneficence. When making such a recommendation we are failing in our competence to decide appropriate therapy, investigation. The patient is being made to pay for unnecessary drugs and tests. Most drugs and several tests carry the risk of harm to the patient. Since the drug/s and test/s are not indicated on medical grounds, we are putting the patient to unnecessary risk. Certainly, we are not acting in the best interests of the patient.

3. *Perfunctory informed consent* This violates the principle of respect for autonomy and the right of the patient to know. We are especially guilty when we hide possible harm that may follow and then violate also the principles of nonmaleficence and that of beneficence.

4. *Mystifying medicine* This violates the principle of respect for autonomy of patient.

References

1. Mason JK, McCall Smith RA: *Law and Medical Ethics* Butterworths, London. Third Edition. 1991.
2. Beauchamp T, Childress J: *Principles of Biomedical Ethics* Oxford University Press, Oxford. Second Edition. 1983.
3. Gillon R: Teaching Medical Ethics in Medicine. In: Byrne P (Ed.) *Medical Ethics and the Value of Life.* John Wiley & Sons, London. 1990.