

Ethics in Medical Practice

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Ethics has been a part of medical practice since the time of Hippocrates. Recent advances in medicine and the amazing advances in technology have brought ethical issues in the forefront; the potential for human cloning, use of fetal tissues in the treatment of diseases, legalized abortion in some countries, the legalization of physician assisted suicide in some parts of the United States and the tremendous increase in the cost of treatment have placed significant moral and ethical pressure on physicians. Education in medical ethics is lacking in most countries. In the United States of America by the end of 1980 only 34% of medical schools had introduced bioethics as part of their curriculum.

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During the clinical management of patients most of our decisions are based on medical judgment. Ethical issues arise when patients or their relatives refuse to accept these decisions, or simply cannot afford them. How do we physicians react when confronted by such issues? Should we act only on intuition and personal biases or preferably think critically about ethical issues using sound moral and ethical reasoning?

Definitions

Health care ethics is the application of human values of right or wrong, in making meaningful moral choices in health care delivery.

A moral dilemma can exist in two forms. First, when two opposite actions are both considered morally right and there is an obligation to do both, or when an action is considered morally right and wrong at the same time, this may occur due to different standards of morality in different cultures.

In western cultures two ethical theories are generally practiced. Utilitarianism states that an action is morally right if it causes the best outcome for most people. There is more value than disvalue of the action taken. Theory is result based, the end justifies the means, use of nuclear bombs and the killing of hundreds and thousands of innocent people was morally justified as it resulted in the end of the Second World War. 'Deontology' (DEON = Duty in Greek), states that the features of actions themselves rather than the consequences

determine what is right or wrong, for example, killing is wrong and is morally not permitted regardless of circumstances or outcome.

In Deciding clinical ethical issues Beuchamp and Childress², promote the use of a common morality, they use the principles of beneficence, normalfidence, respect for autonomy and justice. Beneficence is the obligation to do good. Normalfidence is the obligation of not to do harm intentionally; the first duty of a clinician is 'to do no harm', a frequently cited medical maxim. Respect for autonomy is a norm of respecting the decisions of an individual. Autonomy 'rule of self' is a core belief in western culture, however often in the culture of Middle Eastern and Asian societies especially Pakistan it may not be applicable. Often clinical and medical decisions are made by the head of the family and the individual is sidetracked. Justice is the obligation of fairness. It is a set of norms for distributing benefits and risks fairly.

Many times the Doctrine of Double Effect is also used in ethics. This is a controversial phenomenon where a potentially harmful act can be morally acceptable if the intention is to benefit the patient. A classic example of this is the administration of very high doses of narcotics to relieve pain in cancer patients. This may result in respiratory depression which may do harm to the patient, but the intention was to relieve the pain therefore the act is acceptable.

Important rules for ethical practice are the concepts of veracity, confidentiality and professionalism. Veracity is the obligation of truthfulness in our relationship with our patients, this is the most important part of the patient-physician relationship and helps in developing the patients' trust. Confidentiality is expected by our patients, it also encourages trust and strengthens the relationship between the doctor and the patient. Professionalism is a collection of rules of behaviour, which are defined by our society and community.

Methods for Ethical Problem Solving

There are no crystal cut set of ethical guidelines for the physicians to follow. Then how do we in our

routine clinical practice manage ethical dilemmas? The American Medical Association has developed ethical guidelines and principles which 'are not laws', but standards of conduct which define the essentials of honourable behaviour for the physicians.³ In making clinical decisions the 'Case based ethical reasoning model' described by Jonsen⁴ is a practical method for evaluating clinical ethical problems. In order to solve an ethical dilemma four basic topics must be reviewed, as these are always present in every case regardless of the circumstances. These are:

1. Medical indications
2. Patient preferences
3. Quality of life
4. Contextual features, i.e., the external socio-economic features.

The four principles of bioethics are then utilized in solving these individually. For example, medical indications and quality of life will involve principles and rules of beneficence and non-maleficence. Patient preferences may deal with issues of autonomy and informed consent. Contextual features might deal with concepts of justice and fairness. One should always consider patients preferences and ask the patient if he has been adequately informed and understands about the risks and benefits. If the patient is knowledgeable and has understood everything it is his right to choose, which should be respected. In Pakistan, the contextual features take a very important aspect of solving an ethical dilemma, as they include family issues, religious and cultural factors, legal implications and above all, the issue of economics.

In some cases ethical theories and principles do not help physicians in resolving conflicts, other approaches to clinical ethics have been suggested.⁵ Instead of relying on theories some writers resolve dilemmas by looking at the concrete details of a particular case.⁶ They believe that moral rules are not absolute; they merely create presumptions that may be rebutted depending on the particular circumstances. Proponents of case based ethics emphasize the need for what Aristotle called 'practical wisdom' i.e., the ability to make appropriate decisions according to the circumstances of the case.

Ethics and Research

The World Medical Association has developed the declaration of Helsinki as a statement of ethical principles that provides guidance to physicians and any other participants in medical research involving human subjects.

It was adopted by the 18th World Medical Assembly in Helsinki in June 1964 amendments were made in 1975, 1983 and 1989. It was updated at the General Assembly in Somerset West in the Republic of South Africa in October 1996.⁷ Recently a clause has been added by the World Medical Association at its General Assembly in 2002.⁸ The main aim of this declaration is to highlight the responsibilities of researchers about the patients or the human subjects that they are using. In its 'Introduction' it states that it is the mission of the physician to promote and safeguard the health of the patient. His/Her knowledge and consciousness are dedicated to the fulfillment of this mission. The Declaration binds the physicians with the words 'the health of my patient will be my first consideration' and the international code of medical ethics declares that a physician shall act only in the patients interest in providing medical care. It is extremely important to remember that in medical research considerations related to the well being of the patient, should take precedent over the interest of science or society. Responsibilities of the investigators increases manifold if the research is being conducted in developing countries.

A recent article by Quinn et al⁹ on 'The viral load and heterosexual transmission of human immunodeficiency virus type-1', which was recently published in the New England Journal of Medicine, has been under intense debate. These investigators believe that there is no need to provide better care to human subjects than is generally available in the community in which they are living. They argue that since Ugandans in rural villages cannot obtain the anti-retroviral treatment they should not be treated for HIV within the research study, subjects used for research purposes were not treated and the argument for not treating them was that since the drug was not available in Uganda, it was morally right not to treat them. Many people believe that the different standards are justified because local economic conditions are different than those in developed countries. I believe that the research should be relevant to the population from which the subjects are drawn. It is not appropriate or ethically right to take subjects from developing countries and use the benefits of that research for the treatment of people of developed countries. All investigators should be responsible for their subjects and if the investigators consider themselves to be responsible, ethical physicians then these types of studies should not be conducted. Marcia¹⁰ in her editorial has argued that our ethical standards should not depend on where the research is performed and she believes that investigators should assume

responsibility for the welfare of the subjects they enroll in their studies, a responsibility which is the same as that of a clinician. The debate still goes on, the physicians and researchers should decide whether it is better to do research in patients of poor developing countries and provide the benefits of research to developing countries because the drugs which were being tried for the treatment of a certain disease are too expensive to be used in developing countries, or not to do research at all. Is that ethical or not? Problems like this will continue. It is the duty of physicians and researchers in developing countries to assume the responsibility of making moral and ethical decisions considering the well being of their patients.

In conclusion, I would like to say that our patients and our society expect us to understand the basic principles of bioethics, and use the many tools that are available for moral reasoning that allow us to make appropriate ethical decisions.

References

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Abstract

Objective:

To study the prevalence of hepatitis C virus in lymphoproliferative disorders.

Methods: A case control prospective study was performed on 143 patients with lymphoproliferative disorders and 29 patients with non-hematological malignancies were taken as controls. All the patients in both groups were analyzed for various risk factors for infection with hepatitis C virus and were tested for the presence of hepatitis C virus antibody (anti HCV), cryoglobulins and rheumatoid factor antibody. Hepatitis C viremia was documented by detection of HCV RNA by polymerase chain reaction.

Results:

There was no significant difference for risk factors for hepatitis C virus infection in both the groups except for the increase in number of surgical procedures being carried out in the control group. There was no significant difference in the presence of rheumatoid factor antibody in both the groups and cryoglobulins were not positive in any individual. Five percent patients with lymphoproliferative disorders and 3.4% with non-hematological malignancies were positive for anti HCV. HCV RNA was detected in 29.2% cases and 31.0% in controls.

Conclusion:

There was no association between hepatitis C virus infection and lymphoproliferative disorder in our population. However, further studies are required from this region to establish any causal relationship between hepatitis C virus infection and lymphoproliferative disorder (JPMA 54:202;2004).