

Ethics in clinical medicine

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"...The Tuskegee Study of untreated syphilis in the negro male examined the natural course of untreated syphilis in African American males. It was conducted by the United States Public Health Service with the prestigious Tuskegee Institute from 1932 to 1972. A group of 399 infected and uninfected controls were followed up. Treatment was denied to the infected persons even after penicillin became available in the 1940s. The patients were not told that they had a sexually transmitted disease. It is estimated that more than 100 subjects died of tertiary syphilis. The study ended in 1972 when the program and its unethical methods were exposed in the Washington Star. In 1974, the federal government paid 10 million dollars as compensation to the subjects. That same year, the US Congress passed the National Research Act, making it mandatory to obtain ethical approval for all research involving human subjects. In 1997, US President, Bill Clinton, issued a formal apology, to the subjects of the study...."¹

Ethics relates to the philosophical analysis of morality of human behaviour². Philosophical is to take a reasoned out approach and morality is to do with right or wrong. Therefore ethics would concern with taking a reasoned out approach to what is right or wrong in human behaviour. Ethics concerns a vast area of philosophy. Bio medical ethics is the area which is of immediate relevance to the clinician. Medical practitioners treat patients and or pursue biomedical research or do both. In the course of pursuance of the above they are frequently confronted by moral or ethical dilemmas. The role of biomedical ethics would be to provide a reasoned analysis in order to clarify and resolve such issues in medicine.

Fundamental or classical ethical theories exist to resolve ethical issues faced by man. These could be used to resolve issues in biomedical ethics too. Teleological and the deontological theories make the two major categories. The most prominent of the teleological theories, Utilitarianism / Consequentialism was proposed by the English philosophers Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873)³. Utilitarianism states that rightness or wrongness

of human action is exclusively a function of goodness / badness of the resultant consequences. Utilitarianism proposes that when one is faced with several alternatives, the consequences of each action should be evaluated and the one with the best consequences, i.e. one which maximizes utility should be chosen. Promotion of the maximum amount of happiness to the greatest number of people would be the most ethical action. The strongest criticism leveled at utilitarianism is the apparent trading off of the individual's best interests against the best interest of the community. The use of QALY's (quality adjusted life years) to determine resource allocation is a classic example on the use of Utilitarian principles in delivery of healthcare.

The other major school are the deontological or the duty based ethical theories. The most prominent of these is the "Kantian deontology", proposed by the great German philosopher Immanuel Kant (1724-1804)⁴. He speaks of a "Categorical Imperative" – the need to treat humanity with respect, never as means only but always as ends too. Kant describes perfect and imperfect duties human beings owe towards one's self and others. Perfect duties can never be broken (duty not to harm another, duty not to lie etc). Application of these concepts would form the cornerstone of obtaining informed consent from human research subjects.

The classical ethical theories could indeed be used to resolve ethical dilemmas. But Utilitarianism and Kantian deontology themselves run into volumes and there are a number of other well recognized ethical theories like the duties proposed by W.D. Ross and Virtue ethics proposed by Plato and Aristotle and others afterwards⁵. Therefore it would simply not be reasonable or pragmatic to expect the practicing clinician to be versed in the workings of all these classical theories for bedside decision making.

The landmark event of modern day biomedical ethics came in 1979. Professors T. L. Beauchamp and J. Childress from the Kennedy Institute of Ethics in USA published a book titled "Principles of Biomedical Ethics"⁶. Based on the ethical theories they go on to define four fundamental principles – Autonomy, Non maleficence, Beneficence and Justice.

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Autonomy recognizes the capacity of the patient to think, decide and act freely and independently in making decisions about the illness and treatment. The doctor is vested with the responsibilities of providing the information to help them make informed decisions, respecting and following such decisions. The concept of obtaining informed consent to a treatment procedure or taking part in a research project and preserving confidentiality of all patient related information would be extensions of the process of respecting patient autonomy.

The principle of non maleficence recognizes that virtually all decisions doctors take with regard to the patients have some element of risk or harm. The doctor is expected to weigh the potential benefits with the potential harms and do only what would seem to carry an overall benefit.

The principle of beneficence recognizes that doctors have to move beyond the "do no harm" principle but do all possible to promote what is best for the patient. The doctor is expected to be pro active in decision making and promote good. Under this principle, the onus of deciding on what is best falls on the doctor. Under autonomy, the patient decides what is best and usually there is no conflict between the two. Often the patient chooses what the doctor sees and informs the patient as the best course of action. But in the rare instance, these principles come into conflict and doctors and patients recognize different options as being the best.

Aristotle first spoke of "distributive justice". In contrast to the previous three principles which were directly in the context of the doctor-patient relationship, the principle of Justice recognizes the doctor's duty and responsibility towards the society as a whole. However affluent the society is, there are always time and resource constraints that do not allow every patient the best possible treatment. Doctors have to decide on the limitations on treatment that can be offered at each level. For instance, time and resource constraints do not permit every Sri Lankan patient with end stage renal failure to have renal transplantations / renal replacement therapy. In ensuring equitable time and resource allocation, it must be recognized that patients in similar situations should normally have access to similar healthcare and when determining what level of healthcare should be available for one set of patients, we are ethically bound to consider the effect of such a use of resources on other patients. Many doctors are drawn into ethical dilemmas as the principle of justice is often in conflict with the principle of beneficence.

A few hypothetical case scenarios could be used to familiarize one's self with the application of above principles.

Scenario 1 – "Mr M, a 76 year old gentleman was admitted complaining of dysphagia and an endoscopic diagnosis of a malignant stricture of oesophagus (confirmed histologically) has been made. The relations request the doctor not to reveal the diagnosis for the fear of making Mr M depressed. But he is keen to know from the doctor what is wrong with him". The issues in contention are as follows. The patient has a right to information (autonomy) but this information may actually cause some harm too (non maleficence). In addition, providing information to the patient against their wishes may lead to a break down of the relationship between the family of the patient and the doctor. It has to be recognized that the primary duty of the doctor is towards the patient and the needs of the patient would outweigh considerations of the relationship the doctor has with third parties e.g. the patient's relations. In this scenario, there is a conflict between two of the fundamental principles, viz, autonomy and non maleficence. The literature is not definite on a hierarchy of the principles but bioethicists consider autonomy to be "the first among equals". In the above scenario, the most ethical action for the doctor to pursue would be to discuss the illness with the patient according to his wishes, following good communication principles so that the possibility of his getting depressed would be minimized and counseling be arranged incase depression does become an issue.

Scenario 2 – "Mrs Q, a Jehovah's witness is admitted with dengue haemorrhagic fever, having severe haematemesis and is in circulatory collapse. She refuses a life saving blood transfusion". The issues here are, the patient's life will be harmed if the blood transfusion is not given (non maleficence) and the patient has a right to decide what she wants (autonomy). The ethically sound decision would be to withhold the transfusion respecting her autonomy but employ all other possible measures to resuscitate her⁷. If for instance, the patient happens to be Mrs Q's nine year old daughter the outcome would be very different. Even if Mrs Q as mother and the child as patient refuse the transfusion, the doctor is ethically bound to transfuse blood as the child does not have the capacity to give or refuse valid consent. For consent to be valid, it has to meet the following criteria. Relevant information must be given to the patient, patient must understand the information, the decision must be made free from duress and undue pressure, give consent explicitly (written or spoken) and importantly have the capacity to consent (Above 16 years, mentally sound). In this instance where the patient does not have to capacity to consent, the onus and the responsibility of making a decision falls on the attending physician and not the relatives⁸. But it constitutes good practice to make information available to the relations at all stages and make them partners in decision making. If there is a

dispute some hospitals in the west have the provision to obtain urgent magisterial orders to provide treatment in order to obtain indemnity from future law suits.

Scenario 3 – "Mrs A, a 68 year old lady with end stage renal failure needs a renal transplantation and has no suitable related donor but she finds someone who is willing to donate a kidney for a financial consideration." The ethical issues are, the fact that the patient needs treatment as a life saving measure (autonomy and beneficence) and the donor is willing to part with the organ (donor's autonomy) and such action will lead to an increase in the precious few number of available donors (justice). From an ethical point of view, all seems well but the above action has been prohibited by the Tissue Transplantation Act. The legal prohibition has been placed as such an action would lead to many excesses (unconsented removal of vital organs for transplantation) and would lead to a collapse of social order⁹. Therefore any ethical considerations would be secondary to legal considerations and doctors would have to abide by the laws in force at all times, whatever the obligations are in the doctor patient relationship. Ofcourse if any laws are considered archaic and are not keeping in with the needs of the society, doctors could form part of pressure groups to convince law makers to change the laws, but until then we have to abide by the law. The analysis of controversial ethical issues like abortion would follow much the same reasoning.

What of the patient who demands a CT scan for the headache he has? The doctor will have to make an independent judgment on the need for this. To demand inappropriate treatment does not fall within the purview of the ethical principle of autonomy.

What of the person with decompensated alcoholic liver failure who needs a liver transplantation? If a motivational interview reveals that he is unlikely to abstain, the principle of justice makes it ethical for the doctor to decide against recommending a liver transplantation as the donor pool is very small and the procedure consumes so much of precious resources. Everyday, an endless number of such scenarios confront us at the bedside of the patient.

Recent advances in medicine like assisted reproductive technologies, surrogate motherhood, human cloning, genetic testing, stem cell treatments

are pushing the boundaries of biomedical ethics into hitherto unexplored territories. Only constant dialogue, research and adoption of uniform standards will help us conquer these challenges. As of now, all of the biomedical ethical theories and principles have originated from the thinking of philosophers from the Western Hemisphere. Bio medical ethics from an Asian / Oriental perspective remains an uncharted territory¹⁰. Till a day dawns where we have our own theories and principles to guide us, we will have to adopt the existing principles. But it remains incumbent on all bioethics enthusiasts to conduct medical, sociological and anthropological research so that culturally valid ethical standards could be adopted by medical practitioners in the Eastern hemisphere.

Practice of medicine is a moral enterprise. It often raises the questions not only of what should be done, but how it should be done. To be familiar with the principles of medical ethics, be able to apply them to moral dilemma and be able to make ethically sound decisions would be to the advantage of the patient and the practitioner both.

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