

Journal of Applied Sciences Research, 7(13): 2394-2398, 2011
ISSN 1819-544X
This is a refereed journal and all articles are professionally screened and reviewed



ORIGINAL ARTICLES

Ethics and Medicine

Akram, Mohd Shair

Dean Ahmad Ibrahim Kulliyah of Laws, International Islamic University Malaysia.

ABSTRACT

This paper provides a brief overview of competing ethical approaches to various substantial legal issues in a Medical or Healthcare context. In a nutshell, there are three main reasons for considering ethical approaches separately from and prior to examining the law. This is because many of the legal principles in medical law are based on ethical foundations, for example the law on consent to treatment is based on respect for autonomy. Secondly, on many of the topics in medical law, law is insufficiently developed to provide guidance for health-care professionals, e.g. the equitable remedy for breach of confidentiality. And thirdly, there may be ethical reasons for not attempting to extend law into certain areas, e.g. attempts to regulate the behavior of pregnant women which may be better influenced by education and information, rather than law.

Key words: Medical Ethics, Code of Hammurabi, Hippocratic Oath, Human Clone, Xenotransplantation.

Introduction

Medical ethics makes news, but are far from new. From the formulation of some form of ethical rules for practicing medicine in Ancient Egypt by Imhotep, (who was the archetypal combination of physician, priest and court official) - as early as the second millennium BC to the first Babylonian legal code – Code of Hammurabi (1900 BC) to promulgation of the Hippocratic Oath in Ancient Greece to the present day doctors have debated among themselves the codes of conduct which should govern the art of healing.

These days, philosophers, theologians, lawyers and even journalists insist on joining the debate. Outside interest, is not new either. Imhotep, was a combination of physicians, priests and court officials. Hippocrates was a philosopher. The Muslim ‘ulama and the Christian churches through countries have asserted the right to pronounce on medical matters of spiritual import, such as abortion and euthanasia, and to uphold the sanctity of life. All major religions across the globe similarly pronounce on matters of medical ethics. (Sinclair, 2003; Sheikh and Gartrad, 2003; Code of Medical Ethics, 1981; Cromwell, 2003)

The effective example of organized medicine is to be found in Egypt, where the father figure of medicine Imhotep – practiced. The Papyrus discovered in the 19th Century indicates that Egyptian medicine was comparatively advanced as early as the second Millennium BC. Several features of that organization are outstanding in their relation to modern practice. The concept of national health service seems to have been well developed – patients were not charged for visits to the healers, who were themselves, supported by the community. Then rigid rules were laid down as to experimental treatment- there was no culpability in failure to cure so long as the standard textbooks were followed. Severe penalties were, however, threatened for those who ignored the instructions, the reason being that very few men would be expected to know better than the best specialists who had gone before – an interesting attitude towards negligence which was still being adopted by the courts at the turn of this century. More importantly, the idea of specialization was deeply instilled. Medical treatment, however, remained very much the practice of the priest caste.

The Code of Hammurabi – contained elements of ethics and laid down inter alia, system of payment based on results, and to some extent, on the ability to pay and on the status of the patient, and also listed penalties for negligent failure, some of which were somewhat draconian, which would have deterred many from entering the profession.

The Hippocratic Oath makes interesting reading. Its first premise is that the doctor owes loyalty to his teachers and his brethren. An obligation to exercise skill for the benefit of patients’ health comes second. Abortion, direct euthanasia and abetting suicide are prohibited. Improper sexual relations with patients are banned. Confidentiality in all dealings with patients is imposed. In 2,500 years, these basic precepts of medical practice changed little. Dramatic changes in all kinds of moral and ethical problems confronting the doctor have appeared only in the last 50 years or so.

The art of the Greek philosophers-physician has become a science for many practitioners. Science has given the doctor tools to work marvels undreamed of by earlier generations. *In vitro* fertilization (IVF) and gamete

Corresponding Author: Akram, Mohd Shair, Dean Ahmad Ibrahim Kulliyah of Laws, International Islamic University Malaysia.
E-mail: akram@iiu.edu.my

donation to assist infertile couples to have children are no longer seen as extraordinary. The technology to create artificial gametes is on the horizon, so a man who produces no natural sperm might be able to father a child via sperm 'constructed' from other cells in his body. A family with a child dying of certain genetic diseases can be helped to create a 'saviour sibling'. Tests will ensure that the new baby does not suffer from her sibling's diseases, and is an exact tissue match for her. Then stem cells taken from the newborn infant's umbilical cord may constitute a 'cure' for the elder child.

Creating a human clone looks technically feasible now as mammalian cloning has proven possible. Reproductive cloning attracts much media attention and disapproval, but it is the potential for therapeutic cloning, better described as stem cell therapy, which excites doctors and scientists. The possible uses of embryonic stem cells hold out the hope of being able to replace damaged cells in patients with diseases such as Parkinson's disease. Further, in the future, some suggest that stem cells can be used to grow new organs to replace diseased kidneys or livers. (Kuehnle and Goodall, 2002, at 372)

Babies born at even earlier stages in gestation, or born with severe abnormalities, can be offered a chance of survival by amazing developments in neonatal intensive care. Some forms of foetal handicap are correctable by surgery carried out while the baby is still in the womb. Ventilators keep alive accident victims whose heart and lungs have given up. Dialysis and transplant surgery save kidney, liver and heart patients from certain death. The list of technological 'miracles' is endless. They have placed in the hands of doctors powers which humanity once ascribed to God alone.

Technological progress has been matched by social change. People are less willing to accept without question the decisions of those who exercise power, be they judges, politicians or doctors. Paternalism is out of fashion. Feminists ask why doctors should determine which infertile women receive treatment. Lawyers and philosophers, not to mention parents, wonder why the doctor is best qualified to judge whether a baby's quality of life is such as to make life-saving surgery desirable. The power of the doctor to end life by switching off a ventilator or by deciding not to give a patient a place in a dialysis unit disturbs us all. These moral dilemmas are just as acutely felt by doctors. Their difficulties are accentuated by the fact that new technology cannot be made available to all those in need: there is just not enough money or resource in the State Health Service. Above all, the medical profession faces a society deeply divided on virtually every moral question. The public demands a say in medical decision-making on sensitive ethical issues. Yet, from the 'hot potato' of whether doctors should help couples to have a 'saviour sibling' to help their dying child, through the debates on abortion to euthanasia, the doctor, who seeks guidance from public opinion, will discover division, bitterness and confusion.

Questions of medical ethics arise throughout the field of medical practice. Most medical students receive education in ethics as an integral part of their studies and several texts address medical ethics in detail. (Beauchamp and JF Childress, 2001; Gillon, 1996; Wiley and Harris, 1985; Routledge and Jackson, 2005; Jackson, 2006) Increasingly, those scholars who address the ethics of medicine speak of bioethics rather than medical ethics. The change of terminology is not merely semantic. The most difficult dilemmas begin in the laboratory, not at the bedside. Consider xenotransplantation, whereby animals might be genetically-engineered to produce organs compatible for transplant into humans with organ failure. The essential question is whether science should continue to pursue the research that may transform such possibilities into reality. Scientists need education in ethics as much as doctors. Equally importantly, the term bioethics is seen as less doctor-centered than medical ethics. All health professionals confront ethical dilemmas.

The scale of grossly unethical abuse of medicine revealed in the wake of the Second World War destroyed any complacent culture of paternalist medicine. A series of codes of medical ethics were promulgated internationally. Moral philosophers began to subject medicine to a much more rigorous critical analysis. "Critical" medical ethics emerged, offering a framework within which ethical dilemmas could be the subject of debate and reflection. Beauchamp and Childress's seminal book *Principles of Biomedical Ethics* (1979) proved especially influential.

Beauchamp and Childress formulated four basic principles – autonomy, beneficence, non-maleficence and justice – as a framework for ethical conduct. Today, the four principles are a fashionable subject for attract but they do not, and never sought to, provide easy answers to particular questions or to offer a comprehensive ethical analysis. (Clouser and Gert, 1996) They do, as Gillon says, '... Help us bring more order, consistency and understanding to our medico-moral judgments. The influence of the four principles, and their delicate relationship with legal principles, is such that any study of the law relating to health care should give a brief account of them.

Respect for Autonomy: Self-Determination:

Autonomy literally means self-rule (as opposed to heteronomy – rule by others). We should respect autonomous choices made by other people. Crude paternalism is the antithesis of respect for autonomy. Non-consensual treatment of a patient, even for her own good, violates her autonomy. Gradually, common law, via principles governing consent to treatment, clothed the moral principle of autonomy in legal reality.

Respect for autonomy does not demand unthinking deference to any choice made by another human being. To demand respect, a choice must be maximally autonomous – an informed and free decision made by someone with the capacity to make such a choice. A very young child will ‘choose’ not to go to the dentist and ‘choose’ not to be injected with antibiotics. His choice will be dictated by the nastiness of the procedure involved. He is not able to weigh the benefits of good dental care, or antibiotics to cure his streptococcal infection, against the immediate unpleasantness. An older person with severe mental disabilities may be similarly disabled from making any real choice. A paranoid schizophrenic may be led by his ‘voices’ to refuse treatment because he knows that the doctor is ‘Satan’. The preferences expressed in such cases are not autonomous choices. In setting boundaries of mental capacity, the law struggles with the concept of what constitutes an autonomous choice. The temptation to regard a choice you disagree with as non-autonomous choice. The temptation to regard a choice you disagree with as non-autonomous is strong. The outcome of the choice should be irrelevant. A woman who rejects surgery for breast cancer where the prospects of complete recovery are good because she cannot tolerate any mutilation of her breast makes a decision that we may see as bizarre. The Jehovah’s Witness rejecting a blood transfusion does so on the basis of any interpretation of the Bible which not all of us share. Their choices remain autonomous choices, made by people able to reason and on the basis of adequate information.

Beneficence: Do Good:

An injunction to act beneficently requires doctors to frame their actions to benefit their patients. The needs of the patient should be the professional’s pre-eminent concern. A patient should never be a means to an end. What does such a pious hope mean in practice? The ethics of clinical research have attracted much philosophical attention. The failure of doctors to act beneficently and the treatment of human subjects as little more than research tools explains that emphasis on research ethics. Ethical professionals should put the individual’s welfare first, even if to do so conflicts with their own interests (for example, their research objectives).

Another problem with beneficence might be that it could be seen as just another name for paternalism. The beneficent doctor does what he thinks is best for the patient. If natural childbirth is dangerous for the patient and the child she carries, the beneficent doctor must perform a caesarean section whether she likes it or not? The answer is no, because beneficence demands respect for autonomy. The professional should offer his judgment on what is good for the patient, but doing good for her requires that ultimately he accepts her decision on what is good for her.

Translating the ethical imperative of beneficence into legal principle is tricky. The law imposes a duty of care owed by doctor to patients. That duty, however, generally involves not doing harm. English law does not impose any duty to be Good Samaritan. Once a patient is admitted to hospital, staff must provide him with adequate and competent care. A doctor or nurse who witnesses a road accident but passes by on the side commits no legal wrong. Yet if she fails to help when she could easily do so, she fails to act beneficently.

Beneficence illustrates an important point about law and ethics. Ethics demand a higher standard of behavior than the law requires. A competent surgeon who removes a patient’s gallstones without mishap fulfils her legal duty of care. If she dismisses the patient’s complaints of pain with scorn, makes him feel like a child and treats him as just another patient number, is she acting ethically?

Non-Maleficence: Do Not Harm:

Raanan Gillon (1992) says of non-maleficence: ‘Among the shibboleths of traditional medical ethics is the injunction *Primum non nocere*- first (or above all do no harm’. Gillon does not challenge the principle of non-maleficence as such. Its importance is self-evident: what he rightly points out is that principle cannot be absolute. Medicine often involves doing harm. Removing an inflamed appendix inevitably involves a degree of harm, risk, pain and scarring. The benefits obviously outweigh the harm in that case. Practices which avoid all risk have ultimately done more harm than good. Sometimes agonizing dilemmas arise, as was the case in relation to the conjoined twins, Jodie and Mary, separated by surgeons in Manchester in 2000. Without surgery both girls would die. Separating Mary from her sister would and did result in her death. ‘Do no harm’ to Mary meant not doing good for Jodie.

Justice:

The idea that justice is a moral issue that doctors can properly ignore is clearly mistaken. (Newdick 2005; Gillon, p. 87) Few would disagree with a proposition that doctors should treat patients justly. ‘Justice’ in this context might be interpreted as meaning that patients are entitled to be treated fairly and equally by their doctors. The Minister should be treated no differently from a homeless person brought into Casualty after he is

found unconscious in a doorway. Health professionals should not show preference for patients who enjoy a particular status, or provide sub-standard care for patients of whom they disapprove.

Alas justice is much more complex. Resources are limited. Not every treatment can be offered to every patient who may derive clinical benefit from such treatment. Imagine that a Minister and the homeless person both needed a liver transplant. The demand for donor livers far exceeds supply. How should a just decision be made about whether either of them should receive a transplant? The Minister is 60, but in good health. The homeless person is 35, but is an alcoholic and his general health is poor. Other contenders compete for livers, a number of them younger than the Minister and in better health than the homeless person.

We might agree that the Minister should not get a transplant just because he is the Minister. We might agree that the homeless person should not be refused a transplant just because he is homeless. Is it relevant that if he continues to drink after surgery, the transplant is likely to fail? Even if he overcame his addiction his lifestyle may militate against success. Poor diet and no settled home will make it difficult for him to comply with the post-operative regime necessary to avoid rejection of the donor liver. There is a lively debate about how far lifestyle and/or 'fault' should affect access to state resources.

The complexity of notions of distributive justice in health care, coupled with scarcity of resources, has resulted in health economics entering the debate. They have advanced the merits of an exercise based on 'quality adjusted life years' (QALYs), which measure health as years of life after treatment weighted by the patient's quality of life. QALYs embody an attempt to provide an objective framework to assess how society should determine priorities for treatment.

Autonomy and Patients' Responsibilities:

Of Beauchamp and Childress's four principles, autonomy became *de facto* the dominant principle – especially in legal debate. So dominant did that one principle become that Daniel Callaghan declared:

Nothing has exasperated me so much as the deference given in bioethics to the principle of autonomy. (Callaghan, 1996)

The emphasis on autonomy has meant, as Draper and Sorrell explain:

Medical Ethics is one-sided. It dwells on the ethical obligations of doctors to the exclusion of those of patients. (Draper and Sorrell, 2002)

An in *R v Collins and Ashworth Health Authority, ex p Brady*, Kay J commented:

... it would seem to me a matter of deep regret if the law has developed to a point in this area where the rights of the patient count for everything and other ethical values and institutional integrity count for nothing. (Lloyd, 2000)

The problem is that the notion of autonomy has become distorted. Autonomy is wrongly understood as simply a right to what 'I want'. The doctor becomes little more than a technician delivering what the consumer-patient demands. As Onora O'Neil has eloquently pointed out, such an interpretation of autonomy is mistaken. (O'Neil, 2002) Autonomy involves:

... privacy, voluntariness, self-mastery, choosing freely, choosing one's moral position and accepting responsibility for one's choices. (Faden and Beauchamp, 1986, p. 7)

O'Neil adds to that list 'self-control' and 'self-determination'. Expressing a non-reflective preference is not a manifestation of autonomy. Responsibility requires reflection on how our choices affect others. Making a case that patients owe ethical duties to others, including their doctors, is relatively easy. Clothing such ethical responsibilities with legal force is a harder task. Reflecting, however, on patients' responsibilities forces us to consider the growing support for a view of communitarian ethics. In judging the ethics of a particular course of action, the impact on the community, not just the individual, must be evaluated.

To Whom (or what) Do We Owe Ethical Obligations:

Principles of medical ethics often conflict. If an obstetrician performs a Caesarean section without a woman's consent, he violates her autonomy. If he does not intervene and the child dies or is born severely disabled, he has done harm to the child. Withdrawing treatment from a patient in a permanent vegetative state may be seen to harm him. Yet continuing to keep him alive can equally be classified as harming him. Money spent on sustaining such a patient over several years deprives others of treatment in a cash-strapped health service. Keeping X alive may be an injustice to Y. The 'trump card' invoked to demand that the foetus and the patient in persistent vegetative state (PVS) be accorded priority centres around beliefs in sanctity of life. What we mean by sanctity of life, and whether it is a trump card, is hotly debated. (Gillon, Chapters 7 and 8)

Conclusion:

As can be clearly gleaned from the matters discussed hereinbefore, ethical values are not only relevant in a societal context, nay, it even has a significant role in the practice of medicine, in the context of diagnosis, treatment surgery and research.

References

- Beauchamp, T.L. and J.F. Childress, 2001. *Principles of Biomedical Ethics* (5th edn,) OUP.
- Callaghan, D., 1996. 'Can the Moral Common Survive Autonomy?', *Hastings Center Report* 41.
- Cromwell, S.C., 2003. *Hindu Bioethics in the Twenty-First Century*, State University of New York Press.
- Draper, H. and T. Sorrell, 2002. 'Patients' Responsibilities in Medical Ethics (2002) 16 *Bioethics* 335.
- Faden, R. and T. Beauchamp, 1986. (In collaboration with NMP King), *A History and Theory of Informed Consent* CUP, pp: 7.
- Gillon, R., 1996. *Philosophical Medical Ethics*,
- Jackson, E., 2006. *Medical Law: Text, Cases and Materials*. OUP, Chapter 1. *Journal*, at 372.
- Kuehnle, I. and M.A. Goodall, 2002. 'The Therapeutic Potential of Stem Cells from Adults' 325 *British Medical Journal*.
- Kuhse H. and P. Singer (eds), 1998. *A Companion to Bioethics*, Blackwell.
- Lloyd's Rep Med, 2000. No. 355 at 367.
- Newdick, C., 2005. *Who Should We Treat? Law Patients and Resources in the NHS* (2nd edn) OUP.
- O'Neill, O., 2002. *A Question of Trust* Reith Lectures.
- O'Neill, O., 2002. *Autonomy and Trust in Bioethics*, CUP.
- Routledge and J. Jackson, 2005. *Ethics in Medicine*. Polity Press.
- Sheikh, A. and A.R. Gartrad, 2000. *Caring for Muslim Patients*, Radcliffe Medical Press.
- Sinclair, D.B. and Jewish, 2003. *Biomedical Law: Legal and Extra-Legal Dimensions*, OUP.
- The Islamic Code of Medical Ethics, 1981. International Organization of Islamic Medicine.
- Wiley, John and J.M. Harris, 1985. *The Value of Life*.