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Ethics and the medical practitioner

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One would like to think that the current practice of medicine is based on solid ethical foundations, and the medical profession as a whole can boast of ethical practice of the highest order. Yet, from time to time, certain events such as the 'embryo holocaust' experienced in England, the euthanasia legislation in Australia, or more recently still, the threat of cloning human beings, serve to highlight the tenuous basis of our ethical practice, and bring to the fore, the fine line that divides the good from the questionable in medical practice.

I intend here only to highlight certain aspects of medical ethics that affect particularly the scene in Malta, and to bring to the fore changes that are or should take place in our community.

Historically, the inculcation of good ethical practice within the Maltese medical community has been achieved through a high ethical standard assumed by our teachers which was expected to pass on, as by osmosis, from them to their students. These apprentices learned during their ward rounds and later as housemen, how to tackle difficult ethical problems. There were no formal lectures, and no public discussion about ethical principles. The doctor followed a strict paternalistic attitude based on the unshakeable belief that he knew best what was good for the patient, and that under all circumstances, he would strive to achieve that goal.

Even in the dim past, however, the need was felt to have the capacity to impose disciplinary measures on larrikin elements in the profession, and this was achieved through bodies such as the Medical Council which could (and still can) impose sanctions, including forbidding a person to continue to practise in the profession.

Another important element within our society which tends to be forgotten or ignored is the ethical and moral background that all Maltese imbibed through their strongly religious background. It is particularly important to emphasise the role of a strong religious upbringing with its clear-cut rulings on what is right and what is wrong, particularly at a time when such upbringing is ceasing to be the norm and hence less and less reliable as a prop for our moral and ethical standards.

Finally, the luxury of a more liberal education ensured that all medical students were exposed to a course with a wider scope, and included lectures on philosophy, including ethics, which, while never popular, at least provided some opportunity for discussion. Religion, of course, was a compulsory subject for admission to University.

While one welcomes a more liberal and more tolerant society, it would be a pity if the jettisoning of a religion were replaced by no moral system whatsoever, which would lead to a vacuum, an undermining of any basis for our moral behaviour, indeed, "throwing out the baby with the bath water".

Hence, the need of a more active approach to the instillation of good ethical principles in our medical students. We cannot assume any more that they have brought with them to medical school a strong ethical upbringing. We cannot assume that they can distinguish clearly the basis of right or wrong based on any religious or philosophical system. We cannot assume that their general education has ensured that they have gone in any depth into a discussion of ethical aspects as would be expected in someone nurtured on a liberal education, including and in particular, literature for example.

What are the aspects that need to be looked into?

1. Teaching ethics to medical students

So far, there have not been any set courses in ethics incorporated within the undergraduate medical curriculum. There have been several attempts at providing short courses on a voluntary basis which usually attracted a small proportion of students, quite likely being the converted rather than those who needed such courses most. Recent recommendations to the medical curriculum have included a formal course of lectures on ethics starting from the first year of the course and going through to the fifth year. Attendance would be compulsory, and students have to attend a minimum of 75% of the course.

One feels that there is a cohort of several qualified medical practitioners who may benefit from specific courses in lectures on ethics. A recent course organised by the Gozo branch of the University, given by Rev. Dr. Emmanuel Agius attracted over 100 persons, many of whom were of medical background. It would be highly recommendable if similar courses were held in Malta to cover as large a number of participants as possible.

2. Specific issues relating to medical practice in Malta

While, as mentioned above, one must be impressed with the ethical standards of the medical profession in Malta as a whole, nonetheless, there could be areas in need of improvement.

I suggest starting with some of the following:

Confidentiality

It has been stated that in the UK a confidential document such as the medical history is often perused by as many as 100 persons within the course of a short stay

in hospital. This is probably unavoidable, and medical and paramedical personnel often have to be aware of a patient's medical details. However, one is struck by the glib nature of talk with one's colleagues, and how often the names of patients as well as their intimate medical details are disclosed over canapes and drinks at wedding parties. I, for one, would be a far happier person if I ceased to hear these details flaunted in public, (albeit the medical public, and their spouses and possibly their wider family group).

Also related to confidentiality within a small place like Malta is the possible impact of the use of an ID number attached to all aspects of a patient's life. One has the highest respect for the custodians of our most personal details, and one hopes that their computers are sufficiently well protected to ensure that medical information is not disseminated too widely and be used indiscriminately. It is to be noted that this fear has prevented many other countries from installing an overall ID system.

Informed consent

The issue relating to informed consent is currently receiving a considerable degree of attention. The Council of Europe Convention on Bioethics has a chapter related to this topic. It emphasises, among other things, the importance that 'an intervention in the health field may only be carried out after the person concerned has given free and informed consent to it' (Article 5). Special regulations hold for situations where a patient is not able to give consent.

On the local scene, the Consultative Committee on Bioethics has been working on a document on bioethics, and this was presented to the former Minister for Social Development. The Department of Health likewise has reviewed the consent forms for hospital use.

Underlying all these activities is the perceived need that patients are given all the information necessary for them to make an informed decision and hence give meaningful consent. The practice has swung from paternalistic concern which characterised medical practice in the past to a situation which emphasises the need for autonomous informed choice by the patients themselves. It is no longer acceptable for a medical practitioner to put his hand on his chest and declare that he has done all that he thought was good for the patient. It is more acceptable to ensure that the patient was well informed, and that a decision was taken only after such discussion. The final word must be that of the patient not of the all-knowing physician.

To many, no doubt, this sounds very futuristic, and many would argue that it is not practicable when dealing with a situation like our average out-patient department, where queues of 50 patients are not unusual. It is moreover, very easy to state that information must be given, and very difficult to ensure that only the right amount of information is given, sufficient to inform, but not to alarm. In any particular case, there are almost insurmountable obstacles to ensure that what the patient thinks is an adequate amount of information has been adequately given.

At a practical level, it is desirable that the requirement for furnishing information should not be yet another burden for the medical practitioner. It should be shared by all those responsible for providing the service by ensuring that the facilities are available to encourage such patient-doctor interaction. It goes even beyond the hospital and into the education system, where authorities should ensure that potential patients have received sufficient biological background in their education to enable them to understand their bodies better. Our educational system currently ensures that the lowest number of students take biology as part of their secondary school education. The over-weening emphasis on physics, a compulsory subject in secondary school, not only serves to put many students off science completely, but ensures that the average public is blissfully ignorant of the basic health issues.

Ethics of transplantation

Transplantation is becoming more of an everyday occurrence, and 'miracles' of organ, including heart transplantation has become almost an everyday event. The practice is, however, inherently associated with a number of ethical considerations which affect the donor, the recipient as well as the medical team itself. Priority among these is the absolute need to avoid any financial considerations in obtaining organs, a practice not unknown in certain third world countries. As Ray Billington has emphasised in a recent publication: "in a society ruled by market forces, if a mortgage could be paid off for the price of an eye, there are those who will find the offer irresistible". (Living Philosophy - An Introduction to Moral Thought, 2nd edition, 1993; p 221).

As far as the medical profession is concerned, it is of paramount importance that the criteria for selection of a recipient for a transplant should be crystal clear and utterly transparent. A document relating to these issues has been prepared by the Consultative Committee on Bioethics.

In the final analysis, a legislative framework is mandatory to ensure that ethical practice is supported and unethical practice discouraged. This is an area which must be tackled with some urgency, particularly now that the Council of Europe has endorsed a Bioethics Convention that covers several of the points mentioned above. It is a strong recommendation that Malta should become a signatory of this Convention without any further delay.

Ethics of reproductive technology

Any practicing doctor is well aware of the ethical issues associated with the practice of reproductive technology. In Malta in particular, a plethora of issues long dead overseas, still command a considerable degree of attention and discussion. The list of issues is indeed vast, stretching from the use of contraceptive devices to the latest technology associated with in-vitro fertilisation.

How is one supposed to tackle this problem, in an open-minded and liberal fashion, to ensure that it is acceptable not only to the catholic majority of this country but also to ensure that the minority are not penalised?

The Bioethics Consultative Committee has struggled (yet again!) with these issues to try to find a consensus

of opinion in relation to the many issues raised. It is hoped that a newly instituted committee would tackle this problem as a matter of priority.

A number of other issues could have been discussed, including issues relating to euthanasia, the problems relating to discontinuation of supportive care, the rights of potential donors, the ethics of animal experimentation, to mention only a few. However, space does not allow me to address these important issues.

3. Ethics and medical research

The medical profession in Malta has only recently felt the need to control medical research through the establishment of a Research Ethics Committee. This has now been a feature of our Faculty of Medicine for several years.

The existence of such a committee has now become a necessity in view of the increased prominence of medical research in Malta, a healthy development which should be encouraged. All those envisaging a research project which involves procedures on patients or healthy volunteers should submit their project to an institutional research ethics committee, such as the one set up by the Faculty of Medicine. Currently this is the only functional Research Ethics Committee on the Island.

In spite of this, however, only a small proportion of research projects are submitted for approval by this committee. For instance, only a small fraction of the 250 papers presented at the Maltese Medical School Conference in November 1995, had been approved by the Research Ethics Committee.

Why is there such a perceived lack of need for ethical clearance? In the first instance, there is no legisaltion in Malta which requires that medical research should be thus approved. There is a glaring need for Malta to follow the practice of most European countries to ensure that this legislation is introduced. Moreover, a large proportion of the work given as oral papers at local conferences never actually reaches publication in an internationally reviewed journal, which usually requires that all medical research is vetted and approved by a Research Ethics Committee. It would be commendable that local journals also follow this directive.

In my experience as previous chairman of the Research Ethics Committee of the Faculty of Medicine, the main shortcomings of research applications are the following:

- The absence of suitable information to be passed on to patients using language that they can understand
- The inappropriateness of the consent form
- The definition of responsibility of the person carrying out the research. It should be emphasised that when a student is carrying out a research project on patients, it is the medical supervisor who should carry all responsibility relating to that project, including ethical aspects of the research. It is the supervisor who should explain the procedure to the patient and countersign the consent form
- No supervision of research from the Research Ethics Committee
- No final report sent to the Research Ethics Committee

While, eventually, legislation will ensure that all research should be approved by a suitable institutional Research Ethics Committee, it would not be advisable to wait that long before we start ensuring that this process is in place and functioning.

Conclusion

The public expects the medical profession to have the highest ethical standards. In fact, in most surveys carried out overseas, medical practitioners are invariably put up at the head of the list of persons whom one could trust. On the other hand, we, like any other profession, can expect to encounter the occasional black sheep, and it is our duty to ensure that we do everything in our power to eliminate this possibility. I believe that the fundamental basis of our ethical existence is constantly shifting and we can no longer expect the future generation of medical practitioners to be motivated with the same rules and goals that served us well in the past. Malta is fast catching up with developments overseas, and cannot for long escape the influence of liberal and polyglot points of view. Those of us who have had to make decisions in relation to practice which involves a deadly conflict with our most cherished ideas, realise what a traumatic experience this can be.

Ethics has emerged as the fastest growing area of philosophical study. It has replaced religion as a basis of moral action in most countries and in the minds of a considerable proportion of the younger generation. It is crucial that we inculcate the need to question, to delve deeper into the basis of our practice and to ensure that what we practice is based on fundamental moral laws and not merely legal prohibitions.

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