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Medical Responsibility as Moral and Ethical Foundation for the Professional Conduit

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Abstract

The diversity of the contemporary medical act and the complexity of the doctor-patient relationship require, due to their position in the centre of healthcare services, a profound and exhaustive analysis in several domains of the medical practice, from the point of view of professional responsibility. Thus, the unification and shaping, in accordance with the principles of ethics, of the information from the field of medical education, social environment and health policies will create common points of view which will enable the visualization and design of solutions for public health issues. This paper aims for a unified approach on certain key aspects of medical professional responsibility, represented by *competence*, *conscientiousness*, *prudence* and *devotion*, investigated from the point of view of ethical principles and associated moral values, beyond the standards of clinical practice.

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Keywords: medical responsability; ethical foundation; professional conduit.

Introduction

From the point of view of professional responsibility, the key aspects of medical professional responsibility (represented by *competence*, *conscientiousness*, *prudence* and *devotion competence)* is a mandatory request for all members of medical community. Consequently, efforts are necessary to ensure the availability of adequate mechanisms for the achievement of this objective, taking into consideration that competence in medicine becomes a type of honesty (doctors must be responsible for the update of their medical knowledge and clinical abilities

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necessary in order to be able to provide quality healthcare). At its turn, honesty is the commitment towards professional competence, through which trust is bestowed in the relationship with the patient and value is returned to the professional role, by the correlations between information and knowledge. The role and significance of competence result both from the positive meaning, focused on professional accomplishment, but also from the negative meaning, that of *incompetence*. By its major effects mostly in emergency situations, *incompetence* becomes evident every time the doctor is not *adequately informed*, *oversteps his competence* or *refuses to do* what is necessary for the well-being of the patient.

1. Competence and professional responsibility

The ethical values engaged in correlation with competence and professional responsibility make reference to a series of aspects:

1.1. The standards

The standards for medical practice, in the ethical interpretation, are founded on the basis of everything the doctor should do with regard to what is *valuable, good and just* (Code of Medical Ethics, 2012). In clinical practice, these standards engage various and controversial points of view in relation with the safety and quality of the medical act. From the point of view of the right to practice certain medical procedures, the medical standard generates conflict zones and ethical dilemmas, while the freedom of choice over the type of medical procedure preferred makes a reference to the manner of understanding, acceptance and application of the *new* as a foundation of Evidence-Based Medicine (EBM) (Ross, 2013). EBM comes with a series of remarks from which we notice the modality of perception of the concept (the new in medical practice) and moreover, the manner in which the two partners (doctors and patients) commit for the achievement of EBM in creating opportunities and opening a path for the global progress (Kruger, 2010). At the same time, medicine is based also on ethical values, and a balanced combination between evidence and values remains an objective difficult to reach, if we take into consideration the mandatory ethical requirements regarding moral and physical integrity and the do-no-harm principle (Wohlgemut, Jansen, 2013). In this sense, bioethics tries to establish the correctness or incorrectness of certain actions involved in healthcare focused on the antithesis between *risks and benefits, do-no-harm vs deontology, utilitarianism vs respect* and *dignity of the individual*. The ethical analysis concerning the standards for medical practice is performed concomitantly with the differentiation between the point of view of the patient, who relates himself to the professional competences of the medical staff, and that of the doctor, who relates himself to the point of view of the standards for medical practice. The translation of these opinions in medical practice allowed for the focus and exploration of the areas for ethical intervention, aiming to ensure and guarantee the right to health, with the commitment to turn to advantage the ethical dimensions associated with the development of medical competences, but also with guarantees for safe and quality healthcare (Treat of establishing a Constitution for Europe, 2004).

1.2. Performance

The synthesis *care-integrity-compassion-confidentiality*, as attributes associated to *competence*, redefine performance in terms that emphasize the competence to become informed and qualified in the evaluation and assuming of risks. As ethical principles, the *risk vs benefits* articulate, by a sum of moral and deontologic attitudes, professional competence to the ability of the doctor to do what is best for the patient. In order to perform and recommend high performance interventions, doctors need opportunities that allow them to be active and assume risks in safer circumstances (Health Reform, 2006). However, in medical practice, the requirements for the personal development of the doctor become limited when the professional environment does not provide learning conditions. This is the reason why the confidence of the doctor that he can manage successfully certain risks encourages in a positive way the approach of a superior professional level, which, once “conquered”, helps him to increase his self-esteem and self-conscience. Thus, the synthesis *risk-control-confidence-competence* redefines performance, which, through ethical validation from the point of view of sense and significance, becomes defining for the professional responsibility.

1.3. Informed consent

Informed consent, according to the ethical model, must be clear, enlightening and comprehensible for the patient (Thompson, 2006). In practical application, one of the most important debates on informed consent is related to the influence of the recommendation of the doctor regarding the options of patients for treatment, as well the discouragement of therapeutic options without medical recommendation. It is desirable to be cautious and to increase the responsibility of the doctor in recognizing of strong influences in the decisions of the patient, with the obligation not to manifest personal interests and to respect the objectivity of clinical recommendations. The ethical analysis of this context brings an emphasis on the differentiation in interpretation for the utilitarianist attitude, which aims for the maximum good, as opposed to the deontological approach, which focuses on the means for reaching the maximum good (Moye, Marson, 2007).

1.4. Communication

This bioethical concept comes into conflict with the belief that health is maintained and re-established only through positive language, for it has the power to form and control future events. In clinical application, communication, including the presentation of therapy risks, is deemed as a negative approach for certain patients and their family members, a breach of traditional values and, by default, of medical practice. Moreover, communication could change a situation, improving or worsening it, could influence quality of life or create situation full of dilemmas when the patient is confronted with the diagnosis of a serious disease with unfavourable prognosis. *Bad news, how bad could they be*? So bad that it could influence the comprehension of information, the level of optimism, the satisfaction regarding received healthcare and invariable psychological damage that requires qualified help. The word has power, such as it is proven by the communication in the field of oncologic disease through SPIKES protocol, which expresses the invaluable dimension of word regarding the psychological and social aspects of the patient, with the usage of a series of measures based on survival (time, as essential element), perception (what the patient already knows), information (what the patient wants to know), knowledge (information transmission), care for emotions (empathic response) and cooperation (working together in times of necessity) (Grinberg, 2010).

1.5. Deontology vs utilitarianism

Deontology vs utilitarianism in medical practice, the manner in which we investigate a patient, how long we investigate and especially who do we investigate, as well the choice for a specific therapy orientation often generates ethical dilemmas, which centre on the conflict between *justice and equity vs utilitarianism*. The impact is significant both for patients as well as for doctors, who have to be clear about the manner in which their decisions and actions converge towards the essence of *ethical principles* of *autonomy, dignity and respect for the individual* (Mill, 2013). It is obvious that such an approach, subjected to an ethical analysis, turns to deontology, which states that the modality to achieve a goal is often more important than what it is gained. The obligation is to respect the ethical demand to prevent or to get rid of the bad (*do-no-harm principle*) and to promote the good (*principle of benefaction*). This does not mean that we can dissociate the goal from the means, even if the result is one that maximizes the well-being of the patient, without taking into account the risks or counter indications, which, in some cases, overstep the benefits. The conceptualization, on the basis of win-win principle, of the therapeutic objectives in chronic diseases represents, from the perspective of the winner, deontological equilibrium between the best decision of the doctor (for a specific therapeutic protocol) which offers the best chance (for the complete cure) to the patient (Gardiner, 2003).

1.6. Medical error and mistake

Medical error and mistake from the perspective of their effect are based on aspects related to professional behaviour. Error represents a false representation of reality, which can be taken into consideration when the element

regarding the portion in error had a *determining role* for the medical act. In reality, errors, by the dimension of their medical, social and economic impact, go beyond the field of ethical and moral significations, as it results from the analysis of the information provided by medical institutions. A few examples from the computerized models in hospitals reveal the consequences of medical errors, i.e. adverse effects of medication (28%), temporary work incapacity (18%), impressive costs associated with negative results of medication, estimated to 76.6 billion $, which is the equivalent of the costs for the care of patients with diabetes mellitus (Donaldson, 2008).

1.7. Malpraxis

Malpraxis synthesizes medical responsibility towards the prejudice inflicted to the patient by his actions. We must highlight the ethical significations attached to the term of prejudice: risks, injury, vulnerability, discrimination, dignity of the individual, equality and equity, identified when an incorrect medical act, a real and definite prejudice, and a causality relationship between the action or inaction of the doctor and the prejudice of the patient are produced. Frequent situations which can be regarded as malpraxis cases involve professional negligence in the performance of a medical act with diagnosis or therapeutic purpose, error, lack of prudency, insufficient medical knowledge, dissatisfaction of the patient, who feels ignored when doctors are exceedingly preoccupied with strictly medical aspects (Benner, 2008).

2. Conscientiousness

Conscientiousness is another requirement for a responsible behaviour towards professional obligations.

2.1. Doctor-patient relationship

Doctor-patient relationship - the ethical values that arise from conscientiousness are centred on the *doctor-patient relationship*, built on the basis of respect for human dignity, understanding and compassion for suffering (1). Thus, from the paternalist attitudes, accepted in the interest and for the well-being of the patient, until deliberate empathic and altruist actions, the *relationship doctor-patient* must be one with a powerful ethical content and deep moral background. The aim is to preserve the balance that enables the avoidance of dominance or power excesses. In medical practice, the most competent doctors make as many mistakes, with effects equally as important and severe as the incompetent doctors, if they are not conscious about their obligations (e.g. they do not fully examine the patient, do not have the patience for a complete history etc.). This is the reason for which the doctor has the responsibility to classify the different realities in accordance with theories, practices, prejudices, values and convictions, while the patient, under the influence of the healthcare system and in agreement with the ethical norms, takes part in the medical decisions (Chaytor, Spence, 2012).

2.2. Consent

Consent highlights, with respect to conscientiousness, the significance of the information element and of the communication manner practiced by the doctor, in order for the patient to be able to express his will freely and unconditionally. In the interpretation of the law, the terms *free* and *unconditioned* are deemed as causes for invalidation of consent. An example in this sense is *psychic violence*, as a state of fear caused to the individual by the exertion of an act of power, or acts of threat or intimidation (WHO) (Goodin, 1985). By the inclusion of the term of power, the conventional nature of the definition is broadened by the underlining of the acts resulted from the negligence and the omission acts encountered in the study of the phenomenon of violence against the elderly.

2.3. Vulnerability

For the medical act, *vulnerability* and the significations attached to it promote an ethical determinism and recognize the necessity to be defined in measurable and operational terms. The ethical essence of the concept is given by *autonomy*, *do-no-harm*, *benefaction* and *justice*, principles that give signification to this term for different

social categories and healthcare systems, to which the medical act relates. Vulnerability expresses a commitment to morality, which in the medical act leads to the logical action of care, solidarity and responsibility. In the European approach, the ethical contents of vulnerability leans towards *biolaw*, justified by the interpretation of the concept together with the principles of *autonomy, dignity and integrity* (Neves, 2011). Vulnerability, by stigmatization and marginalization, has an impact on the health status, its precarity, in many cases, being the consequence of public policies and practices without just cause. This is the reason why the active intervention of bioethics is necessary in order to guarantee the respect of human dignity for vulnerable individuals, both in healthcare but also in research and mostly health policies. In this large context of the medical act, the effort to protect vulnerable patients, who do not have the ability to make informed choices, could be deemed as paternalist, and the autonomy risks to become a principle with totalitarian attitude (Schramm, 2011).

2.4. Equity in healthcare

Equity in healthcare, as ethical concept, is based on the *principle of distributive justice* (the distribution of resources in order to equalize health results), which ensures equal chances to be healthy for all population groups, including less-favoured ones (Carse, 1991). This conceptualization comes with a sum of equalities that summarize, through "*health for all*", the identical access to healthcare services, resources spent equally for each individual or for each case with a certain condition, the right to benefit from care according to needs and with the same quality of healthcare. From the perspective of utilitarianist ethics, equity in health represent a modality to celebrate the respect for human dignity, which, at the level of health policies becomes a nuance of sufficientarism, a support for professional human, financial, logistic resources, etc. for a decent minimum of medical care deemed as sufficient, i.e. a minimum pack of medical services and cautious health insurance (Pantilat, 2008).

3. Caution

Caution is another requirement of the *professional behaviour*, with a prophylactic role which updates, in the age of medical technology, the principle "*primum non nocere deinde salutare*". Ethical values, as principles, are correlated with risks and benefits.

3.1. Do no harm principle

Do no harm principle means to "*not hurt*", because *evil is a simple thing and has infinite shapes* (Blaise Pascal). In medicine, the aim is to promote the well-being of patients by those that have competence and knowledge, with the obligation to prevent and eliminate evil, to evaluate and balance possible benefits against possible risks, to protect and defend the rights of other individuals, to save the persons in danger and to help those with disabilities. In medical practice, the pertinent ethical issue is whether the benefits surpass negative effects, for many procedures, interventions and medication are (sometimes) more harmful than beneficial. It is a context where do no harm postulates that risks must be understood in the light of potential benefits (e.g. stopping a medicine which is proven to be harmful or the refusal to give a treatment whose efficiency is not fully proven) (Toader, 2009).

3.2. Confidentiality

Confidentiality derives from the special relationship created when a patient requests care, treatment and/or medical advice. Confidentiality is based on the general principle according to which individuals that require medical assistance should not be afraid that their medical issues or conditions will be revealed to others. According to the obligation for confidentiality, doctors cannot disclose any medical information on their patients without their consent, and this obligation continues even after the patients are not treated by these doctors. Although the respect for confidentiality and autonomy represents the basis for doctor-patient relationship, confidentiality is neither absolute nor universal (Toader, Toader, 2004). However, in medicine, confidentiality is not fully outlined, and consequently, is a concept which must be particularized for each case.

4. Devotion

Devotion of the doctor towards his professional obligations is another requirement of professional responsibility. Devotion is best appreciated by the patient and is the attitude that obligates to always put the interests of the patient before the reputation of the doctor. We must take into consideration that the individual (patient) "goes into the disease" with a certain kind of temperament, a specific character and intelligence, with a certain inheritance, with complexes and misconceptions and a particular cultural horizon. The patient takes various attitudes in front of the disease, but at the same time also in front of the medical team: trust, respect, sympathy but also, possibly, doubt, fear, sometimes disdain. The integrative synthesis of doctor-patient relationship helps the patient to better understand the disease and therapeutic strategy, to cooperate with all factors involved in medical assistance, to live healthy and to improve quality of life (Sandu, 2012).

5. Cultural diversity and religious convictions

Medical responsibility can be discussed also in the context of the medical act that involves *cultural diversity and religious convictions*. Thus, respect for cultural differences in the performance of the medical act and the reduction to minimum of any negative consequences of cultural differences are prophylactic elements of the professional responsibility for facts done out of mistake or error. The respect for cultural differences must be ensured for the comfort and in accordance with patient autonomy, because there are many situations when doctors are confronted with cultural practices that come in conflict with medical ones. The respect for different cultural values requires an approach from a pluralist perspective, which should allow a series of different points of view. In a multicultural context, a proactive approach is necessary, with flexibility and openness to adjustment, so that the members of various cultures, patients of different ethnicity, religion or nationality feel welcomed in a medical institution where competent and high quality care can be provided. The ignorance of social and cultural factors could lead to stereotypes or discriminatory treatments, on the basis of culture, language, religion or social reasons. In an UNDP report from 2004 it is specified that in the world, a person out of seven supports the negative consequences of the attachment to a cultural community non predominant in the state where he lives (Human development report, 2004).

In conclusion

Ethics comes with the central message to give true meaning to the disease and pain of all those in suffering and to expand the concept of health from a personal issue, limited to the satisfaction or dissatisfaction of patient, to the promotion and protection of the right to health to the highest standard. Consequently, in the medical act, *Responsibility and Ethics must be brought together in order for all that is JUST to be STRONG and all that is STRONG to be JUST*. These requirements of the professional behaviour become guarantees for the respect of dignity and autonomy of the individual in its quality of patient, who must benefit equally from the best healthcare.

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