

Medical Education Systems, Inc.



Medical Ethics in Healthcare



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MEDICAL ETHICS IN HEALTHCARE

Ethics in health Care: Values, Obligations and Rights

Learning OBJECTIVES

At the conclusion of this course participants will be able to:

1. Define ethics and medical ethics, and explain the sources of these ethics.
2. Identify how medical ethics impact patient care.
3. Recognize new medical ethics issues.
4. Apply ethical principles to help improve patient care.
5. List and explain the four underlying principles of bioethics.
6. Understand the relationship between laws, professional ethics, and professional codes such as the AMA Code of Ethics.

INTRODUCTION

There have been huge advances in the last 150-200 years in the field of medical science, increasing patient safety and longevity. Even the very scope of the practice of medicine has been expanded. No longer limited to treatment and cure, advances in technology and pharmacology have brought about a rapidly increasing ability to intervene in life and death situations; to alter the physical and the emotional; and soon, to alter human genetics. As the healthcare professional is constantly being faced with new areas in which appropriate actions have to be defined, medical ethics must now race to keep up with medical advances.

This course is designed to provide an overview of the current state of medical ethics to better enable healthcare professionals to provide the best patient care possible. It will also provide tools for guidance in making ethical decisions regarding patient care and interactions with colleagues and facilities. It is divided into three sections:

1. History and background;
2. Deciding ethical questions;
3. Contemporary issues.

This course does not seek to provide definitive answers to what is and what is not ethical, because too many variables exist, including an individual's own religious and/or moral values. Instead, it provides information and direction so that the healthcare professional can determine his or her own standards of ethical behavior, for it is a determination that will have to be made over and over throughout one's medical career.

HISTORY AND BACKGROUND

Before we can explore medical ethics, we must first define ethics. No easy task, since from the beginning of the written word almost every philosopher who has addressed the topic has had a slightly different perspective on the subject.

According to Plato, ethics deals with the absolute good toward which all human activity should be directed. A couple of thousand years after Plato, Immanuel Kant attempted to separate ethics from the realm of religion with his categorical imperative, which he considered the ultimate moral imperative and the rational basis for all moral behavior. According to Kant, the categorical imperative was the natural law by which one should conduct life, despite personal impulses or desires. The British philosopher Bertrand Russell assumed a more cynical point of view with his definition of ethics:

“Ethics is in origin the art of recommending to others the sacrifices required for cooperation with oneself.”

For the physician, perhaps the best definition of ethics comes from the poet, W. H. Auden, who wrote in “A Certain World” in 1970 that: *“In order to be a good doctor a man must also have a good character, that is to say, whatever weaknesses and foibles he may have, he must love his fellow human beings in the concrete and desire their good before his own.”*

Agreeing on a definition of ethics, however, is only the beginning of the journey. The next step is to determine what is and is not ethical behavior, which has been another source of discussion for centuries.

The Hippocratic Oath – which even today is revered by physicians – was conceived in about 400 BC. Around 1750 BC the Babylonian King, Hammurabi, established precise laws for how medicine was to be practiced as part of what became known as “The Code of Hammurabi.” Ever since, the ethics governing the practice of medicine have continued to evolve.

Ethics vs. Laws

Ethics should not be confused with laws. A code of ethics is based on morality and standards rather than legislation. Black’s Law Dictionary offers the following definition of ethics: “What is generally called the ethics of the profession is but a consensus of expert opinion as to the necessity of professional standards.”

The Hippocratic Oath concerns ethical behavior. This behavior was considered so sacred, the oath was sworn to the god Apollo, the physician, and it states in part: *“I will follow that system of regimen which, according to my ability and my judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.”*

The Code of Hammurabi, on the other hand, is a strict set of laws governing how much a physician will earn for his efforts, and what will happen if he fails. For example:

- **“Law #215:** If a physician make a large incision with an operating knife and cure it, or if he open a tumor (over the eye) with an operating knife, and saves the eye, he shall receive ten shekels in money.”
- **“Law #218:** If a physician make a large incision with the operating knife, and kill him, or open a tumor with the operating knife, and cut out the eye, his hands shall be cut off.”

It’s fairly clear why elements of the Hippocratic Oath survived and Hammurabi’s laws didn’t.

The struggle to create standards for the practice of medicine has continued throughout the centuries and the lines between ethics and laws often blur.

The Evolution of Medical Ethics in the United States

In 1803, Sir Thomas Percival, British physician, philosopher and writer, created a code of ethics that became the foundation for the first American document designed to govern the practice of medicine in the United States. It was published in 1847 by the American Medical Association, which held its first meeting specifically to establish a code of medical ethics, and to create minimum requirements for medical education in training.

Since 1847 the code, which has become known as “The Principles of Medical Ethics,” has evolved with the times, but the guiding principles remain the same. In 1957 a shorter version was adopted that eliminated some of the provisions that dealt more with matters of etiquette than matters of principle.

The preamble to the revised AMA Principles makes clear their intent:

“The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self.

The following principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.”

The American Osteopathic Association is also guided by an official Code of Ethics, which was most recently revised in 1985. Complete AMA and AOA codes are included in the appendices.

Most state medical associations, many healthcare facilities and even private practices also have published written codes of ethics, which further underscores how important it is to develop an understanding of at least the basic standards of acceptable conduct.

The World View

There are two important international documents that must be included in any study of medical ethics. The first is the “Declaration of Geneva,” which was adopted by the General Assembly of the World Medical Association at a meeting in Geneva, Switzerland in 1948. This declaration, a copy of which is included in the Appendix, begins with the following statement:

“At the time of being admitted as a member of the medical profession: I solemnly pledge myself to consecrate my life to the service of humanity.”

A second crucial document, the “Declaration of Helsinki” was adopted by the World Medical Association in 1964 and sets forth ethical guidelines for human research. Its official title is “Recommendations Guiding Doctors in Clinical Research,” and in its introduction it states:

“Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, the World Medical Association has prepared the following recommendations as a guide to each doctor in clinical research. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil and ethical responsibilities under the laws of their own countries.”

DECIDING ETHICAL QUESTIONS

The following section provides a model for healthcare professionals to use when faced with difficult ethical questions. At such times, it is appropriate to ask four questions to help determine whether or not an action is ethical, and should be taken. The first three of these questions were published in Kenneth Blanchard and Norman Vincent Peale’s book, “The Power of Ethical Management.” The fourth question will help healthcare professionals round out their examination of the difficult ethical questions they encounter. These questions should be given very careful consideration, and all four should be answered before any action is taken, because each can have an impact on the other.

The Questions

1. Is it legal?
2. Is it balanced?
3. How will it make me feel about myself?
4. Have my peers determined and published a standard of behavior?

Is it legal?

As we have discussed, being legal is not the same thing as being ethical; however, the consideration of whether or not an action is legal should be one of the first to be addressed. Consider the following situation:

A concerned mother brings her adolescent daughter in to see a plastic surgeon. The young girl has a huge, ugly nose that ruins her looks and is causing her to be teased at school. As a result she has become withdrawn, depressed and has made a serious attempt at suicide. The mother's health insurer does not cover elective cosmetic surgery, nor does it provide mental health benefits.

Therefore, without a physical reason to do the surgery, the child will not be able to have her nose fixed. The girl does have a mild - very mild - deviated septum. The surgeon decides to "code" the condition so that the health insurer will pay. The young girl has a new, smaller nose and is much more attractive physically. Her confidence is given a giant boost and her self-esteem is on its way to being restored. Her suicidal tendencies have totally been eliminated.

In this situation the surgeon may have committed fraud in a strictly legal sense. At the same time, she has done what is best for her patient and has possibly saved her life. Though the doctor's choice may have been ethical, it could be questioned on legal grounds.

It is equally important to remember that just because an action is legal doesn't mean it's ethical. In some instances, a facility can legally refuse to treat a patient who has no health insurance, but is it ethical to deny treatment to a sick person?

This brings us to the next consideration. Is it balanced?

Is it Balanced?

Before any ethical decision can be made, one must consider both sides of the question. Referring to the rhinoplasty example, the physician weighed all the factors, which were:

- ☞ Without the surgery, the child would continue to deteriorate emotionally and mentally, and quite possibly commit suicide;
- ☞ The mother was not in a financial position to pay for the surgery;
- ☞ The physician was not in a financial position to perform the surgery on a pro bono basis;
- ☞ A real physical condition did exist that fell just short of being covered by the insurer.

In this instance, the physician felt that the result of "fudging" her diagnosis just slightly, which meant that the insurer would spend several thousand dollars they shouldn't have had to spend, tilted the balance toward performing the surgery because she truly believed it was a life or death decision.

Even in less grave situations, it is incumbent upon the physician or other healthcare provider to weigh all the options and make sure the final decision reached is fairly balanced. In the case cited, the physician felt her decision was balanced and therefore felt good about it, which is very important and is also the third question that must be considered, "How will it make me feel about myself?"

How Will it Make Me Feel About Myself?

Feeling good about oneself is paramount in all decisions. Not just in the short run, but for the long term. What seems like a good stopgap solution in the present might be setting up future difficulties. Additional considerations in answering this question that must be taken into account are:

- ☞ How will it affect my patient?
- ☞ How will it affect my peers and co-workers?
- ☞ Will it establish a pattern that will be hard to break in the future?
- ☞ How would I feel about someone else who took the action or made the decision I am considering?

One key element to bear in mind when contemplating any situation which falls into a gray area is that you will have to live with whatever decision you make, and the possible ramifications of that decision. If in the rhinoplasty example the physician had not treated the patient, and the patient had subsequently made a successful suicide attempt, could she have had a clear conscience because she had done her job according to a strict application of the insurance company's rules? Instead of assuming the cost of the surgery herself, she passed it on to the insurer. Is being a sort of medical Robin Hood moral? Is it ethical? What about in a less grave situation?

For example, a man wants a complete medical check-up simply as a preventative measure, but his insurer doesn't cover annual medical check-ups for men in their 30's. The man wants to find a way to pass the expense on to his insurer. Would his physician be justified in recording in his medical record that the man came in with unexplained symptoms that required a complete physical? Could his physician feel good about passing along costs to the health insurer that could have been covered by the patient?

Again, these are significant considerations, which lead us to the final question, "Have my peers determined and published a standard of behavior?"

Have My Peers Determined and Published a Standard of Behavior?

Back in the 1800's, when the American Medical Association published its first code of ethics things were much more black and white than they are today. In fact, so many shades of gray now exist in the area of medical ethics that in 1997 the American Medical Association created an independent academy devoted solely to ethics. The 2001 revision of Principles of Medical Ethics added two new principles. One emphasizes that a physician, while caring for a patient, regard responsibility to the patient as paramount. The other asserts that physicians should support access to medical care for all people. Even with all these guidelines, very often the answer to the question of whether or not there is a published standard of behavior is "maybe."

For example, at one time some managed care organizations included in their contracts with physicians either an explicit or implicit "gag" clause. Basically these clauses obligated the physician to withhold information from patients about treatment alternatives not covered by their

health plans. These clauses outraged the AMA. In 1996, its Council on Ethical and Judicial Affairs declared:

“...the physician’s obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient’s managed care plan. Patients cannot be subject to making decisions with inadequate information. That would be an absolute violation of the informed consent requirements.”

Gag clauses were also challenged in the courts and have subsequently started to disappear; however, at the time of their existence they created quite an ethical dilemma. The physician could sign a legally binding contract containing the gag clause, obligating himself to withhold treatment in some cases, or he could refuse and therefore not be able to treat patients covered by managed care providers. That option would limit his patient base, restricting his ability to practice medicine and earn an income. Or he could sign the contract and ignore the clause whenever he felt it necessary. Doing so would put him in legal and probably financial jeopardy, but it was the only way he could do the best for his patient. And the only way he could feel good about himself was to do his best for his patient.

As difficult as the topics explored in this section might seem, they pale in comparison to some of the more complex issues that have arisen as a result of the leaps and bounds made in medical technology in recent years. And for every advance there is an explosion of ethical questions, the answers to which can only be decided on a case-by-case basis.

Contemporary Issues

No area of medicine has been untouched by the swift advances made in this technological age. Diagnostic tools like MRI and the CAT scan enable a physician to make much more precise diagnoses. The laser has made it possible to treat conditions noninvasively that once required major surgery. New drugs with the promise of curing some cancers are on the near horizon.

For the most part, all of these advances have been greeted with enthusiasm. But technology has also created an incredible ethical morass in at least two areas: reproductive medicine, and the ability to sustain human life through artificial means. As technology progresses the questions become more difficult, and no hard and fast “one-size-fits-all” answers can be found.

The effects of technology on medical ethics have been so profound that an entirely new category has been created to encompass them - “Bioethics.”

The Rise of Bioethics

Until the end of the 18th century, when Jenner discovered that a vaccine using cowpox could prevent smallpox, the role of the physician was to ease the pain and suffering of a patient, and hopefully effect a cure. With continued advances in immunization, especially Pasteur’s discovery of

a rabies vaccine, and Salk's polio vaccine, medicine made a steady march toward another important goal, prevention. These were all hailed as miracles of medicine, and generally received with favor.

Then in the 1950's medicine took a sharp turn down an uncharted path that some equate with the road to an ethical Pandora's box - the testing of an oral contraceptive.

The test was successful, and in 1960, Enovid 10 became the first commercially available birth control pill. For the first time in the history of medicine it was possible to artificially control a "natural" bodily function. This breakthrough was not greeted with widespread acceptance. The Roman Catholic Church responded by banning the use of oral contraceptives, a ban that is still in effect.

The moral questions posed by the use of oral contraceptives are definitely food for thought. Does humankind have the right to interfere in the natural order of life? Is the person who is not conceived potentially a genius, or another Ghandi?

The potentiality of "controlling human life" has created an ethical crisis that has yet to be resolved, and also spawned another equally sensitive controversy, "who determines what is natural?" The ethical dilemma of what is natural versus what is unnatural covers not only controlling life, but controlling death, and other debatable aspects of medicine that seem to expand exponentially as technology advances.

Does the medical profession assume the role of final determiner of the norm? Or should it be the general population? Or perhaps a "participatory patient democracy" should be created so that ethical questions regarding a certain area of medicine are decided only by those immediately affected. This is not simply a theoretical question, it is one that is being argued daily. An example is the controversy that has arisen over the use of implants.

Ethical Questions in the Use of Implants

The legal and ethical dispute over the use of silicone breast implants dominated the media during the 1980's. Not just regarding the health risks that seemed to be arising from the implants, but the ethical question of whether or not it was "right" to alter a woman's body by implanting an alien substance just to enhance her physical attributes. That raises another interesting ethical question:

- Should certain medical techniques only be used to correct a medical abnormality?

In other words, is a plastic surgeon being ethical when she performs a breast implant as part of breast reconstruction following a mastectomy, but unethical when she performs elective surgery

to increase a patient's bust size? Is it morally right to perform rhinoplasty to repair a broken nose, but wrong to simply shorten a long nose, or remove a bump? And who decides?

Surprisingly, one of the most controversial examples of implant surgery has to do with a small device that was first introduced in the 1970's - the cochlear implant.

Cochlear Implants

The cochlear implant is a device made up of several electrodes that is surgically implanted in the cochlea, then connected to a transmitter coil that is placed under the skin and held in place by a magnet. The device has an earpiece microphone with two wires extending from it that are connected to the coil, and to a signal-processing component that can be worn in a pocket, or attached to a belt.

The implant works differently than a hearing aid, which simply amplifies sounds. It creates a sound, or electric signal, when the electrodes stimulate the cochlea. This signal requires "interpretation" so training and speech therapy are necessary to maximize the benefit of the device.

Proponents of the implant - who explain that the signals allow the user to hear cadence, and therefore learn to speak orally more clearly, and to improve lip-reading skills - believe this is a major step forward in enabling the hearing-impaired to lead more "normal" lives. However, there is a very vocal opposition to the implant, on moral as well as medical grounds. The moral questions are wide and varied, but the most ethically challenging is, "What's wrong with being deaf?"

To those in the hearing world, that may seem a ridiculous question. To never hear music, or birds singing, or another human voice seems cruel. But can one miss something one has never had? And by trying to "fix" a child who is non-hearing to make him/her more able to function in a hearing world, is that child instead being consigned to a sort of limbo? Neither part of the hearing or non-hearing community.

There is a very strong, viable non-hearing community which has fought for years against the stereotype of the old "deaf and dumb" label that for so many years created a general feeling that those who could not hear were somehow less mentally capable—an assumption that has been proven over and over again to be totally without merit.

There is a fully accredited university that is entirely made up of non-hearing students. Nonhearing persons are able to live full, happy lives and to interact successfully in the mainstream of their communities. A few years ago, a deaf woman became Miss America.

The World Federation of the Deaf and other groups who support the existence of a separate Deaf culture maintains that surgically implanting a device into a child automatically labels him/her as "abnormal." Further, they feel it is an example of oppression of a minority by a majority. This is the extreme view, but many clinicians also question the use of the implant in young children, who cannot understand the possible long-term effects. Can a hearing parent understand the

impact that the device might have on the child and his/her relationship to the deaf community? Can this device alienate the child from all avenues of “normalcy?” If the device is not implanted until a child is old enough to understand and make the decision personally, has a great disservice been done by slowing down and perhaps permanently retarding his/her ability to learn to speak orally? Just what constitutes “normal” anyway?

Those are all hard questions with no easy answers. As are the ethical questions constantly evolving in another surgical area - transplants.

Transplants

Medical transplants began with corneal transplants. In 1954 a kidney was successfully transplanted from one identical twin to another. The first successful liver transplant was performed by Dr. Thomas Starzel of the University of Colorado in 1967.

None of these important medical milestones was greeted with much negative reaction by the community at large. But in 1967, when another successful transplant was performed, this time by Dr. Christiaan Barnard in South Africa, it was cause for an outcry that in its extreme called Barnard another Dr. Frankenstein. He had transplanted a heart from a dead person into a 55 year old man named Louis Washkansky. Washkansky only lived 18 days, but the deed had been done and the alarm sounded. This was unnatural. This was desecration of the dead. What if a person wasn't really dead when you took the heart? Would doctors and nurses still try to save a patient whose heart could be used for transplant? This could lead us down the path of moral ruin!

Over 50 years later, heart transplants are almost routine and commonplace, as are other organ transplantations. Many patients receive more than one organ at a time. Recently there has been a great deal of success transplanting sections of a lung or liver from a living parent into a child. The fears that were raised have mostly proved to have been hysterical reactions to new technology. Of course, there is a persistent “urban legend” surrounding organ transplantations that refuses to die, perhaps because another technological marvel - the internet and e-mail - work so hard at keeping it alive. An E-mail chain letter surfaces every few months to warn of the horrors of travel, because you might wake up to find yourself sitting in a tub of ice with one of your kidney's gone.

For the most part, the medical aspects of transplanting organs from one human being to another have become accepted practice, and legislation has been passed to help provide safeguards against abuse:

In 1968 the Uniform Anatomical Gift Act was passed which created the organ donor card, although even if a person signs the donor card the family must be consulted before organs are harvested. This act has since been revised in 1987 and in 2006. It also prohibited the organ donor's attending physician from participating in the organ removal or transplantation.

In 1984 the National Organ Transplant Act passed. This act prohibited the sale of human organs, and created a national transplant network that would oversee the procurement and distribution of

organs. In 1986 The United Network for Organ Sharing was awarded the contract to oversee the national transplant network.

The latest arena for ethical issues in transplantation has risen from a highly controversial area of research, xenografting - the transfer or transplantation of animal tissues and/or organs into a human body. The transplantation of certain cells from animals to humans has garnered some success, for example in the treatment of Parkinson's disease. Again, the ethical question of "what is natural?" surrounds an area of medical advancement. Is it unnatural to implant an organ from a lower species into a human being? Does transplanting an animal organ, or animal tissue, violate certain Judeo-Christian religious ethics? Is the religious ethic the only one that has moral authority?

Among animal rights activists there has been a general hue and cry that this is the greatest form of animal cruelty yet devised by humankind. What right do we have to kill other animals and cut their hearts out? Is human life the only life that has value?

As genetic research advances we will be able to change the genetic makeup of lower species, pigs for example, to make their organs acceptable to the human body. By using genetic manipulation to create animal organs that are more conducive to transplantation into humans, are we violating the natural order of the universe? Are we subverting other species entirely for our own survival?

And what about genetic manipulation in general? This leads us to another very hot topic in modern medical ethics - the Human Genome Project.

The Genome Project

In 1990, the United States Federal Government made three billion dollars available to fund a 15year research endeavor known as the Human Genome Project. Beginning on October 1, 1990 and completed in April 2003, the HGP gave us the ability, for the first time, to read nature's complete genetic blueprint for building a human being. Since then some commercial companies have entered the race, promising to create the map quicker and more cheaply. In the early going this vast undertaking produced limited practical applications, but even these have raised a wealth of ethical issues.

For instance, we can now identify genes that cause certain diseases - but we still have no way to cure these diseases. Is there then a benefit to genetic testing of individuals to determine whether or not they or their children are going to develop a certain disease?

One of the most publicized examples relating to genetic testing is Huntington's disease, a hereditary neurological disorder. It is possible to test an individual to determine whether or not they carry the gene for this disease, and whether or not they have the possibility of developing it themselves, or passing it along to their offspring.

Is there any real benefit to knowing that one is going to develop such a dread disease? As of now, there is no cure. In fact, there is no successful treatment. So knowing that one carries the gene only creates a sense of doom and foreboding.

Legally, if one carries the gene does that create what health insurers call “a pre-existing condition?” Is the physician morally obligated to make the results of genetic testing a part of the patient’s record, thereby possibly making it impossible for the patient to be insured and receive treatment if/when the disease does develop?

Another ethical knot created by the knowledge that one carries a potentially deadly gene affects the decision of whether or not to have children. At present, it is not possible to remove or correct a defective gene in an embryo, so the only thing a person can do to prevent passing on the gene is to opt not to have children. What impact will that have on the person - and the world at large?

Consider the disease Amyotrophic Lateral Sclerosis (ALS), commonly known as Lou Gehrig’s Disease. This is another catastrophic neurological disease for which there is no cure and no effective treatment.

- ☪ If gene testing had been available two generations ago, would the sports world have been deprived of baseball great Lou Gehrig?
- ☪ Would the world of science have lost the brilliance of Stephen Hawking?

In this age of ever advancing technology, will there possibly be a cure someday, or will those who carry the ALS gene simply not reproduce and therefore stop the search for a cure, leaving those who develop ALS spontaneously to suffer and die with no hope?

Even if developing a dread disease with an adult onset is inevitable, who is to say that a short life is not worth living? Mozart died in his 30’s, yet he was one of the most brilliant and prolific composers in the western world. Did he not merit being given life?

At some point - probably sooner rather than later - it will be possible to test embryos for their genetic make-up, and this will open up another level of ethical nightmares. Will parents want to order a child like they do a new car? Will physicians be faced with a laundry list that says, “Blue eyes, blonde hair, tall, athletic, brilliant?” What happens if during pregnancy something goes wrong and the child doesn’t meet the parents’ standards? Do they get a refund? Is the child put up for adoption? If prenatal tests show that there is a perfectly healthy but unfortunately red haired child in the womb, will it be aborted? How much control should we ethically and morally exercise over human reproduction? Are human beings that are less than perfect less valuable? Who determines the standard of acceptability - the physician, the parents, the government? All of us have heard with horror of the so-called medical experiments made on human beings during the Holocaust in order to create Hitler’s “superior race.” Doesn’t what is happening right now in genetics raise similar ethical questions?

The area of medicine that has made the prenatal manipulation of genes a future probability - reproductive medicine - is another that is rife with conflict and ethical pitfalls.

Reproductive Medicine

One of the most respected physicians of this century, Albert Schweitzer, winner of the Nobel Peace Prize, once wrote:

“An absolute ethic calls for the creating of perfection in this life. It cannot be completely achieved; but that fact does not really matter. In this sense reverence for life is an absolute ethic. It makes only the maintenance and promotion of life rank as good. All destruction of and injury to life, under whatever circumstances, it condemns as evil. True, in practice we are forced to choose. At times we have to decide arbitrarily which forms of life, and even which particular individuals, we shall save, and which we shall destroy. But the principle of reverence for life is nonetheless universal and absolute.”

Dr. Schweitzer wrote those words in a magazine article in 1936. Now, more than 60 years later, the ethical question of “...even which particular individuals, we shall save...” is only one life and death decision a physician must grapple with. There is now also the question of who should be born?

The birth control pill was only the beginning of the impact modern medicine has made on human reproduction. Artificial insemination and *in vitro* fertilization have become so much in demand that they have made treating infertility a medical specialty—a specialty full of potential ethical pitfalls.

With the rise of artificial insemination came the unfortunate rise of several sperm banks and specialists who have made headlines for their unethical and illegal actions. One physician was using his own sperm to impregnate women who thought they were selecting a donor from a sperm bank, or being impregnated by sperm from their husbands. This physician not only lied to his patients, he also created the potential for possibly incestuous relationships among persons who were unknowingly half-siblings. This was a morally heinous act, and the physician lost his license and was imprisoned.

Another clear-cut ethical violation was committed by a practice specializing in *in vitro* fertilization. In this case, fertilized embryos were being implanted in the womb of a woman who was not the egg donor, without her knowledge. Several children were born to parents not their own. Once this became public knowledge it created untold emotional pain for the families involved. Not only for the “birth parents” who discovered that their child was not truly theirs, but for the “genetic parents” who had biological children in the care of total strangers. DNA testing can answer the biological question of who is biologically related to whom, but the emotional and legal quagmire this situation created will take years to clear up. Should the children be returned to their biological parents? Should the biological parents be forced to contribute to the support of these children? Again, those involved in perpetrating this horrible fraud were jailed.

In these two examples the ethical violations are easy to see, but this isn't always the situation. Other ethical and legal questions have arisen from *in vitro* fertilization:

☪ Who “owns” the fertilized embryo?

- ☪ If a fertilized embryo is not to be implanted, what should be done with it? Is it just medical waste to be disposed of?
- ☪ Should these embryos be kept viable in a frozen state until technology finds a way to successfully incubate them outside a human womb?

Consider a hypothetical situation:

Two couples come to the same specialist for *in vitro* fertilization. We'll call them couple A and B. The couple A mother is a blue-eyed blonde, the father a brown-eyed brunette. Their procedure is successful and several embryos are fertilized. Couple B has pretty much the same physical characteristics as couple A, but their procedure fails. Then couple A is killed in an auto accident, leaving their fertilized embryos in legal limbo. Instead of destroying the embryos, or putting them into the control of the couple's estate, the physician makes a decision to offer the fertilized embryos to couple B, telling them that they belonged to other parents who are now dead. The implant is successful, and nine months later the mother has a good outcome, delivering a healthy baby. Now this couple who had wanted so desperately to have a child has one, and the child has a loving, supportive family.

Is this legal? Probably not. At least not without going through perhaps years of legal wrangling. Therefore, the physician has made a decision to possibly violate a state statute, but it can be argued that laws were created to serve the best interests of humankind, humankind wasn't created to serve the law. Instead of destroying the potential for human life, the physician has enabled it to have the opportunity to be born. Is that morally wrong? Is that unethical?

These are questions to which there are no definitive answers. They require physicians and other healthcare providers to rely on their own personal ethics and moral standards in making decisions. That same requirement exists in another outgrowth of advancing technology determining who shall die.

Life and Death Decisions

At the end of the 19th century it was very easy to define death. When someone stopped breathing and the heart stopped beating death had occurred. At the end of the 20th century, it's not so simple. Technology has made it possible to keep a human being alive, at least in the technical sense, almost indefinitely. Therefore it was incumbent upon the medical field and society in general to come up with a new definition of death. In the United State the Uniform Declaration of Death Act was drafted in 1981 by and it basically established that for legal purposes, that when brain death occurs a person is dead. Unfortunately, defining when death occurs only addresses the tip of the iceberg. Far more complex quandaries lie below the surface.

Life Support Decisions

In common parlance, the decision of when to “pull the plug” on life support equipment has been the subject of much legal and ethical debate. Many hospitals now require that each patient being admitted for even minor surgical procedures must complete a living will. This document requires that the patient or the patient’s legal guardian make the choice before surgery of whether or not extraordinary measures will be taken to prolong life, and at what point these measures will be stopped. Legally this protects a physician, but again the line between what is legal and what is ethical blurs.

Does a man or woman 30 years of age entering the hospital for a minor surgical procedure really expect something to go wrong? Even if that person has given his informed consent, did he really understand what might happen? Perhaps not. As medical technology has advanced most patients expect miracles, not problems. Short of creating true terror by describing everything that could possibly go wrong - and pointing out the number of patients who do suffer harm because of medical mishaps - can a physician or other healthcare professional be sure that the patient really wants no extraordinary measures? Again, a tough question. Should the family routinely be consulted about life support decisions even if a living will has been signed? What if there is no family? What if the exact criterion for discontinuing life support is borderline? What if the person is very young and might be able to benefit from future technology?

In emergency situations the question of what to do is sometimes clearer and sometimes more confused. In many emergency rooms life support equipment is routinely used until a determination can be made whether or not a person can be saved. At that point it is up to the chief emergency room physician to make the call. The same is often true in intensive care situations - the physician in charge makes the decision. If continued efforts will prove futile, none are made. Although the term “futile,” which is defined as “meaningless, without any hope of a useful result,” is now discussed by the medical profession on a regular basis, it too is subject to interpretation.

Sometimes a patient’s request to stop life support will be at odds with the physical criteria, and with the physician’s point of view. For example, a patient who is mentally aware but must rely totally on life support and feeding tubes for her existence may request that life support be stopped, which will mean death. There are legal guidelines for dealing with this “right to die” issue, but what about the ethical question? Does the physician have the right to force another human being to live strapped to electronic devices? A human being who is totally dependent and for whom only the most innate human dignity is still possible?

A very famous life support legal case involved a father who wanted the feeding tube that was keeping his daughter alive removed. The young woman had been the victim of an automobile accident and although not brain dead, had no hope of recovery or return to even a semblance of independent life. This became a *cause celebre* for both right-to-die and right to life political forces. Pro-life proponents pointed out that the woman still made sounds, and still made movement. Right to die supporters countered with the fact that these were simply reflexes totally void of cognitive awareness. This case dragged on for years, and went all the way to the Supreme Court. In the end, the father was given custody of his daughter. Her feeding tube was removed and she died shortly thereafter.

Is suicide ever right?

“I have not asked to come into this world, and I don’t have a right to make the decision when I am to leave.” That is a very common opinion, and it has been prevalent throughout history among most cultures. But for some, the pain of living seems too great. Can a healthcare professional ever go against her vow to do no harm and help a patient to end her life? Another ethical maelstrom has presented itself in the guise of “assisted suicide.”

The Supreme Court has ruled that the Constitution does not guarantee a person the right to terminate his/her own life. Therefore if a state wants to pass laws legalizing assisted suicide, they will have to rely on something other than the United States Bill of Rights to defend that legislation. Even if assisted suicide is deemed legal, is it ethical? If suicide, which is self-murder, is declared legal, will broad use of euthanasia follow on its heels? These are the expressed concerns of many religious and ethical groups, as well as many members of the medical profession.

Further, if assisted suicide becomes legal, must a physician working in a public health facility assist in suicide even if it violates his or her own personal or religious ethics?

Perhaps the most emotionally charged field in which life support decisions must be made is that of neonatal intensive care. Thanks to technology, extremely premature infants can now be kept alive.

Babies weighing less than 2 ½ pounds who were given almost no chance of living in the not-too-distant past are now routinely surviving—even those with complex congenital problems.

The question here becomes not can the infant survive, but should the infant survive? Should a child who faces a futile future be kept alive just because we can do it? If a child is doomed to a life of severe mental retardation and multiple physical disabilities, is it ethically appropriate to keep him alive? Conversely, does the physician have the right to play god and decide what quality of life must be achievable in order for a life to be saved? Who really suffers when a severely retarded infant is saved, the child or the parents?

Some terms from the Death with Dignity National Center:

Advance Directive - a general term that describes two kinds of legal documents, *living wills* and *durable powers of attorney*. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

Aid-in-Dying - a physician's response to a request from a terminally ill, mentally competent adult for the means to hasten death at a time of the patient's own choosing. This usually takes the form of a prescription for lethal medication that the patient may obtain and self-administer. Advocates stress that aid-in-dying should occur only in the context of strict guidelines and safeguards to ensure that reversible causes of despair have been addressed, and that a request is rational, voluntary and enduring.

Comfort Care - an approach to care of the dying that emphasizes the relief of discomfort rather than cure of illness or prolongation of life. Physical, social and emotional needs are the first priority, even when treatment such as high dose pain medication may have the effect of hastening death. Also called *palliative care*. Considered legal and ethical in all jurisdictions.

Death with Dignity - A death that is consistent with an individual's personal values and sense of integrity. This may vary considerably between individuals and clinical circumstances. What is tolerable and meaningful for one individual may be unacceptable to another.

Do-Not-Resuscitate Order (DNR) - also called a "no code," a DNR is usually placed on a patient's medical chart to indicate there should be no attempt to restart a failed heartbeat or apply cardiopulmonary resuscitation (CPR) to restore normal breathing. A DNR order can be changed and experts say it should be reviewed regularly. In a DNR situation, a patient is still provided comfort care. Without such an order, emergency medical technicians are legally required to perform CPR.

And another ethical consideration rears its ugly head here - "At what financial cost?"

Shall she have an abortion or not?

One short way to define ethics is to call it the study of right and wrong. Ethics seeks answers to questions like "Is it OK to have an abortion?" "What is usually the right thing to do?"

"I would never have an abortion".....

The outward manifestations of Post Abortion Syndrome can include:

1. Self-destructive behavior, suicidal behavior, drug and alcohol abuse, eating disorders, domestic violence
2. Chronic problems with relationships, marriage and family breakdown, child neglect and abuse

Double Effect - a doctrine established by St. Thomas Aquinas in the 13th Century that an action having two effects: a good one that is intended, and a bad one that is foreseen. The action is acceptable if the

actor intends only the good effect. The doctrine is often applied to the use of high doses of morphine and to **terminal sedation**, in which the action is intended to relieve suffering but the predictable effect is to cause death. Sometimes called **indirect euthanasia**, this practice is considered ethical and legal.

Durable Power of Attorney -a document naming a person to make medical decisions in the event that the individual becomes unable to make those decisions himself or herself. Also called **healthcare proxy**.

Hospice - an organization offering comfort care for the dying when medical treatment is no longer expected to cure the disease or prolong life. The term may also apply to an insurance benefit that pays the costs of comfort care (usually at home) for patients with a prognosis of six months or less to live.

Life-Sustaining Treatment - any treatment that, if discontinued, would result in death. This includes technological interventions such as dialysis and ventilators, and also simple treatments such as feeding tubes and antibiotics.

Patient Self-Determination Act - a 1991 federal law requiring healthcare facilities that receive Medicare and Medicaid funds to inform patients of their right to execute **advance** directives concerning their end-of-life care.

Terminal Sedation - delirium cannot be controlled while keeping the patient conscious. Patients die after a number of days of - a coma-like state induced when symptoms such as pain, nausea, breathlessness or the secondary effects of sedation, such as dehydration or pneumonia.

Withholding or Withdrawing - to omit or cease **life sustaining treatment**, such as a ventilator, feeding tube, or medication that, if used, would prolong the patient's life. Sometimes done upon patient request, but also in accordance with an advance directive or because of judgments of medical futility.

Recognized as legal and ethical in every jurisdiction.

*Death with Dignity National Center
1818 N Street, NW Suite 450
Washington, DC 20036
Telephone: (202) 530-2900*

3. Mental health disorders, postnatal depression, depression, anxiety attacks, compulsive disorders and other mental health problems

Abortion is listed as one of the possible precipitating causes of post-traumatic stress disorder in the *Diagnostic and Statistic Manual of Mental Disorder*. Many women suffering abortion trauma are not consciously aware that the abortion is the root cause of their problems. Health professionals are not being trained to identify, treat or prevent Post Abortion Syndrome. Very few counselors or health professionals are prepared to deal with abortion trauma, and even fewer are skilled to do so. Most women seriously damaged by abortion have no access to the professional help they need.

Although studies vary widely, some worldwide studies reveal:

- The suicide rate after aborting is six times the rate after birth.

- A 2011 study published by the British Journal of Psychiatry says that women who had an abortion were 81% more likely to experience mental health problems, and were 155% more likely to commit suicide than the general population.
- The psychiatric admission rate is 53% higher for aborted women than for women who deliver and the rate is *more than twice* that of women in general.
- A computer record link of the whole Danish population (considered to be the best methodological study to date) showed that women who aborted and who were separated, divorced or widowed were nearly *four* times as likely to be admitted to a psychiatric hospital. Teenagers who abort were nearly *twice* as likely compared to those delivering.
- A 2018 study from the U.S. National Library of Medicine reports that a history of abortion is consistently associated with elevated rates of mental illness compared to women without a history of abortion;
- In 1994 a UK Parliamentary Commission of Inquiry into the effects of abortion on women found 87% of women surveyed experienced long-term emotional consequences with 15% actually requesting counseling.
- A recent study in America found that within three to five years after aborting, one in five women met the full diagnostic criteria for Post-Traumatic Stress Disorder.

• **“I had four abortions. What is the big deal?”**

Description of the Abortion Procedure:

A surgical abortion is usually given up to anywhere between 7 and 24 weeks of pregnancy. You are numbed by a shot that is given in your cervix, which dulls most of the pain, but not all. Then they dilate you with a metal instrument. A tube is inserted into your vagina and a vacuum sucks the tissues (fetus and placenta) from the uterus. There are other ways of removing the fetus. If you have been pregnant for 7 weeks or less, you may be given a medication to terminate the pregnancy. This sometimes doesn't work and is rarely used. This method takes anywhere from 3 days to 3-4 weeks. Another way is induce early labor. This is usually done after 22 weeks of pregnancy. This could take anywhere from a few minutes to several days.

After Care:

Right after the abortion, the woman is observed to see if her blood pressure, heart rate, and bleeding is normal. Before she goes home she may be given an antibiotic, and a 24-hour number to call if any problems occur. For the rest of that same day, it is required for her to keep active. This will reduce the chance of problems. For the next 2-4 weeks, she cant use douche, swim, take tub baths, use tampons, or have intercourse.

Abortion Post Exam:

Three weeks after the abortion, it is required that you have an exam with your abortion clinic or with your own healthcare provider. This exam will usually consist of a pregnancy test and cervical check. This is to make sure the abortion is complete and to discover and treat any problems that may have developed.

Risks:

Reaction to anesthesia, excessive bleeding, infection, puncture of the uterus (rare), emotional or psychological distress, increase chance of breast cancer

Cost:

The cost varies with different surgeons, clinics, how far along the pregnancy is, etc. In 2014 The National Abortion Federation found that the average price for an abortion (medical or surgical) performed between six and 10 weeks is \$350 at an abortion clinic and \$500 at a doctor's office. At 16 weeks, the average price rises to \$650 at clinics and \$700 at doctors' offices.

Teen Pregnancy and Abortion:

As of 2011, 750,000 teens become pregnant each year – the vast majority (82 percent) of these pregnancies unintended. A 2007 study showed 14.5 out of every 1000 obtained an abortion. In some states clinics require a legal guardian's permission to have an abortion. But in other states it is strictly confidential.

NOTE:

It is recommended that the woman makes the decision on her own and doesn't have any doubts at all. This is to avoid emotional distress after the abortion. Although it *is normal* for a woman to feel happiness, sadness, relief, anger, gratefulness, disappointment, confidence, fear, loneliness, and guilt. In most clinics counselors will talk to the woman about their decision and all their options that include termination of the pregnancy, to keep the baby, or adoption.

How much does the doctor tell you?

This question does not only deal with physicians, but also with nurses and other healthcare professionals. Generally it is a comfort for patients to know that they can learn what is wrong with them, and that they have control about the passing on of that information. But should the healthcare professional always tell the patient what is going on? And can she pass that information to others?

CHICAGO (Reuters) 12-22-1999-

U.S. physicians rarely fully inform their patients about the caregiving decisions affecting them, a survey of more than 1,000 doctor-patient discussions concluded on Tuesday.

Audiotapes of 1,057 patient visits involving 59 primary care physicians and 65 general and orthopedic surgeons revealed that only 9 percent of 3,552 medical decisions made met the researchers' criteria of complete informed consent.

The criteria for informed decision-making was defined by researchers at the University of Washington, Seattle, as making the patient aware of his or her role in the decision, the nature of the treatment, alternative treatments, the pros and cons of the alternatives, the patient's understanding of the decision, and the patient's preferences.

The physicians were found to be more likely to explain to patients the nature of the planned medical intervention but were unlikely to assess the level of patients' understanding. There are quality-of-care concerns, since there is mounting evidence that inadequate patient involvement may interfere with patient acceptance of treatment and adherence with medical regimens," the report's author, Clarence Braddock III, wrote in the *Journal of the American Medical Association*. This low level of informed decisionmaking suggests that physicians' typical practice is out of step with ethical ideals," he wrote. A shortage of time, especially for primary care physicians, is part of the problem.

Ethical principles tend to be established around four basic principles that have served humankind for generations. This is not to say that these principles are the only correct principles, but they are four that have been well accepted and form the basis of many codes of ethics across divergent cultures and organizations.

Respect for Persons

Respect for others relates to how the physician interacts with people. Demonstrating respect for persons depends on the following 4 factors:

1. Autonomy
2. Truth-telling
3. Confidentiality
4. Fidelity

Autonomy

Autonomy states that each patient should be able to determine his or her own affairs. However, the basic principle that underlies informed consent states that for patients to determine their own affairs they must not be coerced. Informed consent requires that patients be provided with a basic understanding of key issues and information necessary to govern their own medical decisions. Informed consent is necessary from the standpoint of medical ethics because ultimately only the patient can give consent to invade the patient's body.

This principle causes ethical dilemmas when family members, the health care team, or an insurance company attempt to make decisions that remain the ethical right of the patient. The issue is complicated by the fact that the patient, by directly or indirectly joining a health insurance plan, gives up certain rights and agrees to abide by the values of the insurance company.

Practice Activity

Consider the following scenario.

For three days, a patient in previous good health experiences low back pain without radicular pain following a day of water skiing. She has a friend who had a lumbar laminectomy for herniated disc, and the patient requests an MRI to rule out disc herniation. Your assessment is that there is little likelihood that surgery would remedy the situation, based on the absence of radicular symptoms. Describe the ethical dilemma.

Response: There is a conflict between the physician's respect for patient autonomy (which support the patient's right to make decisions regarding their own welfare) and the physician's respect for beneficence, the desire to do only those things beneficial for the patient. An MRI is likely to show no disc rupture, and thus will not influence the course of therapy. The issue is complicated by the fact that money not spent on this patient may be available to cover the cost of care for another patient.

Truth-telling

Truth telling states that the physician will tell the whole truth, not a half-truth or "white lie." The truth is required even when, in the physician's opinion, it would harm the patient's psychological well-being. A dilemma arises when the patient's desires run counter to truth telling. Consider the situation of the unusual patient who says, "I don't want to know any bad news.

Just figure out what is wrong, and treat me as best you can!" You want to respect the patient's request, but you also know that the patient has cancer and will need to make informed decisions about staging and treatments. You know that you cannot make the decisions for the patient because the decisions involve alternative approaches that depend on personal values and goals. You must balance the application of truth telling with the application of autonomy.

Trust—which is built on truth telling, beneficence, and nonmaleficence—has additional implications in the patient-physician relationship. Trust allows for mutual win-win problem solving. It allows a patient to place his or her welfare in the hands of the physician, but also convinces patients that their physician is not directly responsible for sub-optimal medical outcomes.

Practice Activity

Consider the following scenario:

You have been the primary care physician for Mary for many years. Recently, she sought your advice for tiredness. Mary's T4, T3RU, and TSH indicate normal thyroid function. She has a normal thyroid gland by palpation and scan. You advised that the thyroid was not a cause of her tiredness. Nonetheless, she sought advice from another physician who runs a weight loss clinic. He advised weekly tests of thyroid function, and thyroid supplementation. She asks your counsel. You should:

- Terminate the physician-patient relationship, noting that you cannot provide care for her if she is consulting another physician.
- Advise her to follow the recommendations of the other physician.
- Advise her that you see no reason for weekly tests or supplementation, but will continue as her PCP even if she chooses to take advice from another physician.
- Report the other physician to the state medical board for unethical practices.

Response: In this case, autonomy mandates that the patient is the ultimate decision-making authority. Even though you are her PCP, she has the right to seek advice from others. In a disagreement about appropriate treatment you should acknowledge the diversity of opinion in medical issues, but reiterate your position that she does not have a thyroid problem. You should also state that you support her right to obtain second opinions, and your willingness to continue as her advocate and PCP despite the difference of opinion. An ethical issue is involved if the other physician is intentionally giving false advice (as opposed to unintentionally giving bad advice).

Confidentiality

Confidentiality is the third element of Respect for Persons. Physicians are expected to keep confidential what they know about patients. The advent of health insurance, utilization management, and disease management threaten this element. Patients, by virtue of their contracts with insurance companies or their use of legal entitlements, have given up some of their rights in order to get benefits (usually by signing an insurance form).

These agreements allow all diagnoses and clinical information to be shared with insurers, the government, managed care organizations, and numerous others. However, each organization that receives information is expected to maintain the confidentiality so that none except those who need to know are provided with the information.

Practice Activity

Consider the following scenario:

Gary is a 13-year-old boy with abdominal pain, diarrhea, night blindness, and guaiac positive stools. You think the symptoms and signs are likely due to inflammatory bowel disease involving the terminal ileum. You submit to the health plan a request for preauthorized payment for the patient to have an upper GI endoscopy performed by an out-of-network gastroenterologist. The request is denied because the gastroenterologist is out-of-network. The employer has called stating their support of the patient's interest, and requests a periodic update. Your office manager asks whether it is ethical and legal to divulge patient-specific data to the health plan without the patient's written consent.

Response:

Patient-specific information can be divulged only with the patient's consent. When the patient signed for health insurance (either directly signing for it or indirectly choosing the insurance from a menu of plans offered by the employer), the patient likely agreed to the insurance company being given medical information for the purpose of utilization review or claims payment. The health plan has a legal right to the medical information. The patient's consent, however, is limited to the health plan. You do not have a legal right, despite good intentions, to divulge the information outside the health plan network of physicians. Specifically, you do not have the right to divulge information to the employer. Doing so will place you in medical-legal liability.

Fidelity

The fourth element of Respect for Persons is fidelity. Fidelity means keeping one's word. Physicians are expected to do what they say they will do with regards to treatment of the patient. Put another way, physicians need to keep their promises.

In summary the four parts of Respect for Persons are:

1. Autonomy
2. Truth telling
3. Confidentiality
4. Fidelity

Practice Activity:

A useful mnemonic to remember the 4 parts of Respect for Persons is: **ACT**
w/ **Fidelity** ---

A

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C

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T

ruth Telling

Fidelity

Beneficence

Beneficence is acting with charity and kindness. Medical care is intended to benefit the patient. This requires the physician to do all he/she can to aid the patient. Charity is love of one's fellow human being, an act of good will or showing a caring attitude. It is from this principle that many of the not-for-profit charitable health care organizations were formed. The mission of charitable institutions requires that charity care be given even when patients cannot afford to pay for the service. Providing free care in your office is beneficence. Other acts of beneficence include opening the office for a patient who arrives after hours, providing services or advice for a community organization, or providing special services that benefit the community.

Nonmaleficence

The third principle in ethics is nonmaleficence. This principle is similar to the Hippocratic Oath, "First, do no harm." Physicians are expected to undertake those actions that are beneficial to the patient and to avoid those that are harmful to the patient. Though few physicians would disagree with this principle, its complexity is illustrated by situations where the patient may experience pain or potential harm from a treatment. The more dangerous or threatening the treatment, the more nonmaleficence plays a role in decision-making.

Practice Activity:

Consider this scenario:

Besides his clinical practice, Dr Johns serves as director of the local blood bank, for which he receives a fair salary. Because the bank is recognized as an important community resource, Dr Johns has benefited from positive publicity, including a newspaper biography that describes his work for the blood bank as beneficent. Is it?

Response:

Beneficence is characterized by kindness and charity. Beneficence is more a state of mind, and demonstrated over time, rather than by a single act.

It does not have to involve money. Since he has a salaried position, it is difficult to straightforwardly declare Dr John's work for the bank as beneficent. On the other hand, if the work is in addition to his clinical work, it may cost him more of his most precious commodity: time. The salary may be incidental. If he has given of his time, especially if it affects his personal

life, then one could make an argument that his work is beneficent. If he later gives the salary to charity, then both the blood bank work and the cash gift demonstrate beneficence.

Justice

Webster defines justice, the fourth principle, as being righteous, impartial, and fair. Justice is applicable not only to the care of the individual patient, but also in the case of resource allocation decisions now required daily by Medicaid, Medicare, HMOs, insurers, and employers.

Equal treatment is also a concept that falls under justice. Justice requires that all patients with equal health insurance benefit or coverage (or who will pay their own bill) be offered equal treatment, regardless of the source or amount of payment. Justice does not require equal treatment if the patients have different benefits or will not pay their bill. Further, justice does not allow discrimination based on payment. If two patients have similar benefits, but you have contracted to accept different payments, the two patients have a right to equal treatment. Justice, in delivery of contracted health care, depends on the benefit, not on the payment methodology.

The physician is confronted daily with different payers who have various levels of coverage. This results in different expectations on the part of both payer and patient. From the insurer's perspective, as long as the patients under one insurance benefit plan receive equal care, justice has been served for their beneficiaries.

Furthermore, justice does not imply that services should be provided even if the patient is unable to pay the bill directly or via health insurance coverage. Providing services for free would be at the physician's discretion and expense, and would be an example of beneficence. In other words, justice also allows for fairness to the physician. If he/she treated every patient for free, then the clinical practice would probably fail financially. Not only would the physician be harmed, but also his/her services would no longer be available for community benefit.

Practice Activity

Consider this scenario:

Your medical clinic offers the only diabetes education resources within a 75-mile radius. The education service has been losing money since the new director you hired instituted guidelines to insure that all patients receive fair and equal treatment. You discover that the services are being provided to all patients regardless of their insurance coverage. Your director says she has an ethical responsibility to treat all patients equally, and that you have an ethical responsibility to accept the monetary loss incurred by provision of these services.

Response:

Justice requires that you offer necessary services to all patients who require them. Justice does not require that you deliver the services for free. The director will benefit from education about the ethical principle of justice.

Economic Considerations

In the best of all possible worlds financial cost would never be a consideration in medical treatment. But this is the real world, and economics is increasingly a factor with which all physicians and healthcare providers grapple on a daily basis.

What if a physician wants to order an MRI but the healthcare insurer doesn't think it's necessary. Does the physician tell the patient the healthcare insurer is wrong? Does she challenge the healthcare insurer on behalf of her patient? Does she simply order the test and to hell with the consequences? Someone has to pay for the test, and if not the insurer, who? Is a person to be denied healthcare simply because of economic factors?

Another ethical question that rises from economic factors is, "Should all steps be taken to prolong life even in an elderly person who will probably only survive a few months or years anyway?"

With the pressure on the medical field to cut costs, should we spend hundreds of thousands of dollars to save the life of a person 80 or 90 years old, instead of saving that money to spend on saving the life of people in their 20's or 30's?

The fastest growing segment of our population, statistically, is people over 100 years of age, and it has been estimated that as many as 50% of the baby boom generation will live to be 100, so these are questions that are not going to go away. Who decides how long a life is long enough? Do people lose their basic human rights simply because they live a long time? Again, who decides?

Ethics and Managed Care

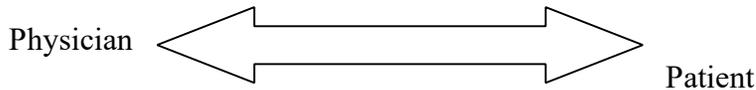
As the changes in technology have escalated, so have the costs of medical care. It has become fiscally impossible and irresponsible to continue to offer unlimited services upon demand. This state of affairs has given birth to many changes in medical care, including the emergence of "managed care."

Like any other new endeavor, managed care burst upon the scene with perhaps more speed than planning, and the growing pains have been taking a toll on the practice of medicine ever since,

including making it necessary to consider a very fundamental question, which is: Can current medical ethics that apply to individual cases even survive, or must they, like the practice of medicine, become group-based?

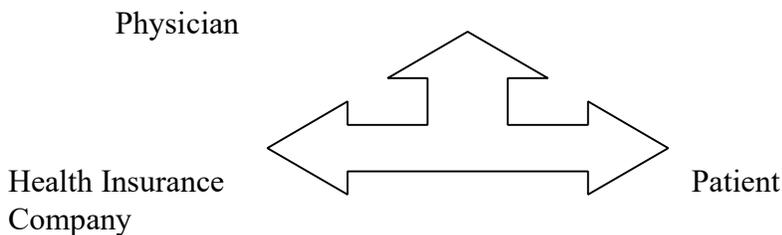
Consider the impact of the changes in the structure of Physician - Patient relationships that have evolved in the 20th century, especially as managed care has become the form of health insurance coverage for the majority of US patients.

One hundred years ago there was a one-to-one relationship in which ethical judgments had to be made.



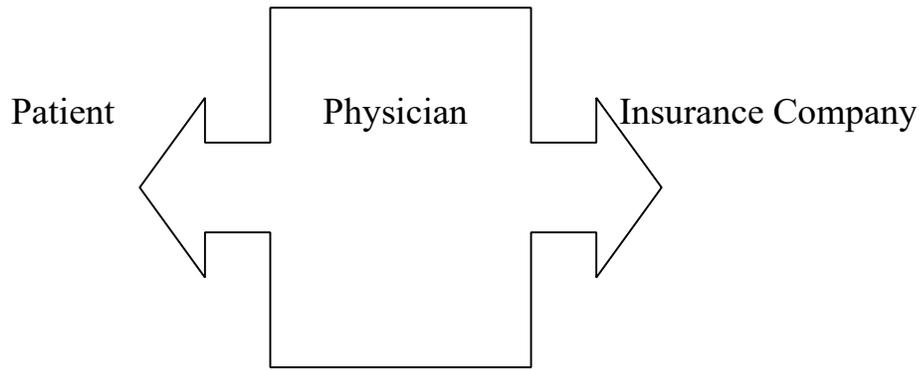
In most instances the patient sought out a physician, the physician treated the patient, and the patient paid the physician.

Early on in the 20th century this simple structure was complicated by the addition of another element resulting in a three-part relationship in which ethical judgments had to be made.



In most instances the patient had health insurance, the patient sought out a physician, the physician treated the patient, and the patient's health insurance company paid for all or part of the physician's services. There was no contract regarding care between the physician and the patient's health insurance company, and the physician's ethical choices continued, for the most part, to be steered by her one-on-one relationship with her patient.

With the advent of managed care, things have changed. The physician facing ethical questions has contracts with both her patient and with her patient's health insurance company. Where she was formerly her own boss regarding patient care decisions, now she has an employment or agency relationship with her patient's health insurance company.



And, as we have discussed, these contracts can create real ethical quagmires for the physician as she has to weigh fiscal as well as physical considerations in her treatment choices.

As physicians have become more vocal in their criticisms of managed care, the medical care world has been responding. Legislation, popularly dubbed “The Patient’s Bill of Rights” was introduced in Congress partly in order to “...protect consumers in managed care plans and other healthcare coverage.” Individual states have created laws to override some onerous managed care dictates. For instance, the state of New Jersey was among the first to pass a law that requires all healthcare insurers to allow women to stay in the hospital for 48 hours after the vaginal birth of a child, instead of the 24 hours that had become the norm.

Conclusion

Codes of ethics provide guidelines, but each human being must search inside to determine the ethical course of life, both professionally and personally. No one else can do that for you. The Dadaist poet Hugo Ball once said:

“Everywhere, the ethical predicament of our time imposes itself with an urgency that suggests that even the question ‘Have we anything to eat?’ will be answered not in material but in ethical terms.”

The medical field has not yet reached that plateau, but ethical decisions have become an integral part of the everyday practice of medicine.

In the end, the most difficult decisions come down to, “What do you as a human being believe is ethical?” and, “Are you willing to act on that?”

Ultimately, the answers to these questions can be guided by what the Hippocratic oath has urged for all these centuries - putting what is best for the patient first in all ethical considerations.

“The most sublime act is to set another before you.” *William*

Blake, Proverbs of Hell

APPENDIX A

THE AMERICAN MEDICAL ASSOCIATION CODE OF ETHICS

PREAMBLE:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self.

The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

APPENDIX B

AMERICAN OSTEOPATHIC ASSOCIATION CODE OF ETHICS

Section 1: The physician shall keep in confidence whatever he may learn about a patient in the discharge of professional duties. Information shall be divulged by the physician when required by law or when authorized by the patient.

Section 2: The physician shall give a candid account of the patient's condition to the patient or to those responsible for the patient's care.

Section 3: A physician-patient relationship must be founded on mutual trust, cooperation, and respect. The patient, therefore, must have complete freedom to choose his physician. The physician must have complete freedom to choose patients whom he will serve.

However, the physician should not refuse to accept patients because of the patient's race, creed, color, sex, national origin, or handicap. In emergencies, a physician should make his services available.

Section 4: A physician is never justified in abandoning a patient. The physician shall give due notice to a patient or to those responsible for the patient's care when he withdraws from the case so that another physician may be engaged.

Section 5: A physician shall practice in accordance with the body of systematized and scientific knowledge related to the healing arts. A physician shall maintain competence in such systematized and scientific knowledge through study and clinical applications.

Section 6: The osteopathic profession has an obligation to society to maintain its high standards and, therefore, to continuously regulate itself. A substantial part of such regulation is due to the efforts and influence of the recognized local, state, and national association representing the osteopathic profession. A physician should maintain membership in and actively support such associations and abide by their rules and regulations.

Section 7: Under the law a physician may advertise, but no physician shall advertise or solicit patients directly or indirectly through the use of matters or activities which are false or misleading.

Section 8: A physician shall not hold forth or indicate possession of any degree recognized as the basis for licensure to practice the healing arts unless he is actually licensed on the basis of that degree in the state in which he practices. A physician shall designate his osteopathic school of practice in all professional uses of his name. Indications of specialty practice, membership in professional societies, and related matters shall be governed by rules promulgated by the American Osteopathic Association.

Section 9: A physician shall obtain consultation whenever requested to do so by the patient. A physician should not hesitate to seek consultation whenever he himself believes it advisable.

Section 10: In any dispute between or among physicians involving ethical or organizational matters, the matter in controversy should first be referred to the appropriate arbitrating bodies of the profession.

Section 11: In any dispute between or among physicians regarding the diagnosis and treatment of a patient, the attending physician has the responsibility for final decisions, consistent with any applicable osteopathic hospital rules or regulations.

Section 12: Any fee charged by a physician shall compensate the physician for services actually rendered. There shall be no division of professional fees for referrals of patients.

Section 13: A physician shall respect the law. When necessary a physician shall attempt to help to formulate the law by all proper means in order to improve patient care and public health.

Section 14: In addition to adhering to the foregoing ethical standards, a physician should whenever possible participate in community activities and services.

APPENDIX C

1948 Oath of Geneva

Adopted by the General Assembly of the World Medical Association at Geneva in 1948 and amended by the 22nd World Medical Assembly at Sydney in 1968, the Declaration of Geneva was one of the first and most important actions of the Association. It is a declaration of physicians' dedication to the humanitarian goals of medicine, a declaration that was especially important in view of the medical crimes which had just been committed in Nazi Germany. The declaration of Geneva was intended to update the Oath of Hippocrates, which was no longer suited to modern conditions.

At the time of being admitted as a member of the medical profession:

- I solemnly pledge myself to consecrate my life to the service of humanity;
- I will give to my teachers the respect and gratitude which is their due;
- I will practice my profession with conscience and dignity;
- The health of my patient will be my first consideration;
- I will respect the secrets which are confided in me, even after the patient has died;
- I will maintain by all the means in my power, the honor and the noble traditions of the medical profession;
- My colleagues will be my brothers;
- I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;
- I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.
- I make these promises solemnly, freely and upon my honor.

AARC Code of Ethical Behavior for Respiratory Care Practitioner's

AARC Statement of Ethics and Professional Conduct

In the conduct of their professional activities the Respiratory Care Practitioner shall be bound by the following ethical principles. Respiratory Care Practitioners shall.

Actively maintain and continually improve their professional competence, and represent it accurately.

Perform only those procedures or functions in which they are individually competent and which are within the scope of accepted and responsible practice.

Respect and protect the legal and personal rights of patients they treat, including the right to informed consent and refusal of treatment.

Divulge no confidential information regarding any patient or family unless disclosure is required for responsible performance of duty, or required by law.

Provide care without discrimination on any basis, with respect for the rights and dignity of all individuals.

Promote disease prevention and wellness.

Refuse to participate in illegal or unethical acts, and shall refuse to conceal illegal, unethical or incompetent acts of others.

Follow sound scientific procedures and ethical principles in research.

Comply with state or federal laws which govern and relate to their practice.

Avoid any form of conduct that creates a conflict of interest, and shall follow the principles of ethical business behavior.

Promote the positive evolution of the profession, and health care in general, through improvement of the access, efficacy, and cost of patient care.

Refrain from indiscriminate and unnecessary use of resources, both economic and natural, in their practice.

Role Model Statement for Respiratory Care Practitioners

As health care professionals engaged in the performance of cardiopulmonary care, the practitioners of this profession must strive to maintain the highest personal and professional standards. A most important standard in the profession is for that practitioner to serve as a role model in matters concerning health.

In addition to upholding the code of ethics of this profession by continually striving to render the highest quality of patient care possible, the respiratory care practitioner shall serve as a leader and advocate of public respiratory health.

The respiratory care practitioner shall participate in activities leading to awareness of the causes and prevention of pulmonary disease and the problems associated with the cardiopulmonary system.

The respiratory care practitioner shall support the development and promotion of pulmonary disease awareness programs, to include smoking cessation programs, pulmonary function screenings, air pollution monitoring, allergy warnings, and other public education programs.

The respiratory care practitioner shall support research in all areas where efforts could promote improved health and could prevent disease.

The respiratory care practitioner shall provide leadership in determining health promotion and disease prevention activities for students, faculty, practitioners, patients, and the general public.

The respiratory care practitioner shall serve as a physical example of cardiopulmonary health by abstaining from tobacco use and shall make a special personal effort to eliminate smoking and the use of other tobacco products from the home and work environment.

The respiratory care practitioner shall strive to be a model for all members of the health care team by demonstrating responsibility and cooperating with other health care professionals to meet the health needs of the public

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Ethics Examination

Select the *best* answer to each of the following items. Mark your responses on the Answer form.

1. Healthcare Ethics is the study of moral issues that concern healthcare professionals in _____.

- a. medicine
- b. sociology
- c. theology
- d. all of the above

2. Medical ethics in particular trace its roots to the old Greek Hippocratic Oath, which required physicians above all to _____.

- a. “do what you learned”
- b. “obey all laws”
- c. “do no harm”
- d. none of the above

3. According to _____, ethics deals with the absolute good toward which all human activity should be directed.

- a. Hippocrates
- b. Plato
- c. Aristotle
- d. the AMA

4. The British philosopher _____ assumed a more cynical point of view with his definition of ethics:

“Ethics is in origin the art of recommending to others the sacrifices required for cooperation with oneself.”

- a. Lord Byron
- b. Immanuel Kant
- c. Bertrand Russell
- d. none of the above

5. _____ Dictionary offers the following definition of ethics: “What is generally called the ethics of the profession is but a consensus of expert opinion as to the necessity of professional standards.”

- a. Black’s Law
- b. Webster’s
- c. Taber’s Medical
- d. none of the above

6. The _____, on the other hand, is a strict set of laws governing how much a physician will earn for his efforts, and what will happen if he fails.

- a. AMA’s Code of Behavior
- b. Code of Hammurabi
- c. Hippocratic Oath
- d. none of the above

7. In 1803, Sir Thomas Percival, British physician, philosopher and writer, created a code of ethics that became the foundation for the first American document designed to govern the practice of medicine in the United States. It was published in 1847 by the _____, which held its first meeting specifically to establish a code of medical ethics

- a. American Surgeons' Society
- b. American Hospital Association
- c. American Medical Association
- d. none of the above

8. So, very often the answer to the question of whether or not there is a published standard of behavior is “_____.”

- a. yes
- b. no
- c. maybe
- d. none of the above

9. Surprisingly, one of the most controversial examples of implant surgery has to do with a small device that was first introduced in the 1970's -.

- a. the cochlear implant
- b. the breast implant
- c. the heart transplant
- d. none of the above

10. In 1968 the Uniform Anatomical Gift Act was passed which created the organ donor card, although even if a person signs the donor card the family must be consulted before organs are harvested. This act also prohibited the organ donor's _____ from participating in the organ removal or transplantation.

- a. surgeon
- b. attending physician
- c. family
- d. none of the above

11. Beginning on October 1, 1990 and completed in April 2003, the _____ gave us the ability, for the first time, to read nature's complete genetic blueprint for building a human being.

- a. Genetic Research Project
- b. Human DNA Universal Coding Project
- c. Human Genome Project

d. none of the above

12. One of the most publicized examples relating to genetic testing is _____, a hereditary disorder. It is possible to test an individual to determine whether or not they carry the gene for this disease, and whether or not they have the possibility of developing it themselves, or passing it along to their offspring.

- a. Parkinson's disease
- b. Huntington's disease
- c. Cervical cancer
- d. none of the above

13. In the United States this was accomplished in 1981 by passage of the Uniform Brain Death Act, which basically established that for legal purposes, _____.

- a. when brain death occurs a person is dead
- b. when the heart stops beating, a person is dead
- c. when a person stops breathing, a person is dead
- d. none of the above

14. In common parlance, the decision of when to "pull the plug" on life support equipment has been the subject of much legal and ethical debate. Many hospitals now require that each patient being admitted for even minor surgical procedures must _____.

- a. have signed waivers absolving the hospital and staff of blame for the results of surgery
- b. complete a living will
- c. have their spouse and/or primary family member sign a document indicating the patient is competent
- d. none of the above

15. The Supreme Court has ruled that the Constitution _____ to terminate his/her own life.

- a. does not guarantee a person the right
- b. allows persons
- c. strictly prohibits allowing a person
- d. none of the above

16. _____ is listed as one of the possible precipitating causes of post-traumatic stress disorder in the *Diagnostic and Statistic Manual of Mental Disorder*.

- a. Attempted suicide

- b. Abortion
- c. Medical malpractice
- d. none of the above

17. The third principle in ethics is _____. This principle is similar to the Hippocratic Oath, "First, do no harm." Physicians are expected to undertake those actions that are beneficial to the patient and to avoid those that are harmful to the patient.

- a. malpractice prevention
- b. nonmaleficence
- c. the good Samaritan principle
- d. none of the above

18. The fastest growing segment of our population, **statistically**, is _____.

- a. newborns
- b. people over 50 years of age
- c. people over 100 years of age
- d. none of the above

19. Codes of ethics provide _____, but each human being must search inside to determine the ethical course of life, both professionally and personally. No one else can do that for you.

- a. guidelines
- b. rules
- c. regulations
- d. none of the above

20. The 2001 revision of Principles of Medical Ethics added two new principles. One emphasizes that a physician, while caring for a patient, regard responsibility to the patient as paramount. The other asserts that physicians should support access to medical care for all people.

- a. True
- b. False

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