1.20 Ethics in healthcare

Introduction
Ethics is the study of morality. Morality is defined as the values used in human behaviour and decision making.

Medical ethics
Medical ethics is the branch of ethics that deals with moral issues in medical practice.

Anyone who is involved in patient care uses ethics, whether or not they have had formal teaching in medical ethics (most people have not).

Usually law and ethics are closely related, but there are some differences:
- Laws differ between countries, whereas ethics are applicable to all countries.
- Ethical obligations take priority over legal duties.
- When law conflicts with medical ethics, healthcare workers should advocate for changing the law.

There are four basic principles of ethics in healthcare which apply to most moral issues that arise in healthcare:

1. **Autonomy**: this means self-determination. If a patient is fully informed and competent (i.e. is able to understand the implications of having treatment or no treatment), they have the right to refuse or accept treatment. Such decisions must be respected, even if they are not thought by health workers to be in the patient’s best interests.

2. **Beneficence**: this means doing good and promoting well-being. This has to be considered for the individual patient, and may conflict with autonomy.

3. **Non-maleficence**: this means doing no harm. In healthcare, it is recognized that there is a risk of harm whenever investigations or treatment are carried out to benefit the patient. Maleficence refers to harm inflicted with no intended benefit to the patient.

4. **Justice**: this means equality before the law or fairness. It refers to the fair allocation of scarce resources to patients, and the justification for money spent in the health service. This may mean equal access to healthcare, maximum benefit of resources available, or allowing people choice in their healthcare. This decision may not be able to be taken by an individual. In a society where justice prevails, the aim is for all citizens to have equal access to healthcare.

Medical ethics in different countries
Different cultures and societies have different expectations about the relative values of the individual ethical principles. Some societies expect a beneficent or non-maleficient approach, whereas others expect an overriding respect for autonomy. It is essential that, as well as working within professional ethics, health workers respect the law in the countries where they practise, provided that the law does not harm the patient.

If a law or laws do harm patients or fail to protect them from harm, the healthcare workers should advocate for appropriate change in those law(s).

Some cultures put less weight on individualism, and involve the family and/or community in decision making.

Gender may also affect decision making. In some societies, decision making is the man’s responsibility and the woman has no autonomy.

In some countries, health workers will not be forced to do anything unethical, whereas in others, there may be pressure from the police or the army to participate in torture or reveal the names of patients and their injuries and so break confidentiality.

In 2001 in South Africa, the Treatment Action Campaign (TAC) launched legal action to demand more widespread access to nevirapine to reduce mother-to-child transmission of HIV/AIDS. The High Court issued an order to the government to make nevirapine available to pregnant women with HIV.

In the USA, the emphasis is on the individual’s autonomy, whereas in Africa the community may be more important, so the principles of beneficence and distributive justice may predominate.

Codes of ethics

The nursing and medical professions have their own international codes of ethics, adopted by the International Council of Nurses (ICN) and the World Medical Association (WMA), respectively.

There are more similarities than differences in medical ethics worldwide, and the World Medical Association has the role of setting standards in medical ethics that are applicable worldwide. The association was set up in 1947 to prevent a repetition of the unethical conduct of physicians in Nazi Germany and elsewhere. The WMA has developed an *International Code of Medical Ethics*, which was last revised in 2006.

The International Council of Nurses developed a code of ethics for the nursing profession in 1953, which was last revised in 2005.

**WMA International Code of Medical Ethics**

- This was adopted by the 3rd General Assembly of the World Medical Association, London, England, in October 1949.
- It was amended by the 22nd World Medical Assembly, Sydney, Australia, in August 1988.
- It was next amended by the 35th World Medical Assembly, Venice, Italy, in October 1983.
- It was most recently amended by the 57th World Medical Association General Assembly, Pilanesberg, South Africa, in October 2006.
Duties of physicians in general
A physician shall:
- always exercise their independent professional judgement and maintain the highest standards of professional conduct
- respect a competent patient’s right to accept or refuse treatment
- not allow their judgement to be influenced by personal profit or unfair discrimination
- be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity
- deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception
- not receive any financial benefits or other incentives solely for referring patients or prescribing specific products
- respect the rights and preferences of patients, colleagues, and other health professionals
- recognise their important role in educating the public, but use due caution in divulging discoveries or new techniques or treatment through non-professional channels
- certify only that which they have personally verified
- strive to use healthcare resources in the best way to benefit patients and their community
- seek appropriate care and attention if they suffer from mental or physical illness
- respect the local and national codes of ethics.

Duties of physicians to patients
A physician shall:
- always bear in mind the obligation to respect human life
- act in the patient’s best interest when providing medical care
- owe his or her patients complete loyalty and all the scientific resources available to him or her. Whenever an examination or treatment is beyond the physician’s capacity, he or she should consult with or refer to another physician who has the necessary ability
- ensure that he/she remains competent to provide medical care in his/her field by continual professional development
- submit him/herself to assessment of health, probity, knowledge and competence by peers when appropriate
- respect a patient’s right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality
- give emergency care as a humanitarian duty unless they are assured that others are willing and able to give such care
- in situations when they are acting for a third party, ensure that the patient has full knowledge of that situation
- not enter into a sexual relationship with their current patient, or into any other abusive or exploitative relationship.

Duties of physicians to colleagues
A physician shall:
- behave towards colleagues as he or she would have them behave towards him or her
- not undermine the patient–physician relationship of colleagues in order to attract patients
- when medically necessary, communicate with colleagues who are involved in the care of the same patient. This communication should respect patient confidentiality and be confined to necessary information.

The ICN Code of Ethics for Nurses
This code has four principal elements that outline the standards of ethical conduct.

Elements of the code
1 Nurses and people
- The nurse’s primary professional responsibility is to people requiring nursing care. In providing care, the nurse promotes an environment in which the human rights, values, customs, spiritual beliefs of the individual, family and community are respected.
- The nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment.
- The nurse holds in confidence personal information, and uses judgement in sharing this information.
- The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations.
- The nurse also shares responsibility to sustain and protect the natural environment from depletion, pollution, degradation and destruction.

2 Nurses and practice
- The nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning.
- The nurse maintains a standard of personal health such that the ability to provide care is not compromised.
- The nurse at all times maintains standards of personal conduct which reflect well on the profession and enhance public confidence.
- The nurse, in providing care, ensures that use of technology and scientific advances is compatible with the safety, dignity and rights of people.

3 Nurses and the profession
- The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education.
- The nurse is active in developing a core of research-based professional knowledge.
- The nurse, acting through the professional organisation, participates in creating and maintaining safe, equitable social and economic working conditions in nursing.

4 Nurses and co-workers
- The nurse sustains a cooperative relationship with co-workers in nursing and other fields.
- The nurse takes appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person.

Ethics in different situations, namely consent, confidentiality, end-of-life decisions and research, will be discussed below.
The ethics of consent

Informed consent is the process of a ‘competent’ patient receiving information needed to make a choice. It has five elements:

1. Disclosure of information: The patient has the right to the information necessary to make his or her decisions and to be informed of the consequences of his or her decisions.
2. Comprehension: The patient should understand the purpose of any test or treatment, the implications of the results, and the implications of not having the test or treatment.
3. Voluntariness (freedom from control by others): The patient has the right to self-determination, which includes making free decisions regarding himself or herself.
4. Competence: A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy.
5. Choice: Children may be able to consent to some procedures, but not to other more complex procedures.


‘A child who is capable of forming his/her view has the right to express those views freely on all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.’

The child’s competence and parental involvement: respect for autonomy

Where a child is not competent to give or withhold consent to treatment, a person with parental responsibility must act as an advocate for the child to authorise investigations or treatment which are in the child’s best interests. Parents have the right to be involved in the decision-making process, and this right is protected by law in most countries.

It is the doctor’s responsibility to assess a child’s capacity to decide whether he or she can consent to, or refuse, a proposed investigation or treatment before providing it. A competent child must be able to understand the nature, purpose and possible consequences of the proposed investigation or treatment, as well as the consequence of non-treatment. Competence is presumed at different ages in different countries. Children’s competence is related to experience as well as to age, and young children can often clearly demonstrate that they have the competence to make decisions about treatment. Such competence has a legal standing in some countries (such as the so-called ‘Gillick’ competence in English law).

Providing the information: an essential component of consent

In some societies, disease and pain are interpreted in terms of sin and retribution. This may make it difficult for health workers to explain diagnostic and management options in medical terms.

Information should include details of the possible diagnoses and prognosis, possible management options, the purpose of a proposed investigation or treatment, and the likely benefits and probabilities of success, and discussion about any serious or frequently occurring risks. Wherever possible the information should be given in a way that is clearly understood and remembered.

All this information may be overwhelming for patients and their families. The principles of beneficence and non-maleficence might suggest that a more paternalistic and less forthright doctor might be behaving more ethically. However, it is important that personal views about how much to disclose are not imposed on the patient when explaining an illness or treatment to them.

When providing information, it is essential that professionals do their utmost to find out about the patient’s (and family’s) needs and priorities. This is often the most difficult part of the communication process, and involves responding honestly to any questions the patient or family raise and, as far as possible, answering these as fully as possible. It is for the competent patient, not the doctor, to determine what is in the patient’s own best interests.

Finally, information for decision making should not be withheld from the patient and their family, unless it is judged that disclosure would cause the patient or family serious harm (the principle of non-maleficence). It may also be inappropriate to discuss treatments that are not available.

Emergency situations

If the patient is unconscious or otherwise unable to consent to, or decline, treatment and there is no one legally able to consent for them (this varies between countries, and may be the patient’s child, brother, sister, etc.), urgent investigation and treatment may be carried out. This is sometimes called presumed consent, where the healthcare worker does what they think is in the best interests of the patient.

The UK General Medical Council (1998) advice on consent for emergencies includes the following:

‘In an emergency, where consent cannot be obtained, you may provide medical treatment to anyone, provided the treatment is limited to what is immediately necessary to save life or avoid significant deterioration in the patient’s health.’

Summary of consent

- Practice within the limits of the law of the country (unless this is harmful to the patient).
- Assess the level of competence of the patient before deciding how much and how to tell them.
- The patient and their family can tell you how much information they need to make a decision.
- All decisions must be free from coercion.

Confidentiality

This is not an ethical principle, but it involves a respect for autonomy, beneficence towards the patient, and a desire to act with non-maleficence.

Confidentiality respects an individual’s autonomy and their right to control information relating to their own health. In keeping information confidential, the doctor is acting beneficently.

Most countries have laws to enable the breaking of confidentiality in some circumstances – for example, to protect the safety of a third person, or:

1. to prevent a serious crime, as information may need to be disclosed to the police
2. to report suspected child abuse
3. to report someone who is HIV positive who is unwilling
to inform their sexual partner(s) about this and does not consent to the healthcare worker telling the partner(s). The healthcare worker should inform the patient of his or her intention to inform the partner(s).

Information should only be disclosed without the patient’s consent by health workers to individuals who need to know, and the recipient(s) of such information should keep it confidential.

Patient rights (family rights in the case of young children)
These are as follows:
1. to participate in developing a plan of treatment
2. to receive an explanation of how components of treatment will be provided
3. only to have confidentiality broken under certain conditions (e.g. knowledge or suspicion of child abuse, intent of the patient to harm him- or herself or others, or the presence of a communicable disease that may harm others)
4. to receive clinically appropriate care and treatment
5. to be treated in a manner that is free from abuse, discrimination and/or exploitation
6. to be treated by staff who are sensitive to the family’s cultural background
7. to be given privacy.

End-of-life issues
These include the following:
- attempts to prolong the life of a dying patient
- euthanasia and medically assisted suicide
- care of terminally ill patients.

Attempts to prolong the life of a dying patient
Where there is no benefit to the patient these attempts are unethical. Futile treatments are those that are assessed as bound to fail and which are prolonging the dying phase. Withholding or withdrawing treatment is not the same as participating in assisted suicide or assisted euthanasia. This does not include palliative treatment, which must always be offered (see Section 1.16).

The patient may decide to discontinue treatment for a life-threatening illness while able to understand the information needed to make an informed choice, and prefer to die with dignity, being treated palliatively. Alternatively, they may wish to continue treatment even if they understand that it can provide little benefit. They must always be offered palliative treatment, whatever their choice.

Euthanasia and assisted suicide are illegal in most countries and prohibited in most medical codes of ethics, and the WMA states that assisted suicide is unethical.

Euthanasia
Euthanasia (also known as ‘assisted dying’) means intentionally performing an act that is intended to end another person’s life and:
- the patient has voluntarily asked for their life to be ended and is competent, informed and has an incurable illness
- the agent knows about the patient’s condition and their desire to die, and commits the act with the intention of ending life
- the act is undertaken with compassion and without personal gain.

Assisted suicide
This is knowingly and intentionally providing a person with the knowledge or means to commit suicide, including counselling about lethal doses of drugs, prescribing or supplying the drugs.

This does not mean that healthcare workers should abandon dying patients, but rather they should provide compassionate end-of-life care, including relief of pain and suffering (see Section 1.16).

This includes patients who have refused potentially life-saving treatment while competent to do so. For example, if a patient refuses potentially life-saving surgery for a ruptured ectopic pregnancy, they should still receive nursing and medical care and symptomatic relief of suffering.

Withholding or withdrawing medical care
If the patient is a child, the healthcare team and the parents must enter a partnership of care whose function is to serve the best interests of the child.
1. Although there is no significant ethical difference between withdrawing and withholding treatment, there are significant practical differences.
2. Optimal ethical decision making concerning patients requires open and timely communication between members of the healthcare team, the patient and the family.
3. Parents must decide on behalf of a child who is unable to express preferences, unless they are clearly acting against the child’s best interests. Cultural practices and religious beliefs may have an impact on this.
4. The wishes (anteceadent, if known) of a child who has sufficient understanding and experience should be given substantial consideration.
5. Resolution of disagreement should be by discussion, consultation and consensus.
6. The duty of care is not an absolute duty to preserve life by all means.
7. A shift from life-sustaining treatment to palliation represents a change in aims and objectives, and does not constitute a withdrawal of care.
8. Health workers should never withdraw treatments that alleviate pain or promote comfort.
9. There is a difference between treatment of the dying patient and euthanasia. When a dying patient is receiving palliative care, the underlying cause of death is the disease process. Treatments that may incidentally hasten death are justified, if their primary aim is to relieve suffering.

Hospital ethics committees
Despite the growth of medical ethics and the publication of many professional codes of practice in recent years, it is still difficult for individuals to obtain guidance in resolving specific ethical dilemmas they face. Some hospitals have set up a hospital ethics committee or clinical ethics forum to discuss these dilemmas.

The jurisdiction of the ethics committee includes clinical
situations involving all patients, including infants and children under 18 years of age.

**Function of hospital ethics committees**

1. **Education:** The committee should provide members of the hospital/medical staff with access to the language, concepts, principles and knowledge of ethics.

2. **Policy review and development:** The committee can assist the hospital and healthcare staff in the development of policies and guidelines regarding recurrent ethical issues and questions which arise in the care of individual patients.

3. **Case review:** The committee should be a forum for analysis of ethical questions that arise in the care of individual patients.

**Appointment and membership**

The committee is multidisciplinary, and should include doctors, nurses, midwives, social worker, pastoral care, hospital director and chief of medical staff. A 30% membership from the general community has been suggested to ensure breadth of perspective and clarity of output.

**Research ethics**

Each year £35–40 billion is spent on healthcare research worldwide, but only 10% of this is aimed at the health problems of 90% of the world's population.

Under-resourced countries need research to help to prevent and treat diseases such as tuberculosis and malaria, but lack funds and trained personnel, and therefore need expertise and financial support from public and private sectors in wealthy countries. This can lead to exploitation of the people in the country where research is needed and undertaken.

The principles that should be followed by anyone who is designing or conducting healthcare research in under-resourced countries are as follows:

- to alleviate suffering
- to show respect for people
- to be sensitive to cultural differences
- not to exploit those who are vulnerable
- the scientific and social importance of the research should outweigh the risks and burdens to the study subjects
- all research should have social as well as scientific value
- the populations involved in the research should benefit from the results
- staff working in the public sector where there are insufficient staff to provide proper care for patients (e.g. in most of sub-Saharan Africa) should not be taken from their work in order to undertake research.

It is important that there are national guidelines in every country which set priorities for healthcare research, and if external sponsors propose research outside these priorities, it must be justified to the appropriate research ethics committees.

There should be three levels of review for each research proposal:

1. relevance to healthcare priorities in the country
2. scientific validity
3. ethical acceptability.

There are a number of national and international guidelines and regulations with regard to research (e.g. WMA, Council for International Organizations of Medical Science in collaboration with WHO, European Council and European Parliament), but these are often inappropriate for under-resourced countries.

**Consent to research**

For this to be valid, it should be given freely after full disclosure of all relevant information in a manner understandable by the research subject. Consent for the research may be withdrawn by the subject at any time without there being any adverse effects on the subject. However, in some communities it is usual for male members of the family or a community to make decisions on behalf of women and children.

**Level of care**

The level of care provided to the control group (i.e. the group that is not having the active potential treatment) is controversial. Some argue that, if the research is externally sponsored, the people in the control group should receive the same standard of care as would be received in the sponsor's country. Others argue that this prevents some research from being conducted. For example, if two treatments are being compared in the under-resourced country, it is more appropriate for the new treatment to be compared with the one currently available in that country, not one that is inaccessible there.

**Post-research considerations**

If an intervention is effective, should it be made available to the research participants and the community? The country concerned may not be able to afford this, particularly if it is a new and expensive drug, but a decision should be made with the national government via its research ethics committee about what will happen after the trial period is over.

**Healthcare worker relationships**

As well as having an ethical duty towards patients, healthcare workers have an ethical duty towards other healthcare workers, to the healthcare system and to society.

**The health worker–patient relationship**

1. The healthcare worker’s primary role is to be an advocate for each patient’s care and well-being. They should always place the interests of their patients first. The healthcare worker also has a duty to accept responsibility for his or her clinical decisions.

2. The healthcare worker must treat each patient with honesty, compassion, dignity and respect. They should not exclude or discriminate against any patient because of ethnic origin, race, sex, creed, age, socio-economic status, diagnosis, physical or mental disability, or sexual orientation.

3. The healthcare worker’s commitment to patients includes health education and continuity of care by good communication with subsequent health workers.

**The healthcare worker–healthcare worker relationship**

Traditionally, healthcare workers have been part of a hierarchical system, both within and between professions.
Doctors have been at the top of the caregiving hierarchy, above nurses and other healthcare workers. This situation is gradually changing, with other healthcare professionals increasingly questioning the reasoning behind a doctor’s decision.

1. Healthcare workers have a responsibility to maintain moral integrity, intellectual honesty and clinical competence. They should be aware of the limitations of their expertise and seek consultation or assistance in clinical situations in which they are not expert.

2. Healthcare workers should work as a team, supporting each other and working together for the benefit of the patient.

3. Healthcare workers have an obligation to educate and share information with colleagues, including trainee healthcare workers. They should be committed to lifelong learning and continuously improve their knowledge and clinical skills relevant to their practice.

4. There is an ethical obligation to report impairment or misconduct of colleagues in order to prevent potential harm to patients.

The relationship between the healthcare worker and the system of care

1. The healthcare worker’s duty of patient advocacy should not be altered by the system of healthcare delivery in which they practise.

2. If there are conflicts of interest, the patient’s interests should take priority over those of others.

3. Healthcare professionals should campaign against unethical practices.

4. Healthcare professionals should not be influenced by commercial enterprises (e.g. companies that manufacture drugs, diagnostic tools or equipment). The duty of the physician is to evaluate objectively what is best for the patient. Gifts designed to influence clinical practice are not acceptable.

5. Healthcare professionals should advocate to their departments of health for improved medical facilities and treatments for patients where acceptable basic facilities and treatments are lacking (e.g. oxygen, effective pain relief, blood transfusion services, access to vital skills such as surgery, basic life-saving drugs).

In many countries, there are huge divisions between the rich minority and the poor, exploited and disadvantaged majority. Healthcare professionals should be aware of this and acknowledge how their actions support such divisions, and aim to provide high standards of care independent of a patient’s or family’s ability to pay.

The relationship of the healthcare worker to society

Healthcare workers have a responsibility to society as well as to patients, and sometimes society’s best interests may take precedence over those of the patient (e.g. mandatory reporting of patients with a designated disease, those who are unfit to drive and those suspected of child abuse).

In other circumstances there may be requests from the police or the military to take part in practices that violate human rights (e.g. torture). Healthcare workers should report unjustified interference in the care of their patients, especially if fundamental human rights are being denied. If the authorities are unhelpful, contact with a national medical or nursing association, the WMA or World Nursing Federation, or a human rights organisation may be needed.

The increasing mobility of society means that healthcare workers have a responsibility for global health, including preventing the spread of infectious diseases between societies and countries.

Another effect of globalisation is the mobility of healthcare professionals, and their migration from low-income to high-income countries. The shortage of healthcare workers is one of the biggest health problems facing low-income countries today.

The governments of low-income countries invest in the education and training of healthcare professionals, and therefore lose these resources and the contribution of these workers when graduates migrate. The factors considered by the migrant may be economic, social and/or family related. Often in low-income countries there are low wages, poor working conditions, lack of leadership and very few incentives, as well as limited opportunities for their children. High-income governments encourage migration when there is a need, often with no compensation for the government where the migrant was trained.

This presents an ethical dilemma whereby if emigration was prevented it would restrict the autonomy of the individual, but on the other hand the health of a society suffers if there is mass migration of healthcare professionals.

Further reading


Medical Foundation for the Care of Victims of Torture www.freedomfromtorture.org (accessed 9 December 2012).


Nuffield Foundation. The Ethics of Clinical Research in Developing Countries. http://nuffieldbioethics.org/project/research-developing-countries-follow/
