Patient

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Medical ethics

Introduction

Ethics involves the application of a moral code to the practice of medicine.

Ideals and the Hippocratic Oath have been covered in a separate article but it is worth repeating the summary of the Oath here:

- 'A solemn promise:
  - Of solidarity with teachers and other physicians.
  - Of beneficence (to do good or avoid evil) and non-maleficence (from the Latin 'primum non nocere', or 'do no harm') towards patients.
  - Not to assist suicide or abortion.
  - To leave surgery to surgeons.
  - Not to harm, especially not to seduce patients.
  - To maintain confidentiality and never to gossip.'

It is no longer enough simply to treat the patient as you would wish to be treated yourself. Follow such a tenet blindly and you could well find yourself on the wrong side of the law. Medical and social ethics have advanced to an extent that doctors are likely to be faced with controversial issues on a regular basis. Euthanasia, information sharing and the use of human tissues are typical examples. Every clinician must keep up-to-date on current legislation and ensure that they are practising within the law and within the guidelines laid down by their professional body. In the UK, the principles enshrined in *Good Medical Practice* - the handbook of the General Medical Council (GMC) - are a good place to start[1] .

Much has been written about medical ethics and it would be impossible to cover everything here. This is an attempt to cover some of the aspects that are more pertinent to general practice.

Principles of biomedical ethics[2]

Biomedical ethics is a huge subject in its own right. It is based on four key principles first propounded in 1979 by Beauchamp and Childress in their book *Principles of Biomedical Ethics.*

1. Respect for autonomy
2. Nonmaleficence
3. Beneficence
4. Justice

Respect for autonomy
Health professionals should enquire about their patient's wishes to receive information and to make decisions. It must never be assumed that because a patient is part of a particular culture or community, they affirm that community's values and beliefs. Respect for autonomy is not a mere ideal in healthcare - it is a professional obligation.

Nonmaleficence
The principle of nonmaleficence obligates us to abstain from causing harm to others.The principles of nonmaleficence support several moral rules, with examples here including:

- Do not kill.
- Do not cause pain or suffering.
- Do not incapacitate.
- Do not deprive others of the goods of life.

The obligations of nonmaleficence include not only obligations not to inflict harm, but also not to impose *risks* of harm. It must be remembered that the principle of nonmaleficence and its specifications in moral rules are prima facie and not absolute.

Beneficence
From an ethical viewpoint, morality requires that we not only treat patients autonomously and refrain from harming them, but that we also contribute to their welfare. These beneficial actions fall under the heading 'beneficence'. The principles of beneficence potentially require more than those of nonmaleficence, because doctors must take positive steps to help people and not merely refrain from harm. Patient welfare embodies medicine's goal, justification and rationale - examples here include public health, preventative medicine and biomedical research.

Justice
No single moral principle is capable of addressing all problems of justice and no single theory of justice or system of distributing healthcare is sufficient for constructive reflection on health policy. Countries that lack a comprehensive and coherent healthcare system typically have larger numbers of unprotected citizens and therefore need to improve both utility (efficiency) and justice (fairness and equality). This is further complicated by the fact that the construction of a unified theory of justice that captures our diverse conceptions and use of principles of justice in biomedical ethics remains controversial and hard to pin down.

Biomedical ethics and evidence-based medicine [2]

Evidence-based medicine (EBM) - the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients - can sometimes be challenged by one or more of the principles of biomedical ethics. Under the auspices of the latter, clinicians are encouraged to take on board the values and preferences of patients and arrive at a shared decision. This decision may contradict guideline recommendations. Fortunately, in many healthcare systems, the ethical framework is flexible enough to encompass this. Indeed, in the UK, care of the patient as an individual is a paramount principle (see below).

Care of the patient as an individual

Treating the patient as an individual is an important principle. Dignity and respect for the patient are considered by the GMC to be of great importance and a whole section is devoted to it in its handbook. Providing care that meets the needs of individuals is not always easy when faced with demands to make efficient use of resources. Furthermore, one must consider the interests of the public at large and practise within legal boundaries. However, it is important to tailor care to the needs of the individual patient. Even that great promulgator of guidelines, the National Institute for Health and Care Excellence (NICE), prefaces its guidance to the effect that treatment and care should take into account patients' individual needs and preferences.

Caring for patients as individuals also means leaving one's prejudice at the surgery door. Patients should be provided with the best possible care irrespective of age, sexuality, ethnicity, religious beliefs or politics. This is particularly true of lifestyle issues. Whatever the clinician's view of smoking, obesity and drug dependency, it is his or her ethical duty to be supportive, not judgemental.

Confidentiality

The notion of confidentiality is enshrined in the Hippocratic Oath but it is not inviolable[3] . The recommendations regulating the sharing of patient-identifiable information between NHS organisations and with non-NHS organisations was set out in the Caldicott Report. After public consultation, eight principles were published by the National Data Guardian in 2020[4] .

The legislation governing the processing of personal information is contained in the Data Protection Act. See the separate article Data Security and Caldicott Guardianship for more information.

Breach of confidentiality is not to be taken lightly and it may have serious consequences for the doctor/patient relationship and the doctor's reputation. However, there are occasions when one's obligations to the safety of others and the greater public good must override one's duty of confidentiality to the patient, such as the disclosure of a serious crime.

Fortunately, comprehensive GMC guidance is available on their website to cover many eventualities[5] . These include:

- Reporting concerns about patients to the DVLA (England, Wales and Scotland) or the DVA (Northern Ireland).
- Disclosing records for financial and administrative purposes.
- Reporting gunshot and knife wounds.
- Disclosing information about serious communicable diseases.
- Disclosing information for insurance, employment and similar purposes.
- Disclosing information for education and training purposes.
- Responding to criticism in the press.

Following GMC guidance does not absolve clinicians from using their own clinical judgement in individual circumstances. When in doubt, one's medical defence organisation can be most helpful.

Other examples of circumstances in which the safety of a third party may override patient confidentiality are in the arenas of:

- Child protection[6]
- Drug dependence[7]

When talking with relatives, the default position is to obtain the patient's express consent. This may be verbal but, even so, such consent should be recorded in the patient's notes. If relatives wish to raise concerns with clinicians, the GMC advises that no guarantee should be given that such a discussion will not be reported to the patient.

Where a patient does not have the mental ability to make an informed decision about whether information should be disclosed (ie 'lacks capacity'), the GMC recommends that the clinician should:

- Make that patient's interests their first concern.
- Protect their privacy and dignity.
- Encourage them to become involved in such a decision as far as their abilities will allow.

To facilitate an assessment of the patient's best interests, a clinician may need to share information with the family, friends or carers or anyone authorised to represent the patient, but this does not mean allowing free access to all information. Further guidance on mental capacity can be found in the separate Mental Capacity Act article.

Informed consent

It is not enough simply to obtain consent; that consent must be informed[8] . This raises questions about how much information should be provided and how this can best be presented in a way that the patient understands. Informed consent applies to all medical interventions, including prescribing, and not just to procedures or operations. The case of *Montgomery v Lanarkshire Health Board* (2015) raised the issue of patient autonomy and required doctors to pay due regard to individual patient priorities and tailor information to their needs[9] . However, a balance needs to be struck. If a list of every possible complication were to be recited it is unlikely that anyone would ever take any drug or submit to any procedure.

An assessment needs to be made as to whether a person under the age of 16 has the capacity to make an informed decision about their care. The courts have defined this as 'sufficient understanding and maturity to enable them to understand fully what is proposed'. This is known as Gillick competency. The issue of Gillick competency normally arises when the question of contraception in an underage girl is considered but may be relevant in any patient under 16 who requires care. More details can be found in the separate article Consent to Treatment in Children (Mental Capacity and Mental Health Legislation).

Primum non nocere

The concept of 'first do no harm' has been enshrined in medical ethics for centuries but one must bear in mind that there is no intervention that does not have some slight risk. Thus, although doing no harm should be one's first consideration, it must not prevent the clinician from avoiding all treatments which have some risk attached. Therapeutic nihilism is as unethical as negligent practice. When providing care, consider the risks and benefits and, where significant, discuss these with the patient and record the discussion in the notes.

The matter of risks and benefits must be judged on what was known at the time. The retrospective observation of an adverse incident does not necessarily mean that the decision was wrong.

Avoidance of pitfalls

- Ethics is about thinking. Do not be afraid to think.
- There may well be more than one correct answer. Do not be afraid to discuss ethical issues or to seek advice.
- Record ethical considerations just as you would clinical matters.
- Keep the welfare of your patient to the fore. Talk and communicate.
- Patients have the right to make bad decisions. They are permitted to follow adverse lifestyles and a sane person may refuse effective, even life-saving treatment.
- Treat the Mental Health Act with respect. You are being asked to deprive a person who has not committed a crime of his or her liberty.
- Be broad-minded. Not everyone shares your views and values and they have a right to differ.
- You may not have the right to prevent a patient from acting in a way that you consider to be inappropriate but that does not mean that you condone it. You have a right to express your views but not to enforce them.
- Be prepared to justify your position.
- The GMC advises that, if you are concerned about a colleague's conduct, performance or health, the safety of patients must be your first priority. You should submit an honest appraisal of your concerns, to an appropriate person from your contracting or employing authority. If this fails to resolve the issue or there is no local system, you should contact the relevant regulatory body (the GMC, in the case of GPs). You may want to discuss your concerns with an uninvolved colleague, a professional organisation or your defence body before taking this step.

Further reading

- Medical Ethics Committee; British Medical Association
- Kallistratos GI, Fasske EE, Karkabounas S, et al; Prolongation of the survival time of tumor bearing Wistar rats through a simultaneous oral administration of vitamins C + E and selenium with glutathione. Prog Clin Biol Res. 1988;259:377-89.

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4. The Eight Caldicott Principles; National Data Guardian, 2020
5. Good Medical Practice - Explanatory Guidance; General Medical Council
6. Child maltreatment - recognition and management; NICE CKS, January 2019 (UK access only)
7. Guidelines for drug and alcohol treatment providers on sharing client's information with the National Drug and alcohol Treatment Monitoring System (NDTMS); Public Health England, 2013 - updated 2018
8. Consent guidance; General Medical Council
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